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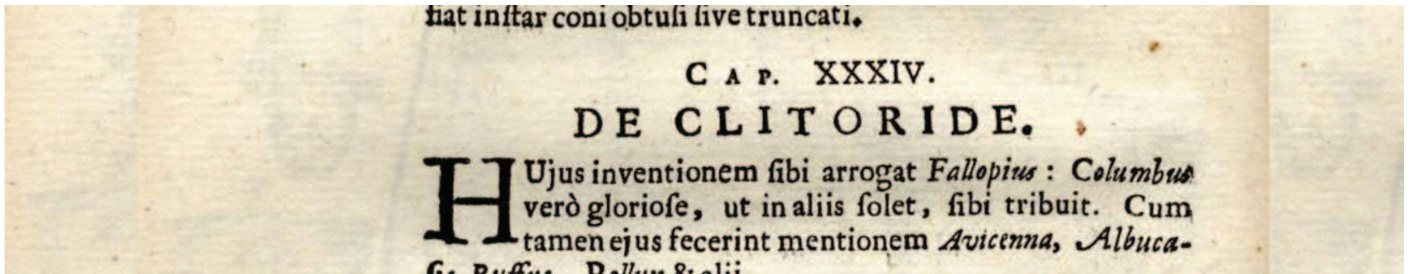

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CAP. XXXIV.

DE CLITORIDE.

Hujus inventionem ſibi arrogat *Fallopius* : *Columbus* verò glorioſe, ut in aliis ſolet, ſibi tribuit. Cum tamen ejus fecerint mentionem *Avicenna*, *Albuca-*

Special Issue: On Cliteridectomy

Guest edited by Dr. Norbert Finzsch, Dr. Marion Hulverscheidt, Dr. Janne Mende, Madita Oeming, Bodil Folke Frederiksen

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About

Gender forum is an online, peer reviewed academic journal dedicated to the discussion of gender issues. As an electronic journal, *gender forum* offers a free-of-charge platform for the discussion of gender-related topics in the fields of literary and cultural production, media and the arts as well as politics, the natural sciences, medicine, the law, religion and philosophy. Inaugurated by Prof. Dr. Beate Neumeier in 2002, the quarterly issues of the journal have focused on a multitude of questions from different theoretical perspectives of feminist criticism, queer theory, and masculinity studies. gender forum also includes reviews and occasionally interviews, fictional pieces and poetry with a gender studies angle.

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Cliteridectomy

Norbert Finzsch and Marion Hulverscheidt

> "For the clitoris is conceived as a little penis pleasant to masturbate so long as castration anxiety does not exist (for the boy child), and the vagina is valued for the 'lodging' it offers the male organ when the forbidden hand has to find a replacement for pleasure-giving."
> (Irigaray 23)

What is Cliteridectomy?

1 Cliteridectomy denotes the partial or complete amputation of the clitoris. It is one of three variants of Female Genital Mutilation. Female genital mutilation (FGM), also known as female genital cutting and female circumcision, is the ritual removal of some or all of the external female genitalia. The practice is found today in Africa, Asia, and the Middle East, and elsewhere within immigrant communities from countries in which FGM is prevalent. UNICEF estimated in 2016 that 200 million women living today in 30 states had undergone the procedures (UNICEF). The applied procedures differ according to the country or ethnic group. They include removal of the clitoral hood and clitoral glans; removal of the inner labia; and removal of the inner and outer labia and closure of the vulva, called infibulation. Here and in this special issue, we will primarily address cliteridectomy, i.e., the removal of the clitoral hood and clitoral glans. We shall not deal with the removal of the inner and outer labia or with infibulation since both procedures were rare in the West. By "West", we refer to an imagined culture that is "absolutely different" from the "Orient," that Edward Said described in *Orientalism* (Said). The "West" therefore necessarily is a form of essentialism since it reduces complex entities (Carrier 3). The "West" is a simplification that we conscientiously use as a "strategic essentialism" or "mimesis" (Abraham, Gaard, Irigaray 76) since in the literature on FGM the discussions revolve primarily around the alleged 'non-Western' practice of female genital cutting. The 'pre-history' of cliteridectomy in the West, however, shows that a clear distinction between the Occident and the Orient is impossible since systems of knowledge about the body were free-floating between these abstractions. 'Western' doctors had learned from Arabic sources what they supposedly knew about female bodies. Arabic sources, in turn, went back to Greek antiquity.

Why Do We Research Cliteridectomy?

2 The topic may seem an unlikely one for historians or scholars of cultural studies, however not so much for historians of medicine. It is our conviction that history and society

are connected with corporeal practices and discourses on the body. Norbert Finzsch stumbled across the topic in 2009 when he wrote an essay on the history of homosexuality in the French Third Republic (Finzsch). For this publication, he used many medical and, to a lesser extent, legal texts because homosexuality in France had been legalized in 1792 and was never put back on the list of crimes and misdemeanors, not even in Vichy France. Its open practice, however, was maligned and persecuted not as a crime, but as a violation of the commandments of decency and decorum. Germany's victory in the Franco-Prussian War of 1870 brought about a new discursive urgency since it was assumed that France had lost the war as a result of a lack of manliness and consequently declining birth rates. Homosexuality came under renewed scrutiny, and many of the medical journals and handbooks accentuated the alleged fact that homosexuals had different sexual organs than heterosexual men and women. Over and over it was said that the penis of homosexual man differed in shape and size from that of the heterosexual and that the clitoris of the tribade or lesbian was larger and more erectile than that of the 'decent' heterosexual woman. This observation led French medical doctors to propose the surgical removal of the clitoris. At the time Finzsch dismissed his 'discovery' as a canard, but upon closer inspection, it turned out that the removal of the clitoris had also been practiced in Germany (Hulverscheidt). The more Finzsch read about the problem at hand the more it turned out to be a standard European procedure, connected deeply to the discussion of female bodies, female sexualities and their control by male doctors. A lot of the debates on FGM revolve around topics like the alleged tendency of Islam to support this gruesome and damaging practice and on the question of cultural relativism versus cultural universalism. The question has been asked if one should tolerate this monstrous custom because it is part of a different culture and it is not the place of white, western activists to demand the abolition of FGM. There is to this day no definitive answer to this question. As Janne Mende shows in her contribution, both positions can and should be reconciled to some extent. Context is paramount for an understanding and eventual abolition of FGM. In the European context, cliteridectomy was applied mainly for two reasons, both of which have to do with the control of female sexuality: The women most affected by FGM in early modern history were so-called tribades (women desiring women or women having sex with women). At the turn of the 19th century, the focus shifted to women who practiced masturbation or were labeled as nymphomaniacs. Sometimes aesthetical reasons were given for genital cuttings, but these ideas always showed up in conjunction with the attack on tribades or masturbators. The justifications offered in the European context thus differ significantly from the rationalizations for FGM in the Trikont. In a sense, we try to provincialize Western

Europe (Chakrabarty), perceive the history of FGM as part of a post-colonial project which de-centers Europe and looks at it with the keen eyes of cultural anthropologists. Provincializing the West in this context means the "double movement of questioning traditional, national paradigms by reconstructing [their] historical development in an entangled modernity on the one hand and of rewriting [Western] history from the margins on the other" (Lehmkuhl, Bischoff, and Finzsch 11). We do so not only as an expression of historical equity but also because we hope that our contributions will help to acknowledge that cliteridectomy was as much a European practice in the past as it continues to be centered in non-Western countries in the present.

The Pre-History of FGM in the West

3 The history of female genital mutilations (FGM) is long and convoluted. One of the first European texts to mention the excision of the clitoris is Strabo (63-23 BC) in his Geographika (Strabo VIII 152).[1] He refers to an alleged practice among the "Egyptians." What used to be a custom in far-away parts of the globe turned quickly into a necessary operation against "immodica landica," the "hypertrophied clitoris."[2] Soranos of Ephesus, a doctor of the second century, wrote a Gynaikeia, a text that is lost in its Greek version. However, the existing Greek index of the Gynaikeia lists a chapter entitled "Concerning an Immensely Great Clitoris and Cliterodectomy" (Brooten 163; Hanson 333).

Caelius Aurelianus, a doctor from Sicca Veneria in North Africa, paraphrasing Soranos, wrote in the fifth century:

> Certain clitorides are of such a frightening size and fill women with confusion because of the ugliness of their intimate parts; a lot of authors claim that these women have erections and feel a desire similar to that of men and manage to engage in a sexual act only under duress. If it comes to that, the woman is to be placed lying on her back and with the thighs closed, lest the viscera of the feminine cavity become distended. Then one has to grasp the superfluous organ with a little forceps and to cut it with a scalpel that which appears to be larger […]. (Brooten 164, transl. by Finzsch)

This operation supposedly was not only necessary for alleged aesthetical reasons, but because of the sexual desire connected to a large clitoris (Brooten, 163-164). The few quotes from ancient texts may suffice to underscore that we deal with an ancient practice.

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[1] "Καὶ τοῦτο δὲ τῶν μάλιστα ζηλουμένων παρ´ αὐτοῖς τὸ πάντα τρέφειν τὰ γεννώμενα παιδία καὶ τὸ περιτέμνειν καὶ τὰ θήλεα ἐκτέμνειν, […]"(Strabo, The Geography of Strabo VIII 152)

[2] "De immodica landica - Quibusdam landicis horrida comitatur magnitudo et feminas partium feditate confundit et, ut plerique memorant, adfecte tentigine virorum similem appetentiam sumunt et in venerem coacte veniunt. Supina denique mulier locanda est conductis femoribus, ne febre [fibrae] feminini sinus distantiam sumant. Tunc [in] midio est tenenda superflua atque pro modo alienitatis sue scalpello precidenda si enim plurimum extenditur porrecta longitudine sequetur […]" (transl.by Finzsch).

5 As social historians, historians of medicine, anthropologists, and political scientists, however, contributing to this special issue, we are not that much concerned with the genealogy or the pre-history of FGM but with FGM in the 'modern' West. Whereas there was something like 'medieval misogyny,' it is debatable whether this was a form of anti-feminine thinking or the expression of clear-cut patriarchy (Rieder). However, even if one concedes that it was indeed misogynist thinking pure and simple, medieval medical thinking put women in an elevated position in comparison with later texts, since women played an active role in conception and pregnancy.

> The belief that the mucus poured out in women during sexual excitement is feminine semen and therefore essential to conception had many remarkable consequences and was widespread until the seventeenth century. […] It was the belief in feminine semen which led some theologians to lay down that a woman might masturbate if she had not experienced orgasm in coitus. (cited in Havelock Ellis, vol. 2, 146)

Contrary to popular conception, FGM has been used against women in Western countries since the 16th century, perhaps even before. The emergence of this practice during the Renaissance in countries like Italy, France, England, Germany and the Netherlands and later on in the United States of America was to some extent dependent on the 'rediscovery' of classical Greek and Latin texts, some of them medical, others philosophical or theological (Finzsch in this volume). Another aspect of the occurrence of this custom was the professionalization of medicine, especially gynecology, which took the care of women out of the hand of female practitioners like midwives and brought gynecology under the control of university-educated male doctors. Monica Green has described the long-lasting development of male-controlled medical practice in a groundbreaking study (Green Making Women's), which justifies some fleeting remarks. Although there was an abundance of Greek and Roman texts on women's medicine in the Middle Ages, the application of medicine for women lay in the hands of midwives (Green Trotula 14-15). The existence of texts on cliteridectomy alone is no proof of their actual application. Most of the medical books were located in monasteries, male places that is, and whether laypersons or women owned or read these texts, is unknown. Their usage also would have rested on the ability to read Latin or Greek. What may have had an impact though on the actual treatment of women by male doctors was the increasing importance of Arabic writings, like the text by Rhazes aka Mohammed Ibn Zakaria al-Razi (865-932), translated in 1175 by Gerhardus Cremonensis. All in all, it is fair to assume that cliteridectomy was not practiced during the Middle Ages and that its rediscovery and

application was the result of a re-reading of the ancient Greek and Latin texts, which is why this special issue starts with the period of the Renaissance and extends into the 21st century.

6 The following topics will be discussed in this issue in depth: Norbert Finzsch develops a longue-durée of the clitoricidal history in the 'West,' i. e. countries like Italy, Germany, England, France, and the United States between 1600 and 1970. Finzsch shows how the discourse and the practice of cliteridectomy changed over time, from a rarely practiced gynophobia operation to control female sexuality directed against women-desiring women to a medical procedure that was supposed to combat masturbation, nymphomania, and hysteria. Finally, the author proposes three hypotheses to explain the diminishing occurrence of cliteridectomy in said countries.

7 Marion Hulverscheidt's contribution focuses on a hitherto unknown footnote in the discourse on surgical practices performed around the vulva. At the turn from the 19th to the 20th century, a group of Chicago-based surgeons performed *Orificial Surgery,* an extension of surgical practices performed hitherto on the mouth and the nose, to the bodily orifices below the waist. Edwin Pratt, a trained physician and homeopath, founded the *American Association of Orificial Surgeons*, which held its first meeting in 1888 (Edson). In 1887 Pratt had published a monograph on orificial surgery. Between 1892 and 1901 Pratt edited the *Journal of Orificial Surgery*. Although the majority of the articles were his contributions, other practitioners also gave examples of their treatment activities. Orificial Surgery fits in well with the idea of reflex neuroses, developed among others by Wilhelm Fließ, which was an accepted explanation not only for neuroses but for disease in general at that time. Pratt recommended surgical interventions on the rectum, circumcision as well as the removal of the hood of the clitoris and even hysterectomy to cure masturbation and insanity, and other so-called chronic diseases.

8 The era of Orificial Surgery was rather short and was strongly connected to its representatives, who were mainly one generation of homeopathic surgeons. Orificial Surgery was framed by the local conditions, a strong claim of usefulness and helpfulness of these treatments, and the high reputation of homeopathy at that time. From today's perspective, they seem to have been outsiders in the medical realm. Contextualizing their treatments at their time, they seem rather modern concerning the operations they performed. Not least, because of the broad variety of treatments offered, which included mental healing and suggestive therapies. This association acted in an open-minded attitude towards women in medicine.

9 Janne Mende researches the controversy over FGM between adherents of a universalist vs. a cultural relativist interpretation of feminism. The case of female genital mutilation/cutting (FGM/C) is a touchstone for controversies between universalism and cultural relativism, both within and beyond feminist thinking. She provides us with a revisit of the discussion about FGM/C and thus stipulates essential insights for contemporary feminist thought. Her contribution touches upon issues that are of high relevance for today's discussions, as the question of human rights, individual and collective identity, othering, the role of civil society and the role of law, inequalities between the global North and the global South, the culturalization of gender and the intersection between gender, class and ethnicity. Discussing FGM/C as a case of juxtaposition between feminist cultural relativism and feminist universalism, the paper reframes cultural relativism and universalism as mutually constituting and conditioning each other. This mediated model contributes to a normative and simultaneously contextually embedded approach as a basis for contemporary feminist thinking.

10 Madita Oeming reflects on a contemporary phenomenon that could be called voluntary FGM in the West. Since the turn of the 21st century, more and more women choose to undergo Female Genital Cosmetic Surgery (FGCS) to fit a vulvovaginal aesthetic ideal. With a focus on reduction labiaplasty as the currently most widespread of these procedures, the article examines FGCS through a critical cultural studies lens to position it within larger feminist debates about body image, consumer culture, and female agency. A central question is where our Western ideal of female genital appearance comes from that increasingly causes the desire in women to undergo surgical body modification? Against the backdrop of post-colonial criticism, the article challenges the differentiation between FGM in non-Western cultures and FGCS in the West as well as the legitimacy of demonizing the former while normalizing the latter. Through bringing together otherwise separate voices from various disciplines, the aim is to present FGCS as an intricate interface between biology, psychology, culture, and media discourse, from which there is a lot to learn about recent Western history.

11 Bodil Folke Frederiksen's essay describes how a controversy over cliteridectomy came to influence the conjuncture of imperial politics and nationalist resistance between Kenya Colony and Great Britain the 1930s. Cliteridectomy was a vital component of the initiation rites of leading population groups in Kenya. Missionaries and medical doctors opposed it on moral and health grounds, African men and some women defended it a precondition of mature and responsible adulthood. An unlikely meeting and collaboration between a group of people – Marie Bonaparte, Jomo Kenyatta, Bronislaw Malinowski and

Prince Peter – who had a keen interest in the issue, generated new insights into the roots of tradition, how it fitted into not only structures of the human psyche but also the social construction of so-called traditional societies. The essay discusses what led to the collaboration, traces its consequences, and situates the cliteridectomy controversy in the context of anti-colonial and female emancipation.

12 Not all relevant issues could be included in this issue. Available sources in archives and the question whether the knowledge of cliteridectomy was not part of a formal network of scientists and doctors in the West demand further research on the topic of FGM. We hope to have laid the cornerstone for a future collaborative effort to address these critical problems.

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"We know the lesbian habits of kleitoriaxein […] which justify the resection of the clitoris": Cliteridectomy in the West, 1600 to 1988[1]

By Norbert Finzsch, University of Cologne

Abstract

This contribution develops a longue-durée of the clitoricidal history in the 'West,' i. e. countries like Italy, Germany, England, France, and the United States between 1600 and 1970. Finzsch shows how the discourse and the practice of cliteridectomy changed over time, from a rarely practiced gynophobia operation to control female sexuality directed against women-desiring women to a medical procedure that was supposed to combat masturbation, nymphomania, and hysteria. Finally, the author proposes three hypotheses to explain the diminishing occurrence of cliteridectomy in said countries.

Purpose and Scope of the Study

1 This paper is the pre-study of a larger project on which I have been working for the last two years now. My study addresses cliteridectomy in "Western" countries, by which I mean predominantly European countries (Said 12). I am not going to address FGM in non-Western countries, and I am not going to research immigrant communities in Western Europe or North America. There is abundant literature on both issues, to which I do not intend to add. The fact that 'white,' i.e., European women have been subjected to genital cutting over the period of nearly 400 years, however, is less well known. I shall, therefore, try to develop a Foucauldian genealogy of the practice in Western countries in the past 400 years. My project is not located in the sub-discipline of social history since I can say very little from the perspective of the women who were subjected to cliteridectomy. Patient files and hospital records are an invention of the 19th century, and very little is known about the biographies of women mutilated by doctors ([Anonymous], 1867; Anderson). Instead, I shall focus on the history of medical knowledge and medical practices. Although I will concentrate on the various practices and their medical and ethical justifications as they show up and disappear into the course of history, I shall also attempt to tell the history of the sexual organ clitoris, since its historic evaluation is intimately connected to the history of cliteridectomy. My initial quote stems from a famous French medical dictionary which was printed in 1815 (Adelon 56). The quote is unusual in many ways. It treats the practice of mutual masturbation as a known

[1] Quote from Adelon et al. *Dictionnaire des Sciences Medicales*, vol. 14. C. L. Panckoucke, 1815, 56.

fact. Moreover, it uses this knowledge as justification for the resection of the clitoris, which can mean either a total amputation or a resection of the hood.

The Antecedents

2 In the first century, Marcus Valerius Martialis wrote an epigram about a woman who had sex with other women by rubbing her clitoris against her. The poem is funny and masterfully composed and indeed was read a lot, given Martial's status and importance. Knowledge about the clitoris and its resection was common in Greece and Rome, but that medical knowledge disappeared once the Roman Empire fell and Latin and Greek were only spoken by a small minority of clerics. The clitoris was not a well-known organ until the fifteen hundreds, mostly because medieval women were reluctant to be examined by academically trained male doctors when they had access to midwives and their expertise. The more midwives were excluded from medical practice, the more male doctors took over. The consequence was a "rediscovery of the clitoris" by medical doctors (Park 171-93). This rediscovery was achieved by access to Greek and Latin sources and the integration of classic systems of knowledge into the process commonly called European Renaissance. Whereas the Italian doctor Aulus Cornelius Celsus did not even mention the existence of the clitoris in his book De Re Medica Libri Octo (Celsus), his colleague, the anatomist Realdo Columbo wrote in glowing terms about the importance of the clitoris and the techniques for stimulating it (Colombo; Laqueur, 64-65).

3 Realdo Colombo, who taught at Padua from 1544 to 1559 published a book entitled "De Re Anatomica" in 1559. Many of the contributions made in his book coincided with the publication of Gabriele Falloppio, also a professor of anatomy at Padua. Both Colombo and Falloppio wrongly claimed to have discovered the clitoris. The clitoris had been described with precision in the ancient texts. Colombo, however, was an anatomist who correctly identified the clitoris as a sexual organ. In his anatomical handbook, Colombo writes: "this is the principal seat of the women's pleasure if they engage in love not only when the penis rubs against them but also when touched with the small finger" (Colombo 243).

4 Columbus was so adamant about the clitoris, not because he was a pornographer or a libertarian but he, like many contemporaries, believed that a female orgasm was essential for conception (Colombo 448; [Pseudo-Aristotle] [1788], 2010, 64; Gardella 13-15). This position gave the clitoris an enhanced discursive presence. Medically and ideologically legitimizing female erotic pleasure, this presence also underlined the autonomy of women, since the pleasure mentioned in Columbus' text did not require the active participation or

even presence of men. The tradition of emphasizing female orgasms as healthy and necessary in a married couple's life continued well into the 19th century, although Victorianism apparently had a negative impact on the liberty with which these issues were discussed (Gardella 39, 72-74). Following Columbus' rediscovery of the clitoris, anatomical surveys that mentioned the clitoris usually warned against its abuse. Thomas Bartholin, a 17th-century Danish anatomist, repeated his findings and warned against the tribades (Bartholin 42). Most of the warnings were accompanied by the stories about the monstrous figure of the tribade, sometimes called *fricatrix* in Latin or *rubster* in English (Traub 16; Andreadis 49). The discursive connection between the rediscovery of the clitoris and the reemergence of the tribade indicated a crisis in the representation of female bodies and bonds. The fact that some of the anatomical texts refrained from discussing enlarged clitoris and tribadism should therefore not be taken as proof of the writer's ignorance in these matters but as a cautionary evasion of subjects thought to be too risky. Thomas Vicary, an anatomist of the 16th century, clearly knew about the existence of the clitoris and its erotic function, since he called the organ *tentigo*, Latin for horniness. He also emphasized the necessity of mixing the male and the female "semen" to conceive which is another hint at the sexual function of the clitoris (Vicary 77-78). Interestingly enough, discussion of the clitoris and cliteridectomy sometimes occurred in a context that was not purely medical. The question, for instance, whether there existed monsters, was widely discussed and among these monsters, so-called hermaphrodites figured prominently. Hermaphrodite was a synonym for tribade in a lot of the older texts, a figure of speech that can be followed back to a scholion on Horatius, in which tribades are called hermaphrodites (Krenkel, Bernard and Reitz 455; Allen 1666, 624). When the French king's surgeon Ambroise Paré published his treatise "Des Monstres et Prodiges" in 1575, he left no doubt that in the case of a large clitoris the organ should be cut "[b]ecause [women] can abuse it [the clitoris] (Paré 26, my transl.).

Tribades, Fricatrices, Rubsters

5 If my assumption is correct and the cliteridectómial frenzy of the 18th, 19th and 20th centuries was deeply rooted in homophobic and gynophobic tendencies that identified the clitoris as an organ of bodily transgression, it follows that these practices were present in many European countries. In the early 17th century, Jean Riolan referred to all the Greek authorities who thought that the clitoris should be cut out if it did not comply with the authors' conception of size and character. Riolan also discusses *in extenso* the vices of the so-called tribades, women that have sex with other women by rubbing the clitoris, and the capital

punishment that these women had to endure when convicted (Riolan 1614, 81-84). The association of the clitoris with female sexual deviance has a much longer history and has exerted a tremendous influence in the modern construction of lesbianism, as Thomas Laqueur and Valerie Traub have shown. Rather than male homosexual desire, what mattered in French and to some degree also in other European countries in the 16th and 17th centuries, was the question of female same-sex desire. I am reluctant to call this lesbianism because that was a term that came only in use in the 19th century. It is important to note that tribadism theoretically carried the death penalty in most West European countries and the German Empire, mainly if a dildo was used for penetration (Borris 72-75; Colwill 156; Soyer 46-47, Martin 83). Since an enlarged or bigger than average clitoris was a clear indicator for the sin of tribadism and vice versa, the amputation of the clitoris not only reduced the number of tribades but helped to pave the way for a "normal", "healthy" heterosexual relationship (Saliceto 62rb-va; Lochrie 82). It also made the death penalty against women superfluous. It was this logic, more than anything else, that drove the thrust for the increasing persecution of tribades and prepared the emergence of the "fatal women" and the "lesbian outlaw" or the "lesbian vampire" in the course of the 19th and 20th centuries (Hart; Robson; Zimmermann and Haggerty 263).

6 The rediscovery of ancient texts as part of the Renaissance also made it possible for 16th-century physicians and medical doctors to make themselves available with medical traditions and knowledge of their ancient colleagues. This "backwards-looking admiration for antiquity" (Crombie 456) converged with the reform of Italian universities, which adopted Platonism and installed chairs for medicine in places like Bologna, Rome, Pisa, and Messina (115-118). The Italian model was influential all over Europe. In London, the (Royal) College of Physicians was founded in 1518 on the Italian model. Thomas Linacre, its first President, was an English humanist and MD who had received his training in the Classics in Italy, took a degree of doctor of medicine from Padua and rose through the ranks in England after his return to London. Padua was considered the best school of medicine in Europe; also, it allowed English students to enroll, despite the fact that technically English students belonged to the apostate Church of England (Bylebyl 335; Johnson 102-119). In England and elsewhere, academically trained humanist physicians saw themselves in bitter competition with unlicensed practitioners in the countryside and the cities (Pelling and Webster 165). In their attempt to gain the upper hand in a professionalized field they reverted both to the Greek and Latin authorities, and to anatomical sections as the basis of their practice, something the unlicensed practitioners without connections to universities had no access to (Mitchell et al.).

The important evidence of the early modern texts in France, Italy, Germany, and England, is that although the tribade figures prominently in them, actual reports of cliteridectomy are rare (Fleming 74, 77). This changes abruptly in the middle of the 19th century.

7 The fear which was connected to the clitoris and which one can easily denote as cliterophobia stemmed in principal from the fear of the lesbian and only to a lesser degree from the fear of masturbation. The allegory of the tribade or lesbian did lead to a wholesale condemnation of masturbation. The rhetoric function of masturbation in the discourse on sexuality was to counter the visible effects of modernization, the displacement of the old order, regulated by the estates, by a democratic mandate, which emphasized equality but subsumed women under the tutelage of men. If we insert into this matrix of power relations the emerging scientific racism, it becomes evident why Europeans and Americans alike were so fascinated by masturbation. It is, therefore, a false dichotomy to understand cliteridectomy as either the consequence of the fascination with female masturbation, as portrayed in Sarah Rodriguez' magnificent study of cliteridectomy in the US or to construe it solely as lesbian "Clitoral Corruption" (Rodriguez; see also Gibson).

Masturbation

8 In the 18th century, a new concern about masturbation arose. This concern was productive in the sense that a lot of texts and practices came off it. 1737 saw the publication of an anonymous text entitled *Onania, or, The heinous sin of self-pollution*, which mostly dealt with men, but there were also some observations about women. "Furor Uterinus" or nymphomania was a well-known affliction in early modern Europe (Musitanius; [Marten] 1756, 325; Nagrodzki). *Onania* tells the frightening story of a woman with this disease, who suffered from fits during which she would "extravagantly Scream out, talk obscenely, pull up her Coats, and throw off her Bed-cloaths, calling to and laying hold of any Man she saw". After the woman's death, her body was dissected by physicians, and "the Extremity or Glans of Clitoris, which was much above its Natural Size, and which, […] is the chief Seat of Pleasure in Women, was observ'd to be Invested with a sharp […] Humour, which […] must […] Itch to a Prodigious Degree, and occasion the titillation and desire" ([Marten] 1756, 162). Here we can observe the shift from the tribade who has sex with other women to the woman with uncontrollable urges that result in masturbation. The reason for her irrepressible urges without any doubt was to be found in the size of her clitoris. Moreover, there is another new element: the itch, in Latin, *pruritus clitoridis*. Pruritus today is a serious condition often

treated by dermatologists (Misery and Ständer). In early modern times, however, pruritus meant something else. It was the word for a strong sexual desire (Stehling 57).

9 The history of gynecology in the West is the history of the subjection of female bodies under the control of white male MDs. In contrast to the 17th century, when gynecology was to some extent still practiced by non-academically trained persons and midwives, the field tended to be dominated by university trained doctors around the beginning of the 19th century. Doctors like the "Father of Modern Gynecology," the South Carolinian Dr. Marion Sims, subjected female slaves to medically doubtful and extremely painful experiments on the operation table, allegedly to find a method for curing vaginal fistulas (Harris; Mair; McGregor; Ojanuga; Wall; Schroeder). Biological reproduction was thus medicalized, both institutionally and discursively, and female sexuality was increasingly exposed to the medical gaze which sanctioned all forms of deviant sexuality in connection with the bio-power of the nation-state. Female masturbation was turned from a sin into a disease that had to be cured by all means necessary. Cliteridectomy, while having been practiced before, became more frequent in the context of demographic change, immigration, public health and the discussion about the domestic sphere reserved for women. One of the important German handbooks of gynecology discussed this in the following terms in 1836:

> Hypertrophy of the clitoris is rather rare. Should it be observed, it usually happens with individuals in which the clitoris had been rather developed during childhood. Later this development is excessively furthered through stimulation of this organ in an unnatural way. In these cases, the only effective and secure method is the extirpation of the clitoris. (Mende and Balling 148, my transl.)

By 1830 female masturbation had gained a prominent place in the medical and popular literature in Europe and the United States. Masturbation was held responsible for a lot of problems and afflictions, i.e., tuberculosis, in some cases even leading to suicide (Wakely 1846, 21, 39-40, 62, 68).

10 It seems, however, as if there was a new silence about the clitoris in Victorian America. As elaborate as the texts address the evils of self-pollution, they do not give the same amount of specific information as the Renaissance books did. Among the many calamities that were said to be the consequence of masturbation were insanity and hysteria (Worell vol. 1, 296). Historian Marylin French labeled the campaign against female masturbation as part of a "war on women" (French vol. 3, 313). This war was a fought on all national fronts, in England, Germany, France, and the United States basically at the same time. The chronology and the intensity of the battles might have varied according to the discursive urgency in the various national societies, but it was a common war nevertheless. In

1828, a French medical journal, quoting the German author Graefe, reported, that “in June of 1825 a 14-year old girl succumbed to absolute idiotism as a consequence of masturbation and was cured by a Berlin doctor through the amputation of the clitoris” (Mongellaz 150-151, my transl.; Graefe; Hulverscheidt 107-108). Another French journal wrote in 1832:

> The clitoris sometimes has an immoderate length or thickness which may affect the genital functions. Women with this disfigurement often succumb to the temptation of these passions that undermine their health and damage their morals. The amputation of the clitoris is the only means to rectify such a case. (Hatin 25, my transl.)

A similar journal quoted the case of a ten-year-old girl

> which practiced onanism since earliest childhood. […] When the parents learned the reason for the girl’s state of exhaustion they undertook everything conceivable to stop the obsession, in vain. […] Therefore the parents decided to have her clitoris removed. The operation was executed with great success by Doctor Jobert. ([Anonymous] 1835, 448, my transl.)

A few years later the author of an article advocating cliteridectomy referred to the ancient Greek practice and wrote:

> […] the clitoris is susceptible to all kinds of degenerations. The Ancient ones amputated it very often with the only aim to moderate the too great humidity of women. Seen from this angle the amputation of the clitoris has been too easily rejected for about the last century. After Doctor Robert had amputated her clitoris, the young woman who had fallen into apathy by masturbation was radically cured of her vicious habit. (Velpeau 343-344, my transl.)

The United States

11 In the United States, the discussion may have peaked a little later than in the European countries, but it developed in a very intensive way. The American readers had the opportunity to have access to the English books and journals without linguistic barriers, which explains why second editions of English books about the subject were printed in the US. In 1844, Calvin Cutter’s book on masturbation appeared, which did not propose cliteridectomy directly, but warned of the great dangers connected with the habit of masturbation. Cutter was not only a surgeon but also fiercely pious which explains the moral undertone of his text.

> Masturbation does more than any other cause, perhaps than all other causes combined, to people our lunatic asylums […]Consumptions, spinal distortions, weak and painful eyes, weak stomachs, nervous headaches, and a host of other diseases, mark its influences upon the one […], insanity, idiotism, show its devastating effects upon the other. It is equally opposed to moral purity and mental vigor. It keeps up the influence of unhallowed desires; it gives the passions an ascendency in the character, fills the mind with lewd and corrupt images, and transforms its victim to a filthy and disgusting reptile. (Cutter 31-32)

Cutter's book is probably among the texts that are most explicit when it comes to the description of the disastrous effects of female masturbation. However, the author does not recommend a surgical treatment of the affliction. Proper clothing, a healthy diet, physical exercise and moral education should do the job where other doctors recommended surgery (Cutter 40-47).

12 Writing only one year after Cutter, Doctor de Fontaine combined his broadside against masturbation with the dangers of lesbianism.

> The tastes of an unnatural love form another aberration. They abandon themselves to a carnal love of their own sex, and voluptuous embraces and enchanting songs and address; breathing their raptures, in the languor, delirium, ecstasy, and convulsion of passions, not to a lover, but to one of her female companions. (De Fontaine 59)

De Fontaine then recounts the story of a female patient who apparently seemed to suffer from nymphomania, and the good doctor describes the seizures and uncontrolled urges of his patient at length, covering six pages, when at the end of the chapter "On the clitoris" he concludes:

> After a few weeks' unsuccessful treatment, even by the use of the most powerful medicines and applications, suggested upon consultations with many eminent physicians, who were, to a man, […] in favor of an amputation of the clitoris. (De Fontaine 289)

This quote stems from one of the earliest medical texts that contain a reference to an excision of the clitoris in North America.

13 There is, however, one phenomenon that is peculiar to the US, and that is the use of homeopathic medicine in connection with cliteridectomy. Usually, homeopathy does not utilize surgery for the cure of disease. Hahnemann's "Organon of the Healing Art" was opposed to traditional surgery such as blood-letting or other operations on the human body. Homeopathy became very successful in the United States when the Bostonian Hans Burch Gram introduced homeopathic medicine in 1825 by translating Hahnemann's Organon. Medical historian Paul Starr wrote, "[b]ecause homeopathy was simultaneously philosophical and experimental, it seemed to many people to be more rather than less scientific than orthodox medicine" (Starr 97). Prominent political figures, including Abraham Lincoln's Secretary of State, William Seward, and Senator Daniel Webster chose to be treated by homeopathic practitioners.

14 Part of that sizeable homeopathic movement in the US was Dr. Edwin Hartley Pratt, a Chicago MD, who practiced what he labeled "orificial surgery". This part of the medical history of homeopathy is under-researched. Marion Hulverscheidt's contribution in this

volume is the first original study of orificial surgery. It seems as if in the 1880s American colleges for homeopathy like the Hahnemann Medical Schools did not deviate from classical medical approaches as much as their European counterparts. Edwin Pratt was a quintessential medical charlatan. "[He] preached that diseases could be treated through a variety of operations on bodily openings, and when [he] went to work, no mouth, penis, rectum, or vagina was safe from manipulation or scraping" (Rutkow 98). Accordingly, he and his followers resorted to complete or partial ablation of the clitoris, especially when they suspected the female patients to indulge in the vice of masturbation (Beebe 11-12). Amputation was also used to relieve girls of permanent orgasms (Pratt 529), even though in some cases, it seems, Dr.Pratt failed to achieve the desired results:

15 Obviously, the patient had arrived with a severe case of bronchitis or tuberculosis, and Pratt concluded: "very weak, case desperate" which did not stop him from performing an invasive surgery. A little more than two weeks after the operation the patient had died (Pratt 532). Pratt was by far not the only surgeon who practiced the pseudoscientific method of orificial surgery. Pratt's colleague Benjamin Elisha Dawson, assisted by Elizabeth H. Muncie, H. E. Beebe, and A. B. Grant, was active in the field until his death in 1922 (Dawson, Orificial Surgery 32). The cutting of the prepuce of the clitoris allegedly not only helped with cases of abscesses but also with menstrual pains (ibid. 58-59).

16 Dawson determined that knowledge of the clitoris and its importance for the mental and physical well-being had sunk into oblivion and wanted to raise awareness of that fact among his colleagues.

> Reflexes travel along the line of least resistance. Irritation in the sexual organs, therefore, may reach the mental or moral faculties, resulting in imbecility, sexual perversion or moral degeneracy. Many neuroses and even psychoses have their origin in pathological conditions of the hood of the clitoris. (Dawson, Circumcision 521)

Dawson did not refrain from operating on small girls several times if deemed necessary (ibid.). The interesting and for Victorians more than plausible assumption of orificial surgery was the interrelatedness of the bodily orifices which turned the clitoris from a disturbing source of masturbation into the key organ for the treatment of all possible diseases.

England and Germany

17 Meanwhile, in England and Germany, cliteridectomy became fashionable and was discussed by prominent physicians (Hulverscheidt). Dr. Isaac Baker Brown treated hysteria with a complete ablation of the clitoris. Hysteria according to him was the direct result of masturbation and had to be dealt with radically.

> M. N., aet. 17; admitted into the London Surgical Home September 4, 1861. History.—[…] Mr. Brown ascertained both from her mother and herself, that she had long indulged in self-excitation of the clitoris, having first been taught by a school-fellow. The commencement of her illness corresponded exactly with the origin of its cause; […] The next day after admission she was operated upon, and from that date she never had a fit. (Brown, 1866, 51-52)

Baker-Brown documented 48 cases in which he performed the "usual operation," ranging from treatments for hysteria to epilepsy. His patients came from all social classes and ages, ranging from ages 16 to 55.

18 Baker-Brown hastened to publish the list of his medical successes since he had become the target of severe criticism by his fellow physicians and tried to counter these attacks by publishing the case histories of his female patients (Brown and Greenhalgh). During 1866, Baker-Brown began to receive negative feedback from colleagues who opposed the use of clitoridectomies and questioned the validity of Baker Brown's claims of success. An article appeared in *The Times* in December, which suggested that Baker Brown had treated women of unsound mind (Fennell 66-69). He was also charged with performing clitoridectomies without the consent or knowledge of his patients or their families. In 1867, he was expelled from the Obstetrical Society of London for carrying out the operations without consent (Sheehan 330-331; Fleming 1029). It is, therefore, correct to assume that the procedure of cliteridectomy was discontinued in England after 1867 (Moscucci). Dr. Patrick Watson wrote about a single case in 1868:

> On the last of these occasions, her mother, who accompanied her, explained that her daughter was given to habits of masturbation […] Various procedures, moral and remedial, were tried […] without effect, with the sanction of her mother, I removed her clitoris, in the manner recommended by Mr. Baker Brown. (Watson 382)

There was another case in 1871 (Arkwright). In contrast to Germany, France, and the United States, where cliteridectomy was continued well into the 20th century, English gynecologists showed almost no inclination to apply the surgery to women. In 1897 James Russell published a paper in the *British Medical Journal* which sounded the knell to all kinds of operations on the clitoris and the genitalia. "Common sense, as well as statistics, prove that sexual disorders in women cannot be such a prolific cause of mental disease as the psycho-surgical gynecologist would make us believe" (Russell 771). As the author proceeded to show, most doctors in institutions for the mentally ill denied any connection between so-called sexual disorders and mental disease.

19 While the British doctors desisted from the application of cliteridectomy, German practitioners continued the operation. Johann Baptist Ullersperger introduced Baker Brown's

procedure and the resulting controversy to the German readership in 1867 (Ullersperger). The renowned journal *Archiv für Pathologische Anatomie und Physiologie und für Klinische Medicin* [sic], edited by Rudolph Virchow, reported on the successful healing of a case of hysteria through cliteridectomy. The doctor who wrote the report in 1882, Nikolaus Friedreich from Heidelberg, claimed that hysteria was caused by the clitoris, which is an interesting case of linguistic confusion because hysteria originally referred to the uterus, Greek ηψστερα (Friedreich 224-225.)

20 Quoting the Austrian physician Gustav Braun, Friedreich narrated the story of two young unmarried women of 24 and 25, who had been vexed by extremely violent sexual arousal and who had indulged in masturbation "of the highest order." [...] after unsuccessful treatment for years healing was achieved through amputation of the clitoris and the small nympha by using a galvanocautery sling"(Friedreich 225-226, my transl). Braun is then quoted as using this method habitually when patients masturbate resulting not only in corporeal but also psychic disturbances (ibid.). Friedreich continues by complaining about the obvious termination of the practice, which he attributes to the London scandal around Baker Brown. Charles West, Baker Brown's most prominent opponent, had called the operation a "mutilation" of the patient and Friedreich expresses his complete lack of understanding for such wording (West 585). "How one can condemn the elimination of such a small and hidden shape with this name, is not understandable, since it is obvious that the feeling of lust is not limited to the clitoris"(Friedreich 226, my transl.) Friedreich then proceeded to narrate eight cases of hysteria in which he used the corrosion of the clitoris with silver nitrate to achieve a betterment, the last one in 1882 (ibid. 230).

Demise 1890-1920

21 It is a fact that in most Western countries cliteridectomy that became rare after 1890, the reasons, however, for this change are not entirely clear. In the US, various authors underlined the operation's adverse effect on the sexuality of women (see for example Beebe). Clitorectomy, as it was sometimes called in the 20th century, continued, however, to be applied in cases of assumed virilization of the genitals which could occur in a hypertrophied clitoris, especially with children. (Fonkalsrud, Kaplan, and Lippe; Randolph and Hung).

22 A French guidebook attributed the diminishing reliance on the practice on its lack of accomplishment. "[The brain is the seat of the erotic impulse ...] For the same reason the excision of the clitoris and its roots, practiced in grave instances of erotic delirium, often remained unfruitful" (Alibert 19-20, my transl.).

23 Another discursive break occurred with the impact of second feminism in the 1970s. Freudian interpretations about the psychological maturity of the "vaginal orgasm" in comparison to the lesbian immaturity of the "clitoral orgasm" were increasingly rejected and replaced with the emphasis on "female clitoral sexual pleasure" (Holbrook 237-238; Rodriguez 123). This movement coincides, albeit was not identical, with the "need" or the "obligation" to reach an orgasm under all circumstances or even to be multiorgasmic. Now that women allegedly were becoming liberated, they were supposed to be super-sexy and multiorgasmic (Rowland and Rowland 551). The compulsion to be "super-sexy" led to new requirements. If this kind of sexual achievement was missing, the reason for this maladjustment was sought again in physical qualities of the female body. Female Circumcision to promote clitoral orgasm became a discussed issue between 1890 and 1945. After 1966 and until 1981 women underwent the removal of the clitoral hood to enhance clitoral orgasms (Rodriguez 75-90, 123-148). This discussion culminated in the "surgery of love" by doctor James Burt of Dayton, Ohio, who operated on women in such a way that he "moved the entrance of the vagina closer to the clitoris in an effort to enable women to have both easier and better orgasms by enabling the penis to more easily provide the clitoris with stimulation during penetrative sex" (Rodriguez 150; Burt and Burt; Adams 59). Hundreds of women underwent this operation – some of them unknowingly and unwillingly – with devastating results until James Burt finally lost his license – in 1988. The mutilations of female genitalia had come full circle: whereas in early modern times men insisted on controlling female sexuality when it did not function in a 'normal' way (women having sex with women; masturbating women), in modernity control of female sexuality encompassed first the psychological normalization of hysterical women and finally the corporeal normalization of women who 'voluntarily' underwent a correction of their bodies. Today operations of the vulva for aesthetic reasons are part of an ideology of bodily modifications. They do not need to oblige women to adapt; some women have accepted the idea of an aesthetic normalization and even pay for surgery that modifies their vulvae as shown in the documentary entitled Vulva 2.0. This aspect of FGM will be addressed in the contribution by Madita Oeming in this special issue.

24 I come to a provisional conclusion: Trying to understand the demise of cliteridectomy in the West allows for three hypotheses that seem plausible and do not contradict the available historical evidence:

1) The first suggestion I call the psychoanalytical hypothesis: cliteridectomy became superfluous due to the growing influence of psychoanalysis. According to Sigmund Freud,

during the transformation of a girl to a woman the seat of sexual pleasure is transferred from the clitoris to the vagina. This transition, however, could produce problems. Psychoanalysis as a theory and practice promised the cure of problems related to sexuality like masturbation, lesbianism, and deviant sexual practices not by surgery, but by the 'talking cure' of psychoanalysis.

2) The second assumption I call the colonial hypothesis. Growing awareness of the practice of cliteridectomy in the French, British, American and German colonies after 1890 underlined the difference between the 'savage' practice of mutilation in the colonies and the 'civilized' countries of the West. Women of the West were allegedly treated with more respect and enjoyed rights that were denied to colonial subjects. British missionaries emphasized the necessity to abolish Female Genital Mutilation among the Kikuyu in British East Africa (Mufaka; Slack 478-479, Frederiksen). If Western culture was supposed to be perceived as superior, the colonizer and the colonized must not use the same techniques to subdue the sexual self-determination of their female population. Hence, cliteridectomy in the West had to go. This does not mean that Christian missionaries spoke out against FGM *per se*, but that they associated the practice with a lack of culture and thus had an impact on the discourses that questioned the application of FGM in the West. Christians in Africa, Roman Catholics, and Protestants alike, continue to mutilate women. FGM is not a religious practice, but a cultural one (Emmett).

3) The third hypothesis I call the hybrid hypothesis: Allow me to quote from a text by the renowned psychoanalyst Marie Bonaparte:

> One day, Freund gave me a book that had been printed in Berlin: Neger[-]Eros by Felix Bryk, a traveler who had lived in East Africa. He had studied the customs of the Nandis […] He described the way the Nandis girls undergo the operation to lose their clitoris. […] The Nandis men, [Bryk] assumed, try to feminize their companions completely by suppressing the last remnant of the penis which is the clitoris and this, he adds, must have the effect to facilitate the transfer of sensibility in the erogenous infantile zones, which is the clitoris, to the erogenous zone of the adult women, […] the vagina. (Bonaparte 213-214; Bryk, my transl.)

What I am hinting at is the possibility that a combination of the psychoanalytical and the colonial hypotheses was at work in the suppression of the cliteridectomy in the West. This change did not happen overnight. Marie Bonaparte reported that in 1929 cliteridectomy was still practiced in Leipzig to heal a 29-year old woman from "compulsive masturbation" (Bonaparte 214).

25 Unfortunately, the history of cliteridectomy in the West contains one unfinished chapter: Sexual or vulvar aesthetic surgery often includes a form of cliteridectomy, albeit for

cosmetic reasons and in accordance with the wishes of women who undergo the procedure. "We are forgetting that these operations are mutilations, which are freely agreed, perfectly accepted and very expensive, whereas they cause the loss of corpuscles and nerves, which are essential for a happy sex life" (Di Marino and Lepidi 136).

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Homeopathy, Orificial Surgery, and the Clitoris in the United States, 1880-1920 – an Eclectic Approach?

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Abstract

This article focuses on a hitherto unknown surgical practices performed around the vulva. At the turn from the 19th to the 20th century, a group of Chicago-based surgeons performing orificial surgery expounded on the curing and helpful aspects of surgical practices performed on mouth and nose and the bodily orifices below the waist. This association was founded by Edwin Pratt, a trained physician and homeopath. In 1887 he had published a monograph on Orificial Surgery, between 1892 and 1901 he edited the *Journal of Orificial Surgery*. Although the majority of the articles were contributions of him, other practitioners also gave examples of their treatment activities. Orificial surgery fits in well with the idea of reflex neuroses, which was an accepted explanation for disease at that time. Pratt recommended surgical interventions on the rectum, circumcision as well as the removal of the hood of the clitoris and even hysterectomy to cure masturbation and insanity, and other so-called chronic diseases. This paper attempts to contextualize the era of Orificial Surgery and their protagonists in the medical and social realm.

Introduction

1 Where and what is the link, the connection between clitoridectomy, today is seen as a cruel violation of human rights, and homeopathy, a holistic and gentle approach to health? This paper will focus on a crucial period in Chicago, United States, where a Society of Orificial Surgery was introduced at the end of the 1880ies. This label was used to summarize surgical interventions via mouth, nose and other bodily openings, and primarily through orifices under the waist line, including operations on the clitoris. Indications for these surgical procedures were various chronic diseases, which were believed to be caused by nerve-waste provoked by orificial irritation.

2 Female Genital Mutilation/Cutting and other medical or surgical procedures addressing either the clitoris, the hood of the clitoris, the labia or the vaginal opening were performed all over the world, for a variety of purposes, and were justified by various theoretical constructs. Norbert Finzsch has provided a brief outline of these procedures; a more detailed investigation was done for Great Britain by Moscucci, and by me for the German-speaking realm (Hulverscheidt, Weibliche Genitalverstümmelung). A remarkable story is that of Isaak Baker Brown, a gynecologist in London, who in 1866 published a booklet on the therapeutic benefits of clitoridectomy (Scull/Favreau; Showalter; Wallerstein,

Säkulare Beschneidung; Black, Hulverscheidt, Medizingeschichte). Dally and Rodriguez provided overviews and case examples as well, taken from US-American practice.

3 In this paper, I will address the procedures performed under the heading of 'Orificial Surgery' by homeopathically oriented physicians in Chicago, US, at the turn of the 19th to the 20th century. Homeopathy in the United States seems to have been different to homeopathy practiced in Europe, and particularly Germany, primarily regarding the relationship between the medical cultures of (allopathic and surgical) medicine and homeopathy. Whether any medical procedure or approach is considered mainstream or 'complementary' is not so much defined by strictly scientific aspects, but to a significant degree depends on local and temporal conditions and discourses. To be a homeopath in Munich may be totally different from being a homeopath in Chicago; the same applies to 1920 versus 2010, for example. The results of these various discourses and appropriations are sometimes astonishing and peculiar. This contribution will investigate one of these spatially and temporally limited peculiarities. History is never objective; a decision must always be made on the perspective or position taken. And the perspective changes the story.

4 The procedures discussed in this article seems to be no more than a minor footnote in the history of American surgery; it is, however, central where this practices originated – in addition to surgical treatments focusing on the effects of (war-inflicted) injuries and accidents (Schlich; Cooter), there was also a branch of homeopathic physicians performing surgical treatment of so-called chronic diseases caused by reflex neuroses. So it seems worthwhile to address this topic in the context of the event of surgery as well as in the context of conflicting medical cultures (allopathy and homeopathy and others) and in the local and personal realm as well.

Homeopathy in General

5 Homeopathy as an alternative medical practice was developed by Samuel Hahnemann in the 18th century in Germany, and today is practiced all over the world (Jütte, Homöopathie; Jütte, Hahnemann). Homeopathy is characterized by a holistic approach, focusing on the individual patient and not on symptoms or a disease. Homeopathic treatment usually begins with an extensive interview called anamnesis. Symptoms are described in great detail, and a homeopathic remedy is selected as a result. Remedies are chosen based on the principle of simile (like cures like). These simile remedies are potentized, diluted and used as instructed. The homeopathic setting seems to promote lasting patient-physician relationships, probably due to the detailed anamnesis and the very close monitoring of treatments, which seem to be

less hierarchical than patient-physician relationships in orthodox medicine (Jütte, Homöopathie).

6 Beyond current conflict lines, mainly defined by allopathy's and homeopathy's claims to overlapping fields of competence, and vaccination, it is sometimes overlooked that Hahnemann viewed homeopathy as a comprehensive system of healing. Today's practitioners may have lost sight of the fact that homeopathy's competences and indication areas have continuously changed, over decades, and even centuries, but within a delineated field. Homeopathy is mainly applied in cases of chronic diseases, as opposed to acute illnesses, such as infectious diseases. In this classification approach, venereal diseases take on an intermediate position, as they seem to respond to homeopathy (Hahnemann, chronischen Krankheiten, vol. 1, 4). Within homeopathy, surgical interventions were considered advisable if indicated. Hahnemann's Organon therefore also included a chapter on surgery:

> Those so-called local maladies which have been produced a short time previously, solely by an external lesion, still appear at first sight to deserve the name of local diseases. But then the lesion must be very trivial, and in that case it would be of no great moment. For in the case of injuries accruing to the body from without, if they be at all severe, the whole living organism sympathizes; there occur fever, etc. The treatment of such diseases is relegated to surgery; but this is right only in so far as the affected parts require mechanical aid, whereby the external obstacles to the cure, which can only be expected to take place by the agency of the vital force, may be removed by mechanical means, e.g., by the reduction of dislocations, by needles and bandages to bring together the lips of wounds, by mechanical pressure to still the flow of blood from open arteries, by the extraction of foreign bodies that have penetrated into the living parts, by making an opening into a cavity of the body in order to remove an irritating substance or to procure the evacuation of effusions or collections of fluids, by bringing into apposition the broken extremities of a fractured bone and retaining them in exact contact by an appropriate bandage, etc. (Hahnemann, Organon §186)

Hahnemann never contested the raison d'être of surgery. During his lifetime, these interventions were mainly performed by army surgeons and barbers. At the same time, he commended the synergetic effects of surgery in conjunction with homeopathy; it should be noted, however, that in his language/way of thinking a physician acted in accordance with homeopathic cauteles:

> But when in such injuries the whole living organism requires, as it always does, active dynamic aid to put it in a position to accomplish the work of healing, e.g., when the violent fever resulting from extensive contusions, lacerated muscles, tendons and blood-vessels requires to be removed by medicine given internally, or when the external pain of scalded or burnt parts needs to be homeopathically subdued, then the services of the dynamic physician and his helpful homeopathy come into requisition. (ibid.)

These passages do not describe surgery as external to homeopathy. But even if Hahnemann considered surgical therapies to be appropriate and compatible in specific cases, he did not necessarily believe them to be an intrinsic part of homeopathic medicine. In his opinion, homeopaths were meant to dynamically support healing and to relieve pain. Surgical intervention is not automatically turned into homeopathic treatment, just because a homeopath performs it.

7 Hahnemann's therapeutic concept was successful; part of the reason for this success may have been a clear distinction from humoral pathology, at that time the most commonly practiced form of medicine, which relied on bloodletting and other draconian forms of treatment, which could only be understood within the context of antique scriptures.

Homeopathy in the US in the 19th century

8 Homeopathy was introduced to the United States around 1825, by German and Dutch physicians (Schmidt). Its dissemination was made easier by the fact that in the 1840s, laws regulating the accreditation of physicians, passed towards the end of the 18th century, had been revoked as part of the anti-monopolist stance of the Jacksonian democracy, allowing all kinds of healers and quacks to practice medicine.

9 Homeopathic associations and colleges were quickly established, as large segments of the well-to-do upper class welcomed this new medicine. Enthusiastic patients were generous, as a way of showing their appreciation (Kett; Fuller). As early as 1844, the American Institute of Homeopathy (AIH) was founded as a professional association.[1] At that time, medical training in the US was not yet regulated, and there were only a few requirements for starting a new college. There were no rules or guidelines in 19th-century America for content or length of a college education. The Hahnemann Medical College of Chicago, which opened up in 1861, actually graduated its first class in February 1861, after only four months of study (Cook and Naudé 128).

10 The number of homeopathic colleges rose quickly, as did the number of homeopaths. In 1898, there were already 20 homeopathic colleges in the United States, 140 homeopathic hospitals, 57 homeopathic pharmacies, 31 homeopathic journals and more than 100 homeopathic medical associations (Kron 15). But was this education comparable to homeopathic education in Europe? And did the American homeopath adhere to the principles of homeopathy, as defined by Hahnemann?

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[1] http://homeopathyusa.org/about-aih-2/our-heritage-our-future.html. Accessed February 2nd, 2018.

11 Practicing homeopaths with greater professional integrity aimed at ensuring high medical standards, and unified, legitimate professional training. But the development had been too speedy, and numerous professional disputes ensued. Taking insiders' perspectives, Cook and Naudé provide detailed information on the factors they consider responsible for the ascendance and the decline of homeopathy in America: homeopathic teaching in the United States differed greatly from pure homeopathic doctrine in Germany, as most of the US-American homeopaths were not able to read German, and therefore could not directly study Hahnemann's bulletins. Many of them did not consider the simile principle to be valid and embraced the bacteriological theory, which considered specific pathogenic agents to be responsible for diseases (Cook and Naudé 129, 133). But in addition to acute illnesses like infectious diseases, there were also chronic diseases for which homeopathy was considered to be eminently efficacious, and about which Hahnemann had written extensively (Hahnemann, chronischen Krankheiten). But once again differing from Hahnemann, US-homeopaths focused on chronic disease rather than the entire patient; their approach may, in fact, be described as allopathic, rather than homeopathic (Cook and Naudé 130).

12 Among these homeopaths, therapeutic approaches and methods used varied greatly. Some of them used only potentized remedies included in the Materia Medica, while others relied on allopathic principles, and considered it grossly negligent to not prescribe quinine in case of malaria or morphine against pain. There were also pronounced differences regarding surgical therapy, as is obvious when looking at Orificial Surgery.

Homeopathy in Chicago

13 Chicago seemed to have been one of the hot spots of homeopathy in the US. The Hahnemann Medical College, founded in 1860, and the Chicago Homeopathic College, established in 1876, were merged in 1904. In 1892, Henry C. Allen set up the Hering College in Chicago, as a counterpart to the less stringent colleges; it was meant to teach 'pure' homeopathy. But even there, professional differences arose, and in 1895, several of its members left to open Dunham Medical College (Kron 39). Also, there was also a homeopathic evening school, so that an observer of the North-American homeopathic landscape arrived at the following conclusion:

> Instead of having only one homeopathic college in Chicago, with well-equipped laboratories and sufficient clinical hospital facilities, that could train physicians well-versed in all branches of medical art and technique, there were five different colleges, and as was to be expected under such conditions, all of them with only insufficient funding. (Kron 39-40)

And homeopathy was by far not the only alternative medical practice competing for patients' attention: by the end of the 19th century, osteopathy, chiropractic, and Christian Science had entered the market, followed by kinesiology. It would by far exceed the scope of this contribution to investigate whether it was this fragmentation within North-American homeopathy, the devastating results of the Flexner Report (published in 1910) or the establishment of the U.S. Public Health Service (PHS) in 1912 that caused the subsequent demise of homeopathy in the United States (Flexner). The field of medical cultures was highly dynamic, with competition not only between the various medical systems but also within homeopathy itself. A pervading eclecticist attitude infused medical culture, even if the direction was not clear.

14 The remarkably speedy increase of newly founded homeopathic colleges corresponds with the exponential growth of Chicago's population: between 1860 and 1890, the number of inhabitants went from little more than 100,000 to one million. This rapidly growing population had hardly a hold on a public health service, despite some union organized workers. So the majority of the population had to choose and had to pay their medical treatment. Homeopathy had a good reputation, it seemed to address the individual patient, it was gentle, and homeopathic remedies were cheaper than the allopathic (Schmidt 105), and, due to its tradition, trustworthy.

Edwin Pratt – Physician and Homeopath, Founder of Orificial Surgery

15 Edwin Hartley Pratt (1849-1930), was born on 6 November 1849, as the son of a homeopathic physician (Rutkow). His father Leonard Pratt (1819-1900) had completed medical training at the Medical College of Chicago, but after graduating had become attracted to homeopathy, a development that was quite common in mid-19th-century North America. In 1892, Leonard enrolled at the Homeopathic Medical College of Pennsylvania, and in 1867 successfully applied for membership in the American Institute of Homeopathy. In 1867, his son Edwin enrolled at the University of Chicago, completing his studies in 1871. For the next two years, he studied at the Hahnemann Medical College in Chicago, receiving his doctoral degree in 1873. He was concurrently also enrolled at the Jefferson Medical College.

16 This very short summary of these two professional biographies already shows that homeopathy in the United States greatly differed from homeopathic training and practice in Germany, even if homeopathic colleges in the US did trace their teaching back to Samuel

Hahnemann and his homeopathic principles. Both father and son had a double qualification in medicine and homeopathy.

17 In his first ten years of practice, Edwin Pratt dedicated himself to general practice. In his biographical sketch, Rutkow describes him as an “engaging entrepreneur” (Rutkow 559), as someone who had a message and a mission. In 1887, Edwin Hartley Pratt published a monograph titled *Orificial Surgery and its application to the treatment of chronical diseases*, after he had outlined his new concept of disease and cure earlier in a contribution to his weekly surgical conference in February 1886 (Rutkow 559). In his publication, Pratt defines himself as A. M., M. D., LL. D., and even more specifically as: “Professor of principles and practice of surgery in the Chicago Homoeopathic Medical college, formerly attending gynecologist to Cook County Hospital, Chicago” (Pratt Orificial Surgery Cover).

18 His publication was highly successful; it seemed as if he had come up with a new branch of surgery with his concept of reflex neurosis. A second edition occurred after three years only. In 1888 he established the American Association for Orificial Surgery, and the *Journal of Orificial Surgery* was edited by himself from 1892 until 1901. Although the majority of the articles were his own, other practitioners also contributed case descriptions. In 1891, Pratt opened up his own sanitarium in Chicago, the Lincoln Park Sanitarium (Rutkow 560). The American Association continued to meet regularly until 1910 but was closed down in 1925. Pratt died after prolonged illness, in 1930, and was buried in Chicago (Chicago Daily Tribune 1930). He was remembered as a local hero, but his idea did not outlive him.

Orificial Surgery

19 Edwin Pratt dedicated his monograph on Orificial Surgery to his father. The first page of his book showed a selection of the instruments he used for operations, several of which he had developed himself. This had first been done by Ambroise Paré, the 16th-century barber-surgeon who is held as the precursor of modern surgery. All instruments are explained in detail further along in the book. Most operations were done in the rectal area, such as the removal of hemorrhoids, papilla, and pockets. The book also includes several cases of uterus dilatation – all of them ‘successfully,’ as seems to have been customary in the 19th century.

20 Which conditions were treated by using orifical surgery?

> In all pathological conditions, surgical or medical, which linger persistently in spite of all efforts at removal, from the delicate derangements of brain-substance that induce insanity, and the various forms of neurasthenia, to the great variety of morbid changes repeatedly found in the coarser structures of the body, there will invariably found more or less irritation of the rectum, or the orifices of the sexual system, or of both. In other

> words, I believe that all forms of chronic diseases have one common predisposing cause, and that cause is a nerve-waste occasioned by orificial irritation at the lower openings of the body. (Pratt Orificial Surgery 14)

This is Pratt's definition of chronic disease, and we should take this into account, as this seems to be his connection to Hahnemann and the concept of homeopathy, which was based on a definition of chronic diseases by Hahnemann (Hahnemann, chronischen Krankheiten).

21 Pratt mentioned the reflex irritation as a relation of orificial irritation to chronic suffering (Pratt, Orificial Surgery 14). He thereby introduced one more disease concept, in addition to homeopathy and allopathy: reflex theory. The Canadian Medical Historian Edward Shorter classifies this explanation model as a precursor of psychosomatic medicine (Shorter 1992). According to reflex theory, all organs of the body are interconnected by the nervous system, so that symptoms may show up at seemingly unrelated, distanced locations on the body. This explanation model made it possible to treat organs that were not normally or easily accessible to surgical access. And it was similarly possible to affect the brain and nervous disorders by treating the periphery. The sexual organs seemed to merit special attention. Changes in these organs, even if they were not accompanied by any local symptoms, were made responsible for all kinds of peripheral and reflective disorders, – and vice versa, peripheral disorders such as asthma, nervousness, diarrhea, discomfort could be addressed by local treatment.

22 Stopping nerve waste and active circulation of the blood are goals to achieve. And the sexual organs in both sexes do have an essential connection to the sympathetic nervous system (Pratt, Orificial Surgery 18). So the waste of sexual power causes a waste of sympathetic nervous power in both sexes.

23 Edwin Pratt appears to be using explanations and theories of disease from various sources: local treatment against local disorders from allopathy, but also local treatment on specific stimulations points for alleviating or curing chronic diseases, therefore reflex theory – and both supposedly under the umbrella of homeopathy. In fact, in this theoretical construction, homeopathy represented the idea of perceiving the entire individual, on a long-term basis, by a well-trained homeopath.

24 In detail, Pratt provides his theory on the pathology of the rectum, the male, and the female sexual organs, together with the instruments used for this surgery. In the chapter on follow-up care, he refers to the simile principle of Materia Medica, but also refers to other remedies which have the power to improve circulation. He states:

> I must urge you to be broad-minded and to pursue a policy of true eclecticism. The true physician, in my estimation, should familiarize himself, so far as possible, with all

> available means for the relief of human suffering, and select those which seem to be best adapted in the individual case (Pratt Orificial Surgery 67-8).

He proves his eclecticism by mentioning remedies such as fluid with tonic effects of heat and cold, electricity, massage and mental therapeutics.

25 The largest part of this volume contains 52 case reports. The diagnoses of chronic diseases provided are asthma, gastralgia, chronic diarrhea, headache, dysmenorrhea, vaginism, rheumatism, insanity, blindness (meaning the inability to concentrate on reading), paralysis, secondary syphilis, jaundice, chronic bronchitis, and hydrocephalus. In this volume, the operation performed and recommended for the female is dilatation of the cervix uteri and removal of the rest of the hymen, no clitoral surgery in mentioned.

26 As an example of the case reports Case 48, chronic diarrhea in a female patient, age not provided, can be drawn upon. The patient has been suffering from diarrhea for years, all prescriptions, and climate changes were not successful. "Finally at one interview she dropped the remark that sexual intercourse always aggravated her trouble," the rectum was found without orifical irritation, but at the vaginal orifice was "the attachment of the hymen, shreds of which were hypertrophied and very red. Under an anesthetic the vaginal opening was smoothed, and the wound surfaces co-apted with fine silk sutures" (Pratt Orificial Surgery 136). This was followed by immediate and permanent relief from chronic diarrhea.

27 Pratt's monograph was successful and a second edition was published in 1890. A year later, the *Journal of Orificial Surgery* was published the first time, with Pratt as editor-in-chief. In the first years, all was about the rectum and the uterus, but no articles or cases on surgical procedures on the vulva. This changed in 1895.

28 In Volume 4, in 1895-96, M.D. Grant Freeborn published on " Amputation of the Labia" (Freeborn 14). Concerning an abnormal development of the labia (minora) he stated: "I have found it in many cases to be the cause of severe nervousness, stomach sickness (sometimes with vomiting), loss of sexual power" (Freeborn 14) and illustrates this with three cases.

29 In the next volume, M. J. Hill published a paper entitled "The Clitoris"; he had read at the Illinois Homoeopathic Medical Association, Ottawa, in May 1896. He writes: "I shall compare it [the clitoris] to an electric button, and truly this little knot of nerve tissue, situated upon the anterior portion of the female genital fissure, is the electric center of the sexual system of the female." (Hill 555).

30 In volume 6, M.D. H. E. Beebe published a talk on the clitoris, which he read before the Homoeopathic Medical Society of Ohio, at Akron, Ohio in May 1897. He referred to Baker-Brown and his practice of clitoridectomy as a cure for epilepsy, melancholia,

masturbation and kindred troubles, to French physicians who performed clitoridectomy, and to the amputation of the labia minora. For Beebe, this was “burning a house to roast a pig” (Beebe 9). He prefers instead the amputation of the hypertrophied hood of the clitoris. But, masturbation, seen as a dangerous crippling habit, was addressed by him the very same way as it was by Baker-Brown:

> Clitoridian masturbation [...] is the most prevalent form of the solitary vice in women and girls. [...] The external form of masturbation is more common than the internal, and with those addicted to it there is a real increase in the size of the clitoris, and it is frequently found situated higher up or farther away from the vaginal outlet than usual.[...] An elongated or hypertrophied hood [of the clitoris] should be amputated (Beebe 11-12).

31 In March 1898, Pratt himself gave an overview of “Circumcision of Girls” (Pratt Circumcision 385-91). In his further explanations, he follows in the metaphoric placing of the clitoris M. J. Hill when he states: “the importance of the clitoris as a telephone station in the nervous organization of women“ (ibid. 390).“ He ends by stating that “it is much easier to prevent than it is to cure” (ibid. 391) and recommends circumcision for girls – which means the surgical removal of the clitoral prepuce – as well as for boys. His recommendations were taken up by his followers, and a list of articles on the irritability of the clitoris followed in the journal (Muncie; Thompson).

32 Elizabeth H. Muncie grew up in a family of physicians and surgeons. She acquired her medical education at New York Medical College and Hospital for Women, where she graduated in 1891. She took her post-graduate courses in Orificial Surgery at the Chicago Homeopathic Medical College from 1892 to 1895. After a short stay in the surgery department at Johns Hopkins Hospital in Baltimore, she established her sanitarium for surgical treatment, first in Brooklyn and then in Babylon, Long Island.

33 During the Annual Convention of the American Association of Orificial surgeons in September 1898, she gave a talk on the clitoris and the many forms of irritation to which it is subject. In assuming her auditorium was familiar with the anatomy and the physiology of this organ she elaborated in great detail on the hygiene and the pathology of the clitoris. She especially focused on the adhesions of the prepuce, which could be caused by “profuse use of powder” in babies with diapers. In young girls, a severe problem was intensive itching after menstruation, because the girls were told: “that they must not wash during the period” (Muncie 161). The result of this poor hygiene was as follows: “These adhesions lead to neurotic conditions which produce a relaxation of uterine ligaments and vaginal walls” (Muncie 162). To cure these conditions, she proposed the surgical freeing of the clitoris from the hood and the application of collodion. In the ensuing discussion, other members of the

association recommend different operation styles and procedures. Cora Smith-Eaton (1867-1939) frankly declared: “I remove more than Dr. Pratt does” (Muncie 164). So she, studied at the Boston University School of Medicine and became the first woman to practice medicine in the state North Dakota, developed her surgical method for the adhesion of the clitoris hood, following Pratt and moving beyond by placing three stitches with silk to keep the remaining parts of the clitoris hood away from the glans. She served as Vice President at the 11th Meeting of the American Association of Orificial Surgeons in 1898.

34 The Chicago based M.D. J. J. Thompson gave a thorough overview of the diseases of the Vulva, and the recommended treatment in the journal (Thompson). His disease classification is rather orthodox, with 14 different diseases mentioned from infections, eczema to abscess, hernia, oedema and new growth of the vulva. His recommendations serve as a good example for the eclectic treatment: surgical procedures were followed by electricity applied and medical remedies, from the Materia Medica, also indicated (ibid. 467). Under the header ‘new growths of the vulva’ he mentioned simple hypertrophy of the nymphae [inner labia], which he specifies: “It is not in reality a diseased condition, although abnormally large nymphae may lead to considerable irritation and sometimes need surgical interference. (…) In such cases, removal of the nymphae is justifiable and should be recommended” (ibid. 507).

35 For the clitoris, which addresses the author separately from the vulva, Thompson notices two conditions, which get a special notice: “the abnormally large hood, with adhesions binding it to the glans and a collection of smegma beneath, and the second is a hypertrophied condition in the glans itself” (ibid. 511). He has seen “a number of cases of masturbation, chorea, epilepsy, and nymphomania which were traced to this condition and which were speedily relieved by proper attention to this organ” (ibid).

36 To draw up an interim balance: When explaining his new ‘miracle cure’, Pratt borrowed only the concept of chronic disease from Hahnemann’s homeopathic theory but then turned to reflex theory, which was highly popular at the time. He combined this reflex theory with his highly ambitious surgical methods, initially focusing his attention on the rectum and male genitals. In the following years, Orificial surgeons increasingly focused on female genital organs as highly interesting locations for surgical intervention.

37 Orificial surgery originated in a highly vulnerable phase for surgical procedures. The specialty of gynecological surgery was in its infancy, but quickly developed due to new surgical techniques and operations on the uterus – frequently with highly questionable indications, as has already been pointed out by feminist literature (Daly). Orificial surgeons were in no way backward; they were modern and progressive, Pratt himself recommended a

new method of hysterectomy in 1893 (Rutkow 562). By that time, hysterectomy was assessed by German surgical gynecologists as a still extremely dangerous procedure, which only be conducted if necessary (Kreienberg 120)

Decline of Orificial Surgery

38 By the turn of the century, Orificial Surgery was already on the way out. This is reflected by the closing down of the journal in 1901. While homeopathic colleges were closing their doors, allopathic medicine, especially gynecology was on the rise, with surgical treatments and, in cases of cancer, radium therapy.

A second wave can be seen in the editing of a textbook on Orificial Surgery by Benjamin Elisha Dawson (1852-1922), in 1912, entitled *Orificial surgery, its philosophy, application, and technique*. His co-editors were Elizabeth H. Muncie, A. B. Grant and H. E. Beebe, Muncie and Beebe had published cases or articles on surgical procedures on the clitoris and labia. Pratt contributed the introduction.

39 Chapter LXIII “Circumcision in Girls” by Pratt is a reprint of his article from 1898.

Chapter LXIV is titled “Preputial adhesion in little girls” by Elizabeth H. Muncie which is more than a reprint of her article from 1898, as she provides a detailed anatomical description of the clitoris and its analogies to the male penis. And she mentions Isaak Baker-Brown, who “boldly removed the offending organ with excellent results in some cases, while in others great disaster followed and the work fell into disrepute, and attention to the clitoris, so far as the medical fraternity was concerned, into oblivion” (Dawson 494). From her point of view, “the world and the profession owe everlasting gratitude to the esteemed and noble pioneer of Orificial Surgery” (ibid.). Not surprisingly for that era, the next chapters of this edition concern the psychological factors and mental healing and suggestive therapeutics.

40 That the articles by Pratt and Muncie were included shows that these practices were conserved to be part of the canon of Orificial Surgery, by established orificial surgeons. This is also made clear in the chapter “Sexual Habits and Necessities,” in which Orificial Surgery is lauded as the healing art that had first turned its attention to the sexual organs, while other medical branches have focused on the other organs of the human body.

41 In 1925, Dawson’s book was re-published by his widow, three years after his death. It is still available as a reprint. Healing concepts did not only compete for public attention, recognition, and number of patients, but also for methods. The choice of methods is at least partially dictated by local, temporal and social conditions, even if we tend to believe that medicine is the same all over the world.

42 In the United States, homeopathy's initial supremacy as the dominant alternative medicine was soon contested by osteopathy and psychoanalysis, chiropractic, electric therapy and the talking cure. These therapeutic concepts took over the first choice of treatment for a variety of ailments, for which until then homeopathy had been considered helpful.

43 Despite the notion of right and wrong it can be put in the context of the American medical landscape at the turn of the century, where homeopathy and allopathy were much closer than today's sometimes rigid demarcation would lead one to believe (Dinges). Rutkow rated that most of the trained orificial surgeons ended up in allopathy, what means that they practice surgery (Rutkow 560). Also in the German history of medicine, a link between homeopathy and surgery was established: August Bier (1861-1949), Professor for Surgery at the Berlin University, was a strong advocate of homeopathy and he was good friend with the first lecturer for Homeopathy at Berlin University, Ernst Bastanier (1820-1953) (Lucae).

44 Pratt classified general health problems and affections as chronic diseases and thus claimed their treatment as belonging to the field of homeopathy. This classification then helped to acquire new patients who then were used to develop and research surgical techniques and methods. Hysterectomy, an operation that was considered fatal in the 19th century, became the realm of more courageous and ambitious orificial surgeons.

Conclusion and Discussion

45 Surgical alterations of the vulva, especially the clitoris, are currently addressed either as female genital mutilation or as a consented aesthetic surgery. But the bloody alterations of the vulva performed by orificial surgeons cannot so easily be categorized in this dichotomous thinking. This is what makes it so elusive for us today.

46 So how to frame, how to contextualize and how to interpret the phenomenon of Orificial Surgery? For Ira Rutkow, a surgeon and medical historian, it was an unorthodox surgical philosophy, which fit well in the late 19th century "the heydays of panacea (…) and outright quackery" (Rutkow 563). The medical historian Edward Wallerstein categorized it as a health fallacy (Wallerstein). The life and world of Orificial Surgery were rather short and was strongly connected to its representatives, who were mainly one generation of homeopathic surgeons. Orificial surgery was framed by the local conditions, a strong claim of usefulness and helpfulness of these treatments, and the high reputation of homeopathy at that time. From today's perspective, they seem to have been outsiders in the medical realm. Contextualizing their treatments at their time, they seem rather modern concerning the operations they performed. Not least, because of the broad variety of treatments offered, the

eclectic approach which included mental healing and suggestive therapies. This association acted modern in an open-minded attitude towards women in medicine.

47 The treatment is closely connected with the individual performing it and reporting on it. Among the protagonists of this particular method, Edwin Pratt and Benjamin Elisha Dawson stand out, as they have published under their names, in various books and journals. There were also several prominent female orificial surgeons, exemplified by Elizabeth Hamilton Muncie and Cora Smith-Eaton, who served in several official positions in the American Association for Orificial Surgery and co-editors. These women were pioneers, both as physicians and as surgeons. With Orificial Surgery, they believed to have found an appropriate way of helping their patients – at a time, when most countries still forbade women to study medicine at all. Over time, Orificial Surgery changed its orientation and its points of surgical access. While Pratt's monography from 1887 hardly mentions the clitoris, its hood, the labia or the vulva as a whole, surgical procedures for therapeutic and preventative reasons became more prominent in the journal and in the publication by Dawson.

48 Local conditions in Chicago towards the end of the 19th century were a fertile ground for the development of new medical approaches, as they were characterized by some positive factors: exponential growth of population – from 100,000 in 1860 to 1 million in 1890 – meant great numbers of patients; and a hitherto unregulated medical profession. Many of the existing medical colleges were underfinanced, understaffed and underequipped. Health insurance did not yet exist; the medical 'market' was therefore wide open; patients, who paid the bill anyway, chose their medical treatment from a variety of offers. Homeopathy was frequently accepted simply because it was more affordable than allopathy. Stronger regulation and reglementation of the market only happened after publication of the 1910 Flexner Report. Before that, the only valid rule was: he who heals is right.

49 Just like today, several medical explanation models and disease concepts existed at the end of the 19th century. The latest newcomer, bacteriology, offered a coherent explanation model for infectious diseases but was not able to provide effective treatments. While locationalism presumed the reason for diseases to be found in the afflicted organs themselves, reflex theory proposed that all organs and symptoms were connected via nervous system, and could also be treated by using the 'detours'. At around the same time, Wilhelm Fließ, a friend of Sigmund Freud's, introduced his nasal reflex theory as a surgical therapy on the nose to cure dysmenorrhea, the medical term for maladies around the monthly menstruation of the female, (Fließ; David/Ebert) to a German-speaking public; there are no known links to Orificial Surgery, although the theoretical concept seems alike.

50 Homeopathy, as developed by Hahnemann in the 18th century, offered an attractive treatment for chronic diseases. Preventive medicine had not yet become part of homeopathy. It did however become part of Orificial Surgery, as surgical interventions were used to avert foreseeable suffering. Models of explanation and treatment methods were mixed and matched by physicians, resulting in arbitrariness, or eclecticism, depending on the perspective. Eclecticists strictly opposed the binding character of pure doctrine, instead proposing to aim for the best possible treatment for individual patients. In a still unregulated medical world, numerous treatments were available: pharmaceuticals, dietetics, surgery, water and electricity, and talking.

51 During the last third of the 19th century, surgery was a booming industry, not least because anesthetics and antisepsis made it possible to survive surgical treatment. New instruments were developed, surgical accesses and methods were described for the first time, and daring pioneers earned credentials (Schlich). Even if from today’s point of view, Orificial Surgery is no more than a short-lived medical curiosity with questionable theoretical constructs, it would be worth considering whether orificial surgeons with their surgical courage (and even surgical mania to operate on orifices below the waist line) had not provided important contributions to gynecological surgery. Even the permanent repetitions of misogynist attitudes of many 19th century physicians and surgeons should not blind medical history to the fact that female surgeons, too, had endeavored to establish themselves in this field, and had also conducted these ‘modern’ treatments (Brock).

52 In my dissertation (Hulverscheidt, Weibliche Genitalverstümmelung), I pointed out that operations on the clitoris must be contextualized within the various other surgical treatments of the female genital organs. The clitoris is an organ that is easily accessible to surgeons – in comparison to the hypothalamus, adrenal glands, lungs or small intestines, and even more accessible than the uterus. The connotation of chronic disease and reflex fields provided models for explaining just how surgical treatment of the external genitalia could improve respiration, digestion or general wellbeing. With regard to neurotic-hysteric conditions and using locationalist thinking, the uterus should have been the target-organ for these treatments. But towards the end of the 19th century, hysterectomies were still extremely dangerous and were only conducted only if conserved absolutely necessary. In comparison, the negative side effects of vulva-operations were much less threatening; and seen from another perspective, the positive outcome did not necessarily have to be great, as the damage was considered negligible. The mutilating operative practice of vulva-surgery needs to be

compared to castration (cutting out the ovaries) and hysterectomy as a cure for psychological disorders in women.

53 Pratt did not practice homeopathy. The only term he loaned from homeopathy was the notion of chronic disease, but even this is interpreted in his way. Orificial surgery, as invented by Pratt, is a blend of surgical medicine, reflex theory, and medicalization of mood disorders, together with pathologization of masturbation – which seems to have been very common at the time.

Orificial surgery was a locally limited phenomenon, It was never popular outside of the United States, and here remained limited to very few centers. Orificial surgeons were ambitious, particularly regarding their surgical techniques. A positive trait of the Association for Orificial Surgeons is that it was one of the first such associations to accept female physicians and medical professionals.

54 In summary, it seems to have been a local phenomenon, which could only arise in the specific context of the US-American academic system.

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Normative and Contextual Feminism.
Lessons from the Debate around Female Genital Mutilation/Cutting

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Abstract

The case of female genital mutilation/cutting (FGM/C) is a touchstone for controversies between universalism and cultural relativism, both within and beyond feminist thinking. Revisiting the discussion regarding FGM/C provides important insights for contemporary feminist thinking because it touches upon issues that are highly relevant to today's discussions involving the question of human rights, individual and collective identity, othering, inequalities between the global North and the global South, the culturalization of gender and the intersection between gender, class, and ethnicity. Discussing feminist universalist and feminist cultural relativist perspectives on FGM/C, the paper reframes the two approaches as mutually constituting and conditioning each other. This mediated model contributes to a normative and simultaneously contextually embedded approach as a basis for a substantial analysis of FGM/C, and for contemporary feminist thinking.

Introduction

1 Feminist theories have increased manifold over the last decades, feeding into variations of, amongst others, queer theories, postcolonial theories and gender theories. Their perspectives on current topics are as diverse as their disciplinary, theoretical and normative background. What is more, they contain a juxtaposition that is more than a century old: the juxtaposition between universalism, on the one hand, and cultural relativism, on the other. While this juxtaposition presents itself in many faces, forms, and scholarly disciplines, it is particularly crucial for feminist thinking.

2 The case of female genital mutilation/cutting (FGM/C) or female genital excision (FGE) is a touchstone for both feminist reasoning and the controversy between universalism and cultural relativism. From the 1980s up until today, the topic is intimately connected to feminist interventions as well as to intra-feminist controversies that fuel feminist theories and practice. This paper revisits the heated feminist discussion about FGE because it touches upon the very issues that are relevant to feminist discussions today, as they involve the questions of the human rights framework, individual and collective identity, othering, the culturalization of gender, the role of empowerment and victimization, the limits and possibilities of change through state law or through civil society, inequalities between the global North and the global South, and the intersection between gender, culture and ethnicity. Positioning FGE in the juxtaposition between feminist cultural relativism and feminist universalism, this paper reframes cultural relativism and universalism as mutually constituting and conditioning each

other. It, therefore, goes beyond "dead-end arguments regarding universal values versus cultural relativism" (Hernlund and Shell-Duncan, Transcultural Positions 2).

3 After a short introduction into the term female genital excision, the paper introduces feminist universalist and feminist cultural relativist perspectives on FGE. On this basis, it provides a mediation between the two viewpoints. This structure enables a renewed approach to FGE which takes into account the strengths and the pitfalls of both feminist perspectives. In conclusion, the paper develops a normatively and simultaneously contextually embedded approach as a basis for contemporary feminist thinking.

Female Genital Excision

4 Female genital excision refers to the partial or total removal or physical alteration of parts of the female genitalia. The forms and consequences of FGE are extensively documented elsewhere (Shell-Duncan and Hernlund; Hernlund and Shell-Duncan, Transcultural Bodies; WHO; UNICEF). Instead of repeating these facts and figures (cf. Leonard), the present paper is dedicated to analyzing the rational of feminist perspectives, attacking and defending the practice, respectively. These perspectives will be discussed as feminist universalism, on the one hand, an approach that is dedicated to the abolition of the practice, and feminist cultural relativism, on the other hand, an approach that is dedicated to understanding the practice. The controversy around female genital excision is already visible in struggles about its term. The earlier term circumcision, a translation of several local terms (Abdel Hadi 107), is being criticized by feminist and human rights activists for belittling the harms and effects caused by the procedure. It cannot simply be parallelized with male circumcision as the term circumcision would suggest (Dorkenoo 4; Gifford 333). Universalist approaches striving for the abolition of the practice vote for its branding as female genital mutilation (FGM)—a widespread term that had entered into international documents and global campaigns by the end of the 20th century. Cultural relativist and contextually sensitive perspectives, in turn, use the terms female genital cutting (FGC), operation, alteration, surgery or modification. The effects of these terms are two-fold. On the one hand, they aim at avoiding insulting the women and communities concerned to lay the foundation for cooperation.

> As a physician, I am deeply convinced that the practice is a mutilation of the genital organs. […] Yet it is very difficult to use the term female genital mutilation in everyday interactions. […] Implying such deliberate ill-will on the part of the parents, circumcisers, and respected leaders is offensive enough to end

> the conversation, short-circuiting any chance of persuading people to reconsider the practice and embrace positive change. (Abdel Hadi 108)

On the other hand, these terms may make the practice appear harmless or even indicate medical necessity (cf. Gifford 333), thereby contributing to its preservation and legalization. In order to use a term that is neither downplaying the practice nor insulting the women and girls concerned, and because "terminology cannot be isolated from the political discourse from which it emanates" (Abusharaf, Introduction 7), the present paper refers to the practice as female genital excision (FGE).

Feminist Universalism

5 Universalist feminist approaches to FGE, developed mainly during the 1980s and 1990s, resemble second-wave feminism. They perceive FGE as a case of universal patriarchy that represents the universal suffering of the global sisterhood of women. The most famous proponents of this universalist view are Mary Daly, Fran Hosken, and Alice Walker.

6 Daly describes FGE as one of many cases of global patriarchy for which cultural or other differences do not play a role, and which exhibits a clear demarcation between men as perpetrators and women as helpless or brainwashed victims. Daly depicts practices of FGE as "unspeakable atrocities" (Daly 153f.) and compares them to contemporary gynecology in the United States, witch burning in Medieval Europe and national-socialist medical experiments in Germany, among others. According to Daly, they are all means to the same end. She aims at showing

> how women in various cultures—which are merely multi-manifestations of the overall culture of androcracy—have often been lulled/lobotomized by the myths and habits of their particular social context. Drugged by the prevailing local dogmas and disabled physically, they have not always seen the intent behind the vicious circle of maiming and murder of mothers and daughters. (Daly 224)

Overall, Daly describes universal patriarchy as a male conspiracy aiming to suppress, colonize and murder women (Daly 1, 23, 155ff.).

7 Unlike Daly's esoteric-philosophical approach, Hosken develops a medical perspective on FGE. She aims at revealing the health risks and consequences of FGE. Her widely quoted study is dedicated to the historical development and forms of FGE and the movements against it in different countries. It provides one of the early categorizations between different physical types of FGE. However, Hosken's conclusion resembles that of Daly's, in that she invokes a normatively one-dimensional frame to argue for the abolishment

of the practice. Like Daly, Hosken sketches a clear dichotomy between male perpetrators and female victims, enhanced by a "conspiracy of silence" (Hosken 315). "It is, therefore, clear that men are responsible for the worsening conditions of Africa: women and children are the abused and voiceless victims" (Hosken 69, similarly 5ff., 324ff.).

8 Walker's personalized and emotionalized representation of FGE represents the third version of universalist feminist approaches.[1] Trying to shed light on the suffering of the girls and women that Walker and her co-author Parmar met during their visits to African countries, their book focuses on the girls' individual stories. Walker connects them to her own suffering of having lost partial eyesight due to a gunshot wound inflicted by her then ten-year-old brother. Both forms of suffering, she claims, represent a "patriarchal wound" (Walker and Parmar 17). Like Daly and Hosken, Walker and Parmar conclude that girls and women are the helpless victims of FGE as a patriarchal practice, "perfectly indoctrinated and programmed to say nothing" (Walker and Parmar 49).

9 The three approaches represent different perspectives of what came to be known as second-wave feminism. They range from differential feminism that is based on the assumption of fundamental differences between the sexes/genders to equality feminism that assumes the genders to be equal (Kerner).[2] Despite their diverse starting points, the three approaches share decisive aspects. They establish a one-dimensional, normative yardstick for analysis and critique. This yardstick is the patriarchal domination of men over women in which roles of perpetrators and victims are divided between the sexes. This yardstick is being universalized and applied to different contexts, while the differences between these contexts or between women are eschewed. This de-contextualization has two far-reaching effects.

10 First, the equalization of highly different societal mechanisms and the generalization of patriarchy disregards the social, cultural, political and economic conditions of FGE (or of any other patriarchal practice, for that matter) (Gruenbaum, Cultural Debates 462; El Guindi 42; Abusharaf, Virtous Cuts 116f.; Walley 418). It thereby not only hinders an adequate analysis and critique of FGE but also jeopardizes the possibility of cooperation and solidarity with the women concerned, since the latter are being misrepresented and not taken seriously in their perspectives, struggles, and incentives.

11 Second, this kind of universalist de-contextualization contributes to an ethnocentric—if not racist—othering. Depicting FGE as an abomination and the women concerned as passive, voiceless or clueless victims, the feminist universalist view introduces a hierarchy of

[1] See also James 1031f. for a critical discussion of Walker, and Caplan discussing Hosken.
[2] Especially Daly's esoteric approach and her invocation of goddesses contribute to the former.

insight, knowledge, and enlightenment, “with all the zeal of the old missionaries” (Browne 261). The ‘other’ is denied of having own interests and perspectives. What is more, if it does, and if it differs from the universalized perspective, this is taken as proof of the other’s deficiency (Gunning 199). This stance reproduces patterns of imperialism, (neo-) colonialism and racism in the cloak of feminism: white women save brown women from brown men (Abusharaf, Virtous Cuts 115; Spivak 92; Anthias and Yuval-Davis; Nnaemeka). It thereby undermines its incentive to establish a notion of global womanhood and a common struggle against patriarchy. “For while feminism is definitely about establishing and defending principles, these principles become meaningless if they no longer serve the real-life women in whose name they have been elaborated” (Winter 972). Ultimately, feminist universalism—while motives and incentives differ—utilizes the practice of FGE to strengthen the universalization of its own normative assumptions.

Feminist Cultural Relativism

12 The topic of FGE was not only a matter of top concern for second-wave feminists but led to sharp intra-feminist controversies that paved the way for what came to be known as third-wave feminism. Its relevance is mirrored in the United Nations Decade for Women 1975-1985 and the corresponding World Conference 1980 in Copenhagen where women from the global South threatened to leave, because of “the angry, emotional responses to female circumcision” by women from the global North (Abusharaf, Virtous Cuts 115). As a direct response to the demonization of FGE, approaches were developed that urged not only to contextualize the practice but also to respect it as a cultural tradition or as a free decision of the women involved. The various critiques amount to three forms of response. The first form is dedicated to belittling the harm that supposedly is caused by FGE. It is argued that facts and figures about health consequences and malfunctions are excessively exaggerated (Obermeyer; Ahmadu), if not simply wrong (Shweder).[3]

13 The second form of response puts FGE on one level with diets and epilation (Boddy 16), with Western cosmetic and plastic surgery (Browne 265; Korieh 120), with tonsillectomies and appendectomies (Erlich 156) or even with abortions (Erlich 162; Korieh 119f.; Shweder 225). These responses aim at criticizing a Westernized perception of FGE as an abomination.

[3] This is not the place to discuss these arguments. Suffice to say that the different forms of FGE cause different degrees of harm and life-long consequences. Cf. WHO, Eliminating FGM; Mende, Begründungsmuster 84–97.

> It is hypocritical, for example, that many Western feminists and governments have devoted themselves to criminalizing female circumcision, while blatantly supporting abortions and pro-choice-extremism. […] One wonders, for instance, which procedure is more morally shocking, female circumcision or partial-birth abortion. (Korieh 119f.)

Thereby, albeit unknowingly, they resemble Daly's approach in assuming universal mechanisms of domination that merely come in different forms. Neither the degree of medical indication nor the mental and physical effects of each procedure are taken into account here, let alone the vast difference encountered in the debates surrounding abortion.

14 The third form of response states that the universalist argument of patriarchy cannot be applied to FGE at all, because FGE, more often than not, is conducted by women (Abusharaf, Virtous Cuts 122; Thomas 131; Skinner 196). A variation of this line of thought is to present FGE as an equivalent to male circumcision (Shweder 221; Skinner 196).

15 Feminist cultural relativist approaches are most visibly represented in the third form of perspectives on FGE because they claim to strive for the women's well-being who supposedly agree to, if not embrace the practice. In this spirit, Shweder calls FGE an improvement (Shweder 224), describing infibulation (which is the most invasive form of FGE) as "smoothing out" (218). According to him, women would fully consent to FGE, looking forward to and celebrating the procedure (211, 222, similarly Leonard). He employs a classical account of cultural relativism, demanding that the "values of pluralism" and "tolerance" be upheld (Shweder 212), "instead of assuming that our own perceptions of beauty and disfigurement are universal" (216).

16 A similar argumentation is developed by Ahmadu. She presents her own experience of FGE as empowerment (Ahmadu, Rites 310) that enables her to juggle with different identities in the United States, where she lives, and in Sierra Leone, from where her parents emigrated (305). According to her, the will of the women concerned should be the crucial point of any normative perspective. "Ultimately, it is up to each generation of women to decide whether to continue or to reject this tradition without fear and coercion from outside as well as inside" (294).

17 These accounts of feminist cultural relativism have a crucial aspect in common. They are based on the cultural relativist demand for tolerance of 'other' practices and the imperative not to judge 'others' based on ones 'own' normative assumptions. However, along the way, they dismiss what they initially stood up for: acknowledging the context of FGE. The parallelization of FGE with male circumcision, cosmetic surgery or even abortion ignores

power relations and access to societal resources and participation in decision-making processes. Shweder's assumes consent and free will, without asking for the conditions of free will and possibilities for alternative choices. Ahmadu generalizes her individual experience, without taking her privilege of knowledge into account.

18 Sierra Leone, where Ahmadu's experience is situated, has been one of the regions to which Daly's and Hosken's diagnosis of a "conspiracy of silence" actually applied. Extensive parts of the society in Sierra Leone were (and partly still are) organized in secret societies that are strictly gendered and hierarchically stratified (Rust). Membership in these societies was an uncircumventable precondition for participation in social, political and economic life, and it required undergoing FGE to become an appropriate, worthy, heterosexual woman. Due to the "code of silence" in Sierra Leone (as explicitly invoked by Ahmadu, Rites 292), knowledge about the practice was scarce— before and even after the procedure. After recent information campaigns, knowledge has now grown, with the result that the procedure is increasingly being performed on girls of a younger age (Rust 101ff.). Ahmadu knew the form and the effects of the ritual, she had the choice to undergo the procedure or to refrain, and she had the viable alternative to leave the country. These are three conditions that are usually not available to the women and girls in Sierra Leone.

19 In these regards, the feminist cultural relativist approaches raise an individualized, subjectivist view. Accordingly, Ahmadu states that if women were not keen on continuing the practice, they would simply end it (Ahmadu, Rites 301), while for Shweder, the debate around FGE is mostly just a matter of aesthetics and individual taste. Power relations within the societies concerned that may pressure women (not to mention children) into FGE, or the mechanisms of socialization and internalization that may explain the participation or even consent of women—all these are tremendously important forms of context that are absent from the feminist cultural relativist perspective.

20 What is more, feminist cultural relativism contributes to the mechanism that it meant to overcome. This approach, too, contributes to othering, by setting an exclusive focus on differences between so-called Western and so-called non-Western views. "To suggest that only those who have experienced a practice or those who can lay claim to it on the basis of racial or ethnic identity have the 'right' to speak essentializes both practitioners and nonpractitioners" (Walley 408). The assumption that controversy simply arises between Western views against FGE and non-Western views embracing it fails to acknowledge the

struggles by the latter that largely contributed to a critique of FGE (Thiam; Koso-Thomas; Dorkenoo, also cf. Bekers).

> They deserve the recognition, admiration and sympathetic solidarity of other women on an egalitarian basis rather than a condescending reemphasis on 'otherness' that, paradoxically, sacralizes the very 'tradition' such women are intimately involved in changing. […] That the guise for this attack has been the struggle against assumed-to-be universal patriarchy makes it no less damaging. (Robertson 615)

Eventually, feminist cultural relativism undermines its own incentives, playing off difference against equality.

Mediation between Feminist Universalism and Feminist Cultural Relativism

21 The discussion of feminist universalist approaches, on the one hand, and feminist cultural relativist approaches, on the other hand, shows that both sides provide only a segmental analysis of FGE. What is more, both sides fail to accomplish their own goals. It is, however, interesting to note that both, apparently contradictory, approaches have a common point of reference: the question of free will. In the following discussion, free will as a common point of reference reveals how both sides can be viewed as being intertwined.

22 Universalist approaches claim the lack of free will. Women and girls would not freely and consciously consent to the practice. Instead, they are forced to undergo the procedure by patriarchal societies. Cultural relativist approaches, in turn, base their arguments on the assumption of free will. According to them, FGE fulfills important functions for the women concerned and is therefore welcomed by them. Against this background, the demand to abolish the practice is racist and devaluating, based solely on Western values. Hence, both approaches refer to free will affirmatively. While they differ about the question whether free will is lacking or given, both agree in acknowledging free will as a normative yardstick.

23 Providing both universalist and cultural relativist approaches with a normative point of reference, the question of free will can significantly contribute to a mediated approach that is based upon the intermingling of both sides. In the intermediated model, each side includes aspects from the other side, and it does so necessarily and inherently, as I will show in the following discussion. Shweder explains his acknowledgment of FGE as follows:

> African women too have rights to personal and family privacy, to guide the development of their children in light of their own ideals of the good life, and to be free of excessive and unreasonable government intrusion. […] Seeing the cultural point and getting the scientific facts straight is where tolerance begins.

> […] Tolerance means setting aside our readily aroused and powerfully negative feelings about the practices of immigrant minority groups. (Shweder 226f.)

He thus bases his cultural relativist argument on universalist assumptions. Certain rights, such as the right to privacy and culture, should apply to everyone. However, Shweder fails to explain why it is only these rights that should be applied universally, but not other rights, as the right to bodily integrity or children's rights. Shweder (necessarily) refers to universalist arguments, but he does so in an unreflected and implicit way. This omission and the impression of a non-normative approach leads to a one-sided cultural relativism that integrates some but skips other kinds of context.

24 One-sided universalist approaches, for their part, deny the women concerned any agency and free will.

> Those who have endured the unspeakable atrocities of genital mutilation have in most cases been effectively silenced. Indeed this profound silencing of the mind's imaginative and critical powers is one basic function of the sado-ritual, which teaches women never to forget to murder their own divinity. (Daly 155f.)

Even if universalist approaches do not intend to portray practitioners as ill-willed or evil (as it is often alleged by cultural relativists), it is the assumption of global patriarchy and brain-washing that characterizes the women concerned as submissive, ill-guided victims. One of the universalist aims is to analyze FGE as a sexist practice that contributes to gender inequalities. It fails in this, however, if it focuses solely on (personalized) power relations between active men and passive women in a dichotomous and generalizing manner. On the contrary, this line of thought invokes binary gendered assumptions. It idealizes or victimizes women, and it paves the way for the counter argument stating that FGE cannot possibly contribute to gender inequality because it is exercised by women (Skinner 196). Indeed, FGE often is being reproduced by women and performed by female circumcisers. If a universalist approach tackling gender inequalities wants to take this phenomenon seriously, without giving in to the cultural relativist notion of FGE being a harmless and welcomed practice, it cannot stick to a binary perspective that perceives (all) women as victims of (only) patriarchy in the same regards. Accordingly, in her open letter to Daly, Lorde notes:

> Your inclusion of African genital mutilation was an important and necessary piece […]. To imply, however, that all women suffer the same oppression simply because we are women is to lose sight of the many varied tools of patriarchy. It is to ignore how those tools are used by women without [and with, J.M.] awareness against each other. (Lorde 67)

The omission of context and difference leads to a one-sided universalism that addresses some but neglects other inequalities.

25 Consequently, both approaches display blind spots and omissions, while at the same time, both also provide necessary and important features for feminist thinking. Furthermore, both approaches interact in that they fill the other's blind spots. To achieve its aim of tackling gender inequalities, a feminist universalist approach necessarily has to take context into account. To achieve its aim of respecting the women and girls concerned, a feminist cultural relativist approach has to take normative perspectives into account.

26 This constellation enables the mediation between feminist universalism and feminist cultural relativism. It puts the discussion of FGE and the question of free will on a solid basis. The concept of mediation does not mean discarding one of the approaches, thereby one-dimensionally over-emphasizing the other. At the same time, it is not mixing up the two contradictory approaches or treating them as identical, either. Rather, the mediation model implements each side's productive elements by means of reflection on each side's repressive aspects. This is possible because each side contains its opposing moments in itself, and each side can only fulfill its own aims if it explicitly reflects on these very internal, opposing moments.

27 Feminist cultural relativism strives for tolerance, the well-being of women, the acknowledgment of differences, or the end of imperialism, colonization, ethnocentrism, and racism.[4] In any of its forms, it rests upon normative assumptions. One reason for this is that perspectives, critiques, and approaches cannot be entirely neutral or unbiased, but they are always situated and contextually positioned (Mende, Human Right 161ff.). While an implicit bias can be neglected—thereby masking rather than circumventing its effects—it cannot be entirely eliminated. Struggles against colonialism and racism provide even more explicit normative starting points. If feminist cultural relativism neglects its inherent normative aspect, it becomes a tool of oppression. It leads to an indifference in which suffering cannot be addressed, as long as it is culturally approved. It undermines its own demand for contextualization by neglecting power relations within a certain community. If, however,

[4] Early forms of cultural relativism, developed in anthropology at the onset of the 20th century, were demanding respect and tolerance towards non-Western cultures, based on the (universal) assumption of equality between different societies (Boas; Mead; Benedict; Herskovits). Epistemological forms of relativism in the 1970s and 1980s denied any possibility of universal truth or mankind, emphasizing the meaning of context (Geertz, Interpretation). Yet they too knew the necessity of normative distinctions between right and wrong (Geertz, Anti-anti-relativism 275ff.). Contemporary cultural relativist approaches that strive for cultural self-determination, the survival of minority cultures and religions can be situated in the frame of (universal) human rights (cf. Mende, Human Right).

feminist cultural relativism reflects on its normative part, not only can the unwanted effects of bias be revealed and diminished, but differing normative yardsticks, concepts of free will and suffering can be discussed transparently and openly. Power inequalities within communities and intersecting axes of difference can be addressed, without losing gender inequalities out of sight.

28 Feminist universalism, on the other hand, referring to human rights, dignity, global sisterhood or equality, aims at the revelation and ending of mechanisms that contribute to gender inequalities, to suffering or to the submission of women. To do so, it rests upon the ability to take the women concerned seriously. This is only possible, if cultural, social, political and economic contexts, in other words: if differences are taken into account. If feminist universalism does not acknowledge its inherent necessity for context, it becomes repressive. It would then dismiss differing experience, and it would enforce strategies, e.g. the eradication of FGE, that turn against the women concerned. It would use the concepts of human rights or feminism to (re-) produce and simultaneously mask inequalities that lay beyond its focus on patriarchy, e.g., between the global North and the global South. A contextually embedded feminist universalism, however, allows reconciling difference with equality instead of treating the two as mutually exclusive (Müller and Mende). It allows for a recognition of differences within and similarities between the global North and the global South (Hall; Sen), without ignoring dominant power relations. It allows for an analysis of intersectionality, without giving up normative references to, e.g., universal human rights. Finally, it provides a critical assessment of the own normative position, embedded in political, social and theoretical context.

29 The mediation between feminist universalism and feminist cultural relativism facilitates an analysis of FGE and the role of free will that does not hypostatize one of the one-dimensional approaches, ending up with either of their pitfalls and deadlocks. It also builds the basis for a contemporary feminism that is normatively and contextually embedded. Both discussions will be taken up in turn in the following, and in the concluding section.

A Mediated Approach to FGE

30 The discussion of feminist universalist and feminist cultural relativist approaches to FGE demonstrates that any normative evaluation of the practice, just as any question about its eradication and about the free will of the women and girls concerned needs to inquire as to the motives, reasons, structures, and incentives underlying the practice. This seems to pose a

major challenge, because of the enormous differences in how FGE is carried out in different societies. The forms of the physical procedure, the age of the girls or women that undergo the procedure, the accompanying rituals, the surroundings in terms of hygiene, the skills, qualifications and gender of the circumciser, and the health consequences differ as much as the historical roots, the legal status, the social, cultural and sexual meanings and the roles of religion and tradition. Extensive research, however, much of it conducted by anthropologists and physicians, reveals recurring reasons and incentives in the different societies performing FGE. These reasons, which may be interwoven and overlapping, can be summarized as follows:

1) tradition (El-Dareer 67; Carr 27; Orubuloye et al. 81; Abusharaf, Virtous Cuts 134),
2) religion (Wangila 106ff.; Boddy 15; Hicks 63ff.; Budiharsana et al. 9; Abdalla; Clarence-Smith),
3) ethnic distinction (Sharkey 130; Walley 417; Johnson 231; Ahmadu, Rites 301; Gruenbaum, Reproductive Ritual),
4) a rite of passage signifying adulthood or womanhood (Ahmadu, Rites 295ff.; Rust 56ff.; Johnson 223; El Guindi 30),
5) functions connected to sexuality, including ritual or religious purity (El-Dareer 73; Gordon 13; Abdel Hadi 107), bodily cleanliness (Koso-Thomas 7; Rust 34), beauty (Abusharaf, Virtous Cuts 122), sexual pleasure for men (Gruenbaum, Cultural Pattern 50; van der Kwaak 783), but also female control over their own sexuality that promises empowerment (Shell-Duncan and Hernlund 27; Silverman 431)
6) the societal control over female sexuality, including the protection of her virginity and fidelity and the prevention of promiscuity, pre-marital sexual intercourse, masturbation and lust (Gordon 9; Hicks 219; Rust 47; Sifuna et al. 344), and the protection of family honor connected to female sexuality (Gruenbaum, Cultural Debate 461; van der Kwaak 781; Abusharaf, Virtous Cuts 130ff.),
7) marriageability, an explicit, almost ubiquitous reason for the practice, meaning that non-excised women will not be able to get married which often is the precondition for any relevant form of participation in social and economic life (Mackie 270; Shell-Duncan and Hernlund 127; van der Kwaak 777; Abdalla 102; Gruenbaum, Reproductive Ritual; Zénie-Ziegler; Leonard).[5]

[5] For the development and extensive discussion of these seven reasons, cf. Mende, Begründungsmuster: 122ff.

The diversity of these reasons, motives, and incentives notwithstanding, virtually all of them share one feature: FGE in its different forms contributes to the constitution of a certain identity, either consciously targeted or unconsciously inscribed in social practices. FGE as a traditionally or religiously motivated act constitutes affiliation to the traditional or religious community. Thus, it is the precondition for participation in communal or religious life, to the effect that a refusal of the practice can lead to implicit (Orubuloye et al. 81) or explicit (Quiminal 183) threats of exclusion. FGE as a marker for ethnic distinction is interwoven with religious and traditional motives, but it is also a function of its own, constituting membership in a collective identity. It facilitates distinction vis-à-vis other ethnically or religiously defined groups or vis-à-vis Western, colonial or imperial powers. In case of the latter, FGE may serve as a marker for cultural and collective self-determination, providing a clear delineation between colonialism and traditional identity. FGE may even be deployed along these lines if it has not been an important cultural trait before (as is the case in Kenyatta). Cultural, ethnic and religious collective identities are thus inscribed in women's bodies. This entails the contempt of women that are not excised, both inside and outside of the collective. This function of distinction is closely interwoven with functions connected to sexuality, marriageability, and rites of passage. In these roles, FGE constitutes the identity of an adult, female, heterosexual woman. It marks the difference between a child and a woman, between a reputable and a despised woman, or between a woman that is allowed to marry, give birth, attend school, get a job, use collective facilities or participate in social life—and a woman who is not allowed or not even considered able to do so.[6]

31 The contextual analysis of the identity-constituting function of FGE builds the basis for several important analytical as well as normative conclusions. First, it shows the close interconnection between collective and individual identity. The recognition of an individual identity as a woman is dependent on collective, often culturally or religiously funded, ascriptions. These are almost never just about the aesthetical or physical alteration of female genitalia but connected to socially shared meanings and ascriptions of what it means to be a woman— regarding behavior, rules, and norms. Vice versa, a collective identity as culturally self-determined, or ethnically or religiously distinct is produced through, and constituted by, the inscription into female bodies and the individual behavior of women. These collective ascriptions are not just superficial, external demands. They also interpenetrate individual perceptions and evaluations of the self, up to the point that notions of internal and external

[6] Accordingly, in some societies the procedure of FGE is accompanied by instructions about female obedience and appropriate behavior of a wife and woman (Browne 249; Mohamud et al. 81).

ascriptions cannot be dichotomously separated. They constitute both the close relation between individual identity and collective identity (Mende, Collective Identity).

32 Second, it shows how deeply the constitution and acknowledgment of both collective and individual identity are embedded in social, political and economic conditions and structures—on local, national and global scales. This embedding exhibits the power of FGE. Undergoing the practice is neither just an individual choice nor a matter of taste, but often, it enables the agency and, eventually, even survival. It is the necessary basis for a socially accepted and economically valid life. This explains why women may very well embrace or at least accept the practice. This is not because they are brainwashed or clueless, but because they are all too well aware of the consequences.[7] On this basis, it is also possible to understand the participation of women in continuing the practice, without thereby skipping notions of gender inequality. Rather, an intersectional analysis of FGE and its interweaving with axes of gender, class, ethnicity, and age is necessary.

33 Third, neither the practice nor its surrounding circumstances nor its justifications are static. FGE is not a natural given that has to be accepted as a matter of tradition, culture or religion. Traditions, cultures, and religions can change significantly, as does the reference to them. This is visible in the different meanings bestowed on FGE within Islamic considerations. There are interpretations of the Quran and fatwas both condemning and embracing FGE, or preferring one form of FGE over the other. Muslim identity can be based on the exercise or the rejection of FGE (El Bashir 155ff.), each employing different assumptions about the position of women (Gruenbaum, Cultural Debate 472). Another example concerns the role of education. In some communities, abolition strategies that are based on the education of girls and the empowerment of women are progressing (Abdel Hadi; Mohamud et al.). However, in several Kenyan communities, the rate of FGE increased, while the age of the girls concerned decreased, just because more girls were visiting schools. With FGE, families, and communities wanted to make sure that the girls would not become too independent and 'indecent' (Shell-Duncan et al. 121; Thomas 147). This dynamic character of FGE and its functions corresponds to the dynamic aspect of collective identity (Mende, Human Right 70ff.; Mende, Collective Identity).

34 Fourth, it is possible to aim at the eradication of the practice without skipping context. This is important because, from a feminist perspective, it is normatively insufficient to aim at

[7] This analysis considers adult women. However, FGE is often performed at under-aged or even very young girls. In these cases, further discussion is necessary, in order to consider to what extent "the person concerned, even if duly informed, will not be in a position to assess the consequences of her decision" (Ouguergouz 106).

the abolition of the practice without considering its larger context. This is visible in eradication strategies that target the physical procedure, but not the accompanying social, cultural and economic conditions, circumstances and meanings.[8] The same applies to the medicalization of the practice.[9] It may reduce suffering from health consequences, but it does not touch upon societal inequalities and disadvantages of women.

> Indeed the comprehensive proposals of Somali women groups call for social, economic, and political improvement in the status of women. This improvement is not only key to eliminating traditions that affect their well-being and prosperity but also for the sustainability of attitudinal shifts towards the abolition of female circumcision. (Abdalla 204)

A normatively and contextually embedded approach to FGE provides the basis for re-approaching the question of free will. It recognizes free will as a normative aim that is dependent on access to viable alternatives. Individual choice is deeply interwoven with enabling and disabling conditions that encompass social, economic and political power relations, identity mechanisms and inequalities, from the local to the global level.

35 In effect, a contextual consideration of the practice enables pluralist forms of feminist solidarity that take the women concerned and their struggles seriously. At the same time, this is not possible without normative notions about inequalities and social struggles.

Normative and Contextual Feminism

36 Feminism today has multiple faces. The topic of FGE hardly plays a role in any of them anymore. This is not because FGE as a practice has been eradicated. An estimate of 140-200 million women and girls worldwide have undergone the procedure, with a further 3 million girls and women facing it annually (UNICEF). But it is largely left to be dealt with by international organizations dedicated to health issues, NGOs dedicated to women's issues, and to anthropological and medical discussions. Whether it is the rise of too many other urgent topics, a matter of temporary fashion or because arguments on the topic of FGE have been exchanged exhaustedly—the reasons for the decrease of feminist interest vary. Still, feminism(s) today can learn from the debates around FGE. These debates paved the way to

[8] The ritual without cutting is a strategy with the aim to eradicate the practice, without necessarily abolishing the accompanying rituals and their social functions, including safeguarding female obedience and gender inequality. It is about "offering alternative ways of achieving the same objective" (Mandara 107). But recent versions of the ritual without cutting include accompanying teachings about human rights and health issues (Hernlund 250; Mohamud et al. 99; Sifuna et al. 353).

[9] Medicalization means to perform the practice in hospitals or similar hygienic surroundings and by trained professionals. It is a strategy to reduce the health risks that are due to a lack of hygiene, training or appropriate instruments (Ahmadu 285; Shell-Duncan et al. 111). A version of this strategy is to substitute invasive forms of FGE with non-invasive "de minimis procedures" carried out by medical professionals (Arora and Jacobs).

the elaboration of feminist universalist and feminist cultural relativist arguments that are still being employed today. The mediation between these two approaches allows for feminist perspectives that are normatively and contextually embedded. The integration of these elements is not a simple mix-up but based on a mediated constellation in which each side is prevented from becoming repressive only by the other side, and vice versa. Thus, both are constitutive for a normative and contextual feminism.

37 The necessity of contextual embedding includes several levels and forms that can be summarized as structure, power, intersectionality, and socialization. *Structure* refers to economic, social, political as well as cultural circumstances, from the global to the local level, that build the frames and conditions for the matter of interest. *Power* analyses show that these circumstances do not just explain differences, but that they constitute relations of hierarchy and inequality. They determine what will be decided on in politics, and what will be addressed or not addressed as a matter of interest in the first place (Lukes). Access to economic resources, the possibilities and limits of social participation, the political and legal involvement or neglect of issues, cultural and societal norms about gender identities—they all contribute to gendered forms of power, empowerment, and disempowerment. *Intersectionality* reveals how gender relations intersect with other axes of power, inclusion, and exclusion (Chowdhry and Nair; Klinger et al.). Notions of *socialization* and internalization (Benjamin; Bourdieu) elucidate the limits of subjectivist, individualistic views that discuss a matter as an individual decision that can be changed to suit the need. Rather, societal circumstances on the one hand and individuality and free will on the other are so deeply interwoven and entangled that they are mutually constitutive. Neither exists without the other, each of them forms the other, yet both can gain a certain form of independence from each other in that they are not identical. This means that individuality is socially constituted, but not statically determined, and vice versa (Mende, Collective Identity 49ff.).

38 The necessity of normative embedding, in turn, does not imply apodictic normative determination. Quite the opposite is the case. In every context, in every society, religion or controversy, there are different normative perspectives. The question as to which normative perspective a feminist approach agrees or disagrees with, is a normative one. It is therefore not sufficient to base an approach on siding with so-called local or disadvantaged perspectives, because here too, normative assumptions and their effects vary. Only if normative assumptions and their implications are being assessed and revealed, is it possible to put them up for discussion, to argue for or against them, and to reflect on them.

39 In contemporary feminist thinking, normative yardsticks can and do differ. This paper's argument for a contextual and normative feminism does not vote for a single or homogenous normative perspective. While normative and contextual feminism is not about claiming a universal truth, it is about employing tools to address and identify suffering, to differentiate between right and wrong, and to reveal and reflect on the basis for such a differentiation, for it to be open to inquiry.

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IN VULVA VANITAS – The Rise of Labiaplasty in the West

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Abstract

Since the turn of the 21st century, more and more women choose to undergo Female Genital Cosmetic Surgery (FGCS) to fit a vulvovaginal aesthetic ideal. With a focus on reduction labiaplasty as the currently most widespread of these procedures, this article examines FGCS through a critical cultural studies lens to position it within larger feminist debates about body image, consumer culture, and female agency. A central question is where our Western ideal of female genital appearance comes from that incites the desire to undergo surgical body modification? Against the backdrop of post-colonial criticism, the article challenges the distinction between FGM in non-Western cultures and FGCS in the West through questioning the notion of informed consent associated with the latter. By bringing together otherwise separate voices from various disciplines, the overall aim is to present FGCS as an intricate interface between biology, psychology, culture, and media discourse.[1]

"It's time to let my labia rip and rearrange this."
– from "Pussy Manifesto" by Bitch & Animal

1 Try this: walk into a drug store, grab a shopping cart, and put inside every product designed to optimize the female-coded body. Spoiler alert! One cart will not be enough. Shampoo to make our hair shiny, lotions to make our skin smooth, toothpaste to whiten our teeth, concealer to hide our freckles, gloss to boost our lips, face masks to make us look like we had enough sleep, fake nails, fake lashes, fake tan – the assortment is as endless as its subtext is loud and clear: your body needs modification! A plethora of anti-something products provide an exhaustive list of things we are supposed to work on: frizz, cellulite, pimples, puffiness, dark circles, body hair, brittle nails, stretch marks, belly fat, to name just a few; and of course, any sign of aging whatsoever, from grey hair to wrinkles to saggy arm skin. "We are bombarded everyday with countless thousands of messages informing us that we do not look young enough, slim enough, white enough" (Penny, *Meat* 1). Flawless faces smiling from posters and labels provide the counterimage, the – often unattainable – goal.

[1] I am fully aware of the trans-exclusive politics inherent in wordings such as "female genitals" and of the fact that neither *only* women nor *all* women are vulva-owners. To avoid reinforcing the genitalia-centered gender binary our culture has so successfully constructed turned out to be an insurmountable task for me in writing about a subject matter basically originating from that very construct. Especially as a white cis-woman writing from a position of privilege, I can only apologize for my inability to find a solution to this dilemma here and express my hope to see the day when language and ideology alike are fully capable of both, trans inclusivity and gender fluidity. The complex question of how trans, gender-reassigned, or intersex people feel about their (neo-) vulvas is one I lack the expertise and data to tackle but would love to see answered comprehensively and respectfully in future research.

Through dictating particular beauty ideals, these grooming products create the body dissatisfactions to which they then offer ready-made purchasable solutions. Modifying female-coded bodies has long been and continues to be a huge market that capitalizes on cis-, and often even more on trans-, women's insecurities about the way they look. "The pursuit of beauty is big business in modern societies" (Sullivan 1). Even at a time when we have more access to power, knowledge, and resources than ever before, anxious Western women invest a lot of energy, time, and dollars every day by cleansing, scrubbing, moisturizing our way towards some feminine ideal constructed by a powerful consumption machinery.

2 "The perfectionist body project" (Tiefer 475) does not stop above the belt. Body-altering, supposedly body-improving, practices and products do also target female genitalia. Shavers, depilatory cream, and wax strips are supposed to help get rid of its natural hair, just like vaginal deodorant and washing lotions eliminate its natural smell, intimate bleaching creams its natural color, and pads and tampons "help keep your period invisible" (Tampax n.pag.) – the ideal pussy is hairless, odorless, colorless, stainless; in short, unobtrusive. Again, the message to women is clear: what 'Mother Nature' has given you needs to be improved; "It looks bad. Shave it. It smells bad. Wash it. Scour it. Deodorize it. It tastes bad. Wash it more. It's dry. Lubricate it" (Greer 74). To achieve genital perfection, more and more women are willing to go even further in modifying their bodies. The 'designer vagina' has become a buzz word in contemporary public discourse – Female Genital Cosmetic Surgeries (FGCS) are on the rise.[2]

The Vulva in the Age of Surgical Reconstruction

3 While exact figures seem hard to obtain[3], it is by now common sense that there is a current trend of increased popularity of FGCS (cf. Braun, "Pleasure" 407; Méritt 180; *ISAPS* 27; Veale et al. 57). As one US gynecologist put it: "It's basically where breast augmentation was 30 years ago" (Jacobsen qtd. in Gurley n.pag.). FGCS is an umbrella term for all genital surgical procedures for which there is no medical necessity. These include vaginal procedures

[2] None of this is to suggest that male-coded bodies are not also put under social pressure to fit a certain prototype. As Naomi Wolf acknowledges in 2002, "a male beauty myth has established itself in the last decade" (*Beauty* 8) – obviously, "men experience body policing, too" (Penny, *Unspeakable* 31). They seem to be targeted by the cosmetics industry, however, for the sheer market opportunity (cf. Wolf, *Beauty* 7) rather than for age-old cultural assumptions about masculinity and are, in turn, not socialized to value their beauty as essential to their identity in the same way that women are. Body dissatisfaction is still found to be more prevalent in the latter (cf. Sullivan 28). While men have increasingly become customers of the cosmetic surgery industry, too (cf. Berer 4; Sullivan 30), women – with 86% of all performed procedures (cf. *ISAPS* 53) – remain their primary consumer (see also Davis 117ff; Meßmer 8; Blum 86ff). So the context is and remains gendered.

[3] This is mainly due to the fact that data are collected by national societies which only survey their members (cf. Méritt 180; Meßmer 9) and that privately paid procedures are not recorded in national registers (cf. Mowat et al. 2) – figures are thus likely to represent just a share of the entirety of surgeries.

such as G-spot[4] amplification (often called 'the G-shot'), vaginal tightening (*perineorrhaphy,* often referred to as 'vaginal rejuvenation'), or hymen reconstruction (*hymenorrhaphy*, 'revirginization'); but – other than the term 'designer vagina' implies – also comprise vulvar procedures such as clitoral hood reductions, repositioning of the glans clitoris, liposuction of the *mons pubis* ('mound of Venus') or the *labia majora*, *labia majora* augmentation, and reduction of the *labia minora* (cf. Cartwright & Cardozo 285; Braun, "Pleasure" 407; Zwang 81; Mowat et al. 1; Meßmer 9).[5] Some of these can be argued to be of functional motivation: both G-spot augmentation and vaginal tightening, for example, aim at heightening female pleasure during intercourse.[6] Others obviously originate in tradition, such as the temporary reconstruction of the hymen requested by women who have had pre-marital sex but want to 'fake' the loss of their virginity in their wedding night.[7] The rest is of merely aesthetic function – "Too big, too small, too narrow, too wide, too high, too low, too flabby, too wrinkled. The permutations are endless. What a great way of making money!" (Berer 5).

4 In one way or another, all of them aim at surgically creating an ideal female genital appearance or experience and thereby reinforce the idea that such an ideal even exists. Given that vaginal laxity, the loss of the virgin state, and the development of the *labia minora* and *mons pubis* are connected to processes of aging or at least maturing (cf. Standring 1288), that ideal is undeniably: young. "A new beauty ideal is looming, according to which vulvas and vaginas are not supposed to show any traces of childbearing, (sexual) experience, or age" (Méritt 181, my transl.). FGCS can thus largely be seen as attempts "to restore the prepubescent look" (Zwang 85) – and feel, for that matter – of female genitalia. This, of

[4] As so many terms used in reference to female genitalia, the word *G-Spot*, named after German gynecologist Ernst Gräfenberg, is misleading since it suggests something like a button you simply need to locate and then press for orgasm. Rather, it is a particularly erogenous several centimeters wide area of the vagina wall (Laura Méritt speaks of "Genuss-Fläche" (72)), the existence, location, and function of which is still disputed among experts (cf. Burri et al. 98ff; Hines 359). Its promotion diverts attention away from the clitoris, the actual center of female sexual pleasure, reinforces a heteronormative and penetration-centered understanding of sex, and perpetuates "the myth of the vaginal orgasm" (Koedt 134) invented by Freud in his 1905 *Three Essays on the Theory of Sexuality*. Many studies – most famously by Masters & Johnson – have shown that only a small percentage of women can reach orgasm through vaginal penetration alone (cf. 64ff). Adherence to the idea of the G-spot may therefore, again, lead to women feeling dysfunctional (cf. Boynton qtd. in Allerhand 72; Wolf, *Vagina* 19).

[5] Feminizing intersex surgeries which are current standard practice for children with ambiguous genitalia as well as male-to-female sex reassignment surgeries are often also referred to as FGCS. However, I find it problematic to refer to procedures of such highly complex psychosexual motivations as 'cosmetic;' plus, they are part of a whole different cultural debate about the gender binary. Although informing an important, and timely topic, they are therefore not discussed in this article.

[6] There is no evidence for an actual pleasure increase of these procedures (cf. Lloyd et al. 645). For the function – and instrumentalization – of female pleasure in framing FGCS see Braun 2005.

[7] The idea of a membrane that completely seals the vaginal opening and ruptures when penetrated 'the first time' is a myth (cf. Valenti (esp. 17ff) or Bernau). Surgeons reinforce this misconception through the procedure of 'revirginization,' some going as far as to implant a capsule containing a blood-like substance to guarantee post-coital bleeding (cf. Cartwright & Cardozo 286). On the more accurate renaming of the hymen as "vaginal corona" see the information booklet by *RFSU* (5ff).

course, ties in not only with the trend of body hair removal but also with a larger endeavor to stop, rewind, delay, or hide the signs of aging; the beauty industry's ultimate nemesis. Needless to stress here that these body-modifying procedures "are never purely about anatomy and physiology but are intrinsically entangled with cultural norms and ideology" (Johnsdotter & Essén 34).

5 Currently, the most common FGCS in the West is reduction labiaplasty (*nymphectomy*), showing a significant increase over the last decade (cf. Cartwright & Cardozo 285; Liao et al. 20; Sharp & Tiggemann 70; Meßmer 9). "An alarmist would be justified in thinking that the start of the 21st century would mark the start of the gradual disappearance of natural vulvar anatomy" (Zwang 84). In 2016, according to the *International Society for Aesthetic Plastic Surgery*, almost 140.000[8] women underwent labiaplasty worldwide (cf. *ISAPS* 7). This development reflects "the rise of a new genital aesthetic ideal" (Johnsdotter & Essén 32) that has been given many names: the "clean slit" (McDougall 776), the "tucked-in look" (Schick et al., "Evulvalution" 79), the "Barbie Doll ideal" (ibid. 78), or German "Brötchen-Ideal" (Méritt 179). In medical terms, this means the procedure's aim is to trim and oversew (labial trimming) or excise and suture (wedge resection)[9] the inner *labia minora* (also: *nymphae*), using laser or harmonic scalpel, to such an extent that they do not protrude beyond, but rather lie 'hidden' beneath, the outer *labia majora* (cf. Liao et al. 20; Aleem & Adams 50). Other than the horizontal, oral lips that the beauty industry has convinced us should be voluminous and red and shimmering to draw as much attention to them as possible, the vertical, genital lips are rendered indiscernible through FGCS. True to the motto "only an invisible vulva is a beautiful vulva" (Sanyal 184, my transl.), protruding inner lips have come to be considered undesirable – "the ideal is one of absence" (McDougall 775).[10] Clearly, it is also one of adolescence. Once again, we are confronted with the ideal of a young, even prepubescent, female in which the *labia minora* are not yet fully developed. Commenting on the result of a labiaplasty, (in)famous L.A. cosmetic surgeon David Matlock proudly proclaims: "She is like a 16-year-old now" (qtd. in Tiefer 469), reminding us one more time "that the Western feminine ideal is a child-like body" (Bramwell et al. 1497).

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[8] As outlined before, this figure, too, is most likely to be underrepresenting the overall prevalence of the procedure.

[9] For a detailed description of various techniques to perform reduction labiaplasty, see Goodman's chapter on "Surgical Procedures I: vulva and mons pubis" (esp. 51-87).

[10] Obviously, this happens in contrast to the phallus, as any random peek into the phallocentric literature of psychoanalysis from Aristotle to Freud to Lacan will underline, which relentlessly constructs the feminine as the castrated, lacking, envious opposite of the presence of the phallus (cf. Braun & Wilkinson 19ff). It seems only logical that the framing of the female genital as 'absent' translates into a procedure of cutting away, whereas the most popular male genital cosmetic surgery – penile enlargement – aims at making the phallus more 'present.'

6 There is a tendency among surgery-seeking patients to frame labiaplasty as functional: "I can't go by bike," "I have to rearrange them before sex," and similar complaints about physical symptoms are commonly brought forward as arguments for the procedure (cf. Braun, "Pleasure" 410; Cartwright & Cardozo 285; Aleem & Adams 50; Smarrito 85).[11] The *labia minora* are, however, not medically linked to any pathological disorder or development that may impede hygiene, urination, or sexual and sportive activities (cf. Zwang 82; Moran & Lee 761). As they are mucosal tissue, "chafing"– another common pre-surgical complaint (cf. Goodman vii; Bramwell 187) – is not actually possible (cf. Zimmermann & Richarz n.pag.). It seems evident that "women's intolerance of the physical sensations of their labia is at least partly informed by a psychological 'discomfort' about how their genitals present" (Liao & Creighton, "Dilemma" 7).[12] The treatment rhetoric used in these cases therefore appears to mainly serve as a justification of labiaplasty against patients' own doubts or against sceptics and possible social shame (cf. Tiefer 470); not least that of the performing doctors themselves: "women seeking such surgery may see medical staff as 'gatekeepers' and tailor their reasons for seeking surgery accordingly" (Bramwell et al. 1493).[13] Several empirical studies have clearly shown, however, that women primarily[14] turn to surgical modification of their vulva for aesthetic reasons (cf. Smarrito 85; Aleem & Adams 52f; Zwier 20; Cartwright et al. 102); their motivation is hence of psychosocial rather than physical origin (cf. Moran & Lee 764).

Vulva Normativa – Am I Normal?

7 The notion of normalcy plays a major role with regard to the phenomenon of labiaplasty. "Implicit in a woman's desire to alter genital appearance may be the belief that her genitals are not normal, that there is such a thing as normal female genital appearance, [and] that the operating surgeon will know what this is" (Lloyd et al. 643). Indeed, many patients presenting for the procedure utter the concern of being "abnormal" (Veale et al. 58) or "defective" (Bramwell et al. 1493), thinking that "there's something wrong down there" (Zwier 16). Without a doubt, women's well-established breast-size anxiety has recently found

[11] Interestingly, this is already to be found in the case report of the very first documented labiaplasties, where one patient complained about "increasing discomfort" because "the protuberant tissue became irritated in walking, sitting, after voiding and having a bowel movement," and the other claimed that her labia "interfered with intercourse" and caused "difficulty with personal hygiene" (cf. Radman 78f).
[12] The fact that men experience similar sensations but do not seek a surgical fix underscores this point (cf. ibid.).
[13] One study of women's motivation for labiaplasty confirmed this assumption in that distress about vulvar appearance was more freely communicated in online communities than in clinical encounters (cf. Zwier 20f).
[14] Some clinical studies suggest that not just most, but *all* labiaplasties are aesthetically motivated (cf. Zwier 21).

a new genital companion: labia-size anxiety.[15] Repeatedly, negative comments – primarily by male sexual partners[16], but also by family members or friends – are named as sources of this insecurity (cf. Veale et al. 59f). ‘Labia shaming’ is also prominent in online forums, where users – of all genders – often speak pejoratively of “beef curtains,” “flaps,” or “outies” to refer to larger labia (cf. *reddit.com*).[17] Even when patients have not directly experienced such negative reactions, they tend to fear them, worrying their partners are or will be dissatisfied with what they see (cf. Schick et al., “Dissatisfaction” 401). In some cases, this genital anxiety leads to women refraining from sex altogether or at least from certain sexual practices: “I’d never have oral sex because I couldn’t bear him seeing me up close” (qtd. in Braun, “Pleasure” 411; see also Schick et al., “Dissatisfaction” 396).

8 The obsession with fitting the norm and the level of distress this brings to women is particularly upsetting once we ask what actually *is* ‘normal’ when it comes to labia size; because up until very recently, there had not been any scientific research into the average variation in the anatomy of the vulva (cf. Bramwell 187). The first medical study to try to even answer this question through measuring external female genitalia was carried out in 2005.[18] The first modern-day cosmetic labiaplasty published in medical literature, however, was performed as early as 1976, where a woman’s “labia minora protruding in wing-like fashion” is referred to as one of the “abnormalities of the vulva” and “corrective” surgery was applied to achieve “normal female genitalia” (cf. Radman 78f). Despite its rather small and homogenous sample group, the results of the recent, long overdue study into female genital appearance reveal a much wider variety than previously documented; with the width of the *labia minora* ranging from 7 to 50 mm (cf. Lloyd et al. 644ff).[19] Based on these findings, the study concludes that anybody’s understanding of what ‘normal’ female genitalia in general, and labia in particular, look like and, likewise, any surgeon’s idea of how it can be achieved

[15] Again, I do not intend to frame genital anxiety as an exclusively female phenomenon. While the penis has an entirely different cultural history marked by positive connotations of power etc. it is also connected to an influential, if different, genital ideal. While our culture’s penis size obsession causes emotional distress in many men, it does not result in even closely as many cosmetic procedures as vulva-anxiety (in 2016, a little over 8000 penis augmentations were carried out worldwide – and almost 140.000 labiaplasties (cf. *ISAPS* 7)).

[16] Though male attitudes are often mentioned in this context, there is a paucity of data regarding male perceptions. A 2015 empirical study tried to fill this gap and found that vulvar aesthetics impacts sexual desire for about 50% of the male subjects but that “while smaller and more groomed labia were described as attractive more often … many [men] remained neutral about labial appearance” (Mazloomdost 731.e6).

[17] Already in 1975, gynecologist Jeffcoate referred to protruding *labia minora* as “Spaniel ears nymphae” (151), which was uncritically reproduced in other, also more contemporary, medical publications (cf. Rouzier et al. 35).

[18] Measurements for male genitals, by contrast, were taken and published as early as 1899 (cf. Loeb).

[19] A 2015 study of a similar set-up arrived at slightly different but equally wide-ranging results in all assessed parameters of female external genitalia (cf. Krissi et al. 46).

through surgical procedures is entirely subjective (ibid. 645).[20] In other words: there is no such thing as a normal vulva, or more precisely: "variation is the norm" (Yurteri-Kaplan 428 e2).

9 And yet, our culture has successfully created a genital beauty ideal that thousands of healthy women are so eager to live up to that they are willing to pay money for, and hazard the pain or risks of surgery "to create morphological changes to their *normal* vulva" (Liao 20, my emphasis). The modified genital created through labiaplasty "is one in which diversity is replaced with conformity to this particular aesthetic" (Braun, "Pleasure" 413). The lack of an actual (biological) norm raises the pivotal question: where does our Western idea of 'normal' and thus desirable female genital appearance come from?[21] As Naomi Wolf reminds us, "ideals don't simply descend from heaven" (*Beauty* 3) – they are culturally constructed. So what agents are at play in forming our aesthetic notion of the perfect pudendal cleft and thereby causing genital dissatisfaction or anxiety in so many women?

Vulva Culpa – Who to Blame?

10 The increased attention paid to vulvar appearance is often considered "a result of the new genital visibility" (Tiefer 472). First and foremost, it is argued that the practice of pubic hair removal, which has come to be normative in Western cultures over the past 20 years (cf. Toerien et al. 403; Yurteri-Kaplan 428.e5; Kelly & Hoerl 141f), has exposed the previously hidden vulvar region (cf. Zwang 84f; Johnsdotter & Essén 31; Sharp et al. 183). Protruding inner labia that may have been obscured by body hair before, now come in plain sight and may appear more prominent. The fashion of skimpy under- or swimwear, possibly showing "a bulge," contributes to this factor, even when not naked (cf. Laufer & Reddy 3; *RACGP* 6). Moreover, the use of tampons as well as the gradual removal of taboos about, and thus rising prevalence of, female masturbation increased women's contact with their genitalia. All of these lifestyle, grooming and fashion trends "render the vulva more visible than ever and contribute to genital appearance consciousness" (Liao & Creighton, "Dilemma" 7). For dissatisfaction, and thus a desire for surgery, to arise from pudendal preoccupation, however, women – being "cognitive averagers" (Placik & Arkins 1084) – must have a means of

[20] Moran & Lee confirm this claim by finding that there is a gendered tendency of male practitioners, gynecologists or cosmetic surgeons being significantly more likely to approve or perform a labiaplasty (cf. 764).

[21] It would be interesting in this respect to look at alternative beauty ideals of the vulva in other cultures and how they possibly come into being. In Japan, for example, the "butterfly appearance" of the labia is considered to be particularly attractive (Scholten 291); and in many African countries, such as Uganda, Rwanda or Mozambique, long labia are praised and therefore, deliberately 'stretched' through a traditional procedure of pulling and applying herbs (cf. Bennett & Tamale 75ff).

comparison, i.e. mental images of the vulva against which we can weigh what we see between our legs.

11 In real life, "women have no direct visual acquaintance with the vulvae of their adult peers" (Zwang 82). A heterosexual woman, unless a midwife, gynecologist, etc., is seldom really exposed to other vulvas, especially labia, up close.[22] Given such absence of 'real' vulvas in everyday life, we must ask what medial representations of the vulva we consume? The first thing to come to mind is, of course: pornography; which serves as the number one scapegoat for the growing popularity of FGCS (cf. Liao & Creighton "Dilemma" 7, Sharp et al. 184; Johnsdotter & Essén 32; Lloyd et al. 645). "The popular porn thesis is based on the assumption that women consume pornography and internalize its norms, which then drives genital dissatisfaction and surgical modification of the labia" (Jones & Nurka 64). While intuitively convincing, it has not been empirically tested and is based on some misconceptions; first and foremost, on the supposition that all women consume pornography.[23] Various practitioners take the fact that women seeking surgery bring pages from porn magazines as an indicator of their impact (cf. Liao & Creighton "Request" 1091; Braun, "Pleasure" 413). Further inquiry reveals, however, that most patients actively researched these images to illustrate their desired 'look' rather than being regular consumers (cf. Yurteri-Kaplan 428 e6; Veale 15); i.e., the images were used to demonstrate dissatisfaction but have not necessarily generated it.[24]

12 Even if women do consume pornography, the widely held notion that it only shows "unreal vulvas" (Braun, "Pleasure" 413) and "standardized versions of labia" (Wolf, *Vagina* 302) is equally debatable. What such a claim – and the discourse at large – fails to do, is to differentiate between 'soft-core' still images in porn magazines, on the one hand, and 'hard-core' moving-image porn, on the other. In the former, it is indeed common to present a uniform 'clean slit' aesthetic through selecting models accordingly or, more commonly, through digitally removing any protruding *labia minora* (cf. Zimmermann & Richarz n.pag.). Other than usually assumed, however, this does not have to go back to heterosexual male preferences (cf. Jones & Nurka 63) but is also rooted in issues of censorship.[25] To let soft-

[22] We tend to, in fact, "have more opportunities to observe young children naked than adults" (Bramwell et al. 1497) which could be argued to contribute to our child-like genital ideal.

[23] Though only an approximation, *Pornhub* reports 26% of their users in 2016 were female (n.pag.).

[24] One may argue that men's consumption of porn can indirectly affect women's dissatisfaction through negative comments but, so far, that has not been confirmed, either (cf. Miklos & Moore 2008).

[25] According to Australian classification law, for example, "realistic depictions [of nudity] may contain discreet genital detail but there should be no genital emphasis" (Office of Legislative Drafting and Publishing n.pag.), i.e. showing the inner labia would render an image "restricted" content. The British Board of Film Classification (BBFC) has similar guidelines.

porn magazines stand in for all porn means to deny this medium its heterogeneity and to overlook the development of porn consumption.

13 In the age of free internet porn, tube sites such as *Pornhub* or *YouPorn* are way more frequently used than *Playboy* magazine is read.[26] Even videos on these 'malestream' pages, not to mention more queer porn, display a wide variety of female genital appearance.[27] In fact, popular female porn performers such as Stoya or Sasha Grey have publicly spoken up against vulva shaming; the former specifically addressing the wide array of shapes and colors in labial appearance she has seen in porn, as well as unashamedly commenting that her "own vulva, if it were a face, would constantly have an expression similar to this: :P" (n.pag.). The popularity of her movies just as the fact that her 'non-flattened' vulva was turned into a life-like Fleshlight® masturbator contradicts assumptions about male aesthetic preferences.[28] Likewise, performers such as Amy Faye or Bobbi Starr are bringing back 'the bush' to mainstream porn. Though we may find it hard to wrap our head around this, hard-core porn is, in effect, a rare place where vulvas with all kinds of labia – even when objectified, fetishized, abused, etc. – are shown and presented as desirable, are flood-lighted and zoomed into rather than hidden; and where genital dissatisfaction does not seem to play a role on screen.

14 This is markedly different in mainstream media. While there is a lack of actual images of female genitalia in popular media, they abound with stories of labia anxiety and suffering, often followed by those of relief through cosmetic surgery (cf. Berer 7; Liao & Creighton "Requests" 1091; Nurka & Jones 417). Especially popular medical reality TV shows like *Embarrassing Bodies* or *The Perfect Vagina* as well as women's magazines have been identified as key sources for information about labiaplasty (cf. Sullivan 159). Women reading or watching these stories may be prompted to think "if she/ her partner finds her/self ugly 'down there,' am I too?", "if she thinks she needs one, do I need one, too?", "if it made her happier, will it make me happier, too?" and so on. Accounts of post-surgical joy and pleasure – "I discovered how amazing oral sex can be" (Braun, "Pleasure" 413) – can have a particularly strong effect; but even when criticizing or ridiculing the popularity of labiaplasty, media representations still spread awareness of its existence. A majority of women claim that they only learned about the procedure through the media (cf. Veale 15; Pó 56). Unfortunately, media coverage often fails to stress the wide range of 'normal' genital appearance or

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[26] In 2016, *Playboy* magazine had a circulation of almost 500,000; that is roughly the number of online visitors *Pornhub* attracts within every 11 minutes (cf. *Pornhub* n.pag.).

[27] Go to one of them, click on twenty random videos, and see for yourself!

[28] Fleshlight® is the self-proclaimed "#1 Male Sex Toy in the World" (n.pag.) modelled after the vulvas of popular female porn performers. The range of different Fleshlights exhibits a variety – if not of color or pubic hair – of vulvar shapes; of the 29 current "Fleshlight girls", no two look the same. Many of them, e.g. Brandi Love and Alexis Texas, show protruding, some asymmetrical labia.

reproduces other assumptions, such as functional motivation for labia reduction, and therefore always has the potential to fuel dissatisfaction and desire for surgery.

15 The most conscious and aggressive advertisers of labiaplasty, though, are the surgery providers themselves (cf. Cartwright & Cardozo 285). Just enter 'labia reduction' as a search term in *Google*, and you will be flooded with websites of private clinics sharing little clinical information (cf. Colwell et al. 5) but countless before-and-after-images of vulvas accompanied by their happy patients' testimonials. Economic and legal changes since the 1990s have erased any barriers – at least in the US, Australia, and the UK – to this kind of commercialized medicine (cf. Tiefer 467f). Online marketing can be said to fulfil three major functions in paving the way towards labiaplasty: "pathologizing the normal," in turn "normalizing modification," while suggesting "that cosmetic surgery is easy" (Moran & Lee 387ff; see also Mowat et al. 8). It creates shame around having a certain vulvar appearance, while simultaneously reducing shame around surgically changing it. Simply referring to labiaplasty as *correction*, for example, suggests a harmless and necessary procedure which seems to (re)create normalcy rather than producing artificiality. Just like the cosmetics industry, aesthetic surgery effectively and profitably provides both, the problem and the solution. Through reframing the perfectly normal labia of women as 'unhealthy' and offering a seemingly harmless cure, clinicians "have created an inexhaustible goldmine" (Zwang 85).

16 As already indicated, a major tool of such 'disease mongering' is language. If, speaking with Foucault, nothing exists before there is a word for it, any pathology requires a name: *labial hypertrophy* is the medical(izing) label given to protuberant *labia minora*.[29] While there is no consensus regarding objective clinical criteria (cf. Laufer & Reddy 3), practitioners usually stick to Franco's 1993 classification system, which identifies inner labia longer than 4cm from the vaginal introitus to the outer edge as *hypertrophic* (cf. Rouzier et al. 35).[30] Even though there are some early Western surgical texts about the existence and also the removal of larger labia (e.g. Arkwright from 1871), gynecological literature of the 1970s describes "the clinically symptomatic enlargement of the labia minora" as "a poorly recognized entity" (Jeffcoate 151). Several publications of this time still suggested a connection of labia size to sexual activity[31], considering excessive masturbation, early sexual

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[29] While created within medical discourse, mainstream media reproduced this language and "contributed to making 'labial hypertrophy' a recognizable – and curable – disorder" (Nurka & Jones 417).

[30] Another classification measures only the protruding labia, with accordingly smaller numbers, and an alternative system based on shape, rather than length, has recently been suggested (cf. Smarrito 85f).

[31] The alternative Latin term for inner labia, *nymphae*, already indicates this connection; as does the German word *Schamlippen*. Up until today, the idea that long labia are a sign of being "worn-out," can be found in public discourse (cf. *reddit.com*). Research, however, shows no empirical evidence for any of this (Bramwell et al. 1493).

contact, hypersexuality, or promiscuity as etiology of 'hypertrophy' (cf. Honoré & O'Hara 61; Rouzier et al. 38f) – yet another chapter in the long history of moral panic about the female sex drive.[32]

17 The medicalization of normal labia not only ties in with the Western tradition of pathologizing female pleasure and the female body, but also has its roots in our colonial past: "This current linkage of 'hypertrophic' labia with ill health, deviance and sexual shame … is informed, in large part, by the discourses of early race science" (Nurka & Jones 418). While it is hard to tell since when exactly labia are being stigmatized in the West, an important historical moment occurred in the 19th century: Saartje (Afrikaans for Sarah) Baartman was brought from South Africa to Britain as a slave, and exhibited as the "Hottentot Venus" for her "large buttocks" and "strangely elongated labia" (Holmes 2). The latter were pejoratively termed "Hottentot-apron," a terminology uncritically taken up by 20th-century publications (e.g. in Jeffcoate 152), already giving away the problematic association with race. Natural scientist Georges Cuvier, in a text book example of scientific racism, interpreted the protruding labia found in Khoikhoi women as an indicator of their animal-like hypersexuality and as such as proof of their racial inferiority (cf. Meßmer 135f). He was a driving force in helping the "Saartjemania" (Sanyal 182), and with it the exoticization as well as stigmatization of larger labia, spread throughout Europe in the 19th century. Cuvier was so obsessed with Baartman that when she died in 1815, he preserved her vulva (cf. ibid.), which was exhibited in the Musée de l'Homme until 1985.[33] This is why a panel in Liv Strömquist's 2014 graphic novel *Kunskapens frukt* (meaning 'Origin of the World') concludes: "If you're having the inarticulate feeling that big labia are somehow more repulsive than smaller ones, and don't know where this feeling is coming from, this might be the source: Baron Georges Cuvier" (24, my transl.).

18 As the above discussion has shown, the question as to what causes genital dissatisfaction and thereby drives the growing desire for labiaplasty is a highly complex one, and the answer may range from seemingly obvious factors such as pornography to less overt influences such as racial stereotyping; from phenomena directly linked to our current digitalized world to remnants from our colonial past; from contemporary to age-old anxieties. To single out just one reason for the rising popularity of labiaplasty (as so fervently done with porn) means to oversimplify a multifactorial problem. Obviously, our "unrealistic genital ideal [of the 'clean slit'] did not develop in isolation, but rather as a function of broader

[32] On the similar pathologization of the ('oversized') clitoris, see Finzsch's article on clitoridectomy in this issue.
[33] In fact, her body parts were only returned to South Africa and finally buried as recently as in 2002.

sociocultural influences" (Sharp & Tiggemann 71). Any simplistic causality fails to acknowledge the intricate ways in which our bodies are interwoven with our culture. It is safe to say, however, that societal norms – especially with regard to an ideal femininity – and the corresponding pressure to live up to them, play a key role in giving each of the discussed agents the power they have.

Quod Licet Iovi, Non Licet Bovi; or: the Arrogant West

19 Given this long list of more or less overt messages to women about their ideal vulvar appearance and the immense psychosexual distress they put on them, it seems highly questionable to frame labiaplasty "as an uncomplicated lifestyle choice based on user autonomy" (Liao & Creighton, "Dilemma" 8) as is often the case. L.A. surgeon David Matlock, for example, (called the McDonald's of FGCS for using the franchise model for his procedures (cf. Tiefer 469)) – considers himself a feminist, because he is "all about the women" (qtd. in ibid). Especially the fact that patients claim to feel more sexually confident with their post-operative vulva is effectively (mis)used to deem the procedure "a liberatory action for women" (Braun, "Pleasure" 417) – neglecting how their genital shame was created in the first place. Paradoxically, "contemporary beauty culture celebrates women's sexual agency by urging them to purchase products and engage in practices designed to prepare their vaginas for sexual activity with men" (Kelly & Hoerl 141). Whereas surgery providers pretend to "address a neoliberal subject who is an informed decision-maker and is both desiring and deserving of bodily modification" (Moran & Lee 388), they often promise potential patients untested benefits[34] and do not usually inform them sufficiently about possible risks and consequences.[35] It would, therefore, be more appropriate to speak of "misinformed consent" (Tiefer 472; see also Liao 23); and even if women *had* all the necessary knowledge to theoretically make a rational choice, we would, in practice, still be controlled by irrational social norms about our bodies. Without a doubt, FGCS are "culturally imbued practices" (Dodge 135).

20 And yet, choice is commonly argued to be the distinguishing feature between FGCS in the West and female genital mutilation (FGM)[36] as practiced in non-Western, mainly African, countries. As a result, the two are framed very differently in public discourse: the former "is

[34] There is no empirical evidence that such procedures *per se* enhance physical, psychosexual or relationship wellbeing for any female population (Lloyd et al. 645; see also Moran & Lee 764).

[35] Labiaplasty involves the removal of tissue and potential disruption of nerves or blood vessels essential to female sexual functioning and may thus impact genital sensation and the ability of arousal (cf. Aleem & Adams 50; Lloyd et al. 645; Moran & Lee 764; Méritt 182).

[36] On the terminology of mutilation vs. cutting vs. circumcision, see Johnsdotter & Essén 30f.

presented as a benign medical procedure while the [latter] is presented as a value-laden form of violence" (Dodge 141); one as a "simple and rewarding surgery" (Agrawal et al. 245), "new and enlightened" (Braun 694), the other as "a bizarre and cruel practice far away in Africa" (Johnsdotter & Essén 30); one as emancipating, the other as oppressing; and finally: one as legal, and the other as a crime and "violation of the human rights of girls and women" (*WHO* n.pag.). Such a strong distinction seems rather absurd considering the similarity of the actual modification: the definition of FGM by the *World Health Organization* – as "all procedures that intentionally alter … the female genital organs / that involve partial or total removal of the external female genitalia … for non-medical reasons" (n.pag.) – is just as applicable to FGCS.

21 Type 2 FGM, "excision," can be considered the equivalent of labiaplasty with (part of) the *labia minora* being cut away in both cases; but one procedure is understood as liberating – "Befreiungsschnitt" (Pó 57) – the other as traumatizing – "Schnitt in die Seele" (Terre des Femmes). Moreover, only the latter is associated with serious consequences for women's sexual pleasure and health (cf. Johnsdotter & Essén 34; *WHO* n.pag.), which means that these are either dramatized to condemn FGM, or downplayed with regard to Western practices. In either case, the disparate treatment seems illogical, which becomes particularly clear regarding legal treatment. There is legislation in both Europe and Africa against FGM, but none against FGCS (cf. Berer 6). This means, *de facto*, that practitioners "are expected to discriminate between European and African female genitals" to decide whether patients with the same request are either "a victim of African patriarchy" or "an adult woman, entitled to free choices concerning her own body" (Johnsdotter & Essén 33) – no need to explain the many ways in which this is highly problematic.[37]

22 I am neither trying to defend FGM or argue for its legalization, nor to deny the fact that it is often performed on young girls without caring about their consent and frequently under unsanitary conditions; but "we should not allow these extreme affronts to female agency to invisibilize the less obvert pressures that affect women in [Western] countries" (Dodge 142). As has been pointed out, "cosmetic surgery cannot be understood as a matter of individual choice" (Davis 117). Even though the rhetoric of normalcy and medicalization helped to construct it otherwise, labiaplasty is just as much driven by societal pressure and notions of ideal femininity as Type 2 FGM. For this reason, I agree that, at least to some

[37] "If this is purely a children's rights issue, then European laws need to include a paragraph stating that a woman above a specific age may choose to have her genitals modified, irrespective of ethnic background. That would protect children while placing adult women, of Western and non-Western origin alike, in the same category – that is, that they have the right to make decisions about their own bodies" (Johnsdotter & Essén 33).

degree, “any distinction is only a Eurocentrist fallacy” (Cartwright & Cardozo 285) and our condemnation of the former highly hypocritical in light of our endorsement of the latter. We need to reflect our Western filter through which we look at the world and automatically normalize what is ‘ours,’ while Othering and stigmatizing what is ‘foreign’. Painting this issue, literally, black and white does not do justice to women on either side, because “women in cultures that practice FGM are not totally void of agency, and women in the West who choose to undergo [FGCS] are not acting with pure agency” (Dodge 141) – we can, and should, reevaluate both sides through the eyes of the other.

Conclusion – Quo V(ulv)adis?

23 As this article has shown, the rise of labiaplasty in the West is a multidimensional phenomenon driven by a powerful gendered narrative about fitting into a perceived norm of femininity. More than ‘just’ another example of patriarchal and capitalist domination of the female body, of its pathologization and commercial exploitation, it turns out to be also a painful reminder of how our supremacist colonial discourse and mindset is still with us in many ways. Since the turn of this century, women have not only become increasingly dissatisfied with their labia, but surgery has also become more easily available – so how can we break this self-sustaining vicious circle of inciting insecurity and offering solutions?

24 Several pragmatic steps have already been suggested to fight the current development. Most importantly, we need to gain a better understanding of the subject matter. Across different disciplines, the literature points to the paucity of data and calls for more – quality multi-method, multidisciplinary, independent, long-term, evidence-based – research to fill the yawning gaps in knowledge about the prevalence, the motivation for, and the demographics of labiaplasty (cf. Meßmer 10; Moran & Lee 764; Tiefer 475; Liao 23; Mowak et al. 9), as well as the physical and psychosexual outcome and possible complications of the procedure (cf. Berer 7; Johnsdotter & Essén 31). Based on these findings, patients need to be adequately provided with information about risks and consequences on the one, and non-existing connections to sexual function and pleasure on the other hand (cf. Krissi et al. 46) – “we cannot emphasize enough the importance of fully informed consent” (Aleem & Adams 53). At the moment, FGCS is a largely unregulated industry which lacks transparency and medico-ethical guidelines (cf. *RACGP* 2). On top of that, there need to be alternatives to deal with genital dissatisfaction beyond the body-changing culture, such as counseling (cf. Moran & Lee 764; Lloyd et al. 645) and comprehensive sex education (cf. Tiefer 475) to foster the development of a healthy sexual self-concept – without a scalpel. Finally, the legislative body

needs to adopt non-discriminatory policies about vulvar modification (cf. Johnsdotter & Essén 35).

25 Eventually, however, we can only fight the symptom, if we overcome the roots: genital anxiety. All agents contributing to genital dissatisfaction need to use their power in positive ways to make more diverse "messages available to women as to what constitutes a normal or ideal appearance for their external genital area" (Bramwell 187). Both the media and frontline clinicians are in a position of challenging negative hegemonic socio-cultural representations and to educate women that their labia are not 'abnormal' (cf. Braun & Wilkinson 27). The problem is, however, that health and media professionals alike take their ideas about ideal female genitalia from exactly the same cultural context as women themselves (cf. Bramwell et al. 1497); and this context is one in which the vulva is made invisible. The lack of awareness of female genital diversity – as a result of underexposure to vulvar variation – has repeatedly been named a major reason for labia anxiety and fears of abnormality. If women knew more about our own bodies and the wide range of 'normal' when it comes to our genitalia, we would be less prone to outside voices telling us that we need to be fixed.[38] Therefore, what we need are more, and more realistic, and, most importantly, more positive images of the vulva. "Pudendal disgust is a social reality" (Tiefer 475) and we need to get rid of it.

26 Many projects have already taken up the task of ending labia-shaming through spreading body positivity and showing vulvar variety: collections of vulvar anatomy are springing up everywhere, such as *VulvaGallery.com* which "shows vulvas of all kinds, shapes, sizes and colors, and celebrates their diversity" (n.pag.), *pussypedia.com*, Dr. Laura Méritt's collection of pussy profiles, books like *Femalia* (2011), *The Big Book of Pussy* (2011) or *101 Vagina* (2013), or the Tumblr "Large Labia Project" collecting self-submitted photographs of female genitalia; a number of websites have been developed as freely available educational tools, such as *LabiaLibrary.org.au* which aims "to bust a few common myths about how normal labia look" (n.pag.); sex education programs are embracing shame-free tools such as the Wondrous Vulva Puppet® or the PAOMI model; artists around the world are spreading vulva art, such as Jamie McCartney's *The Great Wall of Vagina*[39], to demonstrate diversity, redefine its cultural meaning and, as Sophia Wallace and her #cliteracy-initiative, foster knowledge about female genitalia, and you can even have your

[38] A number of studies have already empirically tested to positive correlation of genital awareness and genital satisfaction (cf. Moran & Lee; Nurka & Jones; Lloyd et al.); see also Sanyal and Zwang.

[39] Note how even feminist artists mislabel the vulva (what you can see from the outside) as *vagina* (what is inside) and thus unwittingly perpetuate the penetration-centered understanding of sex in public discourse (cf. Lerner).

vulva cast in plaster or bronze, if you like; in 2011, UK Feminista organized a protest march, "the Muff March," against labiaplasty claiming that "there is nothing wrong with women's labia, [but] there is something wrong with a culture which makes women feel ashamed about their bodies" (Banyard n.pag.) – a real Labia Pride movement is in the making. Even if many of its voices were initially only heard within the feminist filter bubbles, they are beginning to reach a wider public. In other words: there is hope! Deconstructing beauty ideals is hard and tedious, but not impossible. Let the utopian fantasy of a more pussy-positive future be our motivation on the long road of creating a culture in which women leave the light on during sex and enjoy *cunnilingus* not because they had successful cosmetic surgery, but because they learned to accept and adore their body the way it is. Everybody repeat after me: all vulvas are beautiful. Viva la Vulva!

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[40] Fun fact: with the exception of all the texts serving as 'bad examples,' this is an almost all-female bibliography! Everyone in the academe knows how rare this is given the male domination of academic knowledge production overall; and even more so with a topic that involves a considerable amount of medical literature. This is not intended as self-praise; I did not even try, it just happened. Why? Presumably, because women care more about women, because they are tired of having their own body being commodified, and because they are not afraid to talk about the vulva. I am uncertain as to whether I should find that funny or sad or satisfying, but in any case, worthy of a very last footnote.

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An Encounter in Paris – Conversations on Clitoridectomy across Borders

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Abstract

This essay describes how a controversy over clitoridectomy came to influence the conjuncture of imperial politics and nationalist resistance between Kenya and Great Britain the 1930s. Clitoridectomy was a key component of the initiation rites of leading population groups in Kenya. Missionaries and medical doctors opposed it on moral and health grounds, African men and some women defended it a precondition of mature and responsible adulthood. An unlikely meeting and collaboration between a group of people – Marie Bonaparte, Jomo Kenyatta, Bronislaw Malinowski and Prince Peter – who had a keen interest in the issue, generated new insights into the roots of tradition, how it fitted into not only structures of the human psyche but also the social structure of so-called traditional societies. The essay discusses what led to the collaboration, traces its consequences and situates the clitoridectomy controversy in the context of anti-colonial and female emancipation.

1 In the spring of 1935, the park of the Versailles in Paris was the site of an unusual encounter. The two participants were the well-known French writer and psychoanalyst Princess Marie Bonaparte and an African from Kenya Colony, Jomo Kenyatta. She was a descendant of Napoleon Bonaparte, married to a Prince of Greece and Denmark. He was the son of peasants, a leader of African resistance and an outspoken critic of European colonialism.

2 The topic of their conversation was clitoridectomy as it was practiced in Eastern Africa. Bonaparte was in her fifties, at the height of her career as a writer, leading a rich and complicated personal and professional life between London, Vienna, Athens, and Copenhagen. Kenyatta was twenty years younger, at the beginning of his, still unknown in Europe, but thirty years later destined to become the first President of independent Kenya. He arrived at the rendezvous from London, where he had been sent as a representative of his people, the Africans of Kenya Colony. Here, at the heart of the waning empire, one of his assignments turned out to be to give expert witness to the British medical establishment on clitoridectomy (Murray-Brown 35).

3 At this time, the famous anthropologist Bronislaw Malinowski, who was a friend and soul mate of Bonaparte's, conducted a prestigious and well-attended seminar on "Culture Contact in Africa" at London School of Economics (LSE) (Berman and Lonsdale). Among the participants were Kenyatta and a young student of law and anthropology, Prince Peter, the son of Marie Bonaparte. She was deeply involved in a psychoanalytical study of female sexuality. She let Malinowski know that she would be keen to discuss the question of the

influence of clitoridectomy on the sexual lives of African women with his mature student, Jomo Kenyatta. Prince Peter and Malinowski set up the meeting.

4 The idea of this essay on the historical context of clitoridectomy, as it was practiced and debated in what is now Kenya and in Europe, is to show the way that ideas flowed between the colonial and the colonized world – the Western and non-Western – and the way that ideas from what was then colonies on their way to independence sometimes challenged the received wisdom of the West.[1] The 1920s and 30s were the decades of the breakthrough of both anthropology and psychoanalysis. One of the ideas that were debated between these disciplines was that of the mental and civilizational capabilities of colonized people, in Africa and elsewhere – those peoples who had not benefitted from European enlightenment and development. Theories that non-Whites had less developed personalities and intellectual capacities as a result of stagnant traditional cultures were bolstered by ideologues and leading scientists but fiercely resisted by African intellectuals and members of the anti-colonial resistance. For some, the practice of clitoridectomy was a symbol of backwardness, for others it was a sign of a functioning society in which cultural practices contributed to harmony between genders and generations. The latter view lent itself to the functionalist anthropology of Malinowski.

5 I want to demonstrate how the academic disciplines of anthropology and psychoanalysis were centrally involved in defining the terms of the debate between proponents and antagonists of the practice of clitoridectomy, and the broader question of its role in the evolution of a society on its way from tradition to modernity. The sketches of the personalities and contexts of the protagonists of the essay, Bonaparte, Malinowski, Kenyatta and Prince Peter, and the description of the strong links between them are meant to illustrate the significance of the actions of living and thinking human beings in the unfolding of social and intellectual history. Ideas flow across borders, but their inflections are marked by those who articulate them, and their influence on events reflects the power behind their articulation.

6 The four participants and enablers of the Paris encounter were all in different ways implicated in the whirlwinds of social and political reform that swept over Europe and (some) dependent regions in the 1930s. The coincidence of a concern in Great Britain among politicians and pressure groups with the way that female circumcision, a savage custom, was being perpetuated in Kenya, and the presence in London of a spokesman for the colonized, Jomo Kenyatta, who influenced and was under the influence of Malinowski, led to an

[1] This essay is a reworked version of an earlier article, "Jomo Kenyatta, Marie Bonaparte and Bronislaw Malinowski on Clitoridectomy and Female Sexuality", *History Workshop Journal* Issue 65, Spring 2008, pp. 23-49, reprinted in Clark 2011.

entanglement of psychoanalytical and anthropological analysis and theoretical work with feminist activism and anti-colonial political protest.

7 Clitoridectomy, or female circumcision, as the practice was more commonly known, was the question that fuelled the encounter between Bonaparte and Kenyatta. Her preoccupation was the relationship between the modeling of the clitoris and the sites of female sexuality and libido. In addition to Bonaparte's scientific interest in the issue, her interest was personal and political: she sought enlightenment and liberation for women whom she thought to be in the thraldom of patriarchy to the detriment of the full unfolding of their sexuality. She considered herself as one of the victims. Kenyatta's concern was the role the ritual played in the cultural life and politics of identity of his tribe, the Kikuyu. He also had a strong wish to rectify what he saw as prejudiced European ideas about the ritual of female initiation, of which clitoridectomy was a central part.

8 Kenyatta, who had risen to prominence through his political work in a male-dominated environment, did not question patriarchy. To him, the urgency of the problematic of clitoridectomy was entirely different. He was in the middle of a struggle that played itself out both in Kenya and in Great Britain. On the one hand, for the Kikuyu, who practiced female circumcision as part of an initiation into adulthood, its upholding became a key point of resistance against interference from the colonial regime. On the other hand, the colonial regime, and particularly missionaries and some influential feminists, wanted it done away with because of its harmful effects on women's lives and health, and on the health of the population – those communities that practiced clitoridectomy. The concern was one of social hygiene, bordering on eugenics, and in tune with contemporary sexual reform, as demonstrated by the introduction of clinics providing advice on marriage and sexuality, particularly the popular Marie Stopes clinics.

9 The contestation over the meaning and effects of clitoridectomy became central to uprisings in Kenya against British dominance and paternalism in the 1930s. It led to the establishment by the Kikuyu ethnic group of independent schools and churches that endorsed female circumcision and other traditional practices. It also provided an opening for interventions into the African cultural nationalist resistance by the British colonial regime. Protestant missionaries and proponents of female emancipation in Britain, particularly members of the "Committee for the Protection of Coloured Women in the Protectorate", led by the militant feminist Eleanor Rathbone, condemned the practice and demanded, unsuccessfully, as it turned out, that it be abolished (Pedersen; Boddy Chapter 9).

10 In 1930 the Kikuyu had sent Kenyatta to London as a spokesman of his people to protest to the colonial administration against the land alienation that was the result of the British colonial conquest, particularly in what became known as the White Highlands, and to demand that the land be given back to African cultivators. Resistance against the theft of land underlay the entire colonial period and reemerged as a driving force behind the anti-colonial uprising in Kenya, known as the Mau Mau.

11 Kenyatta's mission to the imperial capital was a sign of his standing as a representative of the interests of his people. He was well received in London by intellectuals and politicians related to the Labour Party, and parties to the left of the Labour Party, and tolerated by representatives of the government. He pleaded his cause in speeches, articles, and meetings with left-wing organizations, officials, and members of Parliament. He also had conversations with Thomas Shiels, a medical doctor and Undersecretary of State at the Colonial Office, as an expert on clitoridectomy (Murray-Brown 35). In the early 1930s, however, the protest campaign had run out of steam and money, and Kenyatta found himself stranded in London. Aided by Malinowski and other friends, he reinvented himself as an informant on the Kikuyu language and as a student of anthropology, arming himself academically to continue the political fight with the British on equal ground.

12 Bonaparte made the encounter in Paris happen. Like Kenyatta's, her way into the academic life was unorthodox. As a young women she wanted to be admitted to the Faculty of Medicine in Paris, she wished to penetrate "the hermetic secrets of the internal structures of the human body" (my transl.)[2], but as a child of extreme privilege, her education had been looked after by private tutors, and she lacked the formal qualifications needed to enter university (Bonaparte 1953b 939). She was the daughter of Prince Roland Bonaparte, a descendant of one of Napoleon's brothers. Her mother, an heiress, died in childbirth, and Marie was brought up by her strict grandmother and a distant father, who was a geographer and anthropologist. Early on, Marie fled into the world of literature. Writing was her phallic activity, as she later expressed it (Bertin, Appignanesi and Forrester 330; Thompson).

13 At the time of the meeting, Bonaparte had published a considerable body of self-biographical, essayistic and philosophical works. In her thirst for knowledge, she now devoted her immense energy to psychoanalysis, One of her major works from this period is a three-volume psychoanalytical analysis of Edgar Allan Poe's life and works. In the second half of the 1920s, she had undergone psychoanalysis with Sigmund Freud in Vienna, and she was now preoccupied with fundamental psychoanalytical questions like the women's

[2] 'les secrets hermétiques de la structure interne du corps humaine',

bisexuality, the source and nature of female sexuality, and the universality of the Oedipus complex. Malinowski, her son's teacher, shared her interests. In his monograph that was the outcome of his fieldwork in Melanesia, *The Sexual Life of Savages*, he explored whether the gender identities and psychology he observed among the Trobrianders had developed along the lines of the Oedipal complex.

14 Bonaparte's thesis was that women in the western world had increasingly become alienated from their sexuality. The Oedipal processes had taken the wrong course because of the extreme control and suppression of women's sexual pleasure in childhood, particularly the ban on masturbation (Thompson). According to Freudian theory, the site of libido is transferred from the clitoris to the vagina with adult women. The clitoris is a vestige of the male sexual organ. For large numbers of women in the West, this transfer has not occurred, according to Bonaparte, they suffer from *clitoridism* in her words and cannot attain a satisfactory love life. In Europe, Bonaparte experienced what she considered an epidemic of female frigidity that she attributed to the fundamental bisexual nature of women, which impaired the transfer of the site of sexual pleasure, a process that resulted in women becoming increasingly masculine (Bonaparte 1950, Thompson 357).

15 Bonaparte was a true experimental scientist. She herself became her case. She regarded herself as frigid, and in the early 1930s underwent several operations whose purpose was to transplant the clitoris to a point closer to the vagina to enhance sexual sensations (Bertin 141; Bourgeron 23-4). This surgical intervention was known as Halban-Narjani operation. The interventions were unsuccessful, and later in her career, she concluded that the surgical intervention was "pre-analytical and erroneous": "Psycho-analysis … will be a surer and more elegant solution to such disturbances of instinct" (Bonaparte 1953a 50-2; Bourgeron 23-4, 49-51).

16 Marie Bonaparte was married to the Danish Prince Georg of Greece and Denmark. They had two children. Their son, Prince Peter, became a recognized anthropologist. He worked in continuation of his mother's interests, an aspect of which was a study of polyandry. Princess Marie and Prince George lived in free marriage; both had love relations outside the marriage. Prince George had very close relations with his ten years older uncle, Prince Valdemar, who accompanied the newly-wed on their honeymoon. Marie had several lovers, one being the prominent French socialist and internationalist, Aristide Briant. Princess Marie and Prince George were active members of the transnational Danish royal family who met for holidays and reunions at the caste Lille Bernsdorff, close to Copenhagen (Kristensen).

17 What has all this to do with the African nationalist and student of anthropology, Jomo Kenyatta? Like Malinowski, Bonaparte, and Prince Peter, Kenyatta was part of a transnational, progressive milieu, in his case one that included students, aspiring politicians, and writers from the European colonies – Ghana, Nigeria, the Caribbean – and their British supporters, colleagues, and partners in dialogue. Several groups in this political and intellectual environment worked towards the end of European colonialism, and many took part in Malinowski's seminar. The seminar had a strong representation from East Africa: apart from Kenyatta, the settler writer Elspeth Huxley, and the archeologist and anthropologist Louis Leakey, another white Kenyan who was an archeologist and anthropologist, fluent in Kikuyu, and Kenyatta's rival and evil spirit (Berman and Lonsdale 1991).

18 Kenyatta studied for the Anthropological Diploma at LSE. As part of the program, he presented a paper dealing with girls' initiation rites among the Kikuyu of Kenya. Here he showed material that later became the substance of the chapters on "Initiation of Boys and Girls" and "Sex Life Among Young People" in his monograph on the culture of the Kikuyu, *Facing Mount Kenya. The Traditional Life of the Gikuyu*. Prince Peter was present and took notes, as did Malinowski.

19 This academic event was of the utmost interest to Marie Bonaparte. In the chapters of *Female Sexuality* and her essay, "Notes on Excision", she presented her theory on female sexuality and the role of the clitoridectomy (1950)[3]. According to Freud, clitoridectomy contributed to the feminization women. The purpose of the surgical intervention that had been known from the period of Egyptian antiquity onwards was to move the site of sexual pleasure from the clitoris to the vagina. Experimentally, Bonaparte went along with this thesis and added an anthropological reflection. In "Notes on Excision", she wrote:

> I think that the ritual sexual mutilation imposed on women of some African tribes since time immemorial, - (Cleopatra herself must have been excised!) – constitute the exact physical counterpart of the psychic intimidations imposed in childhood on the sexuality of little girls of European races, and I think that from the point of view of the final sexuality of the women, they produce the same results. With the progressive introjection of the external persons of authority surrounding the child, with the corresponding strengthening of the superego or conscience, less physical coercion seems necessary than in more primitive times when the archaic instincts of humanity were stronger and more difficult to curb. The same results which were formerly obtained by physical violence are then secured by psychic intimidation.[4]

[3] A footnote to the French version of the essay, "Notes sur l'excision", informs that Bonaparte wrote it in French in 1941-2, Bonaparte 1952, 107.

[4] (Bonaparte 1950 78).

To investigate her ideas of the suppression and censoring of female sexuality that was predominant in the Western world, she needed informants among women whose clitoris had been excised to find out whether they had been 'better vaginalized' than their European sisters, as she expressed it. Female circumcision was prevalent among Kenyatta's people, the Kikuyu. He was to be her informant.

20 The Kikuyu were the ethnic group that caused endless problems for the British colonial government. They lived and owned land in areas close to the capital Nairobi and the White Highlands. Around 1930, the controversy over clitoridectomy between Scottish missionaries and Kikuyu-led political organizations led to a radical break between the colonial regime and its subjects, which meant that the Kikuyu rejected British reform initiatives and established their schools and religious and political organizations.[5] Throughout the 1930s, and more violently after the WWII, resistance kept growing and led to the famous Mau Mau revolt against the British colonial regime from 1952 to 1960. Resistance against British representations and understandings of the role of clitoridectomy in African culture and the reform interventions they attempted were thus a contributing reason for the anti-colonial opposition.

21 According to Kenyatta, as laid out in his seminar paper at LSE and elaborated in *Facing Mount Kenya*, circumcision of both boys and girls was a necessary and positive step towards the maturity, self-restraint and the discipline of adulthood. The transition from childhood to maturity would not be complete without the ordeal of circumcision. Kikuyu society, as described by Kenyatta in his monograph, was strongly patriarchal, and it is unlikely that women had any influence on the operation. In his work, Kenyatta described the elderly women who were in charge of the intervention, jokingly, as Harley Street surgeons, and in his detailed description of the procedure of the cutting and its context, he underplayed the pain that girls underwent during and after the operation. Bonaparte was skeptical and, half-jokingly suspected the elderly women who operated finding satisfaction in mutilating the young girls who were destined to replace them as objects of men's love. She also took issue with the notion that clitoridectomy was beneficial to childbirth, which Kenyatta had maintained, arguing that the British medical skepticism of the practice could be attributed the fact that doctors saw only the cases that had gone wrong (Frederiksen 38).

22 Encouraged by Bonaparte, Malinowski had studied female circumcision on his African journey in 1934-5. He wrote to her from a stay with the Maasai in East Africa,

[5] There is an extensive literature on the crisis over clitoridectomy as it unfolded in Great Britain and Kenya. For an overview see Lonsdale 2002, 54-5.

> I am at last with people who do practice clitoridectomy and are very keen on it …. I have had excellent informants … both male and female and mindful of your instructions not to miss any opportunity of studying this subject, I have worked on it pretty fully. [6]

What he found was that the intervention changes young men and women into "something more complete, *volkommen*, really adult and human."[7]

23 Malinowski made use of his observations in his anthropology seminars in London, and his formulations are close to those of Kenyatta's in *Facing Mount Kenya*:

> The real argument lies not in the defence of the surgical operation or its details, but in the understanding of a very important fact in the tribal psychology of the Gikuyu, namely that this operation is still regarded as the very essence of an institution which has got enormous education, moral, social and religious implication, besides the operation. (Kenyatta 133)

Malinowski and Bonaparte both concluded that the decisive difference in the development of sexuality between adolescents in Europe and non-Europeans, like the Melanesians, commonly considered less developed, was due to the great significance of the latency period in Europe, the period when sexuality was dormant and censored by the Oedipal prohibition. During the latency period, according to Malinowski and Bonaparte, sexuality was internalized as shame, repugnance and intellectual and moral attributes – the qualities that make human beings civilized – thought to be the preconditions for the emergence of culture. Their theory was that in Africa, because of the freer play of sexuality during this period, men and women were less likely to suffer from neuroses and blocked sexuality. Where this was the case, when restrictions on the unfolding of sexuality were less absolute, the price young people paid, was a less developed culture and civilization. The price young people in Europe, particularly young women, may have paid for their tortured but ultimately beneficial latency period was a crippled sexuality.

24 Malinowski had earlier come to this conclusion, as a result of his research on the matrilineal Trobrianders of Melanesia. During the latency period, young Melanesians were allowed to engage in socially sanctioned sexual practices. In Malinowski's view this was, as he writes, in many ways "culturally destructive", like the Oedipal taboo, but less threatening: it "helps the gradual and harmonious weaning of the child from family influences" (Malinowski 78). On this point, there was agreement among influential anthropologists and psychoanalysis around 1930. The idea that Africans and other people of color were closer to nature than Europeans corresponded to the dominant ideas and discourses among the political

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[6] LSE Archives MP/Appendix/1, Correspondence with Marie Bonaparte 12 December and 21 August 1934.
[7] LSE Archives MP/Appendix/1, Correspondence with Marie Bonaparte 12 December and 21 August 1934.

elite, ideas that were deployed to justify the perpetuation of colonial rule. Over the next two decades, the era of decolonization and nationalist movements, this view came to be seen as obsolete.

25 For Bonaparte, the real preoccupation was the origins and site of female libido, and the role that clitoridectomy played as a hindrance or helper of sexual pleasure. In spite of her efforts, she did not manage to get access to more than four or five informants from Europe and North Africa. She did not trust second-hand information, not even that of Malinowski or Kenyatta, as we have seen. On the basis of her research and psychoanalytical insights she reached the preliminary conclusion that if the purpose of clitoridectomy was to stifle the ability of women to experience orgasm, the operation was in vain.

26 Bonaparte was enthusiastic about her meeting with Kenyatta. He spent ten days in Paris as her guest, and after the visit, she wrote to Malinowski in London that Kenyatta was very charming and that the visit had brought her great pleasure.[8] Unfortunately, there is no report on the encounter with Bonaparte from Kenyatta's hand. A closer examination of his account of female circumcision in *Facing Mount Kenya*, which was published a couple of years after the Paris event, shows how the meeting with an intellectually open milieu in Europe contributed to his understanding of his people. In his preface to the monograph, he also makes clear that as an African anthropologist, close to his people, his analysis of sexuality and its embeddedness in social structures carried greater weight than that of his European colleagues.

27 Undoubtedly, Malinowski also learned from Kenyatta, and, like other leading social scientists he changed his view on the relations between colonizers and colonized. In a letter to Lord Lugard, the Chairman of the International African Institute, in support of a scholarship for Kenyatta to pursue his diploma, Malinowski wrote, "The highly depoliticising influence of scientific anthropology has worked a remarkable change … another two years of systematic study and the hallmark provided by a Diploma … and the obligation under which he will feel himself to the Institute will, I am sure, complete the change".[9] Malinowski's prediction proved wrong. Kenyatta's monograph, *Facing Mount Kenya,* has been recognized as a masterpiece of analysis and propaganda in support of the way of life of highly developed African societies, like that of the Kikuyu. His work, like hat of other nationalist intellectuals, helped to turn the tide against European prejudice. When Kenyatta returned to Kenya in 1946, he threw himself into the organizing the ultimately successful political opposition against the British regime.

[8] LSE Archives MP/Appendix/1, Correspondence with Marie Bonaparte 18 April 1935.
[9] LSE Archives IAI 629 39/139. 7 December 1936.

28 Struggles surrounding the emancipation of women, and that of colonized peoples were connected, but not in any straightforward manner. In her article on the circumcision controversy as it unfolded in Great Britain, Susan Pedersen remarks that African and European men were likely to have a great deal in common in their fight for the upholding of patriarchy. They made a united front in silencing women's insistence that they, like their male counterparts, had a need of and right to a satisfying sexual life. According to her, this silencing of the clitoris as a site of female pleasure contributed to the toleration of clitoridectomy (Pedersen 664-6).

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Yorkey, Brian, creator, *13 Reasons Why*. Netflix, 2017.

By Patrick Osborne, Florida State University, USA

1 While apprehensively preparing to listen to his own tape, Clay Jensen asks his best friend, Tony, the pivotal question presented throughout Brain Yorkey's *13 Reasons Why*: "Did I kill Hannah Baker?" ("Tape 5, Side B"). The answer to this question is never blatantly stated in the series. However, the series regularly implies, as Alex Standall suggests, that "we all killed Hannah Baker" (Tape 2, Side A). As a show depicting the horrific consequences of slut-shaming, bullying, sexual assault, and the ineptitude of mental health awareness, *13 Reasons Why* provides an interesting commentary concerning the hardships many young women face in a sexist high school environment and delineates such strains as a catalyst for adolescent suicide. Based on Jay Asher's best-selling novel of the same name, the series begins in the wake of Hannah Baker's completed suicide. While much of the school is struggling to comprehend the motivations behind the tragic event, Clay mysteriously receives a box of cassette tapes on his front porch that Hannah recorded prior to her death. The cassettes, each addressed to a different classmate, delineate the thirteen reasons Hannah took her own life and ultimately reveal the truth behind various rumors spread to defame her character. The show thus takes the form of a mystery, as Clay becomes an avenging detective gradually uncovering the motivations behind Hannah's suicide while simultaneously revealing his classmates' transgressions and finally his own.

2 From a purely entertainment standpoint, the show is compelling and commands the audience's attention because of its suspenseful action, numerous cliffhangers, and the desire to understand Hannah's actions. In fact, the series became the most tweeted about series of 2017 and was highly discussed via social media among adolescents making it one of the most talked about shows of the year (Becker 17). In terms of style, the series resembles a more serious and darker teen drama than those that have preceded it and the previously unknown actors/actresses that make up its cast do an excellent job portraying their characters—especially, Katherine Langford who brilliantly expresses Hannah's pain and suffering throughout all thirteen episodes. The series can be difficult to watch at times because the writers do not shy away from depicting terrifying events such as suicide and rape with grim verisimilitude. In fact, following its initial release, the show added trigger warnings before its opening titles following complaints from concerned parents, school officials and mental health professionals regarding the series' graphic

depiction of Hannah's rape and suicide (Andrews). Yet, regardless of the show's bleak subject matter, *13 Reasons Why* is enjoyable to watch and a viewer could easily find themselves in a Netflix-binge over a weekend as they, much like Clay, search for answers concerning Hannah's untimely death.

3 From an academic/critical standpoint, the series is much more problematic: while the series regularly succeeds in its portrayal of male sexual entitlement and gender relations, its depiction of suicide is highly questionable. In delineating the motives behind Hannah's death, *13 Reasons Why* ultimately presents suicide in Durkheimian terms: individuals that struggle to achieve societal goals or are affected by noxious stimuli take or attempt to take their own life due to their anomic condition. Throughout the series, Hannah is consistently bullied by her peers and is slut-shamed following a date with Justin Foley in the first episode. Later in the series, she is deemed "Best-Ass" by Alex Standall on a best-of list thus making it "open season on Hannah" to be groped and gazed upon by her male peers ("Tape 2, Side A"). This negative reputation leads others to falsely view Hannah as sexually promiscuous which ultimately culminates in her rape at the hands of Bryce Walker during a private party. Hannah claims concerning the thirteen reasons behind her suicide that Jessica and Justin "broke [her] heart . . . Alex, Tyler, Courtney, Marcus . . . each helped destroy [her] reputation . . . Zach and Ryan . . . broke [her] spirit," and "Bryce Walker . . . broke [her] soul" ("Tape 7, Side A"). *13 Reasons Why*'s depiction of suicide as a response to feelings of anomie is accurate and admirable, however, by presenting Hannah's tapes as a source of revenge, the series heedlessly romanticizes suicide and implies that others are to blame for her suicidal behavior; often overlooking Hannah's agency in her own death. Will Toledo, who contributed to the show's soundtrack, suggests the series irresponsibly tells "kids how to turn their miserable and hopeless lives into a thrilling and cathartic suicide mission" (Trapp). Many viewers maintain a similar sentiment, and, for this reason, *13 Reasons Why* has amassed criticism by mental health professionals that perceive the glamorization of suicide in the series as a possible catalyst of a Werther effect. Indeed, suicide-related searches increased 19% following the release of the show and psychiatrists began seeing suicide attempts in which the individual claimed to be emulating Hannah Baker (Schrobsdorff 1). Accordingly, the series presentation of suicide as a revenge narrative serves better for creating suspense and therefore should be watched with a critical eye instead of being accepted as an accurate depiction of teen suicide.

4 While the series depiction of suicide is indeed suspect, *13 Reasons Why* portrayal of rape culture, toxic masculinity and male entitlement over women's bodies is both enlightening and decisive. Following the release of Hannah's tapes, the male jocks of Liberty High strive to maintain a sense of normalcy by attempting to "control the narrative" and protect Bryce from accusations of rape ("Tape 6, Side B"). In striving to achieve this aim, the male students foster a culture of entitlement, silence and protection that Michael Kimmel argues is the underlying cause of male violence in American society: "By upholding the culture of silence, guys implicitly support the criminals in their midst who take that silence as tacit approval. And not only does that silence support them, it also protects them" (55-64). This culture of protection extends to the school administrators and counselors, as Mr. Porter questions the legitimacy of Hannah's rape—inadvertently blaming the victim—and suggests there is nothing she can do legally to achieve justice if she won't identify her attacker. This final reason, Porter's negligence and overall dismissal of rape culture, crushes Hannah's spirit and compels her to complete suicide. Accordingly, *13 Reasons Why* breaks the silence surrounding rape culture by powerfully illustrating how every single act of sexual harassment and eventual assault negatively affects Hannah's mental health leading to her eventual suicide. This is a crucial topic for discussion and *13 Reasons Why* should be commended for shedding light on topics such as sexual consent and rape for its teenage audience. While it may be both unfair and irresponsible to blame someone for another's suicide, it is clear by the conclusion of *13 Reasons Why* that Hannah's suicide is ultimately a response to a patriarchal high school environment that reinforces male entitlement over female bodies and allows such provocations to remain unchallenged. Yorkey's series successfully challenges such provocations, and, in doing so, successfully provides an impetus for important conversations concerning toxic masculinity and teen suicide.

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“The Gay and Wondrous Life of Caleb Gallo” (Youtube, 2016)

By Keshia Mcclantoc, University of Nebraska-Lincoln, USA

1 First published to Youtube on January 4, 2016, and later in the inaugural Digital Creators Program at the 2016 Tribeca Film Festival, “The Gay and Wondrous Life of Caleb Gallo” soon became a queer audience favorite. Since premiering, the series has earned a nomination for a Gotham Independent Film Award and garnered over 400,000 Youtube views of its pilot episode (Dry). “The Gay and Wondrous Life of Caleb Gallo” quickly proved itself to be the type of eccentric queer content that a digital audience craves.

2 Over a series of five short episodes the story follows theatre graduate student Caleb Gallo and his friends, a group of queer and straight millennial actors and actresses, in the surrealist landscape of Los Angeles. Unlike his friends, Caleb wants to teach rather than act. In turn, Caleb acts the mediator of the group, often negotiating and participating in conflict while he slowly brings all the individuals together. The dialogue in the series is fast-paced and witty, full of carefully timed jokes and nuanced acting approaches. From the first episode, the show proves that it is not afraid to embrace the awkward moments of life or break the fourth wall. Both clever scripts and artful editing provide a story that is eclectically self-aware and not afraid to make fun of itself. This is captured best in the end of the pilot episode when Karen exclaims “I think this is going to be a great show,” and both music and other characters pause (“The Gay and Wondrous Life of Caleb Gallo – Episode 1). Karen falls back into character, claiming she meant the show she was auditioning for tomorrow, and the music plays again when credits roll. In that moment, the editing perfectly captured the self-awareness that carries through the rest of the series.

3 Brian Jordan Alvarez, a 28-year old actor based in LA, serves as the writer, director, producer, and actor for the titular character in the series. Alvarez commented that he based much of the series on his life, saying “I don’t really think about how I'm supposed to be representing gay people, but I know that I am one and I know a lot of them, so I do it based on my real-life experience” (Horowitz). Despite only working on a budget of $10,000, Alvarez and his team produced a well-defined and polished series. Although this series was funded by a private investor, it is not uncommon for YouTube series to be funded by audience members, through platforms like GoFundMe or Kickstarter. “The Gay and Wondrous Life of Caleb Gallo” is one of many independent web series that have cropped up in the last ten years, most of them funded by a

digital audience. Often, mainstream media lacks or misinterprets queer characters. Independent projects and streaming sites, like Netflix of Amazon Prime, are now working to fill the gaps in mainstream media by presenting an authentic view of the lives of queer characters. Overall, "The Gay and Wondrous Life of Caleb Gallo" showcases an extraordinary pocket-sized view into the queer dating culture of Los Angeles, where moments of queerness that would normally need to be explained in other series are nonchalantly accepted. The series succeeds because it gives a digital audience these moments where queer characters are actually allowed to be real people.

4 However, the series is not without its faults, and still gives into some persistent stereotypes. In the first episode, Lenjamin McButton makes passing attempts at bisexuality and later says it was just a phase. Although these phases become a joke surrounding Lenjamin, the passing comment adds to the persistence media narrative of bisexual erasure (Cruz). When seemingly straight Billy later hooks up with queer Caleb, this erasure is cemented when neither Billy nor the characters around him discuss a newfound bisexuality. Instead, he jokingly posits himself as a "21st century man" ("The Gay and Wondrous Life of Caleb Gallo – Episode 3"). Even the throuple (or, three-way multi-gender relationship) between Caleb's advisors is named as "lesbian-centric" rather than embracing a label of bisexuality ("The Gay and Wondrous Life of Caleb Gallo – Episode 2"). Although the show makes significant efforts in including the rarely represented identity of genderfluid through the character, Freckle, this does not negate its casual treatment of bisexuality.

5 Additionally, the show calls out racism but maintains a cast of primarily white actors and actresses. In episode four, Freckle recounts a recent sexual venture to Caleb, telling him the race of the two boys who she slept with. Caleb comments that the story could be colorblind, but Freckle insists on the need for diversity, pointing out "if everyone in it were white, then it would be a racist…" ("The Gay and Wondrous Life of Caleb Gallo – Episode 4"). Although this forty second back and forth posits a race problem in media, it does not acknowledge its own flaws. Lenjamin, Caleb's advisors, and Caleb's sister are all played by people or color, and make up half the cast, but they have minimal screen time compared to the white cast members. While their inclusion and the notes on race throughout the series are significant, it falls just short of a satisfactory representation.

6 Despite these flaws, "The Gay and Wonderous Life of Caleb Gallo" still delivers a potent and nuanced portrayal of queer dating culture. The significance of this representation within an

indie web series proves the changing nature of queer-centric media, which is now making more efforts to cater itself toward a digital audience.

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