Becoming-Virgin:

Re-Virginisation Practices in Turkey

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Declaration

This thesis is the result of my own work and includes nothing which is the outcome of work done in collaboration except as declared in the Preface and specified in the text. It is not substantially the same as any that I have submitted, or, is being concurrently submitted for a degree or diploma or other qualification at the University of Cambridge or any other University or similar institution except as declared in the Preface and specified in the text. I further state that no substantial part of my thesis has already been submitted, or, is being concurrently submitted for any such degree, diploma or other qualification at the University of Cambridge or any other University or similar institution except as declared in the Preface and specified in the text. It does not exceed the prescribed word limit for the relevant Degree Committee

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Abstract

Re-virginisation refers to the regaining of women's 'technical' virginity even though the woman might have had penile-vaginal intercourse before. While virginity takes on many different meanings that are culturally determined and socially constructed, 'technical' virginity refers to 'proving' virginity through blood and the sense of tightness of the vagina. Even though studies have shown that neither of these two can be markers of virginity, social change around this myth has not followed the research in the field. Hence, to be 'marriageable' again, women might either be operated on to have a so-called new hymen via hymenoplasty (sometimes accompanied by vaginal tightening surgery) or buy a product called artificial hymen (accompanied by vaginal tightening cream).

Based on 55 in-depth interviews with healthcare staff, artificial hymen retailers, re-virginisers, and women and men who are not directly related to re-virginisation; as well as discourse analysis of online conversations on re-virginisation between women in Turkey and websites advertising relevant goods and services, I argue that re-virginisation is not a moment, but a process. It is not possible to pinpoint a time when a woman feels like a virgin following the operation or the use of the artificial hymen. Instead, women go through a lengthy process involving a variety of physical and emotional changes that might take years, or might never end.

This thesis draws a legal and economic framework within which re-virginisation operates in Turkey, as well as arguing that the nation-state actively ignores these practices in line with its neo-conservative policies. Furthermore, it utilises the notion of "becoming" as originated by Gilles Deleuze and developed with Felix Guattari, and its feminist interpretations to discuss how women's relationship to their body changes, how they perform their emotional and embodied pain, as well as how their perception of time and space changes affectively throughout.

to women everywhere,
for their unabashed courage to thrive

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Doing a PhD is a curious journey. Perhaps it is the length, or where it befalls on your personal timeline that makes it so unique. If you come across these lines and if you are about to embark on your PhD journey, believe me, you are in for a ride.

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It's been a beautiful ride.

Preface

Parts of Chapter 6 have been published in a peer-reviewed journal article. The chapter differs from the journal article in several respects. Most of the contents of the section 'Healing and Bleeding' did not appear in the article. Furthermore, some of the quotations have been changed for the thesis, as a result of further data analysis, and to maintain the coherence of the thesis. The article is published as Güzel, Hande. 2018. 'Pain as Performance: Re-Virginisation in Turkey'. *Medical Humanities* 44 (2): 89–95. doi.org/10.1136/medhum-2017-011414.

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1. Introduction

If there is a mistake worse than the mistake [of having premarital sex], it is hymenoplasty. (…) Please, do it only if you have no other choice. (…) Back then, I thought that there shouldn't be any reminder left of that scumbag on my body. (…) I thought that I would feel as if I was re-born once I'd get off that [operation] table, but I woke up from narcosis crying. There was no one next to me, I struggled to walk. And then I understood that this is not being re-born. When you are born [as a baby], you have your parents with you, but then [at the time of hymenoplasty], [there was] no one… I beg you, please do not make this mistake.

Re-virginiser, posted online (Thread 47, November 2013)[1]

Because if I don't bleed on my wedding night, I'd better throw myself off a cliff. Neither can I go back to my family home [baba evi]*, nor will my fiancé accept me. The only solution would be death for me, I can't live with that grief anyway.*

Re-virginiser, posted online (Thread 43, February 2012)

There is blood. There is pain. There is a woman to be penetrated. If *it* is not going in easily, it is good, she is good. If her vagina is denied a sexual history, it is a vagina worth penetrating, the vagina is good. If she keeps that history to herself, to her vagina, however, she can still be good. If there is blood. If there is pain.

…

One of the questions I asked my participants in this study is "When is the first time you heard about re-virginisation?" The reason for asking this question is re-virginisation being a "public secret" (Taussig 1999). It is not publicly spoken of in offline spaces, and online spaces have become available mostly in the last two decades. I was especially curious to discover the threads that brought re-virginisation into the lives and minds of people who are not seeking and have never sought to re-virginise. Many participants told me that they knew someone

[1] Online data is cited by referring to the number that the thread is assigned, and the month and year the post was published. Please refer to Chapter 3 for further particulars on this.

who knew someone who re-virginised, which attested to the fact that re-virginisation was much more common than many people assumed. However, when I have been asked the same question by my participants and other interested parties, about how I thought of this topic and where I first heard about it, I do not have an answer. I cannot pinpoint the time re-virginisation or hymenoplasty entered my mind.

Nevertheless, and even though I have not re-virginised, virginity has been a topic taking space at the back of my mind throughout my adolescence and adulthood. I have lived and continue to live through a "virginal facade" (Ozyegin 2015). I was raised to be a 'decent, virtuous, good girl',[2] which meant that my family expected me to not have a sexual identity until the day I would get married.[3] On the other hand, especially starting from my undergraduate years and throughout my 20s, this sexual identity started to be expected from me by my friends. It was seen as something that I should of course have, but I was implied to never even consider having it at this stage of my life by my family. As a result, I became part of the "virginal facade", without knowing how to name it, and without knowing that I was not the only one putting one up. Therefore, after having researched re-virginisation for more than four years now, I can see how the underlying norms and ideas have been intrinsic to my life for years. Hence this research, as much as it is a study of re-virginisation in Turkey, has also been a much-needed self-exploration. Perhaps it is not possible to separate the two from each other anyway.

Re-Virginisation: The Basics

Re-virginisation (also called re-virgination) is the process through which a woman becomes a 'technical' virgin. As virginity is both a subjective and constructed concept cloaked in a false sense of objectivity, it is important to emphasise the 'technical' aspect of re-virginisation. In other words, the concept of re-virginisation rests on the myth that women's virginity can be measured by the blood and the pain that a woman produces and experiences during her first penile-vaginal intercourse. Most people around the world believe that a woman should experience a lot of pain and should bleed in her first penile-vaginal intercourse, even though studies show that "40-50% of all women from different cultural backgrounds do not have any blood loss at first coitus" (van Moorst et al. 2012, 94). Re-virginisation, therefore, aims at creating these circumstances to make someone else, such as the husband, fiancé, boyfriend, parents, and/or parents-in-law believe that a woman is a virgin. This proof is irrespective of the sexual history of the woman. Although many women will have had sexual intercourse at the time of re-virginisation, some women re-virginise because they believe they cannot

[2] In Turkish, *kız* [girl] refers to both a female child and a virgin.
[3] Here I use the term "sexual identity" not to mean sexual orientation identity per se, but to refer to how one identifies oneself sexually, in terms of sexual imagination and activities.

provide the necessary proof for reasons such as having an elastic hymen. Furthermore, in order to protect their 'technical virginity', other women resort to engaging in anal or oral sex, or genital rubbing without penetration, which is invisible as long as the woman bleeds and/or provides tightness when penetration occurs. Therefore, re-virginisation is less about a woman's sexual history than the constructed necessity to prove it through certain means, which are blood and pain in the Turkish context. It is also important here to note that the Turkish word for hymen is *kızlık zarı*, which is more similar to maidenhead than hymen (Ergün 2008, 14), with its emphasis on *kız* [girl, virgin, maiden] as well as on *zar* [membrane]. Therefore, in the Turkish discourse, the hymen is imagined as a membrane that covers the entrance of the vagina and as proof of virginity.

In order to prove virginity via blood and pain, women resort to two main methods, which are hymenoplasty and the artificial hymen. Hymenoplasty[4] is the medical intervention into a woman's vaginal entrance in order to ensure bleeding in the next penile-vaginal intercourse. Doctors claim to make this possible via two types of operations. The first one is called permanent (or enduring) hymenoplasty, whereas the second type is referred to as temporary (or transient). Permanent hymenoplasty does not provide permanent virginity per se, however it allegedly allows a woman to be a technical virgin until she is penetrated, no matter how long it takes. A new tissue is created in the woman's vaginal entrance using the flap method, i.e. removing a tissue from the vaginal wall to create a new tissue that partially covers the vaginal entrance. In some cases, the remnants of the original hymen can also be stitched in order to 'restore' the hymen. Following this surgery, the woman is supposed to wait to heal for one to two months, following which she may engage in sexual intercourse. If she has vaginal intercourse during the healing period, she risks severe bleeding. This operation costs approximately £400-850,[5] depending on various factors such as the location of the clinic, and how prominent the doctor is in the field.

Temporary, or transient hymenoplasty, on the other hand, requires the woman to have intercourse within a week following the operation and costs £300-500. As opposed to the necessity of healing after permanent hymenoplasty, temporary hymenoplasty requires that healing do not take place in the new sutures that are made in the vaginal entrance. As the penis (or fingers/an object) enters the vagina, these sutures, which are unhealed, break and cause bleeding. Therefore, while permanent hymenoplasty aims at creating a tissue that will heal and hence bleed, temporary hymenoplasty creates wounds that will not heal and hence

[4] Hymenoplasty refers to all operations done on the hymen, which includes not only the so-called hymen repair/reconstruction/restoration surgery (hymenorraphy), but also imperforate hymen surgery (hymenotomy, the surgical removal of the hymen). However, as hymenoplasty is the dominant concept that is used in the medical and social scientific literature to refer to hymen reconstruction, I will follow this pattern.
[5] As of October 2019, the monthly gross minimum wage in Turkey is approximately £347, whereas the net monthly minimum wage is £274.

bleed. Even though this distinction is clearly remarked by medical doctors who provide this service, more often than not, women are asked to come in a few days before they expect to have intercourse even though they have had a permanent hymenoplasty, and they are given temporary hymenoplasty, in order to 'guarantee' bleeding. Therefore, most women end up having both operations, which means more pain, more intervention into the body, more difficulties in terms of finding the time and excuse to go to the clinic or the hospital, and higher financial costs. Even though most doctors do not charge for the temporary operation following the permanent one, the latter is already more expensive. Hence, even though it is more likely that the temporary operation causes the bleeding as most doctors point out that it is more guaranteed, women are made to pay for the more expensive operation.

Hymenoplasties usually take place in private clinics, and, to a lesser extent, private hospitals, conducted most frequently by gynaecologists and plastic surgeons. In private hospitals, an institutional chain of secrecy is required. Hymenoplasties are generally recorded as "Bartholin's abscess" to protect the woman's confidentiality even though the hospital administration may know that a hymenoplasty is taking place. Bartholin's abscess is the formation of a cyst inside the vaginal opening (NHS 2018), and hence is not far away from where the actual operation takes place. Hospital staff are usually warned to be extra careful about secrecy. However, as patients are admitted to all hospitals based on their identity information, it is not possible to erase the entry to the hospital. That is why many re-virginisers prefer private clinics, where names can be either not recorded, or pseudonyms can be assigned to patients. Women also interact with fewer people in these smaller settings. In rare cases, operations take place in public hospitals. Dr Ceren recalls witnessing a hymenoplasty in her medical faculty in Gaziantep, which is a very rare occasion (Dr Ceren, Izmir, August 2017, personal interview). Dr Hasan, who works in one of the biggest public hospitals in Istanbul, has shared with me two incidents where the fathers begged him to conduct hymenoplasty on their daughters. In one of the instances, "I did the operation because the family was stuck in a difficult situation. A man came in, he threw himself at my feet. He cried, he was older than me. His daughter was a teacher, I listened to the story from the daughter. She had been raped" (Dr Hasan, Istanbul, December 2016, personal interview). Finally, there are some illegal clinics where hymenoplasties take place. This is a more frequent occurrence near or on university campuses, where the demand for hymenoplasty is assumed to be higher. Medical students use their professors' clinics to conduct these operations (Thread 43, August 2015). Furthermore, doctors from other areas of specialisation, such as general surgeons (Thread 17, September 2015) and general practitioners (Thread 43, August 2015), as well as midwives (Thread 20, March 2012) are known to conduct hymenoplasty.

The second prominent method of re-virginisation is the artificial hymen. This product, which can only be ordered online, is usually either a plastic sachet or a pill that contains dye to act as artificial blood. The product is inserted into the vagina several minutes or hours before the intercourse (depending on the product), and the outer layer dissolves in the body through heat and bodily fluids, allowing the dye to mimic blood. This is a less invasive, non-medical, and cheaper method with a price of £30-50, and is the only other commodified re-virginisation method available to women in Turkey.

In addition to blood, the vagina is tightened as well in many cases in order to induce pain and a sense of tightness, which is seen as a marker of virginity alongside, or sometimes instead of bleeding. Sometimes pain can be manifested via hymenoplasty only- an example is "superhymenoplasty" (Prakash and Rani Garg 2015), which leaves a very small opening for menstrual blood to flow through, hence making it painful for the penis to penetrate. It is more common, however, to have an extra operation for vaginal tightening (vaginoplasty) if the woman is re-virginising through hymenoplasty, or to use vaginal tightening cream regularly for a few weeks before using the artificial hymen. This constructed necessity to have a tight vagina and to be in pain during the first intercourse relies on the myth that the vagina gets 'loose' as a result of having sex, and the looser the vagina is, the more promiscuous a woman is (Braun and Kitzinger 2001). Even though there is very little research on the size of women's genitalia, existing research shows that there is "no statistically significant association between any of the different genital measurements and age, parity, ethnicity, hormonal use or history of sexual activity" (Lloyd et al. 2005, 644; see also Pendergrass et al. 1996). Hence, the very existence of vaginal tightening surgery and creams relies on the false assumptions that a 'normal' vagina exists, and that vaginal tightness gives one information about one's sexual and/or reproductive history, among other characteristics.

Even though there are two main methods of re-virginisation that are commercialised and commodified in Turkey and elsewhere, which form the main focus of this thesis, women have devised a variety of methods to re-virginise, especially before hymenoplasty and the artificial hymen became more mainstream and accessible. One example is cutting a labium with a razor blade. As this creates a very fine cut, bleeding does not start instantly, which provides the woman with some time between performing the cut and the intercourse. Some women, on the other hand, engage in sexual intercourse during the later days of menstruation so that the amount of blood is 'adequate'.[6] A more creative home-made method of re-virginisation is making one's own artificial hymen. One of my participants, Dr Mehmet has witnessed this method during his obligatory service in Anatolia, where a midwife was teaching the women

[6] The amount of hymeneal blood that is expected is quite subjective, which will be further discussed in Chapter 5.

in the village to make their own artificial hymen. Women were instructed to use a sheep's intestine and to fill it with the serum of blood (clot removed to match the expected colour and texture of hymeneal blood) (Dr Mehmet, Istanbul, December 2016, personal interview). Another alternative method involving animal blood has been narrated by Çiçek, an interviewee in her mid-60s. Çiçek recalls a story she heard in her village in central Anatolia around the 1960s, when "a young, pretty girl living in a village had been raped by her uncle". On the night of her marriage to someone else, a relative butchered a rooster, whose blood was used to mimic hymeneal blood (Çiçek, Istanbul, May 2017, personal interview).

As this last alternative method shows, re-virginisation dates back at least to the 1960s in Turkey. The medical method, on the other hand, can be traced back to at least the late 1970s, or early 1980s. In its issue from May 1984, *Kadınca* [Womanly], a women's magazine published in Turkey, points at the high demand for hymenoplasty surgeries. It also suggests that these operations started to be performed in France as early as 1973 (Kadınca 1984). The narratives from the interviews conducted for this research support this claim too. A woman in her mid-60s, Nesrin, narrates the story of a woman, the daughter of an MP who had had hymenoplasty multiple times from the late 1970s to the early 1980s (Nesrin, Istanbul, May 2017, personal interview). Similarly, another narrative was provided by Melisa, a woman in her 50s, in which a young girl "flirted [with a man], had sex with him, and then they got separated" (Melisa, Istanbul, April 2017, personal interview). The girl had hymenoplasty after this relationship ended, and was forced to marry soon after. However, the bride's father-in-law knew about the operation and sexually abused the woman for years by threatening her to tell her husband about it. Melisa recalls that the woman had the operation around 1982-1983 at an upscale region of Istanbul at that time. Therefore, it is possible to say that hymenoplasty was available to women in Turkey as early as the 1970s and 1980s, if not before. It might be expected that access to the operation might be limited to upper class women living in urban areas, especially in Istanbul, although there is no data to support this.

I have coined the term "re-virginiser" to refer to any and all women who have sought or are seeking re-virginisation, via any method, be it medicalised, commodified or an alternative route. This term is not only useful linguistically, to condense "women who are seeking or have sought re-virginisation", but also allows us to categorically classify re-virginisers as a whole. As I will detail below, characteristics of re-virginisers cannot be generalised, as re-virginisers come from a variety of backgrounds. Therefore, the term "re-virginiser" is a reminder that as an object of study, we are working with a diverse group of women. Furthermore, this will allow us to analyse how re-virginisers interact with each other as a group, as well as with non-re-virginisers as we will see in detail in the Methodology chapter. Throughout the thesis, I abstain from using the word 'patient' when referring to women who

undergo hymenoplasty unless a doctor refers to them as such. The reason is that being a patient comes with a certain set of relations within the medical institution, one that is generally ascribed to women by doctors. Being a patient means being part of a medical institution under medical rules and authorities. Not only is re-virginisation more than the medical methods, but also, and more importantly, women find themselves in a place to negotiate what it means to be a patient in the context of re-virginisation, which I explore in Chapter 7. It should be noted that I do not argue that re-virginisers are different from the rest of society. As I will discuss below, re-virginisation is part of a much larger discourse that cuts across patriarchal structures, various forms of hierarchy, women's bodies, sexuality, and medicalisation. Hence, re-virginisation is one of the forms through which this junction manifests itself. The term "re-virginiser" allows us to explore the specifics of re-virginisation, rather than exoticising the practices and those who practice them.[7]

Re-virginisers come from a variety of backgrounds. A typical re-virginiser is a woman in her mid-20s, has completed her undergraduate education in a city other than where her family lives, and is working at a minimum-wage job. Typically, she has had a long-term boyfriend that promised to marry her, hence they have had penile-vaginal intercourse. However, the relationship has ended either because the boyfriend has left the woman, or the woman has done so because she was being abused or cheated on. The woman then meets a new man, hopes to marry him and tells him of her sexual past, which the man cannot accept. The woman hence concludes that it is not possible to find a man who will accept her as she is, and starts looking for methods of re-virginisation. Even though this is a typical description of a re-virginiser, it is not possible to draw a generalisation. Throughout my research, I have come across re-virginisers, or narrations thereof from unexpected backgrounds, unexpected for someone who is not familiar with the value ascribed to virginity in Turkey and how it is linked to the modernisation project. There are women who are dentists, psychiatrists, academics, gynaecologists, daughters of MPs that have knocked on the doors of the clinics to re-virginise. At the same time, there are women who have very little education and money, and pay for the surgery by taking out a loan, or borrowing from a friend. There are women who go to clinics on their own, there are women whose re-virginisation is paid for by family members, by their ex-boyfriends, or by their fiancés, whom they have had sex with and are about to marry for fear of needing to supply bloody sheets to parents. There are boyfriends on their way to military service who take their girlfriends to re-virginise so that they can make sure "to find them as they left them" (Dr Jale, Ankara, April 2017, personal interview). Therefore, even though the typical re-virginiser described above is encountered more frequently, the diversity is an indication of how pervasive the virginity discourse is.

[7] I have discussed the perils of marginalising re-virginisers and re-virginisation through films in Turkey in a journal article (Güzel 2019).

Research Questions

I have started this research by asking three questions,

(i) How does the female body *become* through re-virginisation practices?

(ii) How are the female and the male body defined through re-virginisation practices by women themselves, by medical doctors, and by the artificial hymen retailers?

(iii) What kind of an industry is formed around re-virginisation practices?

I set off to answer these questions as a result of taking a Deleuzian approach to the body (i), and putting the body at the centre of my research (ii). The third question, on the other hand, emerged from the necessity to draw the framework within which re-virginisation takes place, as a result of the topic being understudied. By following the money, I aimed at understanding what kind of a relationship economic capital had with other forms of capital, and how these capitals impacted women's access to re-virginisation.

Even though I received answers to all of the three questions to varying degrees as a result of my data collection and analysis, my focus shifted during and following the fieldwork. The body continued to be a fundamental part of my research, yet it became one of the multiple pillars that constitute this thesis. As I engaged with the data, themes and patterns spoke for themselves, informing me of what needed to come to the fore. For both practical reasons, and for being so intrinsic to the process of re-virginisation, the re-virginisation industry continued to be one of the main research questions, while others needed to be revised. Hence, the questions this research aims to answer are,

(i) How do women experience and embody re-virginisation?

(ii) How do re-virginisation providers understand and practice re-virginisation?

(iii) How is the re-virginisation industry shaped?

The first question alludes to two primary aspects of re-virginisation: emotional and physical. Women experience and demand physical change via re-virginisation, and go through a variety of emotions throughout the process. How they experience these emotions impact their sense of time and space, which requires a reading of these two dimensions through notions of affect. While women's experiences are at the core of this thesis, I have also been interested in how their experiences are shaped by their relationality with re-virginisation providers, i.e. gynaecologists and plastic surgeons, as well as artificial hymen retailers. Women's experiences of re-virginisation are moulded by both their interactions with these 'experts' and the discourses created by them around virginity and re-virginisation. As we will see in Chapter 7, doctors claim authority over who is allowed to have hymenoplasty, perpetuating and producing norms around what constitutes virginity and acceptable

behaviour of a woman who is a virgin or who is willing to be a virgin again. Hence, the institution of medicine, and to a minor extent, the commodification of re-virginisation through the artificial hymen are important agents in re-virginisation that come into surface both in face-to-face interactions and phone conversations with women and through their online presence. Therefore, it has become fundamental to my research to unravel the frameworks upon which women's experiences of re-virginisation rests and unfolds.

In answering these questions, I still frame the body and emotions around the Deleuzian[8] term of "becoming", which I explore in the next chapter. However, rather than the sociological analysis of re-virginisation being a practical application of Deleuze (and Guattari)'s theories, I used this term as a lens to make sense of women's experiences of re-virginisation while at the same time branching out to other theories and concepts as well. I have also relied more on feminist interpretations of Deleuze and Guattari's theories than Deleuze and Guattari themselves, as this is a feminist thesis. Hence, I moved away from putting Deleuze and Guattari at the centre of my research to using it as one of the most important means to interpret it. I find Deleuze and Guattari's conceptualisation of "becoming" particularly useful as it prevents us from falling into the trap of conceptualising virginity as a state of being and re-virginisation as a moment.

It should also be noted that I use the concepts of virginity and the hymen throughout my thesis, while simultaneously arguing that their existence is highly questionable. This is not a paradox. On the contrary, this summarises the thesis: from a radical perspective, virginity and the hymen do not exist but are real. In other words, the impact they have on people's, especially women's lives is real. Even though it could be possible to talk about gaining sexual experience rather than 'losing' virginity, or about pain and blood as issues to be avoided rather than celebrated, the existing discourse around virginity is one of loss, which is socially acceptable only under certain conditions. This elusive and arbitrary nature of virginity makes it inevitable to frame it as a continuum rather than a dichotomy, which will be discussed below.

Virginity as a Continuum and Re-Virginisation as a Process

It is not possible to define virginity in objective terms. Throughout history, there have been a variety of markers of virginity that have been accepted and used to determine women's virginity in particular. Historically and culturally, blood and pain have not always been at the forefront of proof of virginity. Some examples for 'proving' virginity include examining the

[8] The concept "becoming" originates from Deleuze, even though it has been further developed through his collaborations with Guattari (May 2003). For this reason, I refer to "becoming" as a *Deleuzian* concept, yet use both authors' surnames when referring to arguments that have been developed by both.

colour of the labia, the perkiness of the breasts, and the narrowness of the hips (Blank 2007). Hence, it is important to be aware of how 'technical virginity' is a modern and contemporary way of conceptualising virginity, and how re-virginisation is tied to this definition, and hence is a temporal and temporary construction. Furthermore, virginity is a highly gendered construction. Even though there are cultures that believe men have hymens on their foreskin (IOL News 2002), this belief is not globalised like the myth around women's hymen. This bears the question of which bodies 'require' more scrutiny and control than others. Women's hymen was 'discovered' only in 1544, and as Blank argues, "we became aware of hymens because we are aware of something we call virginity. We found the hymen because we found reasons to search women's bodies for some bit of flesh that embodied this quality we call 'virginity,' some physical proof that it existed" (Blank 2007, 29). Finally, virginity is a heteronormative construction. Virginity loss is currently dominated by the imagination of the penetration of the penis into the vagina. A woman who has never been penetrated by a penis but has penetrative sex with another woman stands in a vacuum in relation to her virginity, as she might have bled when penetrated with an object or fingers, but this bleeding has not been initiated by the penis.

Throughout my fieldwork, I have come across a variety of definitions regarding virginity formulated by my participants, most of whom struggled to arrive at a clear-cut conceptualisation when probed further. Many people, including some of my participants, claim that "virginity is not between the legs, it's in the mind", in an attempt to circumvent the obsession with the hymen. However, when probed further, what is perceived to be "in the mind" usually translates into all of the connotations that come with virginity, such as being innocent, virtuous and chaste. Hence, I agree with Parla that "the seeming denial of the significance of the physical, the hymen, with a concurrent insistence of the ideal, virginity, (…) produces the effect of the possibility of self-control free from outside intervention" (Parla 2001, 83–84). It is especially a conundrum when we question what we should be controlling against, in other words, our definition of sex. My participants struggled to decide whether sex includes anal or oral sex, touching genitalia, or, as Dr Ezgi suggested, whether being naked with the opposite sex in the absence of the touching of bodies meant 'losing' virginity (Dr Ezgi, Istanbul, November 2016, personal interview). The heteronormativity intrinsic in the definition of virginity aside, the arbitrariness of what constitutes sex and virginity make it even more difficult for women to navigate their bodies within themselves and within physical and social spaces, as well as to negotiate with patriarchy the terms under which this body can be in touch with other bodies, both literally and figuratively. As boundaries are more blurred than they seem to be, re-virginisation serves as a simpler and more straightforward solution to overcome the complexity and arbitrariness of the definition of virginity and to reduce it to pain and blood. In a way, virginity being reduced to measurable

features serves women. Instead of engaging in lengthy negotiations with patriarchy and normative understandings of virginity, they can attain or preserve their social status either by keeping their technical virginity, or by regaining it.

Even though this simplicity works in practice to be or remain marriageable, arguing that virginity is an either/or is highly problematic as soon as we engage with women's experiences regarding sex and virginity. As we will see in the upcoming chapters, the markers of blood, pain, the hymen, and how they are experienced or not, challenge our preconceptions of what virginity should look like or feel like. It is highly likely for a woman to not bleed the first time she has penile-vaginal intercourse, while it is similarly likely for a woman to still have an intact hymen in the eyes of a gynaecologist even though she has had penetrative intercourse multiple times. She might bleed (again) the tenth time she is having intercourse (Yagmur, Istanbul, December 2016, personal interview), or she might have been born without a hymen in the way medicine defines it. The combinations of possibilities are so varied that medical 'facts' do not support re-virginisation, which instead appears to be built on myths around women's virginity. This is where it becomes necessary to complicate re-virginisation. Laura Carpenter, in her research on meanings attributed to virginity among the youth in the USA, outlines three main perceptions regarding virginity, which are stigma, gift, and rite of passage (Carpenter 2005). It is safe to say that re-virginisation comes from not only seeing virginity as a gift but also seeing the lack of it as a stigma. As a result of this stigmatisation, it would be more meaningful to look at both how virginity and the lack thereof are defined in Turkey.

I argue that re-virginisation is a process, rather than a moment. Similar to how revolutions are usually noted down with a date even though they are never a moment but always a process, re-virginisation is a personal revolution in the sense that it is never the moment of surgery or that of using the artificial hymen (or any other alternative method). The seeds of the potential necessity for re-virginisation are sown when young girls are first exposed to the concept of virginity and the fear of 'losing' it. The process of re-virginisation, on the other hand, usually starts around the time when either the woman ends her relationship with her sexual partner, or when she meets a new potential partner whom she suspects may not accept her sexual history. It continues with making the decision to re-virginise, researching methods and doctors and/or retailers (this might take up to a couple of years), deciding on the method and doctor/retailer, travelling to the city where the operation will take place if a medical method has been chosen, having the operation, healing from the operation if permanent hymenoplasty is chosen, having penile-vaginal intercourse, and potentially bleeding and 'providing' tightness. For some women, the process only ends when they have children, as they believe this secures their relationship with their husband, and for some, it

never ends, as they state that they will always carry this 'burden'. Given this lengthy chain of processes, it is not only impossible to pinpoint when one has re-virginised, but also impossible to treat virginity as an either/or, or as a state of Being, as opposed to seeing it as a continuum. Within this continuum, where one falls depends on one's subjective definition of sex and virginity, and how one relates to their body. These definitions and self-perception are never detached from the social and medical constructions thereof. However, how one perceives virginity is also shaped in relation to one's sexual orientation, one's body-perception and definition of sexualities.

Re-virginisation is also a personal revolution as it makes women 'marriageable' once again. This does not negate the fact that re-virginisation is a "patriarchal bargain", a strategy that "influence[s] both the potential for and specific forms of women's active or passive resistance in the face of their oppression" (Kandiyoti 1988, 276). Re-virginisation is in many ways a form of resistance (Ahmadi 2016), as women oppose stigmatisation as a result of not being technical virgins anymore. Hence, I contend that re-virginisation is a unique strategy employed by women that stand between sexual liberation and oppression, by women who live through a "virginal facade". Gul Ozyegin defines "virginal facade" as women's

> identities in relation to their state of virginhood that are purposefully ambiguous. Constructing these identities allows young women to navigate the shifting and undelineated boundaries of what is permissible and prohibited. I call these identities virginal facades to capture the dynamic nature of putting on appearances, pretensions and creating or permitting silences that enable young women to accommodate their own desires and negotiate the often conflicting expectations of parents, men and peers. (Ozyegin 2009, 113)

Re-virginisation stems from feeling the need to put on a "virginal facade". As Ozyegin argues, "through facades, denied and prohibited desires are brought within the realm of the knowable and may be realized. Individuals are allowed to find pleasures even as the collective fiction of a prohibitive gender and sexual order is preserved, and the boundaries of permitted and prohibited are reiterated while simultaneously redrawn in the creation of a new gender and sexual order" (Ozyegin 2015, 5). Hence, via re-virginisation, women are able to experience pre-marital sexual activity while revolving back to norms around marriageability. Circling back to Carpenter's definitions of virginity, virginal facades also manifest when women engage in social relations where they are exposed to the stigmatisation of both being a virgin (by their families) and not being a virgin (by their friends) simultaneously. On the one hand, the very existence of re-virginisation is pointing at how women's bodies are under social and medical scrutiny and oppression, which will be discussed throughout the thesis. On the other hand, re-virginisation is a method through

which women can reclaim and redefine their sexuality within this framework. In the preface to her book *Gender Trouble*, Judith Butler asks the following questions,

> What will and will not constitute an intelligible life, and how do presumptions about normative gender and sexuality determine in advance what will qualify as the "human" and the "livable"? In other words, how do normative gender presumptions work to delimit the very field of description that we have for the human? What is the means by which we come to see this delimiting power, and what are the means by which we transform it? (Butler 1999, xxii)

Even though Butler does not necessarily ask these questions in relation to virginity and re-virginisation, they summarise how we should be thinking about these concepts, as the fear that one cannot 'prove' her virginity to her partner and/or his family throws women to the edge, making their lives not liveable, sometimes literally, other times figuratively. As a result, re-virginisation becomes one of the means through which women transform this delimiting power within their own lives, even though it may not translate into a revolutionary change leading to the abolition of the concepts of virginity and the hymen. In this sense, re-virginisation is a "minor gesture", which creates "subtle shifts" of change, working "the major from within", creating "sites of dissonance, staging disturbances that open experiences to new modes of expression" (Manning 2016, 1–2), as opposed to choosing to not re-virginise in an attempt to overthrow norms around virginity.

In arguing that re-virginisation is a process and virginity, if it exists, is a continuum, I push against framing these practices around the honour/shame complex, religion, and exoticisation, Otherisation, and Orientalisation. Based on Edward Said's work (Said [1978] 2003), I understand Orientalism to be the dichotomous framing and thinking of the 'East' as traditional, backward, primitive, and in need of the 'West's saving, as well as the co-construction of the notions of the 'East' and the 'West'. More importantly, the 'East' is conceptualised as the Other, as the exotic, as the opposite of the 'West'. I join Meyda Yeğenoğlu in underlining the necessity of a "sexualized reading of Orientalism" which "reveals that representations of sexual difference cannot be treated as its subdomain; it is of fundamental importance in the formation of a colonial subject position" (Yeğenoğlu 1998, 2). Yeğenoğlu criticises the existing gendered interpretations of Orientalism and suggests that "representations of cultural and sexual difference are constitutive of each other" (Yeğenoğlu 1998, 1). Virginity and re-virginisation are critical areas through which these differences are reproduced. Hence, alongside many feminist scholars working on Turkey (cf. Koğacıoğlu 2011; Ozyegin 2015; Parla 2001), I contend that analysing re-virginisation through the honour/shame complex, religion, or by Orientalising and exoticising re-virginisation would not only fail to draw a full picture of the practices, but also constrict the ends that this

research can serve, by occluding the associations re-virginisation and virginity have with other forms of gendered negotiations.

This is not to say that religion does not play any role in re-virginisation in Turkey. Religious discourses, institutional or not, have a significant impact on how virginity is conceptualised. I asked the fatwa line of the Directorate of Religious Affairs (Alo Fatva) their views on hymenoplasty.[9] I got an anonymous response from this line, as follows,

> It might be possible for girls, whose virginity is spoiled due to legitimate reasons such as jumping from a high altitude, falling, or illness to come across a situation where they are subjected to scrutiny by men they will marry. In this situation, hymenoplasty via medical treatment can be resorted to. However, it is not religiously permissible [*caiz*] to have a girl re-virginised whose virginity is ruined on other grounds (such as own action, fornication, etc), as it would mean cheating and deceit against whom she will marry. (February 2018, online exchange)

The highest religious institution in Turkey, which is tied to the Presidency of the Republic, has a clear-cut understanding of who is allowed to have hymenoplasty, and the institutional authority it has is one lens through which re-virginisation can be analysed. However, on the one hand, neither re-virginisation nor the question of virginity is restricted to the Middle East, to Muslim populations, or to traditional families. As we will see in the next chapter, re-virginisation takes place across regions and religions. Furthermore, virginity pledges (García 2009), abstinence and born-again virginity in Evangelical Christianity (Diefendorf 2015), as well as the stigmatisation of being a virgin while one's peers claim to not be (Carpenter 2005), are among many problems fixed definitions of virginity bring into people's lives. Furthermore, the debate around re-virginisation is intrinsic to and is only one of the means that women's bodies are controlled through the institution of medicine and consumer products, and through political and social discourses around the body. By freeing re-virginisation and virginity from a regional or religious framework, it becomes possible to see the wider networks through which women's movement is restricted, and the means they employ to free themselves up from these restrictions. This does not mean that re-virginisation does not have its unique dynamics, on the contrary, this thesis is about those unique dynamics. However, this thesis is also about how this uniqueness, at the same time, derives from now commonplace norms and (un)seen regulations around gender. I now turn

[9] The fatwa line can be contacted via dialling 190 or through this website: https://fetva.diyanet.gov.tr/AloFetva190. At the time of my communication (February 2018), one could submit a question by being a member of the website only, under a pseudonym. However, this has been recently changed, and it is now necessary to provide one's Turkish Identity Number to do so, which means that questions can be traced back to those who ask them.

to one of the ways this thesis engages with this uniqueness, by contextualising gender in Turkey.

The Context of Turkey

Seeing re-virginisation as intrinsic to a region and/or religion also brings with it the perception that it is traditional. This approach is problematic for the reasons detailed above, and at the same time re-virginisation practices are inherently modern, as they are a product and continuation of the Turkish modernisation project. The first steps of modernisation in Turkey at the institutional level date back to 1839 during the rule of the Ottoman Empire, when the Tanzimat Reforms were declared. These reforms "deepened incipient trends of centralization and secularization of the Ottoman state apparatus" (Kandiyoti 1998, 273). Although the modernisation project of the Turkish Republic is a continuation of that of the Ottoman Empire, the founding of the Republic in 1923, following the demise of the Ottoman Empire, is generally regarded as the turning point of modernisation within the official discourse of national history (Abadan-Unat 1981). Although the establishment of the Republic is not a rupture in the history of modernisation in Turkey, it has accelerated the project and took a relatively different stance as it constructed its opposite as the Ottoman past, a construction that continued until the AKP [*Adalet ve Kalkınma Partisi*, Justice and Development Party] rule from 2002 onwards.

The Republican modernisation project, similar to its counterparts in the region, was "an elite-driven, consensus-based, institution-building process that took its inspiration exclusively from the West" (Bozdoğan and Kasaba 1997, 3–4). Modernisation was implemented initially from the top, at the institutional level, but rapidly reached the capillary vessels of society. Within this context, "the traditional, the old, [was] presented as 'bad' in such a way as to encourage an exaltation of the modern, not simply as something new but also as something essentially 'good'" (Owen 1997, 249). This profound statement that the modern stood in complete opposition to the traditional was seen as necessary to make the modern real. Therefore, until the Ottoman turn of the AKP government, the pre-Republican period was conceptualised as the traditional, the old, and the backward, and the 'West' was the modern ideal of the Republican era. Turkey's relationship between the 'West', more specifically Europe, has been and still is, sinuous. As Ahıska argues, "Europe has been an object of desire as well as a source of frustration for Turkish national identity in a long and strained history" (Ahıska 2003, 351). Westernisation, understood as modernisation and Europeanisation in the Turkish context has been the utopia that is always out of reach throughout Turkey's modernisation project.

There is no universal consensus on what modernity includes, or what being a modern society brings about. There continue to be "complexities of the 'modern' in Turkish society", as well

as its “local specificities” (Kandiyoti 1997, 129). However, in the making of the modern woman, it was clear from the start that the Western model could not be adopted as it was. Even before the nation-state building process was initiated, women’s sexuality had become a concern for policy makers.

> There is little doubt, however, that in Ottoman society overt preoccupations with marital sexuality did coincide with the emergence of new governmental technologies that redefined subjects as a “population” with its own phenomena of health, morbidity, life expectancy, and fertility. (…) [A]t the center of the problem of population lay sex: it was necessary to monitor ages at marriage, levels of fertility, and maternal and child health. (…) I would, therefore, suggest that what was at stake was not just the remaking of women but the wholesale refashioning of gender and gender relations. (Kandiyoti 1998, 281)

This preoccupation with women’s sexuality and fertility continued strongly into the new nation-state, which brought some novel understandings to society in terms of gender relations. “Sexuality, family relations, and gender identities came to occupy a central place in discourses about modernity” (Kandiyoti 1997, 114) within the national discourse. The new Turkish woman was to be publicly visible, she was equal to men in terms of political rights such as voting. Nevertheless, she could not attain the sexual liberty of men. In other words, the new Turkish woman had to be chaste, virtuous and must employ a self-control mechanism, as she was the bearer of the children of the new nation (Yuval-Davis 1997; Ozyegin 2015, 4). She could be at the forefront within the public space, but her primary space was still the private. The Republican woman ideal gave another reason for women to remain virgins until they married, as women were seen as “an indicator of the moral health of society” (Kandiyoti 1997, 124–25). Here, it is necessary to return to the European ideal of modernity in the Turkish imagination. As Ahıska aptly describes, “from its initial conception in the process of defining the Turkish national identity in the late nineteenth century to this day, ‘the West’ has been contrasted to ‘the East’ in a continuous negotiation between the two constructs. ‘The West’ has either been celebrated as a ‘model’ to be followed or exorcised as a threat to ‘indigenous’ national values” (Ahıska 2003, 353). In the construction of the modern Turkish woman, both forces have been in place. On the one hand, women’s rights and public visibility have been celebrated in line with the European model. On the other, the woman being ‘too modern’, i.e. having sexual freedom was (and still is) seen as a threat to national values.

‘The Republican woman’ idea was not effectively challenged until the 1980s. With this decade, a feminist upheaval began that confronted existing gender relations and questioned the Republican ideals regarding womanhood and femininity, as well as virginity and virginity

examinations. Towards the end of the 1980s, employers that required virginity certificates from their employees started to be talked about (Ergün 2008, 16), which were followed by debates on young girls' committing suicide following forced virginity examinations in early 1990s. Wide protests against the examinations continued throughout the 1990s and early 2000s (Ergün 2008, 16), which led to the examination to be criminalised in 2004. The law, however, covers all genital examinations, which are considered a crime unless a judge or prosecutor states that it is necessary to carry it out. I discuss the loopholes in this clause in Chapter 4. Even though virginity examinations as such have become rarer since then, they have also changed shape, especially as they are required for hymenoplasty.

Re-virginisation is highly similar to virginity examinations in terms of the discussions surrounding the modern/traditional divide. Ayse Parla argues that "virginity examinations must be viewed as a particularly modern form of institutionalized violence used to secure the sign of the modern and/but chaste woman, fashioned by the modernisation project embarked on by the Turkish nationalist elite under the leadership of Kemal Atatürk" (Parla 2001, 66), who is the founder and the first president (1923-1938) of the Republic of Turkey. As discussed above, the Republican woman in Turkey, as the bearer of the 'new' nation, was to be virtuous and chaste. Although concern with women's virginity was not new, this definition's being part of the modern ideal is novel, as well as the ways to keep it under control. Within this framework, I argue that re-virginisation, just like virginity examinations, is in line with the Turkish modernisation project, and is hence a modern practice. As Kandiyoti contends, "the fact remains that attributions of 'tradition' and 'modernity' continue to be part of a political struggle over different visions of the 'good society'" (Kandiyoti 1997, 128–29), and I argue that the vision of what a 'good woman' is, is one of the pillars of the 'good society'. In order to keep up with this image, re-virginisation practices have come to the surface as modern practices. The modernisation of the Turkish woman by unveiling her and exposing her to the public space meant that she had to be more concerned with how she kept to the Turkish feminine ideal, as "a persistent anxiety over sexual morality lodged itself at the heart of images of the 'modern' woman. With segregation and the veil removed, women incurred the constant risk of overstepping dangerous boundaries, which now required diffuse but persistent monitoring. Modern femininities in Turkey continue to be haunted by this unresolved tension" (Kandiyoti 1998, 282). Many women attempt to resolve this tension through re-virginisation, which also continues to reproduce the very same tension.

The current climate of Turkey in relation to gender and sexuality can be best understood when we look at those minute messages one receives through meaning-making sites including, but not limited to education, politics, and the media. Throughout my fieldwork

and afterwards, I kept a record of news and social media posts related to how gender and sexuality are understood and enacted. Here is a brief selection of the highlights, which gives a glimpse into how gender is debated in Turkey.

> A coursebook by the Ministry of Education for students aged 16-18 taught them that "one should preserve their chastity [*iffet*] until marriage", and that "one should only get together with the opposite sex under the protective umbrella of marriage. It should not be forgotten that clean women are worthy of clean men, and clean men are worthy of clean women" (cited in Cepni 2017).
>
> A book called *Family Bliss* [Aile Saadeti] distributed by the Sahinbey Municipality governed by AKP suggests men to "beat the woman who goes beyond the limit" (*Birgun* 2017).
>
> A young girl, upon wanting to report being sexually assaulted, was advised by the police that she should feel comfortable and get on with her life if she is still a virgin and can prove it to her family. (*T24* 2018).
>
> The president has stated that he does not approve of birth control (*Bianet - Bagimsiz Iletisim Agi* 2019).
>
> Femicide rates are increasing rapidly,[10] and repeatedly, news of women killed by their husbands in front of their children are being reported, sometimes multiple times a day, as well as increasing numbers of child abuse and pregnancy as a result (Sahin 2019).
>
> Gender equality has been removed from the social and civic activities curriculum guidelines (*Sosyal Etkinlikler Yonetmeligi*) to be implemented at schools by the Ministry of Education (*Gazete Duvar* 2019).
>
> Ankara Chamber of Physicians has published a report where they detail the "Conservatisation and Religionisation in Medicine" in Turkey, between 2007 and 2017 under the AKP rule, including the de facto ban on abortion,[11] donning cadavers with underwear, and the state's involvement in alternative medicine. (Türksoy 2017)
>
> Istanbul Provincial Security Directorate has asked the Istanbul Sanitation Department to provide a list of people who have had abortions between 1 January

[10] 182 women were killed in 2012, whereas this number rose to 285 in 2017 (Ulukaya n.d.).

[11] Abortion until 10 weeks of pregnancy is legal in Turkey. However, following the pro-natalist politics of the AKP government, it has become practically impossible to have abortion in public hospitals even within this threshold unless the foetus suffers from genetic diseases, or the pregnant woman's life is in danger. Abortion until 10 weeks is still being carried out legally in private hospitals and clinics (O'Neil 2017). However, the situation of abortion in Turkey within the legal timeframe has many similarities with hymenoplasty in terms of legality, which will be explored in Chapter 4.

> 2017 and 31 May 2019 in Istanbul, between the ages of 30-40 and who have polycystic ovary syndrome (*Birgun* 2019).

These highlights display how the obsession over governing women's bodies has not ceased after criminalising virginity examinations. Women continue to experience resistance against their being as they enter into relationships with other people, medicine, politics, education, and security forces. This complex web of discourses creates a fertile ground on which re-virginisation can take root, as they squish women and force them to create alternative ways of being, or more precisely, of becoming.

Re-Virginisation in 'Statistics'

There are no official statistics regarding hymenoplasty, as the operations are not reported due to confidentiality reasons, and as the government does not officially recognise the existence of these operations. However, it is possible to come up with approximate figures based on the interviews I have conducted to give us an idea about how widespread (yet unspoken of) re-virginisation is. Although other authors also underline that there are no statistical figures regarding re-virginisation (Wild et al. 2010; Ahmadi 2016), one ethnographic study in the Netherlands illustrates that a public hospital receives "around 30-50 hymenoplasty patients a year while the [private] clinic sees double that number of patients" (Ayuandini 2017a, 136). Although these figures are from only two centres in the Netherlands, they are still useful to see how high the numbers are in Turkey in comparison.

Although doctors have abstained from giving me exact figures in terms of the number of operations they have done, I have been able to collect many clues that point at the increase in the demand for re-virginisation over the last two decades. Dr Jale, a 'popular' doctor in Ankara, states, "While I was operating on 3 patients a year in 2000, now I am operating on 3 patients a week 17 years later" (Dr Jale, Ankara, April 2017, personal interview). This is the general picture when it comes to 'popular' doctors, i.e. doctors who are known and frequently visited for hymenoplasty. Elif, who answers all the calls for Dr Zafer, a popular doctor in Istanbul states that "there are more than 20 [women] a week who call [for a hymenoplasty], 6-7 of them come to the clinic [to be operated on]. 35-40% of the doctor's patients [come in for a hymenoplasty]" (Elif, Istanbul, March 2017, personal interview). However, some popular doctors have seen a decrease in demand due to the proliferation of doctors who conduct the operation at lesser prices. Dr Önem is one of those, and she suggests,

> I have the statistics in my folders. Until 2 years ago, I used to do 2 to 3 operations a day. This last year-(pause) the last 2 years people fall prey, as the number of people doing this [the operation] has increased, including charlatans. And then

> they of course come back to me. "Önem Abla,[12] I didn't bleed, there was a problem, can you suture [it]?", they say. But [now] it's one a day on average, or let's say over the span of a week, of 7 days, I do at least 3 to 4. (Dr Önem, Ankara, May 2017, personal interview)

While this is the case for popular doctors, the doctors who do not advertise hymenoplasty have generally suggested that they do 1-2 hymenoplasty operations a month.

Based on these narratives and other interviews I have conducted, it is possible to say that on average, doctors who are popular in the field do 4 hymenoplasty operations per week, and 17 per month, whereas non-popular doctors operate on 1-2 women per month. There are at least 10 popular doctors in the three biggest cities (Istanbul, Ankara, and Izmir) each. Although it is not possible to determine the number of non-popular doctors who conduct hymenoplasty, there are 300 doctors registered on the online healthcare platform *doktortakvimi.com* who have specified hymenoplasty as one of their specialties. The numbers of and from popular doctors show us that there are about 500 women that receive hymenoplasty in Istanbul, Ankara, and Izmir in total from these doctors only per month. It is thus possible to deduce that there are thousands of women that receive hymenoplasty every year in Turkey, perhaps more than 10,000. This number should be thought of in comparison to the existence of more than 7 million women above the age of 15 who have never been married as of 2017 (Turkish Statistical Institute 2018). Dr Jale, however, has a different perspective regarding the ratio of women who marry after re-virginisation. Dr Jale did not want to give the number of women she operates on, because she "didn't want to get into trouble with the tax office" as these operations are not reported, but she advised me to "think [instead] about the number of virgin brides, the ones that haven't actually had intercourse. Think about it the other way around, because the number [of non-virgin brides] is very high" (Dr Jale, Ankara, April 2017, personal interview). In other words, Dr Jale suggests that currently, the number of virgin brides is lower than that of re-virginised brides.

Similarly, there are no statistics shared about the sales of artificial hymens either. The interviews have revealed that approximately 1-2 hymens are sold every week by each website. However, on one of the websites, it is stated that as of 2016, 50.000 women have bought artificial hymens (*Yapay Kızlık Zarı Resmi Satış Sitesi* n.d.). This number does not parallel the information gathered during the interviews, and it is possible that 50 thousand women across the world might have bought an artificial hymen. As many companies have merged, or because the market is monopolised, it is difficult to come up with a figure.

[12] *Abla* is a term of endearment for slightly older female friend, it literally means older sister.

However, it is safe to say that at least 100-200 women a year buy artificial hymens in Turkey.

Medical Tourism

Medical tourism becomes a vital part of a re-virginiser's life especially because secrecy and confidentiality are key to the entire process of treatment. As hymenoplasty requires utmost confidentiality, many women prefer to travel to a bigger city in order to decrease the possibility of being recognised. Furthermore, as one re-virginiser shared online, many women believe that "doctors don't have much experience on these things in smaller towns" (Thread 43, July 2011). Thus, Istanbul, Ankara, and Izmir have become the medical hubs for re-virginisation as a result of being the biggest cities in Turkey in terms of population and economic power even though hymenoplasty still takes place in most other cities, if not all.[13]

Although the possibility of travelling to a different city gives a sense of safety to women, it also creates anxiety, as they usually need to travel somewhere they have never been to before. A re-virginiser shares her confusion and difficulties as follows,

> Girls, my mind is a mess. It's very important to take a step forward, but I can't find an opportunity, I can't find the money. I wish I lived in Istanbul, then I wouldn't have such troubles; I'd go to a hospital whenever I'd find an opportunity closer to the wedding. But because I live in a small town I need to make big plans. (Thread 19, March 2015)

"Big plans" are required for these women, as most unmarried women in Turkey live with their families. Therefore, they need to find an excuse to go out of town, call in sick at work, and arrange a one-day appointment with the doctor, which means that they will have the initial examination and the operation on the same day. One woman states, "I don't care which city [I will have to go to]. All I need is for the doctor to give me a sense of trust and that I don't have to go back [to see the doctor] again." (Thread 33, November 2012). As a result, it is also vital for women that they are reassured that a single visit to the doctor will be all that is needed. The secretaries and assistants play a vital role here. They talk many times on the phone with potential clients, reassuring them that the doctor is a good match for them, that the doctor is an expert in the field, that bleeding will be guaranteed, and that they will be treated with sympathy at the hospital or the clinic. Despite these reassurances, however, most doctors inform women only after the surgery that a follow-up visit is required. To solve this problem, doctors may recommend that the woman visit a doctor in her hometown rather than travelling again. Of course, this again creates a crisis of confidentiality

[13] This information has been gathered from women's online discussions and my interviews with doctors-almost all of the doctors I interviewed in the three biggest cities had worked in smaller cities before.

for women, as they fear that they might run into an acquaintance in addition to needing to trust another doctor and hoping that they will not be judged by them.

The cost of the operation also changes based on where the operation will take place. As doctors are aware of the reason why women travel to bigger cities, they also put a higher price on the operation in these cities. Other factors that determine the price include where in that city the clinic or the hospital is located, whether the doctor advertises hymenoplasty, and the relationship that is built between the doctor, the assistant, and the re-virginiser. As many women are in a vulnerable state at the time of seeking re-virginisation, some doctors may financially assist them by not charging them for the operation. Elif, who works as a secretary for Dr Zafer gives two such examples,

> For instance, we had a girl from [city omitted]. She's engaged. Has a mother and two brothers. When she's engaged, her fiancé dies in an accident, close to the wedding. She gets depressed, she attempts suicide and finally tells her mother. The mother says, -and I cried on the phone when she cried too-. She said, "you don't have to be an Easterner, we are from the West, we are from [city omitted] but she has two brothers. If I say such and such, why does this girl not want the suitors who come in, why does she say no to all. If I say such and such, they will kill her", she says. "You don't have to be an Easterner", she says. That woman really touched me. When she came to the clinic, she cried again. I looked at Dr Zafer, and his eyes were filled with tears too. We said, "this is not worth committing suicide for". We sent her away after doing her surgery at no charge. Another one of our girls, she got engaged, and because they're paying off the things they bought for their house [*çeyiz*], her salary goes directly into her fiancé's account. But she had an experience like that [had sex] at one time, [but] she cannot save [money]. What's she gonna do? The wedding date is near. She called me and I was really touched. It's nice to be prayed for, she's among the many we did this for free of charge. (Elif, Istanbul, March 2017, personal interview)

As Elif's narrative displays, the significance attached to virginity is so widespread across Turkey that re-virginisation becomes an everyday occurrence for many. However, some doctors are not aware that re-virginisation is not region-specific. Dr Önem provides the following narrative when inquired about where her hymenoplasty patients come from.

> Hande: Where do the patients come from?
>
> Dr Önem: Mostly Central Anatolia and Eastern Anatolia. Southeast. Because the Istanbul group [re-virginisers living close to Istanbul] generally goes to Istanbul.

> Central and Eastern Anatolia come to Ankara. That's a thing. Izmir, Aegean [region], Mediterranean [region] don't need this, that's very interesting. There are very few that come from Antalya and Mersin. But Central Anatolia, Çorum, Konya, Amasya, Tokat, a little bit from Black Sea [region]. I'm not even mentioning Antep, Urfa, Diyarbakır…
>
> Hande: There must be doctors who do this in Antalya or other bigger cities. Why do they come here [to Ankara]?
>
> Dr Önem: They don't want to have it done in their hometown, because the doctor may turn out to be their aunt's cousin's neighbour. Let's say three people come from Konya on that day, we seat them in this room, we know where they're coming from. They can't-they shouldn't run into them [other women coming from Konya] at the door. They might say "I'm here for my cyst", but we won't even allow that. It's risky to enter through the gynaecologist's door. (Dr Önem, Ankara, May 2017, personal interview)

This gynaecologist, who is one of the most famous doctors in the field of hymenoplasty, is unaware that re-virginisation is extremely common not only in Central and Eastern Anatolia but all across Turkey, including the Aegean and Mediterranean regions. There are two reasons why she assumes that these regions "don't need this [re-virginisation]". The first one is that re-virginisers in these regions tend to either go to doctors in Izmir, or Antalya, the bigger cities in these areas. The second and perhaps more important reason is the internal Orientalism and Occidentalism that many people in Turkey adopt. The Aegean region is the Western part of Turkey, which many people assume to be 'Westernised', hence 'modernised'. Westernness, it is assumed, equals modernity, which equals less concern with virginity. This way of thinking is faulty in three fundamental ways. The first one is that it assumes a dichotomy between traditional and modern, and neglects that both categories are constructed. The second one is that it assumes that in what is regarded as the 'West', virginity is not a 'problem'. I have discussed above that virginity is a global social problem in the sense that it becomes a stigma to be a virgin, or a non-virgin in different societies, or among different circles. The third problem with this way of thinking is that it assumes that there is a geographical distribution of modernity/Westernness in Turkey. This is what internal Orientalism and Occidentalism are. Deriving from Said's Orientalism (Said [1978] 2003), internal Orientalism points at how the Orient or any geography can be further orientalised. This is in line with the idea that Eastern Turkey is traditional, backward, and more prone to 'honour' killings (Koğacıoğlu 2011). The above narrative displays how this idea is ingrained within the institution of medicine as well.

Chapter Outlines

In the next chapter, I initially provide a literature review involving debates on female and male genital cosmetic surgery, and on re-virginisation. As this literature has started to grow bigger throughout my research, I have chosen to leave out the literature on virginity in general. This decision derives from the focus of the thesis being regaining of technical virginity, rather than virginity itself. Within this second chapter, I later go on to discuss the concept of "becoming" as presented by Gilles Deleuze and Felix Guattari, the feminist interpretations of the authors' works, and my contribution to this theory through the concept of Becoming-Virgin. In Chapter 3, I discuss the methodology of my research. I outline the methods I employed shaped by the challenges I faced throughout the fieldwork. I provide an alternative reading of the dichotomy of private and public spaces through the concepts of intimacy and *mahremiyet*, and suggest the blurring of the lines between the virtual and the real.

Before going into Chapter 4, I present a vignette from my fieldwork that brings together my views on being a researcher of re-virginisation and the dynamics of re-virginisation in a medical setting, which sets up the remainder of the thesis. In Chapter 4, I discuss the framework within which re-virginisation is allowed to happen. I bring to the fore the legal loopholes and how they interact with the nation-state's construction of the ideal woman, as well as the relationship re-virginisation providers establish with their profession. I centre Chapter 5 around the (in)visibility of the hymen and virginity. I explore what it means to see the hymen, virginity, and the blood. I unpack the images and texts re-virginisation providers use, and what norms they reproduce through them.

In Chapter 6, I focus on women's embodied experiences of re-virginisation. In particular, I explore their intersubjective experiences of pain through different phases of re-virginisation. I unpack how pain in re-virginisation is performed temporospatially. Chapter 7 takes an affective approach to re-virginisation. I first delve into the emotions that women experience through the process, and how the hymen becomes an affective object through which all emotions roam. Secondly, I provide an affective reading of times and spaces that re-virginisers engage with. In Conclusion, I summarise my main arguments and present ways this research can be taken further, as well as the impact it might create in society.

2. Re-Virginisation in Literature and Theory

As a society, we suppose that the hymen closes the vaginal entrance like a curtain. And it is believed that it will be torn, pierced, go pop in the first intercourse. We have counselees who are scared of intercourse because they think it will make a popping noise.

Psy. Gülüm Bacanak[14]

Re-virginisation is a highly understudied area. The last two decades, however, have seen a relatively rapid increase in the literature especially on hymenoplasty, both by medical and social science researchers. In this chapter, I will initially locate re-virginisation in the broader social scientific literature. I will then review the existing literature on re-virginisation, by focusing on whose voice the authors choose to make audible. Here, I will explore two different types of literature: social scientific and medical. While the former is where my research is located, the latter is both a literature that feeds my research and forms part of my data, especially when coupled with the interviews I have conducted with medical doctors. Following these analytical reviews, I will move on to introducing Deleuze (and Guattari)'s notion of "becoming" and its feminist interpretations. I contend that becoming provides us with the most useful conceptual framework to grasp re-virginisation and why it is a misfit in public discourse. Becoming will allow us to see re-virginisation as a process, rather than a moment, as described in the Introduction. In this section, I also suggest the notion of "becoming-virgin" as a conceptual tool that can allow us to think about sexuality more coherently than Deleuze and Guattari's term "becoming-woman" does, and argue that this concept can be employed outside of re-virginisation studies as well.

Genital Cosmetic Surgeries

All genital cosmetic surgery stems from "genital anxiety" (Rodrigues 2012, 786). Through many means, including medicalisation and commodification of body parts and their alleged 'abnormality', the neoliberal market, and pornography, genital diversity is pathologised (Braun 2009, 137) and genital anxiety evoked in all genders. Simone Davis refers to the relationship between medicalisation and genital anxiety as such, "before people will spend money on something as expensive and uncomfortable as cosmetic surgery, they need to be motivated not only by desire but by concern or self-doubt. Bringing the authoritative language of medical science to the aestheticization of the vagina is one key way to trigger such anxiety" (S. W. Davis 2002, 11). This concern and self-doubt function as motivators for

[14] Bacanak, Gülüm. 'Bekaret Tabusu ile Ilgili Soru ve Cevaplar' [Questions and Answers on the Virginity Taboo]. TavsiyeEdiyorum.com. Accessed 1 November 2019. https://www.tavsiyeediyorum.com/makale_6487.htm.

resorting to genital surgeries for cosmetic reasons. Here, I use the term cosmetic to refer to those operations that relate to appearance, rather than function or operations done for reconstructive purposes.[15]

Despite the impact they have on one's self-perception, the above-mentioned factors do not single-handedly determine whether one would choose to undergo genital cosmetic surgery. Body modification literature has debated whether especially women elect to undergo cosmetic surgery based on their own agency, or if it is structurally determined. Within this literature, there has been a shift from accounts stressing the "structure of oppression" towards putting "a potentially pleasurable instrument of female agency" to the fore (Craig 2006, 159). Earlier studies that research the relationship between the gendered body and cosmetic surgery have "discussed beauty work as a disciplinary practice supervised by an all-encompassing male gaze" (Moreno Figueroa 2013, 138) based primarily on an early Foucauldian approach to gender. Kathryn Morgan, for instance, posits that the apparent liberation causes further oppression.

> In electing to undergo cosmetic surgery, women appear to be protesting against the constraints of the 'given' in their embodied lives and seeking liberation from those constraints. But I believe they are in danger of retreating and becoming more vulnerable, at that very level of embodiment, to those colonizing forms of power that may have motivated the protest in the first place. Moreover, in seeking independence, they can become even more dependent on male assessment and on the services of all those experts they initially bought to render them independent. (Morgan 1991, 39)

As a reaction to women being treated not as subjects but objects within the social system, later authors suggested that women's agency needs to be accounted for. The shift was from "the rhetoric of victimization and oppression to an alternative language of empowerment and resistance" (Felski 2006, 280). One of the authors in this strand is Kathy Davis, who argues that "while decisions to have cosmetic surgery are rarely taken with complete knowledge or absolute freedom, they are, nevertheless, choices" (K. Davis 1995, 13). For many women she has interviewed, the surgery has been preceded by a long time of suffering, which makes the operation a means to "allow her [the interviewee] to take action and regain a sense of control over her life" (K. Davis 1995, 97). Here, Davis treats her participants as those who seek to achieve normality through cosmetic surgery, and who willingly choose to do so. The

[15] Although gender reassignment surgeries are not the focus of this thesis, it is worth mentioning them as they are genital surgeries as well. "Genital anxiety" can be said to be playing a role in decisions to transition, while at the same time making it possible for one to feel at home in their bodies. This is true for all kinds of genital surgery, yet there are different consequences and rationales behind deciding to transition. For more on this topic, see (Halberstam 2018).

emphasis on pleasure gained from beauty practices in this latter strand tends to overcome the focus on domination (Craig 2006, 165).

Female genitalia are not only an individual but more so a societal and national concern. As Rodrigues argues, “as a ‘between’ space, the vagina is also biopolitical by location: it firmly straddles the boundary between the erotic body and the reproductive body” (Rodrigues 2012, 782). The vagina’s being the cradle of reproduction opens it to discussions around biopolitics and the population as well. It is attributed a ‘sacred’ role the moment it is linked to giving birth, however the idea that the vagina has a history prior to giving birth, especially a sexual one is neglected in these discourses. Using an artificial hymen is thus seen as “the destruction of an entire society through tampering with the nature and composition of the female body" (Kiswani 2009, as cited in Mahadeen 2013, 88). Shweder argues that a high esteem of chastity can be seen in “societies in which social reproduction and family building continue to be viewed by both women and men as the major aim of marriage, and where reserving one's sexuality for the intimacies of marriage is associated with honor, civility, self-control, and mature judgment, and is especially valued in women” (Shweder 2015, 177–78). Therefore, the vagina becomes something that can and should only be penetrated for reproductive purposes, for the better of the society and the nation.

It should also be noted that genital anxiety is not limited to women. This anxiety is also cultivated in men especially in relation to penis size, both in terms of length and girth, ‘malformations’, and/or potency. To ‘resolve’ penis size issues, penis enlargement and enhancement surgeries are offered. There are alternatives to surgery, such as penis pumps that can be bought online which cause the penis to swell using a vacuum, as well as pills and lotions that allegedly contain hormones and vitamins. Through the availability of the options to ‘enhance’ the penis, men become more prone to be anxious about their genitalia. In more than one way, penis enlargement and hymenoplasty surgeries are similar, in the same way penis pumps and the artificial hymen are. Operations on both sides are carried out, and products bought secretively, and are tied to emotions such as shame and fear. Of course, there are many fundamental differences between the practices and processes of re-virginisation and penis enlargement/enhancement as well, especially when the potential consequences of not going through with either are considered. Nevertheless, the similarities should direct our attention to the fact that genital anxiety is ubiquitous and does not differentiate between genders, even though the degree of exposure and desire to act upon such anxiety have significant differences.

Penis enhancement surgeries are not the only male genital cosmetic surgeries that men undergo in Turkey. As Dr Kerem has stated, the genital cosmetic surgery that is most frequently carried out in Turkey is male circumcision (Dr Kerem, Izmir, August 2017,

personal interview). There are many debates around whether male circumcision is healthy or necessary (Denniston, Hodges, and Milos 2010; Castro-Vázquez 2015; Frisch 2017), making it possible to perceive circumcision as cosmetic rather than a medical necessity. It is argued by the advocates of circumcision on non-religious grounds that it prevents men from having infections. However, the counter-argument, that circumcision does not necessarily prevent infections, and that it removes foreskin that could provide more sexual pleasure, has been getting increasingly more attention in the last decades. Male circumcision is a taboo topic in Turkey, and it is an unquestioned expectation for all boys from Muslim and Jewish backgrounds to undergo the surgery. Being uncircumcised cannot even be thought of, and even if it were, it would generate "genital anxiety", as "an uncircumcised man in Turkey would experience being the other, and would struggle having a phallus" (Barutcu 2015, 134). Therefore, to understand what the vulva and vagina symbolise for women in Turkey, it is necessary to comprehend what penis stands for as well. Bleeding is not only the display of virginity for the woman but also that of prowess and virility for the man. Therefore, the fragility of masculinity in Turkey is another reason why re-virginisation has become more mainstream. This link between masculinity and re-virginisation needs to be further studied and does not form the backbone of this research. However, it is a significant link that we should keep at the back of our minds as we unpack re-virginisation.

After this general introduction to genital cosmetic surgeries and the general debates thereon, I now turn to the social scientific literature on re-virginisation.

Re-Virginisation in Social Scientific Literature

Social scientific literature on re-virginisation has lain dormant for many years. Even though Mernissi has made a first attempt at complicating and critically analysing re-virginisation, arguing that "the phenomenon of artificial virginity is therefore not ideologically new, but it is sociologically new, and it leads to the following question: why are there more false virgins than before?" (Mernissi 1982, 188), it is only in the last decade that social scientists started to turn towards the topic, especially given the increased demand for re-virginisation. The literature has so far mainly focused on doctors' opinions on the matter, as well as the medical ethics of conducting hymenoplasty. More recently, studies have emerged where women's experiences are being integrated to, or, to a lesser extent, made the main focus of the research. This recent strand of more critical and feminist work on re-virginisation is promising, yet scarce. This is one of the gaps that my research attempts to fill.

Even though re-virginisation is very frequently sought after in Turkey, medical and social scientific literature on the topic does not reflect this frequency. However, since the 2000s, there are more and more studies on the topic. The earliest study on re-virginisation in Turkey is by Dilek Cindoglu, who discusses gynaecologists' views on hymenoplasty (Cindoglu

1997). She argues that doctors hold one of the three views on hymenoplasty; they are either against it on religious grounds, for it on liberal grounds, or they are torn and do not conduct the operation, but refer the patients to those who do. Nevertheless, her arguments on modernity and traditionalism miss the mark. On the one hand, she argues that both virginity tests and hymenoplasty are "modern medical practices" (Cindoglu 1997, 253), yet at the same time, she explains their existence with the "cohabitation of traditional and Islamic gender ideology along with liberal gender ideology" (Cindoglu 1997, 254). Even though I agree with Cindoglu on the idea that re-virginisation is a modern practice, it is contradictory to base this argument on so-called traditional values. As I have discussed in the Introduction, re-virginisation practices, just like virginity examinations (Parla 2001) are markers of the modernisation process of the Turkish Republic, and are very much part of the contemporary Turkish identity. Despite this disagreement I have with Cindoglu's work, it counts as a significant first step in starting a discussion around re-virginisation in Turkey, as she discusses how some doctors frame re-virginisation as a market and see the operation as a price that women who are keeping lies and secrets should have to pay (Cindoglu 1997, 259). After this study, re-virginisation in Turkey has not been researched for almost two decades. Apart from my current research and publications (Güzel 2018; 2019; forthcoming), the most recent publication on re-virginisation in Turkey frames it as "artificial virginity" (Aytemiz 2015), as Cindoglu does as well (Cindoglu 1997). This framing creates a dichotomy between 'artificial' and 'natural' virginity, and hence builds the problem around women's technical virginity rather than the conditions that have led them to undertake this operation. Even though Aytemiz is critical of the obsession of and the myths around women's virginity, it is unclear whether she is critical or supportive of re-virginisers, an area that she avoids touching upon. Türkdoğan and Ozturk (Türkdoğan and Ozturk 2012), on the other hand, stand against re-virginisation, and suggest a re-defining of the hymen, sexuality, and virginity in Turkey, by pointing out that women's bodies are treated like goods, which then leads to hymenoplasty.

Studies have also been conducted to understand the general opinion regarding re-virginisation in Turkey. In a study that investigates nurses' and midwives' approaches towards hymen examinations, researchers have found that "over a third of the respondents said that the procedure should be undertaken if a happy marriage is planned; 22.8% stressed that honesty is the best solution in any situation" (Gürsoy and Vural 2003, 494). It is significant to gauge the opinions of healthcare workers on re-virginisation, as re-virginisers come into direct contact with them in their process. The approaches of the medical staff shape the process significantly. In a later study regarding Turkish nursing students' perceptions on the topic, 33.1% of the participants have stated that hymen repair should be done "given the values of the society", 17.5% have remarked that "being honest about it will

not work", while 74.7% found it "a wrong practice in terms of Islam" (more than one answer could be chosen) (Zeyneloğlu, Kısa, and Yılmaz 2013). Both studies show that at least a third of the respondents, who are medical staff members or those training to be so, are accepting of hymenoplasty. Although reasons for this can be varied, increased training and awareness on women's status in society in relation to gender inequalities and sexuality can serve to increase these numbers and improve women's experiences of re-virginisation.

Whether doctors should grant a woman the right to re-virginise has been one of the most researched areas of hymenoplasty. In some cases, doctors have argued that it is their duty, or even the "physician's law" to help the patients (Ahmadi 2014, 429), and doctors have usually been in the position to "determine the good of their patient" (Kopelman 2014, 11), leading to the idea that "with hymen repair surgeries, the surgeon, therefore, is the hero of the story" (Rispler-Chaim 2007, 346). Women, the real heroines of the story have been pushed into the background, as a result of doctors' being regarded as the only experts in the absence of any regulations (Kozmann 2013) and women's being at the mercy of doctors to qualify as a patient. In a similar manner, some studies question whether hymenoplasty should be funded by the state (Leye, Ogbe, and Heyerick 2018). This is a particular issue for some given the "psychosocial suffering" women experience in its absence (Saharso 2003b, 21), and in relation to whether hymenoplasty is sought following consensual sex or rape (de Lora n.d.). The financial incentive that doctors receive from conducting these operations is usually neglected (cf. Ayuandini 2017b), which is why it is significant to draw the framework of political economy of re-virginisation for every context, as I have initiated in the Introduction, and will continue to discuss in Chapter 4. Without understanding how re-virginisation practices are commercialised and consumerised, it is not possible to fully understand women's experiences.

One of the few studies that is interested in non-medical forms of re-virginisation warns the readers about the potential and unspoken side effects of using the artificial hymen (Mahadeen 2013, 87), whereas another research brings to the fore how Dutch doctors suggest the use of non-medical methods to re-virginisers who come to their clinic for hymenoplasty (Ayuandini 2017b). Ahmadi, however, suggests that "while these more primitive solutions may mimic virginity loss, the more sophisticated reproductive health technology of hymenoplasty effectively recreates virginity itself" (Ahmadi 2016, 228). Another author posits the contrary, stating "in the case of hymenoplasty, the hymen is restored, but the loss of virginity—understood as not having had coital sex—is irreparable" (de Lora 2015, 149). I contend that whether an operation or a product creates or recreates virginity is entirely subjective. As we have seen (and will be seeing) throughout this thesis, alleged physical markers of virginity cannot be used to determine whether a woman is a

virgin, and hymenoplasty does not guarantee bleeding either. Therefore, it is not possible to argue that hymenoplasty is different from other methods on the grounds that it creates virginity. What does appear to be different in hymenoplasty is the creation of a sense of security and assuredness in performing virginity through the power of medicalisation and the authority that medical doctors hold in society.

It is very rare that the emotions women go through in re-virginisation are researched. One of the few exceptions is Bekker et al., who mention that women who are not virgins "report a diversity of problems such as loneliness, social isolation, depression, despair, suicidal feelings, identity problems and serious conflicts with parents" (Bekker et al. 1996, 330). This information suggests an important avenue that needs to be unpacked, which is neglected by scholars. My research takes a first step in unpacking these and other emotions, as well as the affective relations that are formed through re-virginisation. More recent critical researchers of re-virginisation have devised concepts to unpack re-virginisers' ambiguous relationship to virginity. Ahmadi employs the term "liminality" to argue that "Iranian women who undergo hymenoplasty may be construed as liminal, socially ambiguous beings, threatening the stability of the prevailing Iranian social order" (Ahmadi 2017, 1), and frames the possession of a hymen as "a form of physical capital that women can exchange for symbolic and socioeconomic capital" (Ahmadi 2016, 232). Ayuandini, on the other hand, posits the concept of "performative virginity", which she devises as virginity "performed through the act of bleeding after the first penetration" (Ayuandini 2017a, 75).

It is largely accepted in social scientific literature that re-virginisers are neither fully victims nor agents, or are both (Saharso 2003a; Wild et al. 2015), in line with the debates on female genital surgeries. However, the debates tend to change form depending on where the research is located. The geographical and demographic focus of research on re-virginisation is mainly either the Middle East or immigrants from Middle Eastern countries living in Europe. Rare exceptions suggest that re-virginising is not limited to these populations by showing examples from South America in general (Wild et al. 2010), from Guatemala (Roberts 2006), and from the USA (Boras 2006), in addition to works suggesting that it cuts across religions such as Islam and Christianity (Awwad et al. 2013). The hymen has been described as "a fortress against the West" (Eich 2010, 762), and female chastity as "a locus of differentiating the self from the other" (Eich 2010, 762). Where the focus on immigrants leads to arguments such as "due to immigration, these societies now include minority groups whose cultures differ distinctly from the majority culture" (Saharso 2003a, 199), cultural relativism becomes the means to explain hymenoplasty. Nevertheless, such an argumentation obscures the fact that hymenoplasty is only one form gender inequalities take, and how these operations are not mutually exclusive from other forms of inequalities,

as discussed in the Introduction, and in the section below in relation to the medical literature where cultural relativism is even more present and ingrained in discourse.

Due to the difficulty of discussing re-virginisation in offline public spaces, re-virginisers claim certain online platforms for this purpose. Researchers have more recently started to use online data to unpack women's experiences of sexuality and re-virginisation (cf. Eich 2010; Marcotte 2010; 2015). Nevertheless, this does not mean that sexuality is never talked about in offline spaces in "more conservative or religious milieus" (Marcotte 2015, 65). Marcotte argues that "sex talk is ubiquitous in many cultures, but talking about it often remains more difficult for those coming from more conservative or religious milieus where, of these things, not much is spoken" (Marcotte 2015, 65). On the contrary, in the example of Turkey, sexuality becomes an important topic of discussion at least among women after marriage, and among friends pre-maritally. Of course, this does not rule out the existence of the "virginal facade" (Ozyegin 2015). However, the very existence of this facade means that sexuality is being talked about in different circles at different life phases, even if many women may have to form alternative truths about their sexual experiences, or the lack thereof.

Another strand of literature that will be reviewed in this chapter is the medical literature on hymenoplasty, which I now turn to. Increasingly, there are studies carried out by medical doctors on methods of hymenoplasty and what stance doctors should take when a woman requests hymenoplasty from them. This literature forms both a part of the background of my research and is part of the data. It is especially valuable to see what medical journals and articles posit about virginity and re-virginisation, mostly in the absence of any data or research on women's experiences thereof, and the parallels and contradictions with the social scientific literature.

Hymenoplasty in Medical Literature

Hymenoplasty is a largely neglected area in medicine across the world. It is not taught in medical schools, and is rarely found in medical books. All doctors that I have interviewed have said that they learn how to do hymenoplasty through "trial and error" unless they are taught the know-how by a superior. What happens to women who crossed paths with doctors at the 'trial' phase has always been left unanswered. One of the main reasons for this exclusion is the stigmatisation of this operation, as Dr Mehmet states, "You can't put this [in the curriculum] in the faculty, they would shoot you [if you did]" (Dr Mehmet, Istanbul, December 2016, personal interview). The European College of Aesthetic Medicine & Surgery is an exception, as it teaches hymenoplasty as part of their 4-day long module on Master Course in Aesthetic Genital Surgery. Furthermore, one recent attempt to fill the gap of medical books in the field is by Lina Triana, who details a variety of "aesthetic vaginal plastic

surgeries", among which hymenoplasty is placed as well (Triana 2020). This book has significance especially as it discusses potential complications of the operation, which is usually neglected within the medical literature and debates. It is very rare for complications emanating from hymenoplasty to be discussed in these articles. Another work that undertakes this task is from Guatemala, which contends that "gynaecologists report that women who have had hymen reconstructions come to their clinics suffering from numerous health problems, including infections, haemorrhaging, incontinence, fistulas, and extreme pain during sexual intercourse" (Roberts 2006, 1228). This finding is very important and stands against other medical literature that disregards any complications post-operation.

One of the most needed yet problematic discussions that doctors carry out in this strand of literature is whether doctors should provide this operation to women who request it, and if not, whether they should refer them to doctors who do. Many doctors, in line with the findings of my fieldwork, argue that it is the doctors' duty to undertake hymenoplasty for "patients' lives, health and well-being" (Cook and Dickens 2009, 269). Logmans et al, in identifying hymenoplasty as a "ritualistic surgery" akin to male circumcision, contend that "the ethics of hymen reconstruction could be compared to the ethics of cosmetic surgery, an accepted part of plastic and reconstructive surgery worldwide" (Logmans et al. 1998, 460). Other medical doctors question whether they should be involved in re-virginisation practices, underlining that there is very little research and no teaching on the matter (Usta 2000). In these discussions, the concepts of "deception" (Essén et al. 2010; Mitchell 2015) and "deceit" (Raphael 1998) are frequently repeated, suggesting that there is an underlying bias and judgment against women who re-virginise.

Most medical doctors who publish on hymenoplasty support the argument that doctors should provide hymenoplasty to those who request it (Ou et al. 2008; Prakash 2009; Işık et al. 2011; Wei et al. 2015). Raveenthiran argues that

> it is the needs of the society that frequently dictates science. If modern surgery would deny the option of hymenoplasty, then the needy women will fall prey to quack surgeons who will do the same job secretly for exorbitant charges. Therefore, in the best interest of needy women scientific surgery, with an open mind, should accept hymenoplasty as an option. (Raveenthiran 2009, 225)

This statement, on the one hand, defends allowing women to have spaces to practice re-virginisation. Just like abortion, not having access to services of re-virginisation would not stop one from re-virginising, but redirect her to underground or unsanitary options. At the same time, however, this statement establishes doctors as the authority, the charity, the helper with regards to re-virginisation. Unlike abortion, re-virginisation can be practiced safely without medical intervention, using the alternative methods discussed in the

Introduction. Therefore, establishing medicine as the authority on re-virginisation opens up space to claim ownership over women's bodies, and to display medical intervention as the only option available for women, even though it is the most expensive and the most physically challenging method. An exception to this way of thinking is Loeber, who offers alternative, non-medical methods to the readers (Loeber 2015). Of course, it is highly unlikely for women seeking re-virginisation to read medical journals for this purpose, yet it is a step in the direction of de-medicalising re-virginisation.

In discussing the ethics of hymenoplasty, medical literature strengthens the East/West dichotomy. Even though hymenoplasty is not specific to Muslim communities, this is either briefly addressed (cf. Roberts 2006; van Moorst et al. 2012), or disregarded entirely. Furthermore, the majority of the literature creates a stereotype of hymenoplasty seeking women, such as the following, "we focus on what happens when a woman wishes to follow the 'traditions of honour' from her culture of origin and encounters modern Swedish healthcare institutions" (Juth et al. 2013, 451). The traditional/modern binary is perpetuated, the former described as "honour cultures" (Juth and Lynöe 2015), and "immigrants from Islamic countries" defined as having a very different culture, where "other views on virginity are common" (Loeber 2014, 238). This otherisation creates an imaginary abyss between the perception of the woman's body and virginity of immigrants' home countries and their host countries. As I stress throughout this thesis, hymenoplasty and virginity anxiety are only one way "genital anxiety" and concern with women's bodies take form, among many others that 'Western' countries experience as well. Therefore, such a dichotomy obscures the links between different body projects while suggesting that we focus on the traditional, the 'Eastern', or the 'Other'. Bawany and Padela attempt to address and overcome this dichotomy by deconstructing the stereotype of the woman who is escaping honour killings, and suggest that "in contrast to seeking hymenoplasty to meet cultural or religious expectations, some women in the West do so to regain a sense of personal ownership. After experiencing sexual abuse or leaving a relationship, some women have taken restructuring of their hymens as a way to regain what was taken from them and to start anew" (Bawany and Padela 2017, 1005). However, not only do they attribute the regaining of personal ownership only to the women in the 'West', but also make a distinction between "Western-ethics" and "Islamic bioethics" that translates the gap to the realm of medical ethics. Hence, the dichotomy stays in its place. Similarly, within the discussion on whether it is ethical and/or obligatory for a doctor to refer a patient for hymenoplasty in the case where the doctor is not willing to perform the operation, Sohaila Bastami, a medical doctor, discusses whether the woman is being coerced into the operation. She argues,

> In Western countries, informed consent or "an individual's autonomous authorization of a medical intervention" is a prerequisite of any non-emergency medical procedure. Performing a medical intervention on a woman who is being pressured into it is not compatible with the principle of respect for persons. A situation in which a small amount of pressure might be acceptable is when a patient refuses a lifesaving operation without seeming to understand the consequences of the refusal. The example of FGM above also clashes with the principle of nonmaleficence, as this practice causes harm to women and may be a cause of severe distress to them. (Bastami 2015, 154)

This line of argument creates two ways of thinking about hymenoplasty and its associations. The first one is Orientalisation. As discussed above, I argue against the East/West binary, which comes into being as an imagined obsession by the Orient with the hymen, virginity, and women's body, while arguing that women are free in the Occident. The doctor above argues that autonomy exists in the 'West', but the woman who requests hymenoplasty "claimed to be from an ethnic background where virginity was extremely important" (Bastami 2015, 153), and hence lacked autonomy. This brings us to the second point that arises from the medical discussions represented by the quotation above. 'Orientalist' practices such as hymenoplasty and 'female genital mutilation' (FGM hereafter) are regarded as complete opposites to female genital cosmetic surgeries (FGCS hereafter). While the latter are assumed to be autonomously authorised by patients themselves, the former are regarded to be only a result of coercion.

These constructed dichotomies between the 'Oriental' and the 'Occidental' woman, and FGM (and hymenoplasty) and FGCS are perpetuated by the World Health Organisation (WHO hereafter) as well. The WHO defines FGM as, "all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons" (World Health Organization 2018). This definition encompasses not only clitoridectomy, but all types of female genital cosmetic surgery, including vaginoplasty, labiaplasty, G-spot augmentation, vaginal rejuvenation, and mons pubis liposuction (O'Connor 2008).[16] However, all of WHO's campaigns are geared towards eradicating FGM, while ignoring the fact that the definition and many conditions that lead to clitoridectomy have significant similarities with 'mainstream' FGCS. As Braun argues, "despite some important differences, and rhetoric that constructs them as entirely different, there *are* continuities between Western women's 'chosen' FGCS, and non-Western women's genital 'mutilation'. Both are aimed at producing a culturally 'appropriate,' and desirable, genital appearance, and one which is 'properly' gendered" [citations omitted] (Braun 2009, 135;

[16] It does exclude, however, female genital surgeries for non-cosmetic purposes.

emphasis in original). There is not enough space here to discuss the similarities and differences between FGCS and FGM. However, the important point is to be aware of how both FGM and hymenoplasty are Orientalised and exoticised by medical doctors and the media. This only limits our discussions of gender, agency, and the body image among others (Dobson 2008). Recently, some medical doctors who study the ethics of hymenoplasty are laying out the differences between FGM and hymenoplasty in order to oppose the idea that doctors should refuse operating on women who request hymenoplasty on the grounds that the two are similar (Cook and Dickens 2009; Prakash 2009).

Some doctors also refer to the assumed relationship between religion and hymenoplasty and argue that many women seek re-virginisation on religious grounds as the Quran states that a bride needs to be a virgin (Kandela 1996; Paterson-Brown 1998; Prakash 2009). Not only is it not true that there is always an association between religiosity and seeking re-virginisation, but also it is a false statement that the Quran specifically requires a woman to be a virgin and/or prove it via a bloody sheet. The Quran states that any pre-marital or extra-marital sexual engagement is forbidden [*zina*]. However, this is not required to be proved by any means, and in case of doubt, the word of the woman overrides unless there are four witnesses to the contrary. It is in the Bible that a bloody sheet to prove a woman's virginity is required (van Moorst et al. 2012, 95). This false assumption is yet another means through which Islam is otherised through a presumed obsession with blood, hence perpetuating the need for re-virginisation.

Although most medical and social scientific literature seem to concentrate on debates around the ethics of hymenoplasty, this is a very narrow and problematic perception of ethics. The existing discussions around the ethics of hymenoplasty ignore the main protagonist of the operation: the women. In all of these debates, whether doctors should carry out the operation is the main question, whereas what women experience through deciding to undergo and then undergoing hymenoplasty goes unnoticed. Furthermore, such ethical discussions do not have an impact on the structural conditions that lead women to re-virginise or take on a "virginal facade" (Ozyegin 2015). I argue that we should look at the ethics of hymenoplasty from a much broader perspective. I understand the ethics of hymenoplasty to be unpacking how women experience the stuckness between their own sexuality and how the society is pushing them to define virginity, rather than whether it is acceptable to have hymenoplasty in a given society. How we define these ethics is a political statement and stands at the core of how we might engage in overcoming gender inequalities. Instead of whether a woman deserves to become a 'patient', we should be addressing gender inequalities that lead women to undergo such processes. Furthermore, an ethical practice should work *with* women rather than positioning the medical practice *away from*, and in

some cases *against* women. More than doctors' duties, we should consider women's emotions and bodies. Some authors do address gender inequalities while discussing the ethics of hymenoplasty, however, they do not take into account women's emotional or physical experiences while going through re-virginisation processes. One reason for this can be the lack of data and research on the topic, which many authors address as well. This thesis will take the first step in filling this gap.

Other articles present conclusions or success rates of their surgical methods based on a very low number of patients, more specifically on six (Ou et al. 2008) and nine (Prakash 2009) women. These numbers make the methods questionable in terms of applicability, especially given that hymens and women's bodies are diverse. Raveenthiran stresses this diversity and suggests that "unless standards of normal hymen are established, reconstructive efforts will be not only futile but also deceitful" (Raveenthiran 2009, 225), questioning the very existing of hymenoplasty on medical and anatomical grounds. The medical literature has also pointed out several other myths around the hymen and women's virginity. Rogers and Stark posit that the hymen is not necessarily torn following penile-vaginal intercourse (Rogers and Stark 1998), whereas Amy suggests that "it is in many cases unwise for a doctor to state that a woman definitely had or did not have penovaginal intercourse, based upon the appearance of the hymen" (Amy 2008, 112) as the intactness of the hymen does not prove virginity (Shaw and Dickens 2015). Wei et al, on the other hand, deconstruct the myth that every hymenoplasty operation guarantees bleeding. They state that they inform their patients that "even if she regained an intact hymen, the possibility of bleeding during the first intercourse was approximately 50%" (Wei et al. 2015, 15). In a similar vein, Jarral points out how she was not aware of women's hymens despite performing genital examinations,

> As a junior doctor, I worked in a busy urban sexual health clinic in London for many months and conducted several hundreds of female genital examinations. To my surprise, when I look back, I cannot recall recognizing or even noticing hymenal structures. It was only when I trained as a forensic medical examiner in cases of alleged sexual assault that I was able to confidently identify the hymen at all. (Jarral 2015, 158)

This statement calls into question what we come to regard as the hymen. Until someone identifies a bodily tissue or a body part as the hymen, the hymen does not exist, even for someone who is regarded as an expert in vaginas. Just like one becomes a subject only after being interpellated by the police (Althusser [1971] 2001), or is a female or male after being interpellated by the doctor in the ultrasound scan or at birth (Butler 1993), the hymen is a hymen only after it is defined as such. The hymen is a marker of virginity only after it is defined as such. Therefore, the hymen is always already a social construct, just as virginity is.

Furthermore, neglecting this social construction, some studies specifically argue that hymenoplasty gives women "a chance to enjoy the conformation of being a virgin all over again" (Saraiya 2015). It is problematic, in many ways, for a doctor to decide whether a woman is "a virgin all over again". As my research will illustrate as well, some doctors do claim to make women virgins by way of hymenoplasty. Nevertheless, not only this can be determined or decided only by the woman herself, but also virginity is not a being but a becoming as will be discussed below. The idea that hymenoplasty can make a woman a virgin neglects the fact that re-virginisation is a process rather than a moment.

Within the medical literature in Turkey, hymenoplasty is largely neglected. It is mentioned in passing in a book titled, *Forensic Medicine Internship Lecture Notes* (Aşırdizer, Yavuz, and Zeyfeoglu 2005). The book states,

> In the following cases, even if consent is obtained for medical reasons, it does not have legal validity:
>
> - In cases where the risks of treatments and interventions are not explained
>
> - Cases against morality, propriety [*edep*] and law (such as hymenoplasty and sex reassignment surgeries that do not have a legal excuse)
>
> - Consent given for abortion beyond the legal term
>
> - Consent given for cases such as euthanasia (Aşırdizer, Yavuz, and Zeyfeoğlu 2005, 27)

Although there are no laws against hymenoplasty or any re-virginisation practice in Turkey, which is discussed in detail in Chapter 4, these notes, which are aimed at guiding medical students, frame hymenoplasty as a practice that is "against morality and propriety", and hence suggest that future doctors do not accept consent given for hymenoplasty. Operations put into the same category as hymenoplasty have legal grounds for their consent to be invalid, e.g. abortion beyond the legal term and euthanasia are crimes in Turkish legal system. However, there are no regulations on hymenoplasty. Arguing that consent given for hymenoplasty is void and that the operation is against morality and propriety is a subjective statement that goes against the objectivity many of my doctor participants advocate. Furthermore, it creates the ground to prevent women from accessing the operation.

Karaşahin et al. (Karaşahin et al. 2009) and Işık et al. (Işık et al. 2011) discuss the methods they have devised for hymenoplasty. It is noteworthy to remark that Karaşahin et al. suggest, "for hymenoplasty, the possibility of not bleeding during the following intercourse should be discussed with the patient ahead of the operation, to prevent both frustration of the patients and any possible medicolegal consequences" (Karaşahin et al. 2009, 203). Even though this

statement is also aiming to protect doctors from legal consequences, it warns re-virginisers against false guarantees that most doctors give, similar to the task Wei et. al undertake, in stating that "the possibility of bleeding during the first intercourse was approximately 50%" following hymenoplasty (Wei et al. 2015, 15). Işık et al., on the other hand, propose a new method of hymenoplasty and encourage doctors to provide the service to their patients (Işık et al. 2011). Other studies have pointed out the different types of the hymen (Demirci et al. 2008) and methods to operate on an imperforate hymen without removing the hymen completely to make sure the patient remains a virgin (Acar et al. 2003; 2007; Temizkan et al. 2012). The devising of this last method is noteworthy, as it illustrates how ingrained the importance attributed to virginity is, very similar to patients who are technical virgins and who reject gynaecological examinations in their 50s and 60s despite heavy vaginal bleeding, as shared by Dr Emre (Dr Emre, Kayseri, February 2017, phone interview).

Most of the literature I have outlined, both medical and social scientific, and both focused on Turkey and elsewhere are more descriptive than analytical, with a few exceptions (Ahmadi 2016; 2017; Ayuandini 2017a). Nevertheless, a solid conceptual and/or theoretical framework is called for within the re-virginisation literature. Current sociological and anthropological literature has two primary focuses which I suggest we need to nuance: (i) well-researched ethical debates and (ii) dichotomous perspectives which either devise new concepts or use the existing conceptual frameworks to complicate the problem of re-virginisation. In overcoming these issues, I now turn to my overarching theoretical approach.

Conceptual Framework

In this section, I will provide the conceptual framework that I employ throughout my thesis. This framework derives its foundations from concepts developed by Deleuze and Guattari, especially "becoming" and "becoming-woman", as guiding tools to explore virginity and re-virginisation. Hence, here I will introduce the concepts that have allowed me to unpack multiple layers of re-virginisation, alongside their feminist interpretations. I contend that the notion of "becoming" in particular is highly useful to make sense of women's experiences of re-virginisation, and allows us to move away from binary thinking while acknowledging both embodiment and interrelationality. Later chapters also include theoretical sections integrated into the data analysis that take this conceptual framework further.

As put forth in the Introduction, the concept of "becoming" originates from Deleuze himself, even though it has been further developed through his collaborations with Guattari (May 2003). It first appears in *Nietzsche and Philosophy*, where Deleuze argues that "for there is no being beyond becoming, nothing beyond multiplicity; neither multiplicity nor becoming are appearances or illusions. (…) Multiplicity is the inseparable manifestation, essential transformation and constant symptom of unity. Multiplicity is the affirmation of unity;

becoming is the affirmation of being" (Deleuze [1962] 2006, 22). Here, the relationship between being and becoming is of significance. Deleuze suggests that without grasping the idea that we are constantly transforming, being has no meaning. In a framework that is more complicated and developed, Deleuze and Guattari define "becoming" in their seminal work *A Thousand Plateaus* as follows:

> A line of becoming is not defined by points that it connects, or by points that compose it; on the contrary, it passes between points, it comes up through the middle, it runs perpendicular to the points first perceived, transversally to the localizable relation to distant or contiguous points. A point is always a point of origin. But a line of becoming has neither beginning nor end, departure nor arrival, origin nor destination; to speak of the absence of an origin, to make the absence of an origin the origin, is a bad play on words. A line of becoming has only a middle. The middle is not an average; it is fast motion, it is the absolute speed of movement. A becoming is always in the middle; one can only get it by the middle. A becoming is neither one nor two, nor the relation of the two; it is the in-between, the border or line of flight or descent running perpendicular to both. (Deleuze and Guattari [1980] 1987, 293)

Becoming draws our attention to the "in-betweenness" that many women possess in the context of Turkey, especially those who take on a "virginal facade" (Ozyegin 2015). Women, with their ambiguous state of virginity, are always in the middle. As Elisabeth Grosz puts forth, "becomings are always specific movements, specific forms of motion and rest, speed and slowness, points and flows of intensity: they are always a multiplicity, the movement of transformation from one 'thing' to another which in no way resembles it" (Grosz 1993, 176). With its emphasis on process and fluidity, becoming draws our attention to a continuous flow of people and things within themselves and in relation to each other. Hence, it is possible to talk about how women's bodies are constantly becoming, and that they are not fixed entities, especially in relation to virginity. This approach draws attention to the impossibility of maintaining binaries such as virgin/non-virgin, virtuous/non-virtuous, chaste/non-chaste, in and of themselves, as well as in relation to each other. Not only is the definition of virginity always already subjective, but also seemingly objective standards that women are held against to decide whether she qualifies as a virgin or not are not definitive truths per se either. As Deleuze and Guattari argue,

> These lines always tie back to one another. That is why one can never posit a dualism or a dichotomy, even in the rudimentary form of the good and the bad. You may make a rupture, draw a line of flight, yet there is still a danger that you will reencounter organizations that restratify everything, formations that restore

> power to a signifier, attributions that reconstitute a subject—anything you like, from Oedipal resurgences to fascist concretions. (Deleuze and Guattari [1980] 1987, 9)

The binaries of virgin/non-virgin, alongside virtuous/non-virtuous, chaste/non-chaste, are cemented in being (*Dasein*) as opposed to becoming. Being suggests that one can be either a virgin or a non-virgin, and that these states of being oppose each other. Becoming, on the other hand, allows us to be aware of the in-betweenness of not only re-virginisation, but also virginity as a concept. Ahmadi argues that "women who undergo hymenoplasty construct their own fluid, feminine identities, deviating from a fixed, natural notion of gender embodiment. (…) These women undermine the dichotomy between virgin and nonvirgin as normal and abnormal, respectively, because they encompass both domains" (Ahmadi 2016, 233). Reading re-virginisation through being would give us a distorted and simplified version of the process that women go through, which obscures the fact that virginity, if it exists, is a continuum. This becomes clearer when the alleged markers of virginity such as blood, tightness, and even the existence of a hymen can be challenged in different contexts, as this research demonstrates. "Becoming refers both to the endless process of differentiation and to our relation to our own subjectivity" (Brians 2011, 132). Hence, more than a state of being, virginity can be framed as a process through which people relate to their own bodies. Re-virginisation becomes unacceptable to those people who bracket virginity in being, rather than becoming, as it does not fit the existing categories of virgin and non-virgin. Reading re-virginisation through becoming, however, allows us to complicate how virginity is defined and allows room for re-virginisation to exist and to be discussed.

Within the context of re-virginisation, the becoming of women's bodies is one of the main processes that can and should be followed. Even though it is argued that "Deleuze rarely discusses the body directly" (Hughes 2011, 9), Deleuze and Guattari do provide us with conceptual if not theoretical tools to analyse how bodies become. One of the ways becoming can be differentiated from process is the importance given to interrelationality in becoming, which can be explained via the concept of "assemblage". Deleuze and Guattari define an assemblage as the "increase in the dimensions of a multiplicity that necessarily changes in nature as it expands its connections" (Deleuze and Guattari [1980] 1987, 8). The body is always in interaction with its surroundings, and its relationality with its connections is what makes the body constantly continue to become. These "*relations* of becoming" (Coleman 2009, 1; emphasis in original) form the backbone of becoming and differentiates it from process. The becoming of the body is an endless process as it is always in interaction, and a body never ceases to become. Based on this, Coleman argues that "bodies cannot be understood as discrete, autonomous entities, not only because they are always in process but

also because their movement is always through their relations in the world; bodies are not autonomous from the world" (Coleman 2009, 1). The relations of becoming are not necessarily human-human interactions. "As a process a body does not necessarily prioritise the human element in the process of becoming; other elements, other organs, become just as important (or unimportant) as the process becomes" (Coleman 2009, 33). How the human becomes in relation to "nonhuman and material others" (Renold and Mellor 2013, 45) needs to be considered as well, although the 'other' may not necessarily be perceived as the 'other' by the woman herself. From a Deleuzian posthumanist point of view, "there are no firm or absolute boundaries between one 'thing' and the next. Boundaries exist, as zones of consistency, but they remain permeable and open to transformation, or becoming other" (Brians 2011, 132). This is especially useful in unpacking the relationship between women and their hymens, as well as the other 'things' they come into contact with, such as the gynaecological bed, the artificial hymen, and hymeneal and post-operative blood. A re-virginiser's relationality with her 'artificial' or reconstructed hymen plays a significant role in her becoming. Whether this new hymen is regarded as an insider or an outsider to the woman's body by the women themselves, and also by doctors and retailers, changes the woman's relationship to her body, hence impacts the body's becoming as well.

It should also be noted that this becoming does not happen in an environment where all becomings are possible, where infinite possibilities exist. "It is not that an assemblage can become anything - and here the question of power is raised, in that, a Deleuzian approach to the social is as much a mapping of what is impossible, what becomes stuck or fixed, as it is of flux and flow" (Coleman and Ringrose 2013, 9). Many scholars have criticised Deleuze for not taking power relations or structures into consideration, and for treating relations as horizontal rather than tending to the vertical. However, the idea that possibilities of becomings are finite directs at the vertical as well. In the case of re-virginisation, factors such as a woman's social background; financial (in)dependence and social network at the times of virginity loss, considering re-virginisation, and marriage may play deciding roles in which becomings are available for her. All of these factors, and others, are imbued with power, which cannot be ignored.

The Deleuzian body "is not a mute body on which gender can be overlaid or which is only accessible through cultural ideals of gender. Instead the materiality of the body needs to be understood as a force that also shapes how we live in the world" (Stark 2016, 79). This point bears significance as it refers to how discourses that socially construct gender and bodies are intermingled with the corporeality of the body. "The body is always dynamically related to the unity of pluralities. On the grounds of understanding becoming positively, Deleuzian feminists talk about embodied becoming and materiality" (Direk 2016, 286–87). Therefore,

in many ways, the Deleuzian approach to the body can be interpreted as a bridge between social constructionist and existential phenomenologist views on the body. As Guenzel argues,

> Deleuze is ultimately meeting Merleau-Ponty's demands for a topological thinking, which Deleuze thought to be realized in the work of one of Merleau-Ponty's major critics: Michel Foucault. It is Foucault's archeology, which Deleuze considered to be able to understand man as 'foldings' of the modern episteme, as protuberances of a discursive formation. And as a matter of fact it can be shown that Foucault's archeology can be aligned with the phenomenological project to reach the constituents of being by way of going back from the given. It speaks in Deleuze's favor that he does not see a break between phenomenology and structuralism but that he understands structuralism as an attempt to give phenomenology a monstrous child… (Guenzel 2014, 14)

A Deleuzian approach to the body makes space to account for women's bodily experiences of re-virginisation that evoke pain and to a lesser extent pleasure without neglecting the discursive power dynamics that establish the ground on which the demand for and supply of re-virginisation are formed. In addition to these dimensions, affects also form a fundamental part of re-virginisation. They not only have a transformative impact but also characterise the re-virginisation process for women. Affects are not fixed, and they roam through bodies and things, rather than being lodged in them. As Deleuze argues, "affects aren't feelings, they are becomings that spill over beyond whoever lives through them (thereby becoming someone else)" (Deleuze [1990] 1995, 137). Affects impact the perception of time and space, as well as the perception of the body by the individual interrelationally. Therefore, becomings of the body are moulded through affects, which are becomings as well, all of which form assemblages. However, the link Deleuze makes with emotions and capacity for action does not hold true for re-virginisation. Deleuze argues,

> when we encounter an external body that does not agree with our own (i.e., whose relation does not enter into composition with ours), it is as if the power of that body opposed our power, bringing about a subtraction or a fixation; when this occurs, it may be said that our power of acting is diminished or blocked, and that the corresponding passions are those of sadness. In the contrary case, when we encounter a body that agrees with our nature, one whose relation compounds with ours, we may say that its power is added to ours; the passions that affect us are those of joy, and our power of acting is increased or enhanced. (Deleuze 1988, 27-28)

For many re-virginisers, the re-virginisation process causes and is caused by a mixture of what Deleuze calls "joyful" and "sad passions". Re-virginising brings up anxiety, loneliness,

sadness, and fear, which can be labelled as "sad passions", yet these emotions originate from increased capacity for action, which is resorting to re-virginisation. Furthermore, re-virginisation may lead to happiness, which can be labelled as a joyful passion, yet it does not follow "a body that agrees with our nature". On the contrary, it is the result of encountering a body that does not agree with the woman's 'nature', yet the decision to act upon it may lead to happiness. It should also be noted that there are multiple encounters that a body goes through in re-virginisation, ranging from healthcare staff to family members, from old to new partners, as well as a multiplicity of objects. It would be highly simplistic to subtract one encounter and deduce that it results in or originates from a sad or joyful passion, or that it leads to a certain capacity for action. Therefore, as I will discuss in Chapter 7, the relationship between affects and re-virginisation is much more complex than Deleuze suggests.

Deleuze and Guattari's work in relation to their theoretical and conceptual framework has both enriched and been criticised by feminist scholars. Especially Luce Irigaray, Elizabeth Grosz, and Rose Braidotti have been leading figures in re-interpreting the works of Deleuze and Guattari from a feminist lens, and in integrating a Deleuzian perspective to feminism. One of the main concepts that have been criticised by these scholars is the notion of "becoming-woman". Deleuze and Guattari argue that "although all becomings are already molecular, including becoming-woman, it must be said that all becomings begin with and pass through becoming-woman. It is the key to all the other becomings" (Deleuze and Guattari [1980] 1987, 277). On the one hand, Deleuze and Guattari argue that gender is not monolithic, and that experiences of sexual differences are beyond our current "systems of meaning" (Stark 2016, 38), while at the same time positing becoming-woman as the necessary pre-requisite of all becomings. Deleuze and Guattari also contend that the ultimate becoming at the molecular (as opposed to molar) level is the absence of sexual difference, and this is the becoming that we should desire to attain. This last point, in particular, has evoked criticism from feminist scholars, and "Irigaray, Jardine and Braidotti are unanimous in their criticism that becoming-woman erases sexual difference" (Stark 2016, 33). I join feminist scholars in their criticism of becoming-woman in relation to Deleuze and Guattari's establishing eradication of sexual difference as a goal to be attained via becoming. My further point of criticism is, however, in relation to the girl's becoming-woman and social norms that challenge this becoming. Deleuze and Guattari state that

> doubtless, the girl becomes a woman in the molar or organic sense. But conversely, becoming-woman or the molecular woman is the girl herself. The girl is certainly not defined by virginity; she is defined by a relation of movement and rest, speed and slowness, by a combination of atoms, an emission of particles:

> haecceity. She never ceases to roam upon a body without organs. She is an abstract line, or a line of flight. Thus girls do not belong to an age group, sex, order, or kingdom: they slip in everywhere, between orders, acts, ages, sexes; they produce *n* molecular sexes on the line of flight in relation to the dualism machines they cross right through. The only way to get outside the dualisms is to be-between, to pass between, the intermezzo—that is what Virginia Woolf lived with all her energies, in all of her work, never ceasing to become. The girl is like the block of becoming that remains contemporaneous to each opposable term, man, woman, child, adult. It is not the girl who becomes a woman; it is becoming-woman that produces the universal girl. (Deleuze and Guattari [1980] 1987, 276)

Here, Deleuze and Guattari refer to the girl as opposed to the woman. Yet, as opposed to the *kız*/*kadın* divide in Turkish language, they do not differentiate between the two concepts based on virginity, nor do they do so according to "age group, sex, order, or kingdom". Within this conceptualisation, girls go through a process of becoming-women, and are 'allowed' to continuously become. This becoming-woman is not recognised in the Turkish context. Even though a girl might be prepared to be a woman by her mother through learning the 'duties of a wife', this never crosses to the realm of sexuality. An unmarried 'girl' is expected to *be* a woman, without *becoming*-woman with regards to her sexual identity. The girl depicted by Deleuze and Guattari could become-woman "by a relation of movement and rest, speed and slowness, by a combination of atoms, an emission of particles" in the absence of norms that determine her being and becoming. However, the very existence of re-virginisation challenges this ideal becoming. Power and social structures need to be introduced in the discussion of becoming-woman for it to explain a woman's becoming.

Patricia MacCormack challenges Deleuze and Guattari through positing the concept "becoming-vulva". She introduces gendered power dynamics into the discussion, and "uses the term 'vulva' as a navigation of the tensions between Deleuze and Guattari's problematic term 'woman' with Irigaray's model of the two lips" (MacCormack 2010, 94). With a clever imagination, she likens the folds of the vulva to the folds in Deleuze and Guattari's theorisation, and argues that "the many folds of the vulva create connections" (MacCormack 2010, 97). However, by using the word "vulva" and arguing that "becoming-vulva is available to all subjects while resisting the vaguely essentialising fetishisation of the term 'woman'" (MacCormack 2010, 93), MacCormack falls into the same trap that she and other feminist scholars criticise "becoming-woman" for. She argues that "becoming-vulva interrogates phallologocentrism as a structure beyond identity with which all subjects participate" (MacCormack 2010, 97). It is not clear how a bearer of a phallus will participate in this becoming, and how becoming-vulva will evade the erasing of sexual difference that

becoming-woman entails. Therefore, even though becoming-vulva has the potential to challenge Deleuze and Guattari, it perpetuates the problems that it tries to overcome. As a result of the challenges and contradictions that becoming-woman brings up, and becoming-vulva fails to resolve, I propose another notion which in many ways can explain and unpack sexuality better than becoming-woman.

Becoming-Virgin

Although more and more European scholars are interested in the intersection of gender and Deleuze, the same cannot be said for those based in the Middle East. Al-Nakib looks into whether Deleuze can be used to understand Arab Feminisms, suggesting the application of the "disjunctive synthesis" (Al-Nakib 2013). Although he does not make any claims about gender in Turkey, Barış puts forth a Deleuzian analysis of Turkish cinema via concepts such as "becoming-woman", "bodies without organs" and "desiring machine" (Barış 2019). Similarly, Cingöz looks for ways that feminist philosophy can benefit from Deleuze, yet despite being a thesis submitted in Turkey, it does not touch upon the application to this context (Cingöz 2013). Direk makes a similar contribution to the literature by comparing Grosz and Butler on queer theory, without contextualising their theories in Turkey or the Middle East (Direk 2016). Hence, my research fills a gap by arguing and demonstrating that the conceptual framework provided by Deleuze and Guattari can allow us to expand our ways of thinking about gender in the Middle East. This is not to ask to be 'saved' by the White man. On the contrary, it is being aware of what these concepts can contribute to gender politics in general, and based on social, cultural, and historical specificities in particular.

Going beyond becoming-woman, I propose the notion of "becoming-virgin" to make sense of the processes and procedures women go through in their quest to become a (technical) virgin. Becoming-virgin will allow us to think about re-virginisers within a state of relationality. Deleuze and Guattari invite us to discover "new ways of relating to things and new embodied sensations" through becoming (Stark 2016, 25). Throughout the re-virginisation process, women find new ways of relating to their bodies and in particular, their genitalia. Especially, the insertion of the artificial hymen and the hymenoplasty operation produce new embodied sensations, which form one of the indispensable parts of this research. Becoming-virgin can at once seem a circular process, as women aim to become technical virgins, and they start their journeys as technical virgins before they 'lose' their virginity. However, who they become as a result of the re-virginisation process is a different person and a different body than the one they started with. Furthermore, from a Deleuzian perspective, it is not possible to talk about taking off from one destination and arriving at another. As women go through re-virginisation, they continue to become-virgins or -non-virgins, which also continues later into their lives, in relation to how they relate to their

bodies following marriage and childbirth post-re-virginisation, as for some, this results in accepting their bodies as (non-/re-)virgins retrospectively. Deleuze and Guattari argue that "each of these becomings brings about the deterritorialization of one term and the reterritorialization of the other; the two becomings interlink and form relays in a circulation of intensities pushing the deterritorialization ever further" (Deleuze and Guattari [1980] 1987, 10). Generally speaking, deterritorialisation in re-virginisation occurs when a woman either 'loses' her virginity non-consensually and pre-maritally, or when her partner, whom she had a sexual relationship with leaves her before getting married. Women attempt at re-territorialisation through re-virginising practices, as they form new assemblages around their sexuality and their vaginas.

Becoming-virgin is a useful concept to think about sexuality, in a way that becoming-woman does not readily provide, as how one becomes a virgin lays out both the sexual and gendered differences that exist or that are assumed. Sexuality forms an indispensable part of how gender is experienced, and both the presence and absence of sexual relations form our becoming. Becoming-virgin does not presuppose a certain idea of womanhood, instead, how this becoming is experienced gives us the structural, corporeal, and affective framework within which the individual is placed. For instance, born-again virgins in Evangelical Christianity become virgins differently than re-virginisers, as the former become virgins discursively, whereas the latter become virgins technically, although the two can overlap as well. Men become virgins differently than women, as they are rarely ascribed any markers thereof. Becoming-virgin can also be understood as the consciousness of having a sexual identity. Becoming aware that one is a virgin comes after becoming aware that one 'lacks' sexual experience, however what this lack entails is defined culturally, politically, and personally. Becoming-virgin underlines presumed and experienced sexual and gendered differences, while at the same time suggesting ways to overcome gender norms.

Of course, becoming-woman encompasses more than becoming-virgin. However, the latter points at a fundamental way gender is experienced and opens up ways through which we can discuss corporeality, affective relations, and power, while not suggesting erasing sexual difference. Throughout this thesis, it is possible to trace how this becoming is enacted through laws, the re-virginisation market, and women's experiences thereof. The existing literature on re-virginisation neither employs nor builds on a Deleuzian approach, and it largely fails to provide a solid theoretical or conceptual framework on which re-virginisation research can be based. Therefore, this research fills a gap that the existing literature does not recognise.

Conclusion

In this chapter, I have laid out the existing literature on and around re-virginisation. I have first introduced the most common debates around genital cosmetic surgeries, with an emphasis on female surgeries. I have also provided insights on penile enhancement surgeries and male circumcision in relation to hymenoplasty. I have then moved on to reviewing the social scientific and medical literature on re-virginisation.

Following the literature review, I have provided an introduction to Deleuze and Guattari's becoming and becoming-woman, among other concepts that provide a useful conceptual tool to unpack re-virginisation. Through Deleuze and Guattari's own writing and the feminist secondary literature thereon, I have illustrated how a Deleuzian perspective towards bodies and affects allows us to conceptualise re-virginisation as a process. I will further this theoretical approach in later chapters, especially in relation to affective times and spaces.

I now move on to the Methodology chapter, where I will discuss the methods that I have used to research re-virginisation. I will contextualise the setbacks and challenges I have experienced throughout my fieldwork through the concepts of intimacy and *mahrem*, while deconstructing the private/public dichotomy. This chapter will hence bridge becoming with affective intimacies to make sense of what can and cannot be voiced. I now turn to these intimate encounters.

3. Methodology: Making Sense of the Intimate and the *Mahrem*

- *Mum, what do you think about my research topic?*
- *Re-virginisation?*
- *Yes.*
- *I'm not sure if I'm comfortable with it. You are entering other people's* mahrem.

This simple yet crucial dialogue took place between me and my mother in the earlier stages of my PhD research. My mother warned me of the discomfort she felt as I seemed to enter what was considered private for her and for many other people. Yet, this seemingly private realm, this *mahrem* is the very space where normative operations around gender and sexuality take place and come into the flesh, which is the very reason why it is required to enter it. In this chapter, I navigate the spaces I have entered and the actors I have interacted with through *mahremiyet*.

Mahrem refers to two things at once: the forbidden and the sacred. It is the realm of the intimate, the secret, that which is forbidden to the foreigner. Etymologically Arabic, *mahrem* comes from the h-r-m root, shared with the words *harem* and *haram*. While the former refers to the female members of a household and the physical space they live in, the latter means that which is forbidden by religion. With regards to sexuality, it is established in Islam that pre- or extra-marital sexual intercourse is *haram*. Therefore, the realm of re-virginisation is interwoven with *haram* and *mahremiyet*, which is the realm of the *mahrem*. *Mahrem* defines the boundaries between the foreigner and the insider, the forbidden and the permissible. At the same time, *mahrem* defines the boundaries between the researcher and the researched. Re-virginisation is a *mahrem* field not only because of its direct relationship with sexuality, but also because it is a secret practice, and hence is forbidden to the researcher. This has resulted in many challenges during my fieldwork, as will be detailed in this chapter.

Through the challenges I encountered, I have built a bridge between the difficulty of reaching the intimate, the *mahrem*, and the scholarly significance thereof. In this chapter, I display the avenues through which these bridges can be built, especially through the inclusion of online communities in my fieldwork. I accomplish this task by exploring the intersubjective and interspatial webs through which I have developed a methodology to answer my research questions. Recalling that from a Deleuzian perspective, "a line of becoming has only a middle" (Deleuze and Guattari [1980] 1987, 293), "the methodological task is thus to enter the middle, the between; to relate" (Coleman and Ringrose 2013, 18). Hence, my task in this

research has been, in particular, to "enter the middle, the between; to relate" to the *mahrem*, to the intimate, to nooks and crannies of what is hidden in plain sight.

As illustrated in the Introduction, no work exists to understand the political and legal economy of re-virginisation in Turkey. When this is added to the necessity to gauge both the lived experiences of re-virginisers and the role power plays in these experiences, it is clear that this research has called for mixed qualitative methods in order to integrate the views of all actors involved in the process of re-virginisation. With the aim of both understanding women's experiences of re-virginisation, and the social and institutional governance of this phenomenon, I have conducted 55 interviews; 30 of which were held with healthcare staff, 4 with artificial hymen retailers, 2 with re-virginisers, 2 with re-virginisers' friends, and 17 with people who do not have a direct relationship to re-virginisation, yet play a role in the reproduction of relevant discourses (who are generally called as laypeople). Furthermore, I analysed 7000 pages of online forum data[17] and 10 websites that advertise re-virginisation goods and services. Within this framework, I take the Internet as a medium of delivering or exchanging information, experiences, and thoughts, rather than as an actor. The reason for this approach is that I perceive my passive and active interaction with each of the actors as one whole unit that is acquired through multiple media. Throughout this chapter, I detail the further breakdown of these numbers and my journey through these analyses. In the following, in addition to these numbers, I discuss the boundaries the private/public dichotomy creates, and intimacy and *mahremiyet* erase in relation to interviewing re-virginisers and their online engagement. I bring in the notions of secrecy and "amplified intimacy" to make sense of my interactions with re-virginisers. Later, I discuss the ethics of using online data, as well as the visual and discourse analysis of re-virginisation websites. Finally, I move on to interviewing re-virginisation providers, i.e. the medical doctors and artificial hymen retailers within a discussion of power.

Beyond the Public and the Private

In the realm of gender and sexuality research, it has become mainstream to use the categories of public and private from second wave feminism onwards (Landes 1998). Studies that have focused on, among many others, the legal framework (Gavison 1992) and economy (McIntosh 1978) from a gendered perspective, have used these categories as distinct in the earlier years of feminist research. As Carole Pateman, who has revolutionised the field of feminist theory has argued, "the dichotomy between the private and the public is central to almost two centuries of feminist writing and political struggle; it is, ultimately, what the feminist movement is about" (Pateman 1989, 118). Even though early feminist research has

[17] I choose not to disclose the name of the forum to protect women's confidentiality.

benefited from the distinction between private and public, authors have more recently recognized the blurred lines between the two, not only for gender and sexuality research (Wong 1997) but in areas such as media studies where online interaction challenges assumptions about what constitutes private and public. Even though the Internet has been initially framed as a "public sphere" (Allison 2007) or "public space" (Camp and Chien 2000), internet users' 'privacy' kept intertwining with the 'public' nature of the platforms they are sharing, leading researchers to blur the lines between the two concepts. For instance, Lange plays around the concepts of private and public in his discussion of social networking on YouTube (Lange 2007), and brings in the concepts of "publicly private" and "privately public" as a way to emphasise the crossovers between the two concepts; whereas Andreassen proposes "the term 'private public' to capture users' intimate engagement" with a Facebook group that brings together families that have been built through sperm donation (Andreassen 2017, 363). However, approaches such as these still hold onto public and private as distinct categories in their attempt to integrate them. Instead, I argue that a dismissal of the categorical differentiation between private and public is called for, as this research will demonstrate.

The language of the public and the private as distinct categories makes it difficult to make sense of the online sharing of re-virginisation experiences. Many women seeking re-virginisation become a member of online platforms in order to interact with fellow re-virginisers, to consult them on topics such as where and when to have the operation, how to make sense of the changes happening in the body throughout the process of re-virginisation, and whether to buy an artificial hymen. Women can start their own threads specific to the city they are living in, or planning to have the operation in, the doctors they are trying to decide between, or any other aspect of re-virginisation. The forum that I have drawn my data from is not specific to re-virginisation, however, and any topic, as long as they are within the guidelines can be discussed -no threads or posts can be entered that have pornographic content, that are racist, pro-violence, among a long list of other criteria. Entries are posted under usernames only, but in order to be a member of the forum, one needs to provide personal information, such as one's birthdate, gender, relationship status, occupation, level of education, city of residence, and whether one has any children, which is visible to all members. Although the guidelines state that only women are allowed to become a member of the forum, this is not checked or controlled in any way. Only in the form to be submitted to become a member is there a question asking whether one is male or female, and one has to check "female" for membership to be granted.

Being a member of this forum puts one in the middle of a web of connections. One can follow people, and others can view whom one follows and whom one is followed by. All members

can view all the personal information that other members have entered, and all the posts published by a member can be viewed at once. Therefore, even though usernames provide anonymity to members of the forum, the display to other users of personal details and all the entries that have been posted does not provide security. While members can enter false information, other members sometimes fact-check through the entries that have been posted by a single user to be able to challenge them. For instance, one user who is critical of re-virginisation has actively looked for loopholes in re-virginisers' accounts. Luckily, she found one, and detected that one member used to write under two different usernames. She asked the re-virginiser, "if you like, maybe first tell us why you changed your username, and how you piled on your agony, how you described what you went through differently on two different threads, and how you closed your thread to comments and changed your username when the truth came out" (Thread 43, February 2014). Soon after she was attacked by this user, the re-virginiser deactivated her account and left the forum. Therefore, even though these platforms are anonymous, the online subjectivity created by users can be tracked, making this anonymity elusive. As Waskul and Douglass argue, "on-line anonymity is mediated between participants in the course of interaction as a variable element of the on-line situation" (Waskul and Douglass 1996, 134). Therefore, we can talk about a constant mediation of a variable anonymity, based on how online and offline subjectivities are constructed.

Despite this insecurity due to slippery anonymity, women write 'publicly' on what can easily be deemed a 'private' matter. What seems to be a private realm, especially in terms of what is happening inside women's vaginas and their emotions within the framework of a topic that is kept as a secret from one's even most immediate circle is discussed publicly. This conundrum is the very reason why we should dismiss the public/private divide. The very existence of forums where re-virginisation is discussed not only at a conceptual level, but also as a means to communicate emotions and bodily changes that come with it in what approximates an open diary format challenges the concepts of public and private.

Despite the 'public' openness about a 'private' matter, it has proved to be very difficult for me to access re-virginisers to interview them on their journey. Although I have been able to establish contacts with over 20 women who have re-virginised, or who were seeking re-virginisation at the time of our contact, most of them have refused to be interviewed. These contacts had been established mostly through acquaintances, and to a minor degree through medical doctors. As a result, I interviewed one woman during her hymenoplasty operation (whom I introduce before the next chapter); and another one who sought re-virginisation, but decided not to go through with it. I have interviewed a further two women who took part in the re-virginisation process that their closest friends went through, via taking over

researching and contacting re-virginisation providers for them, providing emotional support, and by taking care of them following the operation. Several other interviews were scheduled with women who have re-virginised, only to be cancelled last minute, multiple times. Due to the low number of these interviews, I decided to listen to "stories of re-virginisation". I interviewed people who do not necessarily have an experience of re-virginisation, to gauge their perception of virginity, while at the same time listening to stories of re-virginisation they have heard of, of which everyone has at least one. This also gave me access to the public opinion on re-virginisation, making it clearer as to why some women resort to re-virginisation, while others do not, despite having had pre-marital penile-vaginal sexual intercourse. These interviews with 11 women and 6 men have been useful in order to draw a framework within which re-virginisation can be located in addition to giving access to secondary narratives on re-virginisation.

One of the avenues I had in mind to reach re-virginisers was to contact them through the online forum where they most frequently discuss this topic in detail. After following the public entries in the forum for some time, I decided to send a private message to several women to converse with them about virginity, where I disclosed my identity and my status as a researcher, and suggested to have this conversation online, on the phone, or face-to-face. The next morning, I got a call from a moderator/editor of the forum, telling me that I was not allowed to contact women in this way, which they claimed was clear in the guidelines but was not. Women had filed complaints about me, as they were scared that I would find out their identity and reveal it to their parents-something that happened in the past. They also thought that I was a man and a potential blackmailer. Later I also found out that I was banned from the website, I could not log in, and my username was labelled as "either fake account or trying to advertise-do not trust what she says". I could still access the forum data, as all posts are publicly available without being a member of the forum. However, this incident underlines the fears of women surrounding confidentiality and being exposed as a non-virgin to their families and future husbands. This way of thinking is supported by many passive accounts on the forum, as women go in-and-out, in other words, they become a member, ask their questions, and de-activate their accounts to ensure non-detectability. Here, it is possible to see webs of (dis)connection interwoven with the precarity of women and of the researcher, and the formation of multiple hierarchies. To make sense of these webs, I now turn to the links between intimacy, affect, and secrecy.

Building Affective Intimate Spaces

The current literature on Muslim women's engagement in online communities (Brouwer 2004; 2006), especially on topics like sexuality (Marcotte 2010; 2015) and gender (Piela 2010) derive from dichotomies such as the Muslim woman/Western woman, man/woman,

and public/private. Most of these authors tend to focus on Muslim women's 'liberation' through the Internet, as Muslim women are believed to only now have acquired the chance to talk about private matters publicly. However, I am exploring going beyond these binaries, and am complicating the relationship between women and their online engagement. I argue that there is a strong connection between women writing online about re-virginisation and preferring not to speak to me, and that this cannot be explained via the categorical differentiation between public and private, but through "intimacies". Lauren Berlant, in her discussion of intimacy as an institution, argues that "intimacy builds worlds; it creates spaces and usurps places meant for other kinds of relation" (Berlant 1998, 282). Intimacy creates what we call home, and what can be talked about at and outside of the home. It draws lines between acceptable and unacceptable forms of sexuality, which is contingent upon the dynamics of a certain society. Berlant and Warner discuss what kinds of intimacies are accepted by the public or by the state (Berlant and Warner 1998). Although pre-marital sexual intercourse is not one that is accepted by most strands of Turkish society, women have been able to have re-virginisation accepted to the degree that it can be discussed in forums.

Underlying re-virginisers' preference to engage in online communities to discuss their process, and to not share their stories with a researcher are two factors: (i) the sense of community in online platforms, and (ii) the insider-outsider dynamics in sharing experiences, thoughts, and feelings. Both of these factors are united in the intimacy that re-virginisers feel in their online environment, which they most likely do not have access to through any other means. The sense of community that is established in online platforms derives from the affective nature of intimacy. Berlant defines an intimate public as "an achievement. Whether linked to women or other nondominant people, it flourishes as a porous, affective scene of identification among strangers that promises a certain experience of belonging and provides a complex of consolation, confirmation, discipline, and discussion about how to live as an x" (Berlant 2008, 9). On the one hand, the shared affects create a sense of belonging among re-virginisers, as they "share a worldview and emotional knowledge that they have derived from a broadly common historical experience" (Berlant 2008, 9). Re-virginisers share this "broadly common historical experience" due to their sexual history. Furthermore, as will be discussed in Chapter 7, re-virginisation is imbued with affect and is an affective performance. This performance not only takes place in offline spaces such as the clinic and one's home but also in online spaces. Through online forums, women create a sense of sisterhood that cannot take place elsewhere due to the secretive nature of the practices. Hence, secrecy becomes another means through which an intimate space is created. Aslı Zengin, while discussing the challenges she faced in her attempts to interview sex workers in Turkey, suggests that

> intimacy and secrecy are mutually formative. Secrets create or strengthen the bonds of intimacy between those who share them. In fact, all our intimate relations are grounded in some form of shared secrets and their careful preservation through silence. Hence, we can approach silence as the mediator of such intimacies. (Zengin forthcoming)

As women are silenced about their sexual history and hence re-virginisation, the intimacy that is created online takes on a meaning other online spaces do not necessarily possess. The offline silence is not necessarily created willingly, as "women's silence, on the other hand, mainly denotes a position of subordination and control, a position that they unwillingly chose (or did not choose) to protect themselves by sometimes refusing to talk" (Zengin forthcoming). However, while women are silenced on their sexual history and re-virginisation, they counteract this silence by creating their own intimate spaces, and a sense of identification. Thus, forums characterise how women experience re-virginisation as well. One user states, "but we regret this, and we are ashamed to even ask about it to a doctor, so we seek support from our friends who suffer from the same trouble [*dert*]. Our aim is to not make the same mistake and to have [our hymen] permanently sutured" (Thread 13, September 2014), while another woman claims, "as I share my troubles with you, I feel less and less fearful. May we all have better days to come" (Thread 20, May 2012). This sense of community draws the lines between the insiders and outsiders of the intimate environment as well, both through the secretive nature of re-virginisation and through the practical and emotional support that these communities provide women.

Intimacy established or facilitated by the Internet has been researched by many scholars, framed as "networked narratives" (McNeill 2012), "virtual intimacy" (McGlotten 2013), or "mediated intimacy" (Attwood, Hakim, and Winch 2017; Andreassen 2018). These scholars have discussed whether virtual is a space of potentiality for the real and whether the lines between the virtual and the real can be blurred. I contend that the significance of the Internet as a medium lies in the intimacies it allows to build that are not possible to build offline, especially in cases such as re-virginisation, where online intimacies are built as a result of the impossibility of building offline intimacies. While sharing emotions is fundamental to the creation and sustenance of these online intimacies, equally important are the online subjectivities that are formed and displayed in these spaces. "Digital intimate publics" come with their own dynamics about belonging, which are "effected by reworking the self to better fit into its culture of circulation, creating commonality" (Kanai 2017, 295). I argue that intimacy created through online spaces can be termed as "amplified intimacy", as it amplifies times and spaces that cut across the intimacies built through re-virginisation in this case. The unique characteristics of technologies allow intimacies to be built

retrospectively, exemplified by the woman who reads past forum posts and creates an affective bond with fellow re-virginisers. At the same time, intimacies are amplified across women's workplaces and homes, through the use of online spaces. The very implausibility to talk about re-virginisation in offline spaces, creates wider spaces with closer-knit intimacies online.

To understand why re-virginisers' online intimacy does not translate to a broader intimacy offline, which would allow me to interview them, we need to understand the lines that *mahremiyet* draws. Through the institution of *mahremiyet*, women draw the line between what is forbidden and who is let in in this institution. "*Mahrem* refers to anything and everything one might avoid enunciating" (Sehlikoglu 2015, 80; emphasis in original). By enunciating re-virginisation online, women transcend the boundaries of the institution of *mahremiyet*, yet due to the multi-layered nature of *mahremiyet*, it is not possible for these women to cut through it entirely. *Mahremiyet* is multi-layered, because it refers to the intimate, domestic, forbidden, and hidden, all at the same time. Through the process of re-virginisation, women constantly re-evaluate what is considered *mahrem* for them and for the online and offline society.

It should also be noted that although I introduce intimacy in order to do away with the public/private divide, Nilüfer Göle, who is one of the key scholars of *mahremiyet*, sometimes hesitates as to what *mahremiyet* is, and uses intimacy and privacy in brackets interchangeably to explain what *mahremiyet* means throughout her book *The Forbidden Modern* (Göle 1996). Therefore, instead of doing away with the private/public dichotomy that she opposes, she reproduces it by redelivering the concepts at different points in her text, and by likening the *mahrem*/*namahrem* [non-*mahrem*] divide to the private/public. Even though some scholars have interpreted Göle's *mahremiyet* as one that goes beyond the private/public dichotomy (Sehlikoglu 2015), I contend that she reproduces it anew. In addition, Göle's emphasis on the necessity of the concept of *mahremiyet*, as "using the Western concept of 'private sphere' instead of *mahrem* would have led to the suppression of the distinctiveness of the domestic sphere in a Muslim context. Understanding the particularities from within therefore requires a broad sociological consciousness and conceptualization" (Göle 1996, 18) should not deceive us into framing re-virginisation as 'a Muslim issue'. Not only does re-virginisation extend beyond Muslim populations, but also it is part of the larger picture of norms around gender and sexuality. Therefore, I define *mahremiyet* as the gendered construct of the intimate, derived from Göle's description as the "gendered construct of the private sphere" (Göle 1996, 33), by both emphasising the genderedness of intimacy in the specific context that I am researching it, and by also not restricting the subject to the interplay between the private and the public.

Another re-interpretation that Göle's definition of *mahremiyet* requires, is the idea that what is mahrem is "forbidden to a foreigner's gaze" (Göle 1996, 7). Göle does not define who this foreigner is. However, re-virginisation challenges what is traditionally accepted to be the foreigner to one's body. For a re-virginiser, the previous sexual partner(s) can still be regarded as *haram*. However, the discussion around intimacy has shown that as a result of this sexual activity, women create new communities, which cease to be foreigners. Other women's gaze (as well as doctors') is familiarised or internalised within the process of re-virginisation. This does not make the process of re-virginisation less intimate. The re-virginiser is selecting who counts as a foreigner for herself and for fellow re-virginisers. The gaze of those that are selected is not considered foreign, even though re-virginisation is still *mahrem*.

Online Subjectivities and "Porous" Intimacies

Even though re-virginising women have seen me as an outsider (as my interaction with re-virginisers from the forum displays), I contend that it is not possible to clearly distinguish between who is on the inside and who is on the outside, as intimate publics are "porous" (Berlant 2008, 9). A Deleuzian perspective calls for blurring the lines between the two sides of this binary, as "taking seriously the idea that methodology is a way of relating to multiply assembled worlds suggests that social scientists are themselves entangled within the assemblages they seek to study. Researchers are thus one point of the relations within an assemblage" (Coleman and Ringrose 2013, 15). I am not a re-virginiser, but I am very much part of the discourse around re-virginisation as I have a virginal facade as well, which puts me in a significant point of relation within the assemblage surrounding re-virginisation. How blurred the lines are between re-virginisers and me has been even clearer through a particular interview, with one of my male participants who works as a gynaecologist in a private clinic. The interview was pretty uncomfortable, took place in a small room inside the clinic, with the door closed and no other staff member present. What made it particularly uncomfortable was, however, a question I received from the doctor. In the middle of the interview, we had the following dialogue,

> Dr Eren: Are you sexually active?
>
> Hande: Why do you want to know that?
>
> Dr Eren: To see if you can understand what I'm telling you.
>
> Hande: You can keep telling me, I will understand it. (Dr Eren, Istanbul, December 2016, personal interview)

Even though I was doing a PhD on the very topic of discussion, Dr Eren had wanted to know if I was sexually active, arguing that without the sexual experience, I would not be able to

grasp the concepts or the context. As I did not provide a definitive answer to his question, he stopped answering my questions, and I had to end the conversation. I had shelved this experience as an uncomfortable interview. However, two years after this incident, I found out that this doctor had been charged with raping a patient several years prior to our interview. Upon learning this, my interaction with him took on a different meaning, causing me to re-become through the past and the present. I would not have done this interview had I known about the past of this participant or would take further measures to ensure my safety. This is a clear indication of the vulnerability of researchers, as well as the illustration of the multiple layers of hierarchies and oppression that women encounter on a daily basis, both re-virginisers and non-re-virginisers alike. Even though I was not physically assaulted, the emotional harassment that was transmitted verbally, especially when contextualised, is a palpable reflection of the emotional trauma women undergo throughout the process of re-virginisation. The question posed by Dr Eren is an integral part of the discourse around virginity and women's bodies in Turkey, which made me less of an outsider in this context.

Building on Michael Herzfeld's "cultural intimacy" (Herzfeld [1997] 2016), Andrew Shryock argues that the "concept of intimacy internalizes and renders essential the presence of an outside observer whose disapproval matters, whose judgments can be predicted, and (most important of all) whose opinion is vital in determining what value 'common sociality' can have" (Shryock 2004, 10). In other words, intimacy is a performance of a subjectivity to an audience that does not belong to the intimate environment. The presence of this outside observer is materialised through the posting of the entries online, as well as the interactions between re-virginisers and other members of the forum who are critical of re-virginisation. As re-virginisers account for the "judgments [that] can be predicted", they construct their online subjectivity and their narratives according to the opinion of the audience as well, for the purposes of convincing "an external observer whose opinion is imagined *and imagined to matter*" (Shryock 2004, 11; emphasis in original). "Creating a narrative, as well as attending to one, is an active and constructive process—one that depends on both personal and cultural resources" (Mattingly and Garro 2000, 1), and in this case, it is constructed through the imagined opinion of the observer. This can be seen most vividly when we pay attention to the religious discourse women are using to make sense of their re-virginisation. Re-virginisers frequently refer to religious concepts such as "sin", "adultery" [*zina*], praying, and "gratitude" [*şükür*]. Many repeatedly stress that they are religious, and "God" [*Allah*] is referenced by almost every user. I contend that these references to religious concepts are far from establishing a causality between virginity and religion, and are instead a means through which women are trying to get closer to the non-virgin ideal, by emphasising their sense of guilt, and that they have made a mistake. Here is a quotation from a woman who is not a re-virginiser, but who is offering her comments on the subject matter.

> Friends, everyone can make a mistake, the important thing is to be aware of this mistake, this sin, to vow not to do it again [*tövbe etmek*], and not to do it again. A sin committed in the past is only between you and God. If you really regret what you have done, if you are ashamed of it every time you think about it, then God knows but you have been forgiven. You must not tell anyone [that you are not a virgin] in my opinion. (Thread 13, September 2014)

As this quotation shows, it is important that women display that they are feeling guilty and ashamed as a result of engaging in pre-marital sex. This display is the permission to have the right to re-virginisation, and paves the way to be accepted by the online re-virginisation community. This sense of belonging is important for women, as it does not have an offline counterpart. Therefore, women construct their online subjectivities in a way that will not be too deviant from the norms of the society pertaining to gender in general, and virginity in particular.

The borders of the threads and who is allowed to have a voice in the rooms are determined intersubjectively. Online spaces allow some narratives to be visible, while others are rendered invisible by pushing users out or pointing at inconsistencies across posts. As the discussion below will show as well, online intimate spaces also create a hierarchy among those who only read -who are also part of these spaces-, and who post on the threads. Those who are critical of re-virginisation are pushed out by re-virginisers and moderators. Re-virginisers tend to lay out their rationale for seeking an operation, but decide to ignore the critics' posts when the discussion does not lead anywhere. When ignoring them does not shut them down or push them out, moderators intervene. This intervention creates another relation of hierarchy, where moderators are above all those who engage with the forum.

The moderators, or 'security guards' of the forum intervene in the topics more often than not to set the tone of the topic, and to introduce their own view as well. On the one hand, they issue a warning to users who digress from the topic. In the case of re-virginisation, when the topic moves away from experiences to moral discussions, moderators take the stand to contain the topic. An example is, "Please share only if you have information regarding the topic. This section of the forum is for sharing knowledge and experience-it is not a space to discuss other dimensions of the topic" (Thread 20, January 2011). This act protects women's right to talk about re-virginisation in a safe space, without being judged for having pre-marital sexual relationships. However, as I have spoken to one of the moderators, who was a man, it is problematic that few men control the discussions among thousands of women. Some moderators also put forth their own opinions on the matter as the following excerpt exemplifies,

> The Earth would be much more liveable if everyone knew that only they are responsible for what they did, that both good and bad deeds are personal. They should know and remember the verse, "do not call each other by [offensive] nicknames" if they say that they are Muslims, thank Allah. Per the rule "Topics that turn into personal discussions are closed down", this topic has been closed to further comments. (Thread 13, September 2014)

Moderators' involvement is viewed differently by users. Some women call upon the moderators whenever a heated debate on moral values erupts, while others believe that they are wrongfully warned or suspended from the website by moderators. On the one hand, moderators continue to function as the guards to "discipline and punish" (Foucault [1975] 1995) the users, while at the same time 'looking out' for re-virginisers who have to put on their "virginal facade" (Ozyegin 2015) outside online forums. Women's bodies extend into online spaces especially when they cannot extend to other spaces.

Intimate Online Data

In order to witness the gendered intimacy interwoven in re-virginisation, I have analysed 7000 pages of posts from an online forum, which have been entered between 2010 and 2017. This data comprises of 47 different threads that have been started by re-virginising women and have been viewed approximately 700,000 times over this 7-year period. The selection of which threads to be studied has been based on re-virginisation being the central focus of the thread. Although the topic might come up in other threads as well, I have chosen to focus on the ones dedicated to one or more methods of re-virginisation. Through this decision, it has been possible to trace women's experiences of and opinions on re-virginisation on almost a daily basis, as well as reading the opinions of non-re-virginisers.

Throughout the thesis, I cite the posts of women who have posted on the forum without mentioning their username to protect their anonymity. However, nor do I assign them a pseudonym. This is because there are over 70 women whose posts I have included in this thesis. Assigning them each a pseudonym would make the thesis difficult to follow. Hence, I have chosen to assign pseudonyms only to people I have interviewed. However, I have cross-checked all of the online data I have included here, and in the few instances where I cite the same re-virginiser more than once, I note that in the text. Just like I do not provide the usernames, I do not provide the names of the threads either, to add another layer of anonymity. However, I have assigned a number to each thread, and have included that next to each citation, alongside the month and the year the post was published. As threads are varied in length, ranging from 1 page to 838 pages, some threads have been cited more than others, in particular, Thread 20 and Thread 43. However, this does not provide an uneven

portrayal of the data, as longer threads have had more user engagement, and covered a longer time-span than others.

In the analysis of the data, I have resorted to both phenomenology and post-structuralist discourse analysis, as I was interested in both "how people make meaning of their lived experience" (Starks and Trinidad 2007) and a feminist post-structuralist discourse analysis. Judith Baxter defines feminist post-structuralist discourse analysis as "a feminist approach to analysing the ways in which speakers negotiate their identities, relationships and positions in their world according to the ways in which they are located by competing yet interwoven discourses" (Baxter 2003, 1). One of the strengths of this approach, other than putting gender in the centre in the analysis is to "include *minority* voices alongside more official and openly recognised accounts in order to make space for voices that would otherwise be silenced" (Baxter 2008, 5; emphasis in original). This has been possible by choosing to code all data, rather than selectively or automatically doing so. In addition, by virtue of analysing re-virginisers' own narratives, I have accessed and studied non-official accounts.

In addition to the forum data, I have analysed ten websites, five of which are to advertise artificial hymens and related products, whereas the remaining five were built to advertise hymenoplasty by medical doctors. The artificial hymen websites are not a sample, but the population, as there are only so many artificial hymen websites. The medical websites have been selected based on their popularity, by feeding from the forum data. As websites contain information similar to each other, saturation has been reached at five websites. The images, informative texts, as well as doctor-patient dialogues, have been analysed using feminist post-structuralist discourse analysis.

Due to the proliferation of analysis of online data across different disciplines, the ethics of using these data are being discussed more than ever (Thomsen, Straubhaar, and Bolyard 1998; Varisco 2007; Wilson and Peterson 2002). One of the major concerns in terms of ethics of online data is whether this data is public or private (Wolfinger 2016). Scholars have suggested that most online data are neither, and lies in between, as well as discussing the difference between "publicly accessible" and "publicly distributed" data (Waskul and Douglass 1996). It has also been stressed that "understandably, 'internet communities' members do not expect to be research subjects" (Eysenbach and Till 2001, 1103). I argue that the private and public divide is again one that does not work due to the blurred lines in the online sphere, and amplified intimacy can continue to be the anchor for the researcher to decide how to treat which data.

King argues that what ethical guidelines should be followed when using online data should depend on "the constructs of Group Accessibility (the public/private nature of the actual cyberspace occupied by a group) and Perceived Privacy (the level of privacy that group

members assume they have)" (King 1996, 119). I have previously noted that all online data used in this study, including the forum posts and the websites created by medical doctors and artificial hymen retailers is publicly accessible without membership. The websites created for advertisement purposes are clearly not seeking privacy, as they are willing to disseminate more information about their services and products through the Internet. Many users on the online forum, on the other hand, make it clear that they are only willing to hear from fellow re-virginisers. Nevertheless, many also reiterate that they want more people to hear about re-virginisation for it to be normalised, while some try to talk women out of re-virginisation by using the forum as a means of communication. Members are also aware of the fact that many women seeking re-virginisation are too scared or embarrassed to post in the forum and to actively be involved in the discussions. Yet, as they do not have other means to access this information, they read the forum posts for years in some cases and learn about re-virginisation. Therefore, re-virginisers believe that they are symbols for encouragement. One user states,

> I will write about every change in my situation, so should you, because there are so many people who try to get information, who try to find answers to their questions without being a member. I was one of them as well. I would come here, read the posts, but would not ask anything because I was not a member. We are lucky if what we write benefits even one person. (Thread 43, April 2012)

As this quotation shows, members want to disseminate and 'publicly' distribute their experiences to reach wider audiences. Another user discusses how women are perceived as the 'second sex' in the society and states, "We are already starting life defeated, as a result of being born as girls. In our country, everything is put on women. Women's honour [*namus*], women's dignity [*şeref*], women's pride [*gurur*]-everything is put on women's shoulders. Irrespective of your level of education or your profession-you are part of this society [as a woman]. Let's unite! We can't help each other much individually" (Thread 20, June 2011). She suggests that forums are the means of being united as a front against gender inequality. These quotations explicitly show an alternative way that the users would like their posts to be used.

Trevisan and Reilly, in their research using online data by the disabled, argue that treating disabled people as vulnerable, and hence "being too cautious in the handling of this content [of online data] would have meant turning back to a disempowering 'experts know best' approach that does not represent the lived experiences of disabled people" (Trevisan and Reilly 2014, 1138). Supporting this argument, I treat the online data on re-virginisation with a similar approach. I contend that representing the lived experiences of re-virginisers is of utmost significance and that the online data offers one of the best means for this, even

though sex is considered a vulnerable or sensitive topic by most scholars. This does not mean that no precautions are taken to ensure confidentiality and anonymity. On the contrary, several layers of precautions have been taken. The first one is to not use the usernames of members. Even though they are not users' real names, using them would make it possible for the posts to be traced back to them easily. For the same purpose, posts including identifying data have been removed or replaced. Examples are dates of marriage and operation, as well as smaller cities where operations are performed. Finally, even though direct quotations are used throughout the thesis, all are translations, making it impossible for these quotations to be searched and traced back to the original post. Although translation means some data is lost on the way, such as typos, slang specific to certain groups or communities, or writing style that might give clues about one's level of education, this metadata can easily be traded for confidentiality. Furthermore, by going over the data numerous times, I have been able to integrate this metadata into my analysis. All data, online and from interviews, have been coded using Atlas.ti, based on the principles of grounded theory (Glaser and Strauss 2009), allowing the data to speak on its behalf. As a result, 330 codes were created. Relevant codes have later been merged into code groups to make analysis easier.

Interviewing up: Medical Doctors and Beyond

One of the main challenges in this research has been access to and the nature of the interviews with medical doctors. On the one hand, I was interested in understanding the market of the surgery as a service, on the other hand, I was curious to find out how the institution of medicine defines virginity and operates, both literally and figuratively, within this framework. Overall, I interviewed 30 participants working at medical institutions. Of these, 28 interviews have been carried out face-to-face in the three biggest cities in Turkey, which are Istanbul, Ankara, and Izmir. The remaining two interviews have been conducted over the phone with doctors in Kayseri and Gaziantep, the former being a city in central Turkey, while the latter is one of the biggest cities in South-eastern Turkey. The decision to hold the majority of the interviews in the three biggest cities has been informed by the discussions in online communities. As women prefer to travel to bigger cities for the operations in order to not run into an acquaintance at the clinic or hospital, these three cities have proved to be the hubs of medical tourism for re-virginisation.

Of the 30 interviews, 22 have been conducted with medical doctors. A breakdown of areas of specialty, gender, and cities where doctors work can be found in Appendix 1. 20 of these doctors are either gynaecologists or plastic surgeons, as these specialists are considered as the experts in hymenoplasty. The remaining 8 interviews were conducted with assisting personnel in the medical settings, nurses and secretaries in particular. Most women seeking re-virginisation do not visit the doctor prior to the operation, as they do not want their

families and friends to find out about the situation. Therefore, they speak many times on the phone prior to going to the doctor for hymenoplasty. These phone conversations happen mostly with doctors' secretaries, who frequently take on the role of a counsellor, trying to calm women down, as well as informing them of the procedures. The interviews with the assisting medical staff have therefore played an important part in my research to draw a picture of the first interaction of a re-virginiser with the medical setting.

Doctors are well respected in many communities across countries as gatekeepers of the institution of medicine, with their access to and the possibility to offer medical expertise to which outsiders cannot traditionally access. Although the Internet has played a significant role in undermining this authority, I contend that it has rendered doctors even fiercer in their gate-keeping in order to protect their authority. Medical doctors have historically been associated with the modernisation process in late Ottoman Empire and then the Republic of Turkey, and played the role of the moderniser in the transition period (Dole 2012). "Like Atatürk, they believed that Turkish society should be modernized by adopting modern, Western scientific and technological developments, as well as the European political system and social institutions. Therefore, they internalized the task of solving not only the medical, but also the social problems of the population" (Terzioglu 2008, 6). Although the role of medical doctors in society has changed, as their socioeconomic backgrounds have become more diverse, many doctors continue to see it their task to modernise the society, especially through their interaction with patients, as they see themselves as having the most accurate, science-based knowledge (Terzioglu 2008, 7).

With this assigned and internalised role that puts doctors at a higher position within the hierarchy of professions, interviewing doctors has become a challenge in my research. Even before the interview, the process of reaching the doctor is arduous. Unless one has a common acquaintance, most doctors prefer not to interact with researchers. This is true especially for those in the private sector, as they might perceive the time they take to answer a researcher's questions as the time that could be spared for patients and earn them money. It is typical that a doctor will not reply to e-mails, and that secretaries or assistants will not let the researcher speak to them on the phone. I overcame this challenge using multiple means. One way was to use doctors and researchers I knew as referrals to contact other doctors. This was not always snowballing, as doctors I personally knew were sometimes in fields other than gynaecology or plastic surgery, but they referred me to their colleagues in those fields. Another tactic I used was the method many re-virginisers use. WhatsApp is now quite popular for doctor-re-virginiser interaction for women who have had hymenoplasty to contact their doctors about their doubts that they might not bleed at the nuptial night, and about post-operative complications. Some doctors are quite responsive to these messages, as

a result of which I was able to reach out to a few of them through WhatsApp. In addition, there were some doctors who did respond to e-mails or who returned calls even without any common acquaintances. These doctors were mostly known for performing hymenoplasty through their websites and advertised their services especially via Google, where I reached their contact details.

After accessing them, I found out that the interview process for many doctors is expected to be threatening. Carpenter states that "almost by definition, researchers enjoy a position of power vis-à-vis the people whose lives they study. They decide which issues should be studied and determine what information is to be revealed, when, and by whom" (Carpenter 2005, 210). However, this power imbalance does not necessarily apply to all participants in a study. As a result of their historically constructed position in society, doctors are used to being the authoritative figure in their interactions with other people, especially in ones that occur in their clinic. Hence, they feel vulnerable when they are being interviewed. For many, it is not common to be answering questions that make them evaluate their profession, or critically analyse what they deem to be the norm. Of course, there are different variables that define and shape the relationship between the doctor and the researcher. Two contrasting examples in terms of spatiality will draw a vivid picture of my argument. On one occasion, when I was interviewing a female doctor, aged 33, at a public hospital, she offered me her own seat behind her desk and sat at one of the chairs placed for the patients (Dr Çiğdem, Istanbul, January 2017, personal interview). This meant that she accepted her position as the interviewee, sitting at a physically lower level than me, and answering questions open-heartedly. The contrasting example is with a male doctor at his private clinic, in his 50s (Dr Levent, Istanbul, March 2017, personal interview). He sat at his own desk, situated at a much higher level than the chair that I was not offered but sat on anyways. This interviewee, feeling threatened by being questioned, tried to assume the role of the interviewer himself. He changed the position of the voice recorder without asking me, as if to take control of the situation, and suggested that I design my whole research different from what he assumed I was researching. Although these are two extremes, I can easily say that the positive end of the spectrum, in which I was literally elevated as a researcher is the exception. The variables that have played a role in the difference between these two examples are gender, age, and workplace, among others. As these examples support, it is more likely for a female, young doctor working at a public hospital to be open to being interviewed, although both interviewees voluntarily participated in my research.

As a result of the assumed hierarchy between the researcher and the doctor, interviewing doctors is also a challenge in the temporal dimension. This seems to be the case frequently when researching up (for detailed analyses on the difficulties of researching up, see

Gaztambide-Fernández and Howard 2012; Gaztambide-Fernández 2015; Aguiar 2016; Cerón-Anaya 2019). The schedule of the researcher is usually disregarded, interviewees find it reasonable to ask for the interviewer to be at his clinic minutes after the first phone conversation, and make the researcher wait for several hours. Judging from the researcher-doctor dynamics, it is not difficult to say that re-virginising women may feel powerless in their interaction with doctors as well.

A similar story can be told about artificial hymen retailers, with whom I have conducted four interviews over the phone. Although there are seemingly more brands, interviews and thorough analysis has shown that companies play in the market with multiple brands, which will be discussed in Chapter 4. I have also talked to customer representatives through online chats at four websites, in order to understand how they treat potential customers. The most common denominator in these exchanges was how the retailers saw me. Even when I insisted on my role as a researcher, they assumed that I was pretending to be a researcher with my real intention being to buy an artificial hymen, which could also be heard in their tone of voice. Furthermore, in different instances, I insisted on being told the ingredients of the product as one could be allergic to them. One representative told me to "ask logical questions" (Yaprak Kozmetik, February 2017, online chat). I was mostly denied detailed information and felt like I was treated as a person of lesser value.[18]

Conclusion

Researching a topic that is both part of my everyday life and very distinct from me has come with its challenges, as this chapter has illustrated. On the one hand, my identity as a female researcher who has been brought up in Turkey within the expectation of the "virginal facade" kept this research close to my heart. Constant news about emotional, physical, and sexual abuse of women, as well as femicides have made it even more difficult to research the topic. At the same time, I felt distant from re-virginisers as I had not met any in my immediate circle before starting this research. Throughout my fieldwork, I felt like I played many different roles in different settings. Therefore, unlike a single-site ethnography, or conducting interviews only, employing multiple methods have made me switch from role to role throughout. This multiple role assumption is unique in the fluidity it gave me, as well as the pressures it put on me. I believe that this has made me empathise with re-virginisers even more, as they assume different roles as their life unfolds in unique ways as well.

In this chapter, I provided an account of my interactions in the field through the concepts of intimacy and *mahremiyet*. I have suggested to bring in intimacy to eradicate the private/public dichotomy, as this binary thinking does not allow space to explain why re-

[18] I go into more detail of my interaction with this retailer in the next chapter.

virginisers abstained from talking to me in 'private' but preferred to discuss their experiences 'publicly' online. I have introduced *mahremiyet* particularly to contextualise intimacy and the gendered construct thereof. Through *mahremiyet* and its relationship with secrecy, it has been possible to understand what is hidden and what is forbidden, and hence what needs to be researched as a result of being *mahrem*.

Before turning to an analysis of the legal and liminal framework within which re-virginisation operates, I will present a vignette from inside the operating room. This section will bring together many of the aspects that this thesis unpacks in a nutshell.

Inside the Operating Room

- *How many times did you have sex?*
- *In a way that would generate bleeding again…*
- *Did you understand?*
- *I can't say 100% that it will bleed because it's big.*
- *This one doesn't look like a big tear, but the one over here…*
- *It's a little bit elastic in structure.*
- *We'll bring them together, to generate bleeding again.*
    - *I sometimes have pain, could it be because of this?*
    - *No.*
- *Let's prepare her.*
    - *Will I be in pain or something like that?*

It's relatively early in the morning. I'm waiting in the reception area of the clinic, next to a woman in her 50s, and a man slightly older. The man looks deep in thought, hasn't shaved, does not lift his head up. One can easily overhear the conversation the doctor is having with a woman, whom I will call Ayşe, who is there for hymenoplasty. I wonder how much they care for privacy and confidentiality. I also wonder why how many times she had sex matters, and why the doctor is addressing her with *sen* (informal you) rather than *siz* (formal you). I now want to know if the doctor understands her, as much as he wants her to understand him.

The doctor calls me in, for our interview, and before I get a chance to ask anything, he asks me if I'd like to observe the operation. I feel excited and uncomfortable, nervous and curious, puzzled and lucky. I ask if the woman to be operated on has consented to it. He says he'll ask. I wait outside as they prepare her for the operation. I find out that the woman at the reception is her aunt, and the man is her father. The 'patient', as she is now referred to as, doesn't mind having me there, as long as there are "no names and no pictures" [*isim yok resim yok*]. The aunt is not happy that she has to step out while I step in. I step in, and introduce myself and my research to the patient, and ask again if she'd consent to me being there. She says she does, but she doesn't want to come face to face with me. I stand behind a wooden folding screen near the door. I can see the spread of her legs, the hair on her legs, the doctor moving around towards and away from her legs, and his assistant/secretary standing by the legs. We all have legs, but hers seem to get the most attention for the next 20 minutes or so.

She only gets local anaesthesia, so we start chatting about what brought her here. She jumps between her educational and sexual history. “I dropped out of high school”, she says, “My older brother did this to me”. I ask her how she found out about hymenoplasty. She replies, “I looked this up online, someone wanted to marry me, and I didn’t want to. And then I got engaged [to someone else], I looked it [hymenoplasty] up, I read the reviews [on the doctor’s website]. They were all positive”. I ask her if she has received any professional help regarding the sexual trauma she experienced. She says, “I applied to see a psychologist, no one called me in. I got a job, I went to a boarding course on the Quran. My mum has always been by my side, I don’t need a psychologist. I’m so grateful to have such a family”. She shares with me that she hasn’t told her fiancé about the rape, but told only a friend. The doctor gets suspicious, “What if she tells [other people]?”, he asks. “She did everything she could for me. I fully trust her”. The doctor is not fully satisfied, “You could tell her, ‘we went [to the doctor], they looked at it, they didn’t do anything [it wasn’t necessary]’”.

I ask her who else knows that she has been raped. Her two uncles and sister, apart from her parents. One uncle has paid half of the cost of the operation. The father, the other half. This is unusual, I feel slightly happy for her, as she is financially and emotionally supported. The doctor intervenes to say that they sometimes operate on women for free if they believe they are psychologically in a bad place. I wonder who could be in a good place if they feel the need to re-virginise. And I remember how women feel the need to act out as vulnerable for a doctor to operate on them even when it is the women who are paying this high cost. Without skipping a beat, the doctor asks if she’ll write a good review for him. She agrees to. I wonder what would happen if she didn’t, her legs spread, the doctor operating on her, she can’t move, she can’t see what’s going on in her body. I re-think choice, I re-think medical authority, I re-think vulnerability.

We go back to talking about the ‘incident’, the rape. She says that she attempted suicide, that she wanted to die. “How will I tell my family, what if they don’t believe me?”-her thoughts that led to wanting to die. As if digging a wound, and thinking that he is helping me, the doctor asks, “Did you feel stained?”-“Yes”-“Did you feel worthless?”-“Yes”. I feel shocked at the doctor’s choice of words. Is she expected to feel stained or worthless, I silently ask myself. Even if she didn’t think she should, now she does. “My mother warned me against him, she told me to not trust him. We have the same dad, but different mothers. He used to live in a village. He is from my dad’s previous wife. He came to live with us when his mother died”. The doctor asks what happened to him. She explains further, “My mum kicked him out of the house, she said we should sue him. I have a fiancé, I said, let God punish him”. I think about silence. I wonder what God did to him.

I ask her how she expects to feel following the operation. She says, “I can’t feel better psychologically after getting this done”. I think about the journal articles I’ve read, I think about doctors’ narratives about how they are healing their patients emotionally through re-virginisation. I wonder how much they talk to them and how much they try to understand what they are going through. She tells me how she was scared about the operation before, and how the assistant she talked to on the phone relieved her. They have talked on the phone three times before she came to the clinic today. She says she is like family now. I wonder what family means; the family that supports, the family that rapes…

As the operation comes to an end, the doctor explains to her what she can and cannot do, how she can and cannot move her body over the next month. She is prescribed three types of medication; antibiotics, some cream, and painkillers. I realise that nobody is wearing scrubs or anything sterile in the room. We are in our daily clothes, we can just move on with our lives as if it’s just another day. She can shower now, but cannot shower for the next three days. I ask her where she is headed now. She says, “home, I will rest”. I wonder what home is, where home is. Home is where she was raped. Home is where she will be recovering having technically and hopefully undone the rape.

…

I interview the doctor afterwards. We talk about the operation. He says, “I think that she wanted it a bit too”. He says, “We understand, from the way a patient speaks, whether she has been forced into it or not”. He says, “I asked the patient if she was comfortable, she laughed as she responded”. I wonder if he is aware of what he is saying. I wonder what it means to be a patient, to be a woman. I wonder if they want us uncomfortable, I wonder if they want us never laughing, I wonder what a woman should do, say, how a woman should sit, speak, behave to make someone believe that she has been raped. I remember the discomfort on the father’s face, I wonder if the doctor could or would believe the young woman, in her late teens, if he saw what I saw.

…

On my way out, I am satisfied, I am exhilarated. This is a milestone for my research! I immediately feel uncomfortable, it is a different milestone for the woman I interviewed. I wonder if she thinks of me as much as I think of her. I wonder what she would think if she heard what the doctor said about her. I wonder what the doctor is saying to his assistant about me now. I think about how different we are, I think about how similar we are. I wonder, I wonder, I wonder…

4. The Liminal and Legal Economy of Secrets and Silence: The Murky Waters of Re-Virginisation

> *I don't understand why hymenoplasty is not banned. How can it be ethical to deceive a person, even worse, to deceive a person for life, and to build a marriage on a lie? What's gonna happen? Will you be happy when on that night you moan a bit more, when you bleed, when your husband believes it [that you are a virgin]? How will you look at his face? This man will call you "the mother of my children", will you not blush then? What I'm most surprised about is that when you write these things, you've written, "I hope my husband won't understand, may God help me", do you think someone with a fear of God in them would do this? Do you console yourselves by thinking that you will pray a bit more, make a pilgrimage, sacrifice an animal, and you will be forgiven? Hymenoplasty should be banned.*
>
> Critic of re-virginisation, published online (Thread 43, June 2013)

> *I don't think they will ban it [hymenoplasty]. If they do, doctors will remove it from their websites, but they will still do it. That will be the only difference.*
>
> Re-virginiser, published online (Thread 43, November 2012)

In the Prologue to *Defacement: Public Secrecy and the Labor of the Negative*, Michael Taussig asks, "Yet what if the truth is not so much a secret as a *public secret*, as is the case with most important knowledge, *knowing what not to know*?" (Taussig 1999, 2; emphasis in original). Re-virginisation is imbued with knowing and not knowing, forming different truths and deciding whether to talk about a 'truth' or silencing it. As we will see below, many truths are formed between the doctor and the law, among doctors, as well as within the nation-state and the family. Taussig defines a public secret as the "reconfiguration of repression in which depth becomes surface so as to remain depth, (…) which, in another version, can be defined as *that which is generally known, but cannot be articulated*" (Taussig 1999, 5; emphasis in original). As we will see below, re-virginisation is a "public secret" in the sense that the law and politics, as well as practitioners of re-virginisation, choose to ignore it. It has an absent presence, it is not spoken about in offline public spaces, and it escapes laws and regulations. Taussig also gives power to that which cannot be said, as he argues, "knowing it is essential to its power, equal to the denial. Not being able to say anything is likewise testimony to its power" (Taussig 1999, 6). Re-virginisation as an act of resistance and service to the perpetuation of the myth of virginity becomes more powerful as we continue to ignore it. It becomes more pervasive without us realising it, strengthens gender inequalities silently. It

seemingly resides between the unseen walls of clinics, yet reaches the capillaries of society and perpetuates the myths around virginity without saying it out loud. However, it is possible to add to this definition not only those that cannot be articulated but also those that are reframed and rephrased in different forms. Truths become "public secrets" both in the lack of articulation and through articulation, and grow more powerful through both. How they are articulated is temporospatially and intersubjectively determined.

In this chapter, I will journey through legality and illegality through two areas. The first one is how the law, to aid the nationalist and neo-conservatist discourses of the state, ignores re-virginisation, keeping it a "public secret". I will unpack the loopholes in current legal arrangements both in Turkey and internationally that allow space for re-virginisation without acknowledging it. The second area will be how medical doctors relate to hymenoplasty by regarding it as an operation that must not be spoken of, and framing it as a "medical crime", in addition to dissecting how artificial hymen retailers distance themselves from the product that they are selling.

From *Letting Marry* to *Disallowing Marriage without Virginity*

In the Introduction, I explored the debate between tradition and modernity in relation to virginity examinations and re-virginisation. As there are many different definitions of what being 'modern' entails, I find it important here to outline how I frame this concept. Here, I take Zygmunt Bauman's conceptualization of "liquid modernity" as the foundation of what modern means. Bauman states,

> To "be modern" means to modernise – compulsively, obsessively; not so much just "to be", let alone to keep its identity intact, but forever "becoming", avoiding completion, staying underdefined. Each new structure which replaces the previous one as soon as it is declared old-fashioned and past its use-by date is only another momentary settlement – acknowledged as temporary and "until further notice". Being always, at any stage and at all times, "post-something" is also an undetachable feature of modernity. [...] What was some time ago dubbed (erroneously) "post-modernity" and what I've chosen to call, more to the point, "liquid modernity", is the growing conviction that change is the only permanence, and uncertainty the only certainty. A hundred years ago "to be modern" meant to chase "the final state of perfection" -- now it means an infinity of improvement, with no "final state" in sight and none desired. (Bauman 2012, viii–ix)

This way of conceptualising modernity points at the necessity of changing one's body and behaviour in relation to what is expected from oneself especially when read from a gender perspective. Nation-states, which are also liquid as modern institutions, present ideal ways

of being and behaving for women, and expect women to mould themselves into this model. However, at the same time, what the nation-state demands from women to prove virginity is also changing. Epitomised with the criminalisation of virginity examinations, the Turkish state has become less interested in a woman having an intact hymen than a woman sustaining her ideal-typical family model by proving virginity through other means. This underlines the reason why re-virginisation is neither illegal nor recognised in Turkey. By neglecting its existence, the state silently encourages re-virginisation as re-virginisation ensures the continuation of the family unit. Hence, the state has moved away from women's body to outside markers, from the hymen to the blood in proving virginity, as it is on the one hand adapting to the changes in the modern woman, and on the other, has seen that ultimately, it is not the intact hymen that is necessary to keep the neo-conservative ideals going, but what signals its existence.

In addition to the further and constant modernisation of women, I contend that the state as a modern institution is also in constant flux, especially in relation to the liquidity of what the modern woman ideal in Turkey entails. As a result of the increase in the percentage of women who engage in pre-marital sexual experiences,[19] which would lead to 'non-virgin brides' in the absence of re-virginisation, the nation-state allows practices of re-virginisation to continue. As the family is regarded as the smallest social unit that also fuels the nation, it becomes fundamental to adjust the nation-state's focus according to the changes in the modern woman. Even though all regulations over women's bodies can be said to be biopolitical, the shift from exercising virginity examinations to allowing re-virginisation to take place displays a shift in the exercise of power by the nation-state in Turkey. Applying the relationship between power and life and death, to virginity and marriage makes this shift clearer. Michel Foucault, in his discussion on the transition from sovereign power to biopower, suggests that the sovereign power held "the right to *take* life or *let* live (…) Power in this instance was essentially a right of seizure: of things, time, bodies, and ultimately life itself; it culminated in the privilege to seize hold of life in order to suppress it" (Foucault 1978, 136; emphasis in original). However, this power later shifts, and "the ancient right to take life or let live was replaced by a power to foster life or disallow it to the point of death" (Foucault 1978, 138). In a similar vein, previously, the state held the power to take away marriage from the woman or to let her marry. Virginity examinations *determined* whether a woman was marriageable or not, and the authority to determine this was the state, by commanding that the examination take place, or by delegating the authority for this command to other institutions such as schools. The medical institution was the ally of the

[19] Although there are no quantitative studies on this matter, the interviews I have conducted with medical doctors, artificial hymen retailers, and people who have shared their views on virginity and re-virginisation support this point.

state in the exercising of this form of power. However, the state had to let go of this sovereign power as a result of the pressures from civil society following the suicides committed by young girls forced to undergo a virginity examination, and as a result of the liquidity of the modern woman. Nevertheless, this did not mean that the state would let go of all control over women's sexuality and marriage. Instead of establishing authority by looking at the vagina and determining a woman's marriageability, the state shifted to fostering the body to disallow marriage without technical virginity, be it regained or not.

The role of the law here is more complicated than Foucault's suggestion. He argues that "the law operates more and more as a norm, and that the judicial institution is increasingly incorporated into a continuum of apparatuses (medical, administrative, and so on) whose functions are for the most part regulatory" (Foucault 1978, 144). Instead of the law being the norm in re-virginisation, it is the lack of it that perpetuates the existence of the norm of virginity. Hence, in this case, the law intentionally does not regulate the body so that it can regulate marriage. Nükhet Sirman talks about "the happy family and its secrets" (Sirman 2008, 239) and how this connects to the secrets within the nation-state. Re-virginisation becomes a secret that is not even shared in the family, it is a potential secret. As more and more men learn about re-virginisation, they suspect that their wives might have re-virginised, yet prefer to ignore this potential secret. A re-virginiser's ex-partner states, "I would prefer that you re-virginise than know that you've been with another man" (Thread 20, December 2012). Hence, the possibility that the wife might have re-virginised remains a secret. Similarly, the nation-state ignores re-virginisation through not recognising it as neither a legal nor illegal practice, and thus renders it a "public secret" (Taussig 1999) while simultaneously allowing it space to be practiced. As a result, re-virginisation becomes a "normalisation technology" (Mutlu 2018) that makes families. Burcu Mutlu develops this concept as she argues that having babies through egg or sperm donation, "as long as it is kept as a secret, is a normalisation technology that reproduces the heteronormative family ideal, rather than turning social norms and values upside down" (Mutlu 2018, 161). Similarly, re-virginisation is a "normalisation technology" in that it maintains the continuation of the family unit as long as it remains a secret.

Within this context, the display of virginity becomes more important than virginity itself, which allows the continuation of what is accepted to be the smallest social unit. By actively neglecting re-virginisation, the state passively accepts women's sexualisation before marriage. To go back to Rodrigues' words, "as a 'between' space, the vagina is also biopolitical by location: it firmly straddles the boundary between the erotic body and the reproductive body" (Rodrigues 2012, 782). In nation-states where re-virginisation is unlawful, such as in Iran, the government does not accept the existence of the erotic body.

The woman's body, in this case, can only serve reproductive purposes, and it is believed that this can be achieved through the de-sexualisation of the woman's body outside of marriage. This is not the case in Turkey. On the contrary, the Turkish state accepts the pre-maritally sexualised body as long as it can transcend into the reproductive body. Even though the official discourse might not support this claim, the institutional non-action does. Furthermore, this shift in the focus does not necessarily 'liberate' the woman. In many ways, it brings about a further grip on the woman's body, subtly managed by the state, but delegated to the self. However, it also displays the shift from sovereign to biopolitical control over women's bodies.

Legal Economy of Secrets and Secrecy

Unlike many other countries in the Middle East, there are no laws prohibiting re-virginisation in Turkey. Despite re-virginisation being legally allowed in Turkey, not only is it kept as a secret in public discussions, but also as a secret between doctors in terms of who practices it and who does not. Of course, there are many doctors who openly advertise their re-virginisation services online -the 'popular' doctors in the field of hymenoplasty. However, these constitute only a small fraction of the doctors who perform hymenoplasty. Many doctors do not vocalise that they conduct these operations for fear that they will be criticised or condemned. A professor I have interviewed who teaches at a public university and sees patients at his private clinic, occasionally performs hymenoplasty. He claims to operate on only those women who "suffer from heartache". For him, openly saying that one conducts hymenoplasty is even more demeaning than conducting the operation itself.

> Hande: Why don't you advertise [hymenoplasty]?
>
> Dr Mehmet: You cannot deal with it [too many requests]. I also don't think it's good to be known for that. My main job is not this. I advertise what I do, what I academically work on. I do operations that have a certain characteristic. Hymenoplasty has no characteristic. But it is necessary to respect the people who do this job too. This man does only this, and probably does it better than me. But he writes about it openly. What I find awkward is when a professor or an academic puts there [on their website] that they conduct hymenoplasty. It is ridiculous. It is not your target audience, nor your target job. It's nonsense.
>
> Hande: Does it not suit a professor?
>
> Dr Mehmet: Actually a professor can do it, it's a different thing, but I don't know. There are so many special things you can do that you wouldn't deal with this. It's funny. Hymenoplasty is such an ordinary surgery, it has a social significance, but as an operation, meh. Whoever wants to do it should do it, but then why get that

> title [of professorship]? That's why there are people who shock me. There are actually some academics who still put hymenoplasty on their websites. I embarrassed one [doctor] really badly, they didn't see it coming. I told him, if you teach so much, then you should remove it [hymenoplasty] from your website. A young professor, I recently told him that. What the heck is that? You say that you're doing cancer operations, and then there is hymenoplasty next to cancer operations on your website. Ugh! [*Yuh!*] [exasperated response signalling anger and disbelief] (Dr Mehmet, Istanbul, December 2016, personal interview)

As this conversation illustrates, hymenoplasty is seen as a demeaning operation not only for women but also for doctors. For many or most of the doctors, stating that one conducts hymenoplasty is a sure way to lose prestige. Therefore, most doctors prefer to keep it as a secret that they are active in this field and rely on word of mouth to attract clients. The importance given to prestige also causes some doctors to entirely stay away from hymenoplasty, not only in terms of not conducting it or not vocalising that they do but also in terms of not referring clients to doctors who do.

> Dr Emre: But, of course, I do not forward them [women asking for referrals for hymenoplasty] much. It's a thing, a bad thing both for our career and our prestige. Maybe you know it, there are some centres like that, which you can access via the Internet for abortion and hymenoplasty. Every now and then these places are raided, investigations are opened. In these investigation files, here and there, academics don't want their names to appear. That's why we don't know many [doctors who conduct hymenoplasty]. We don't refer [patients], we don't pave the way. We don't show the way to these centres.
>
> Hande: Do you talk about hymenoplasty with colleagues?
>
> Dr Emre: No, we don't. It's not a taboo, but it's more than abortion, hymenoplasty is, I don't know, more pejorative than abortion, or something like that, in terms of prestige. Gynaecologists see it as a *crime*. (Dr Emre, Kayseri, February 2017, phone interview; emphasis added)

The centres that Dr Emre is referring to are those clinics where abortion is carried out on women who have passed the legal threshold of 10 weeks of pregnancy. For him, and for many others, hymenoplasty, despite not being illegal, is more of a crime than the legally criminal act of performing abortion beyond the legal threshold. Therefore, hymenoplasty sits in this grey area, in a liminal, in-between space, where it is not a crime, but is regarded as such; where it can be vocalised but is actively silenced; where doctors do not need to keep it as a secret but are forced to do so. Ahmadi argues that re-virginisers are "liminal, socially

ambiguous beings, threatening the stability of the prevailing Iranian social order" (Ahmadi 2017, 145). The same argument can be made for re-virginisers in Turkey as well. However, I argue that it is not only women who resort to re-virginisation who pose such a challenge to society. Medical doctors are liminal, medically ambiguous beings that threaten the social order in Turkey. They are perceived as such by way of creating the opportunity for re-virginisation while keeping it silent in most cases. For this reason, some of the 'popular' doctors I have interviewed have stated that they receive death threats for conducting hymenoplasty and that they fear for their lives.

Another grey area in relation to hymenoplasty is virginity testing. Virginity testing, i.e. examination of the hymen is illegal in Turkey unless there is a court order demanding one. Article 287 of the Penal Code of Turkey, which has entered into force in 2005, regulates under which conditions a genital examination can and cannot be performed:

> (1) Where a person conducts a genital examination or dispatches a person for such, without a decision of an authorized judge or prosecutor, shall be sentenced to a penalty of imprisonment for a term of three months to one year.
>
> (2) The provision of the aforementioned paragraph shall not apply for examinations that have been carried out in compliance with the provisions of law or decree which are designed to protect the public from contagious disease. (Lewik n.d.)

This article has many loopholes and problematic areas in terms of what is allowed in relation to genital examination. Within this code, it is not only virginity testing but also any type of genital examination that is prohibited unless there is a decision by a judge or a prosecutor, or the risk of contagious disease. In other words, any regular genital examination, or examination for any genital cosmetic surgery would also theoretically be prohibited. Of course, this is not how the law is practiced. However, the article itself creates an in-between area regarding genital examination in general. Even though virginity testing is regarded as illegal within this framework in practice, the over-encompassing nature of the article makes it possible for the test to fall in the grey zone as well.

The United Nations Human Rights Office, in collaboration with the World Health Organisation has issued an interagency statement regarding virginity testing. The statement suggests that "health care professionals must never perform or recommend virginity testing" (WHO n.d.-b), including under investigations of sexual assault, as "the examination is likely to cause pain and mimic the original act of sexual violence, leading to re-experience, re-traumatization and re-victimization" (World Health Organization, United Nations Human Rights Office of the High Commissioner, and UN Women 2018, 7). It is also stated

that "in many situations, it is performed without the consent of the victim, thus constituting a form of sexual violence; by standards of international legal jurisprudence, this could amount to rape or torture, depending on the context" (World Health Organization, United Nations Human Rights Office of the High Commissioner, and UN Women 2018, 7). However, the statement does not refer to hymenoplasty, which is being neglected by the UN and WHO overall. As a result, the 'need' for virginity testing in order to determine if there is a 'need' for hymenoplasty goes unnoticed. As discussed in the previous chapter, the WHO has made many statements regarding female genital cutting, on the other hand, which is defined as follows: "Female genital mutilation (FGM) comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons" (WHO n.d.-a). This definition not only includes clitoridectomy, which is what female genital cutting[20] is assumed to be by mainstream media and by WHO's actions fighting FGM, but also all kinds of female genital surgery, including hymenoplasty. Therefore, in theory, hymenoplasty is seen as a "human rights violation" (WHO n.d.-a) based on the definition of the WHO in relation to FGM, and so is virginity testing. Nevertheless, hymenoplasty is still not spoken of, and hence put in a grey area where it is theoretically seen as a violation of human rights in many ways, yet because of the silence regarding it, it finds itself a comfortable seat where it becomes untouchable, and immune from any national or international regulation in the Turkish context. I do not argue that recognising hymenoplasty as a human rights violation would be a viable or practical solution for women, however it is highly curious that it remains as a "public secret" for the WHO as well, which gives further power to the practice and the discourses surrounding it.

Protecting the Prestige

Within this safe and untouchable space in the midst of smoke but not fire from different sources, virginity testing takes place so that hymenoplasty can as well. Gynaecologists are aware that virginity testing is illegal under the terms stated above. However, they perform it for hymenoplasty, as without virginity testing, it would not be possible to determine whether an operation is required, and which parts of the hymen have been 'ruptured'. Nevertheless, doctors do not acknowledge that this constitutes virginity testing as well.

> Dr Levent: We don't do virginity testing, we don't do *just* virginity testing. As far as I know, you need permission from the prosecution office, and it's conducted by forensic medicine institutes.

[20] Following other scholars (cf. Gruenbaum 2005), I use the term "female genital cutting" as opposed to "female genital mutilation" to underline that I am against the Orientalisation and exoticisation of this practice, which is fed by WHO's definitions provided above.

Hande: What happens when the woman wants to see for herself, for instance, what if I…

Dr Levent: If she says she wants to [have a virginity test], I don't do those. Virginity tests are problematic.

Hande: Does she need to say that she is here for hymenoplasty?

Dr Levent: Well, if the hymen is gone, hymenoplasty can be done under the conditions I mentioned, but just the virginity test itself, it has to be legally only under ermm, under forensics.

Hande: But if someone comes in for hymenoplasty, you will have to check her [hymen]?

Dr Levent: Yeah, correct, we check it then, we check it then and there's no problem with doing that and sometimes it [hymenoplasty] is not needed. Sometimes the hymen is still there and we tell [the woman] that it [hymenoplasty] is not needed. Not every bleeding means that the hymen is ruptured.

Hande: But that's also a virginity test.

Dr Levent: It is, but we don't perform it under virginity testing. Coming in just for an examination, for virginity testing, that's a bit problematic, legally problematic. It's problematic for you [the woman] too. You can experience problems. That's why I don't do virginity testing in my clinic. (Dr Levent, Istanbul, March 2017, personal interview; emphasis added)

As seen in the example above, doctors do not want to be regarded as virginity testers, however without a virginity test, hymenoplasty is not possible. Therefore, by way of including a virginity test, hymenoplasty is touching the murky waters of illegality. Doctors who do and do not openly advertise their service of hymenoplasty, however, distance themselves from this concept in order to protect their prestige. Here, it is possible to draw attention to a similarity between re-virginisers who are part of online communities, and doctors who advertise their hymenoplasty services online. Both groups are outliers in their communities; re-virginisers are outliers for having had pre-marital sex, doctors are outliers for performing re-virginisation. Furthermore, both groups create a new subjectivity in order to be 'the lesser evil'. Re-virginisers do this by suggesting that they are not promiscuous, whereas doctors do this by distancing themselves from virginity testing and by employing screening processes to women who reach out to them for hymenoplasty, which will be discussed in Chapter 7. In a similar vein, many men fear becoming an outlier if they marry a

woman who has had sex before marriage, especially with someone other than themselves. It is more acceptable for a man to marry a woman who has had her first sexual experience with him even if it has taken place before marriage, than a man marrying a woman who has had sex with one or more men before. As will be discussed in Chapter 5, these women are regarded as 'second-hand', 'punctured', and 'faulty'. It is important for a man to not marry such a woman in order to not be an outlier himself. Of course, this is not the case for all men, and more and more men are challenging patriarchal gender norms (Inhorn 2012; Ozyegin 2015) and becoming feminists. However, the fear of being an outlier, that many men possess, feeds the demand for re-virginisation.

How doctors use technology within the realm of re-virginisation is another indication of how they relate to prestige with regard to hymenoplasty. The NHS, UK's National Health Service, defines colposcopy as "a simple procedure used to look at the cervix, the lower part of the womb at the top of the vagina. It's often done if cervical screening finds abnormal cells in your cervix" (NHS 2017). During colposcopy, a special microscope called a colposcope is used to illuminate and magnify these cells to detect cervical cancer. This technology has been used in cases of sexual assault (Hobbs and Wynne 1996) by doctors. However, my fieldwork has shown that it is being used in cases where no assault has taken place and when the woman wants her hymen to be examined. Therefore, there is a translation of technology according to societal needs in this circumstance. However, the doctors that I have interviewed who used this technology for hymen examination for hymenoplasty (not necessarily in cases of rape) openly expressed their uneasiness with the translation of this technology. Diagnosing cervical cancer is a medical mission that doctors are proud of undertaking, whereas detecting hymeneal ruptures is not, as Dr Mehmet has maintained above. Therefore, the translation of the colposcope into a *hymenotechnology*, as a "normalisation technology" (Mutlu 2018) where having an intact hymen before marriage is the norm, creates not only uneasiness but also a sense of betrayal to the medical profession for doctors (Dr Aysel, Izmir, September 2017, personal interview).

The necessity to define oneself through sexuality in order for the nation-state to continue its idea of the family makes women into "techno-sexual citizens", to use Mark Davis' term (M. Davis 2009). Davis refers to online dating and Viagra (advertised online) as technosexuality. It is possible to expand this idea of technosexuality into medical technologies, as well as the online advertisements of re-virginisation methods. By way of translating technologies that are not developed for hymen examination to the realm of hymenoplasty, gynaecologists reinforce this citizenship through technology. Furthermore, the enlarging of the image of the hymen through colposcopy, alongside the commodification of the hymen through hymenoplasty and the artificial hymen, re-constructs, solidifies and

makes real the hymen as a body part. The hymen does not exist until it is made real via the re-virginisation industry, the belief that blood comes through the rupturing of the hymen, or the association of the hymen with lack of sexual experience.

The increase in demand (and supply) of re-virginisation is in line with the increased use of the Internet among young women in Turkey. As information regarding re-virginisation is accessed mostly through online resources, having access to the Internet becomes a defining feature in whether a woman has access to re-virginisation. From 2004 to 2018, computer usage has increased from 16.2% to 50.6% among women in Turkey, whereas internet usage has increased from 12.1% to 65.5% (Turkish Statistical Institute 2019). Increased internet use allows women to access information regarding the varied methods of re-virginisation, in particular hymenoplasty and the artificial hymen, as well as allowing them access to the artificial hymen itself. This also steers women away from alternative or home-made methods of re-virginisation and plays into the hands of consumerism and commercialisation of the hymen and the vulva. The increased use of the Internet has also accelerated the consumption of porn by women in Turkey (Tzankova 2015). Tzankova emphasises the agency that easy access to porn gives to women, especially in societies where sexual repression is the norm. Looking at women's anonymous 'confessions' about porn, she argues that "Turkish women's publicly shared experiences about their porn consumption can be seen as a transgressive and emancipatory sexual endeavour which negotiates between the erotic and the socially prescriptive" (Tzankova 2015, 210). Framed in this way, it is possible to see the similarity between porn consumption and re-virginisation. Although not valid for all cases, both practices may emerge from women's inability to experience sexual freedom in the presence of their desire, and consumption of porn and re-virginisation practices is one of the expressions of women's agency in this sexual facade. As the Internet plays the role of the intermediary in both cases, it is not a coincidence that the consumption of the Internet, of porn, and of re-virginisation is increasing all at the same time.[21]

Commercialisation of a body part allows this body part to be real, which is enacted through two apparent binary conceptualisations. On the one hand, the 'information' available especially online about the hymen makes it palpable, concrete, and real, even though the platform where this information is shared is considered virtual. On the other, the hymen is reified via this commercialisation independent of whether the hymen exists or is imagined. Therefore, the hymen is created, constructed, realised, manifested as a body part that the

[21] Porn is a contested topic in feminist debates, usually discussed around whether the production and consumption of porn contributes to or stands in the way of the feminist cause. For an analysis of these debates that have started in the 1980s, please refer to (Ellis, O'Dair, and Tallmer 1990; Schneider 1993). For more recent debates, see (Attwood, Mercer, and Smith 2015).

re-virginisation market can regulate. Even though the hymen has its own temporospatiality as will be discussed in Chapter 7, and is part of the woman's body (if it exists), multiple actors appear to have a stake in claiming ownership over it. For example, the artificial hymen salespeople and medical doctors, as well as the woman's family and husband/ boyfriend/fiancé claim ownership of this body part, which comes into existence the moment this ownership is claimed. A body part does not exist unless there is a function to it, or when there is an (immediate) effect of that body part. A woman does not have a hymen until she is told by someone that she does. Even if and when a woman bleeds during or after intercourse, she does not have a hymen unless she is told that she does, as the blood may generate from an injury inflicted upon the walls of the vaginal canal as well.

By making the hymen real, the supply of and demand for re-virginisation are made possible, which in turn renders the circulation of capitals for women, doctors and artificial hymen retailers active. It is now to this circulation that I turn.

Circulation of Capitals

Re-virginisation is not only a process in and of itself but is also a circulation of various forms of capital across different entities involved in the process. Ahmadi argues that "possession of a hymen is a form of physical capital that women can exchange for symbolic and socioeconomic capital" (Ahmadi 2016, 232). The circulation of capitals cuts through not only re-virginisers but also medical doctors and artificial hymen retailers. With both groups, there is a tug-of-war between economic capital and symbolic capital, as established by Pierre Bourdieu (Bourdieu [1979] 1984). On the one hand, doctors are eager to conduct hymenoplasty operations due to the economic capital it brings them. On the other hand, this economic capital endangers their symbolic capital by way of the damage it potentially does to their 'prestige' among their colleagues. A similar give-and-take takes place between forms of capital for artificial hymen retailers.

Artificial hymen retailers mostly prefer to keep their identities and the identifying information of their company secret. Therefore, it is not possible to geographically locate the company from the information provided on the website. Nevertheless, a thorough research shows that these companies also sell penile enhancement products, and on the pages where they advertise these products, all contact details including the address of the company are openly displayed. Furthermore, customers are invited to visit the company to discuss the products. In these instances, vendors are willing to put themselves on display, whereas while selling the artificial hymen, they prefer to be secretive. This is a curious representation of how gendered bodies are understood and consumed in society. The online sales companies allow users to identify them with products that are meant for modifying men's genitalia but feel guilty about doing so with women's. This was also apparent in the interviews I conducted

with the owners and employees of these companies. One interviewee stated, "We're not doing the sales in an encouraging way", and added that "We are not on social media, it's a matter of conscience" (May 2017, phone interview). Retailers have further shared that they do not approve of pre-marital sexual activity, yet "people have all kinds of moments in their lives, they have bad moments too. They might have experienced something private as a result of trusting that person" (May 2017, phone interview). Therefore, they sell this product, as "[women] may make mistakes, they might have elastic hymens, there might have been unjust treatment [*magduriyet*]" (August 2017, phone interview).

Retailers parallel the normative idea that it is morally wrong to 'fake' virginity, but morally right to 'fake' penis size. They believe that being associated with penile enhancement products does not decrease their symbolic capital, whereas artificial hymen does. Furthermore, they are happy to meet with their penis enhancing customers, but not their re-virginising customers. Of course, visiting the company or the warehouse carries a bigger risk for women than men. However, some women might potentially find it safer to buy the product in person rather than having it sent via mail, especially if they are living with their families, as most unmarried women do in Turkey. An interviewee, Nazan, put forth that she helped one of her friends to research re-virginisation practices. A retailer Nazan spoke to gave them the option to have the artificial hymen delivered in person by a shopping mall (Nazan, Antalya, May 2017, phone interview). This is the only possibility outside of mail delivery that I have come across in my fieldwork. Not providing the opportunity is the important nuance that demands attention.

Another retailer has stopped selling artificial hymens. He states, "We started selling it [the artificial hymen] 1-2 months ago. We're not selling it anymore because we don't find it ethical" (August 2017, phone interview). When I asked him about how he defined virginity, he further claimed, "I can't help [you] with the definition of virginity, I didn't deal with this business, I was just a mediator" (August 2017, phone interview). This retailer did not want to be associated with re-virginisation and distanced himself from it by calling himself a 'mediator' rather than a 'seller' of the product. Furthermore, this 'mediator' has sacrificed economic capital for symbolic capital by choosing to stop selling or being a mediator of artificial hymens. That companies do not regard penile enhancement products as a detriment to their symbolic capital but perceive artificial hymens as such points at a deeply ingrained dichotomous understanding between female and male bodies. Selling products towards increasing a man's 'prowess' can be displayed publicly and is morally acceptable, whereas those that re-construct virginity are not. Of course, re-virginisation and penile enhancement are not necessarily equivalent. However, they both carry the element of secrecy, as both men and women would be pretending and forming a new truth in relation to

their genitalia. Through how they communicate with their customers, these retailers perpetuate the idea that a woman purchasing a product related to her genitalia is not as acceptable as a man to his.

Artificial hymens can be exclusively bought online. An initial search of artificial hymens that are sold in Turkey has revealed that there are seven different websites offering four different artificial hymens, claiming to be products made in Germany, the UK, Japan, and Portugal, and particularly underlining that they are not Chinese. Each website offers one brand of hymen, except for one that offers both a UK and a German product to be chosen from. Nevertheless, even though these websites pretend to be different companies, many of them are indeed the same company. I have come to this realisation via the phone interviews that I held with the salespeople working for these companies. Upon realising that two men whom I interviewed at two supposedly different companies were the same people, I cross-checked the phone numbers provided on the websites, which revealed that there were different phone numbers in common between several websites. It is also important to note that, even though chatboxes on the websites claim that customers will be conversing with a saleswoman on their questions about the products, all the salespeople that picked up the phone were men. This is most likely a tactic to gain women's trust and remains undiscovered, as it can be expected that most women would prefer to chat online to not disclose their phone numbers. Furthermore, I ordered a particular artificial hymen and received another. When I contacted the salesperson to ask why I did not receive the one I ordered, the response was that "We sent you the one that's ready to use" (April 2017, phone conversation), as the one I had ordered had to be mixed with a few drops of water to be used. Nevertheless, there was no mention of this product on their website. The real reason why I got a different product was that they operated multiple websites and perhaps did not track which website the order came from, or ran out of one of the products. At the time of writing this chapter, I re-visited the websites two years after the initial viewing. This time, it was possible to see that monopolisation of the artificial hymen market has intensified even further. There is one company that dominates the entire market in Turkey.

Conclusion

Within the under-researched area of re-virginisation, the relationship between institutions and re-virginisation has found itself very little place. However, even if the state, the law, and the medical institution seemingly do not have a policy regarding re-virginisation methods, and especially then, this relationship needs to be explored, and dug deeper. I have explored this relationship initially through the making of the modern woman in Turkey, and by arguing that re-virginisation practices are the showcase of the modern state and its relationship to the "liquid modernisation" (Bauman 2012) of the woman in Turkey. I have

then contended that the lack of policies or guidelines regarding re-virginisation points at the importance the state gives to the continuation of the "healthy, stable, national family" (Parla 2001, 84), as opposed to the importance given to virginity. However, this does not mean that the state does not hold its grip on the woman's body. On the contrary, it does so by delegating it to the women through mechanisms of self-surveillance that manifest themselves as various stages in the process of re-virginisation. In order to ensure the family model, the state allows for re-virginisation methods to be freely practiced by placing it in a liminal position. Through this liminal position, and by way of being practiced as a "public secret" (Taussig 1999), the power that re-virginisation and virginity possess over bodies and norms grows even more.

In addition to the nation-state and the law, providers of re-virginisation products and services also treat re-virginisation as a "public secret". On the one hand, medical doctors abstain from openly talking about their hymenoplasty practice, and shame those who do. On the other hand, artificial hymen retailers aim to keep their distance from the product as they do not agree with women's using it, despite accumulating economic capital through the artificial hymen.

While re-virginisation is rendered invisible via its liminality, it is made visible via the markers and images of, and discourses around virginity. In the next chapter, I will unpack how this visibility is imagined.

5. The Imagined Visibility of the Hymen and Virginity

Of course, those who marry and bleed that night won't face any danger, because the man in front of her won't open it and look into it. And even if they go to the doctor, they can't tell [that she's had hymenoplasty] I guess because what was done has been undone. But if bleeding doesn't happen, then she's in real trouble.

Re-virginiser, posted online

(Thread 17, March 2015)

The idea that not every blood is the same occurred to me soon after I hit puberty. When I was menstruating, and when it leaked onto my underwear, I was supposed to handwash it before putting it in the washing machine per my mother's instructions. Although I did not enjoy doing it, it made sense, as the blood seemed 'dirty'. A while later, however, I saw that my father's shirt which had drops of blood from shaving his beard was placed into the washing machine without a pre-handwash. This got me puzzled, as, if blood was dirty, then all blood should be dirty. This is the moment I realised how *some* blood was deemed as dirty, and menstrual blood coming from the vaginal canal was indeed one of them. As Mary Douglas states, "there is no such thing as absolute dirt: it exists in the eye of the beholder" (Douglas [1966] 2001, 11). However, it is not that this blood was coming from the vaginal canal that made it dirty. Hymeneal blood is believed to derive from the same part of the body, yet it is regarded as almost sacred, something to be worshipped, as long as it is *seen* within a marriage. Hence, the value attributed to blood is intrinsic to temporalities (as in the case of marriage and hymeneal blood) as well as spatialities (as in the case of what bodily space it originates from).

In this chapter, I will explore the ideas of seeing, visibility and invisibility along multiple axes of re-virginisation. Firstly, I will look at how genitalia and sexual activity are named, called or addressed, drawing attention to the link between language and (in)visibility. I will accomplish this also by referring to the concept of "compulsory visibility" (Foucault [1975] 1995, 187). Later, I will explore what seeing the hymen means and what blood signifies in different contexts, and what seeing this blood does to relationships. I will then move on to the only other visual we are exposed to in relation to virginity, which are the images displayed on re-virginisation websites. I will unpack what kind of an "image world" (Poole 1997) these websites construct and how that relates to our imagination of virginity. Reading these seemingly different facets of re-virginisation through visibility and invisibility is

required, as even though virginity is traditionally associated with lack of sexual experience, the primary marker of virginity that is sought after is not necessarily associated with this lack, nor does the hymen need to be 'seen'. Instead, a politics of seeing hymeneal blood is at play, as discussed in relation to the legal economy of re-virginisation in Chapter 4 as well. Therefore, this chapter will employ visibility as the means to see the body and beyond in its interaction with re-virginisation.

What's in a Name? *There*, *the thing*, *something*…

(In)visibility has a strong link with language. How we name a body part has a significant impact on our relationship to it, and on what we decide to do with it, depending on what is deemed acceptable by society. I argue that how women refer to their genitalia and sex throughout their re-virginisation processes derives from and into how virginity is understood in Turkey. How women refer to their vulvas and vaginas provides us with significant information regarding how they relate to their bodies. Many women abstain from naming their vaginas or vulvas as such and instead use indirect ways of referring to their body parts. It is quite common to refer to genitalia as the "thing"-for example, I was brought up to call my vulva *my thing* [şeyim], or as *little Hande* [küçük Hande]. Another common way of referring to the vagina or the vulva is calling it "there" [*ora*]. A re-virginiser talks about self-cleaning in the post-operation period as such, "I [shower] with my underwear, but now that my period is coming to an end, I don't know how I'll clean it *there*" (Thread 20, January 2012; emphasis added). Similarly, another re-virginiser says, "I'm going nuts, my mind is *there*. I've never thought about *there* this much in my life" (Thread 43, April 2012; emphasis added). Not explicitly referring to the vagina or the vulva is not a characteristic that can be attributed only to re-virginisers, nor is it specific to the context of Turkey (cf. Braun and Wilkinson 2001). However, this distancing oneself from one's body parts is intrinsic to the discourses around virginity and re-virginisation. In particular, the de-sexualisation of women in Turkey prior to marriage as discussed in the Introduction goes hand in hand with not explicitly naming genitalia. Furthermore, even though women are expected to be hyper-sexualised within their marriage, this expectation does not recognise women's pleasure or sexual desire but imagines women as sexual only to the extent that they fulfil their husband's desires.

This distance also manifests itself in how women refer to the penis. Re-virginisers abstain from calling it penis and use euphemisms instead. For instance, a re-virginiser names the penis as the *thing*, "Girls, doctors say that the man's thing's size impacts whether bleeding occurs" (Thread 43, November 2012). This re-virginiser, while recounting her gynaecologist's description of virginity loss in an earlier post, refrains from writing the word 'penis' out. She states,

> Yes honey what you see are the tissues around the hole on the outside. Not on the inside, so when you have sex [*ilişkiye girdiğinde*], because the p…s is bigger than its diameter, it tears on the edges while going through it and then bleeding occurs. That's how the doctor explained it to me. (Thread 43, January 2012)

The word "penis" is not censored on the forum, not spelling it out fully reflects the author's preference. By way of not writing the word penis explicitly, the re-virginiser distances herself from men's sexuality as well. However, at the same time, women share their experiences and thoughts about sexuality openly. This goes hand in hand with the stuckness women feel between engaging in sexual activities pre-maritally and the norms around sexuality.

The distance created in discourse is not limited to how women refer to their own, or men's genitalia, but also in how both men and women refer to having sex. Especially the phrase "*bir şeyler yasamak*", which literally translates into "living something", or "experiencing something" requires attention. Experiencing something is used when referring to sexual activity (not necessarily involving penetration) before or outside marriage. As this is not 'allowed', in other words, as it is not socially accepted to engage with one's partner sexually before marriage, words such as "*seks yapmak*" [having sex], or "*sevişmek*" [making love] are used much less frequently than "experiencing something". This is not a way of not talking about sexual activity, as what the phrase is referring to is known in common parlance. However, admitting to engaging in sex or foreplay premaritally is emotionally charged for many people, especially bringing about emotions such as guilt and shame. As a result, it feels disgraceful and dishonourable to utter the word 'sex' and to admit that one has had sex pre-maritally. Hence, a distance is created between one's self, including body and emotions, and one's experience of sexual activity, as both the activity and the discourse surrounding it become imbued with guilt and shame.

In addition to distancing, naming is fundamental to stigmatisation as well. This becomes evident especially when we pay attention to how women who have 'lost' their virginity pre-maritally are referred to by those who were virgins at the time of their marriage. One of these names is "open" [*açık*]. This adjective creates a contrast between "open" and "closed", operating through an imagination of the hymen as a membrane that covers and guards the vaginal entrance. Once a woman loses her virginity, it is assumed that she is 'open', which also means that she is 'open' to have intercourse with any man. Women also fear that they are perceived as 'open' especially by male doctors, which they believe might lead to being raped during surgery. A re-virginiser shares her fears as such,

> Girls I don't trust general anaesthesia at all, if you're going to do it [hymenoplasty], then let it be local anaesthesia, that's how they do it even when giving birth. How do we know the man [doctor] won't do anything bad, because

> the patient is *open* already, especially when we're going [to the clinic] on our own? (Thread 43, February 2012; emphasis added)

Another woman, who is critical of re-virginisers calls non-virgins "open doors". She warns re-virginisers as follows, "Pray that the guy you will marry won't be too experienced as he'll be able to tell [that you've re-virginised]-all in all, our *open door* friends who think nothing will happen *give* anyway" (Thread 43, March 2012; emphasis added). Here, the word "give" requires separate attention. The act of having sex before marriage is colloquially regarded as "giving" [*vermek*] if it is carried out by women. This is a rather pejorative way of describing pre-marital sexual activity, and doubles its effect when coupled with the phrase 'open door'. In some ways, the idea of 'giving' sounds similar to virginity as gift, one of the three common ways the young population in the USA interprets virginity (Carpenter 2005). However, while the gift metaphor suggests giving something valuable even if it takes place before marriage (Carpenter 2005), the act of 'giving' in the Turkish context is not about virginity loss but vaginal penetration in general and is devoid of any value. Going back to the open door, the same critic above suggests that women who are 'open doors' cannot be considered trustworthy by men, "No man will trust a woman he describes as an open door. Those who get this [hymenoplasty] done, look at yourselves, are you trustworthy?" (Thread 46, March 2012). Hence, being open is on the one hand seen as being available for the wrong type of sex by critics of re-virginisation, while re-virginisers fear that it is making them available for sexual abuse.

Other metaphors for non-virgins include "punctured" [*patlak*], "faulty" [*defolu*], "ho" [*orospu*]; and specifically for those who have re-virginised, "patchy" [*yamalı*]. A re-virginiser recounts her recent conversation with a male friend who is about to get married and who seemed upset. She recalls that he responded,

> "My fiancée is a rotten egg", I said, "what do you mean?" He said, "she isn't a virgin, that's what I'm upset about". I asked him how he knew. He said that she told him before getting engaged, "she said that they experienced some things with her ex-boyfriend, and I accepted her despite that". I asked, "so what changed now?" He said, "now I feel offended". I got angry, and said, "here's a question for you, give me an honest answer if you're a man. You haven't formally gotten married yet, have you experienced anything with her [*bir şeyler yaşadın mı*]?" He said, "of course I did, why does it matter, it's not like she's a girl [virgin]". I said, "what difference do you have from that man, you're all the same, you're the ones that are rotten. You would deserve it if she had fooled you, you don't deserve honesty. If you're so virtuous, you shouldn't have touched her". (Thread 13, September 2014)

The "rotten egg" metaphor refers to not only food that has gone bad (*rotten*) but also to how women are imagined as reproductive agents only (*egg*). Furthermore, although the word *open* has not been used in this narrative, the line of thinking that it is not a problem to have sex with a woman who is not a virgin, who is already *open* is pervasive here as well. In addition to *rotting* as a result of having had sex, non-virgins are criticised within the parameters of cleanliness. A critic of re-virginisation states, "I pity the man who will take you, he will think you are clean, but he would end up taking a woman [*karı*][22] who is (like) a cesspool" (Thread 43, August 2015). Here, a contrast between cleanliness and dirtiness (being a cesspool) is noteworthy. Women who have had premarital sex are considered dirty, like a "cesspool", while those who have 'saved themselves for their husbands' are clean. In a similar sense, other critics regard women who have lost their virginity as "stained". Interestingly, re-virginisers perceive women who have had sex with more than one man as 'stained', whereas having had sex with one man does not cause a stain from their point of view. One re-virginiser states to another, "It's not like you've been with many men, and went to[23] [married] your husband stained" (Thread 47, November 2013). Here, a line between promiscuity and morality is drawn through cleanliness. This is very similar to Ozyegin's research findings, where she argues that even within the virginal facade, losing virginity in a long-term relationship is valued, while one-night stands are highly devalued (Ozyegin 2015). The same understanding is reiterated among re-virginisers as well, as discussed in the Methodology chapter in relation to "online subjectivities". This pejorative name-calling of re-virginisers is sometimes used by women to feel a sense of empowerment. A woman who calls re-virginisers to own their sexual history and not re-virginise, uses the pejorative vocabulary to demonstrate the problem in discourse. She suggests,

> First of all, get rid of equalising virginity with a bleeding vagina. Yes, anything can happen to people in this life. But claim yourselves, have your own values set in place before experiencing some things. If you can't handle the consequences, do not take on the sin or the pleasure. And do not treat yourself as a second-hand car. You know, they play with the kilometre settings of cars when they're selling them… (Thread 14, August 2012)

Here, the user employs the same vocabulary as those who criticise pre-marital sexual relationships and re-virginisation to suggest that women should cease to re-virginise and not

[22] Here, the word 'karı' has been used instead of 'kadın'. 'Kadın' literally means 'woman', while 'karı' literally means wife, and figuratively refers to woman derogatorily. The latter has been in use in this sentence.
[23] "To go to the husband" [*kocaya gitmek*] is a common term that is used to mean "to marry" in Turkish. It refers to the more traditional practice of living with or near the husband's family after marriage. Hence, it is the woman who goes to the husband, not the other way around. This practice still continues particularly in rural Turkey, although to a lesser extent.

be treated as objects to be repaired or fixed, which stands in opposition to how hymenoplasty is referred to by some doctors, as 'hymen repair'.

On the one hand, these metaphors display that women are seen as objects and that the hymen is seen both as a defining feature of a woman (as in "open" versus "closed") and as a tissue/membrane that can be popped, punctured, and later on, patched. On the other hand, attention needs to be drawn to the senses that are at play in the (re-)production of these metaphors. These metaphors are either tactile (punctured, patchy) or olfactory (rotten egg, cesspool). These dominant senses in non-virgin metaphors are the dominant senses used in sexual encounters. Furthermore, a connection can be drawn from the general perspective that vaginas are smelly (Braun and Wilkinson 2001) and the olfactory metaphors for non-virgins. As women in this context are defined via their virginity status, attention is drawn to the vagina, the area of the body through which this status is supposed to be determined. The smelly nature of the vagina is exacerbated when the woman is not a virgin, whereas when she is, she can be expected to be 'clean', or at least, 'cleaner'. The increased referral to the sensations regarding non-virgin women's genitalia makes them more visible. As unmarried yet sexually active women's genitalia are already being seen by those who 'should not' see them, critics of re-virginisation further amplify this visibility by sensualising the vulva. Hence, it can be argued that the genitalia of non-virgin women are part of a "compulsory visibility" (Foucault [1975] 1995, 187). This concept, developed by Michel Foucault, has been discussed in relation to the Middle Eastern context to demonstrate how the Middle Eastern subject has become more visible especially post-9/11 (Pugliese 2009), and in relation to women in the Middle East to illustrate how domestic violence in this region is rendered more visible than those in the 'West' through media (Jiwani 2015). Deriving from these analyses, I argue that the unmarried non-virgin vagina is made compulsorily visible as opposed to other genitalia. This vagina is 'open' to public discourse as it is already 'open' to all sexual encounters. It can be penetrated, talked about, and looked at. Its visibility is compulsory as it is against social norms around sexuality. By way of coming against these norms, the vagina renders itself visible. This compulsory visibility is also strengthened through the medical gaze, which I now turn to.

Seeing the Hymen

Even though blood is believed to be the ultimate marker of virginity, viewing the hymen is an integral part of the process of both re-virginisation, and virginity examinations that are carried out either due to sexual assault or when a woman is taken to a gynaecologist if she 'fails' to bleed following the first nuptial intercourse, even though this is legally not allowed. In the previous chapter, I have discussed the legal implications of these examinations. Here, I will introduce another layer of analysis and inquire into whether the hymen can be seen,

either by women themselves or by medical professionals, as well as what one sees when one peeks into the vagina. Here, I differentiate between looking and seeing. I conceptualise looking at an object, body part, or a person as the physical act of viewing it, while framing seeing as the act of processing what one looks at through one's filters. I join Caroline Knowles, who researches seeing in relation to photography and race, in her argument that "what we see and how we see it is intricately connected with the forms of social organization within which we are all, including ethnographers, located and with which we have a matrix of connections" (Knowles 2006, 512). What different actors see when they look at what is regarded as the hymen is the focus of this section.

It is important to note here that whether the hymen exists or what doctors look at when they believe they are scanning the hymen is not of significance in this section. What needs attention here is what is imagined and created by looking at what is considered to be the hymen. As this 'hymen' interacts with the medical gaze, with the male gaze, with the parental gaze, as well as women's own gaze on their bodies, the hymen looks back. From a Deleuzian perspective, the hymen and the imagination of the hymen also become through the process of re-virginisation. The hymen gazes on the individual looking at it, and is involved in their becoming as well. Even the experience of looking at the hymen has transformative impacts on the one who looks. Therefore, there is a relational process that continues whether or not hymen as such exists.

As discussed in the previous chapter, some doctors scan the vaginal entrance with a colposcope in order to view the hymen. One reason why doctors prefer to use this device is the possibility of showing women what the doctor can see. In other words, they share with their patients their own gaze. Even though this sharing can be regarded as an attempt to take an inclusive approach towards doctor-patient relationship, what is being shared is through the gaze of the medical doctor through a medical device, based on the doctor's understanding of what the hymen is and how the hymen *functions*. Under these conditions, it is not possible to talk about a shared gaze, but one that is imposed on the woman, even though what is being looked at is her own body. Maud Radstake suggests that "medical professionals generally consider real-time images to be relatively unreliable, 'subjective' representations of bodily realities, because they can only be interpreted by the ones who produce them" (Radstake 2007, 5–6). Doctors sometimes invite women to join in on the gaze, but women's subjectivity is hidden from view and doctors' subjectivity is treated like objectivity instead. Along with the mainstream understanding of virginity testing, viewing the hymen with a colposcope adds to the surveillance practices, which "not only 'dismantle or disaggregate the coherent body bit by bit', but also remake the body, producing new ways of visualizing bodily identities in ways that highlight othered forms of racialized, gendered, classed, abled, and

disabled bodies, as well as sexualized identities" [citations omitted] (Dubrofsky and Magnet 2015, 9). In the case of hymenoplasty, colposcopy becomes a means of the production of gendered and sexualised identities in particular.

This demonstration of the hymen by the colposcope to women also has another function. Even though doctors call re-virginisers 'patients', women themselves abstain from calling themselves that. On the discussion forum, women refer to other women as doctors' patients, whilst not identifying themselves as such. Identifying as a patient brings with it a hierarchical relationship that is established with the medical institution and staff, especially with the doctor. Even though re-virginisers are not in search of a 'treatment', their contact with the medical institution leads them to be called as a patient by their doctors and hence by fellow re-virginisers. Colposcopy has a similar impact, in that being in touch with a medical device that is normally used for cancer screening makes it possible to 'patientalise' a woman. I contend that re-virginisers do not identify with being a patient as a result of not having come to terms with the requirement of re-virginisation, to distance themselves from the process, and to implicitly underline the fact that they do not need to be 'fixed' by the institution of medicine. However, instances such as coming into contact with the colposcope make it difficult to maintain this distance.

Even if the hymen can be scanned with or without a colposcope, what is scanned does not give an indication of whether a woman has experienced penile-vaginal intercourse, as neither blood nor the hymen can 'prove' virginity. Cindoglu's findings support and complicate this method of proving virginity.

> As one physician said, three nurses came to the ob/gyn to check if they would bleed on their wedding night. After they found that they might not bleed extensively, due to the nature of their hymen, they asked the physician to repair them so that they could definitely be sure that they would bleed on their first night. (Cindoglu 1997, 258)

A similar story has been shared online. A re-virginiser states that she has never had penile-vaginal intercourse with anyone. However, upon having a virginity examination to make sure she would bleed once she got married, she found out that her hymen is elastic, which means that the hymen won't 'break' during penile-vaginal intercourse. However, she feared that her husband-to-be will conclude that she has had intercourse before when he does not see blood, which he believes is the indicator of virginity. Therefore, she decided to undergo surgery in order to ensure bleeding on the nuptial night (Thread 20, May 2012). If re-virginisation or lack of sexual experience makes a woman a virgin, then she was twice a virgin at the time of her marriage. To complicate things even further, after she has intercourse with her husband, she will bleed as a result of her operation, yet due to the elasticity of her hymen, it will have

remained intact. Hence, if she bleeds due to her operation, then she will have 'lost' her virginity, whereas her 'original' hymen will be intact, leaving her a virgin. This case shows how neither seeing the hymen nor blood can be indicators of what is called virginity.

Despite attempts to enlarge the view and 'see' the hymen, it is very often the case that doctors are not sure what they are scanning and what constitutes as a 'ruptured hymen'. Dr Emel who teaches at one of the top medical faculties in Turkey suggests the following in our interview,

> We don't give training about the hymen in medical faculties. The hymen doesn't have an anatomic quality. It's not taught in the Ob-Gyn internship either.
>
> General practitioners (GPs) work as forensic practitioners where they are appointed. They don't receive training [about that]. They perform virginity examinations, it's called perineal examination, the examination done on that region. When gynaecologists went through these examinations, they saw that there were a lot of mistakes made, because they [GPs] have no training [on virginity examination]. (Dr Emel, Ankara, April 2017, personal interview)

Given this obscurity, it is not clear what characteristic can be used to determine whether a woman has a hymen, or what kinds of qualities the hymen possesses. Even though the reports written by forensic practitioners are used as evidence in legal cases, the obscurity regarding the hymen and the lack of training on how to scan the hymen and the vagina may cause critical mistakes. The Ministry of Health has published a book titled *Forensic Medicine* in 1995 to help with this examination by general practitioners who act as forensic practitioners. This book provides some guidelines about how to perform a hymen examination, which further obscures the characteristics attributed to a ruptured versus intact hymen.

> If possible, the examination should be done on a gynaecological table, the labia majora should be pulled up and forward while holding them with a gauze patch to stretch the hymen and to make it visible. A fixed light source should be used during the examination and the findings should be described in reference to a clock dial.
>
> The most frequent hymen type is annular. While the diameter of the lumen may have different dimensions, 10-15% of them may be suitable for an erect penis to enter. More attention should be paid to the examination of the hymens that have a wide lumen, that have thin and elastic edges, and that have natural indents. That natural indents can be confused with old ruptures, and a lumen that is

> suitable for the entry of an erect penis can cause difficulties while presenting an opinion [in the report].
>
> In the instances where the hymen lumen is not available for the entry of an erect penis, the membrane [hymen] is usually torn at the rear dial (3-6-9 according to the clock dial). The edges of the tear that are red in the first days [following the penetration] seem oedematous at the circumference. Ecchymosis might occur. Inflammation starts around day 3, whereas mucosal regeneration starts around days 5 and 6, ecchymosis and oedema usually disappear. As the tear characteristics disappear around days 7 to 10, the tear edges take the appearance of the surrounding mucosa. Therefore, in examinations made 10 days after coitus it is almost impossible to determine the time [of coitus]. In such instances, it can be stated in the reports that the hymen has been torn more than 10 days before the examination date, and that medically it is not possible to determine this date precisely.
>
> Natural indents usually do not trace to the vaginal wall. There are no scar tissues at the endpoints of the indents. At the endpoints of old tears, there are scar tissues and the tears usually trace back to the vaginal wall. The scar can present an iridescent-coloured appearance.
>
> In hymens with wide lumened elastic membrane structure, there may be no change in the anatomic structures despite the occurrence of sexual intercourse. In such instances, one can take a vaginal frotti to look for sperm, as well as stating in the report that she is anatomically a virgin. (Gündoğmuş and Çakmak 1995, 11–12)

These guidelines which are in lieu of training for GPs make it clear that what constitutes as an intact or ruptured hymen is subjective at best. The characteristics that are attributed to either state of the hymen are not definitive, hence making it very difficult to use the 'intactness' of the hymen as the defining feature of virginity. Furthermore, when the virginity is 'lost' beyond the 10-day window cannot be determined, creating more obscurity especially in the elastic hymen cases. This obscurity has caused marriages to end, as told in a story by Gamze, about her friend Nazlı.

> Nazlı's family was conservative, and she never had sex with anyone [before marriage]. She got married, and told me and other friends that after having sex, she would send us a message, saying "Aduket"[24]. 3 days passed, no message at all.

[24] Aduket is a misheard word, the original version of which is Hadouken. It refers to a special attack from the video game Street Fighter, and the exclamation of one of the characters as he initiates this attack.

> Then I messaged her asking what's going on. Apparently, she didn't bleed during [or after] sex, and the man got off the bed and went straight to his mother's place. He stayed there for 2 days. When the woman [Nazlı] went to see her mother-in-law, the man [her husband] left the house. The mother-in-law took the bride to a gynaecologist. And the gynaecologist said that "it looks like an elastic hymen, but I can't be sure. She hasn't had intercourse in the last 6 months, but she might have had before that". Apparently, the vagina tightens after a time of no-sex. They got divorced within 2 months in a rush. (Gamze, Istanbul, March 2017, personal interview)

As Nazlı's story illustrates, the obscurity of the understandings of the hymen endangers trust in a relationship. On the one hand, believing that blood is the tell-tale sign of lack of sexual experience is reliant on a myth, as discussed in the Introduction. On the other hand, the institution of medicine causes further obscurity as the doctor suggests that "she might have had sex" 6 months prior. Not only do these 'findings' contradict with the training book by the Ministry of Health, but they also provide confidential information to third parties while conducting an illegal examination. In the end, what cannot be seen results in the woman being pushed out of her marriage.

As women engage in attempts to make virginity visible through re-virginisation practices, what was invisible to them before, becomes visible as an unintended consequence. This is especially the case for women who have never looked at their vulvas or vaginas in the mirror, and who do so as a result of getting on the re-virginisation process. What is normally visible for the doctor becomes available for the woman to look at as well. Women not only peek into their own genitalia by way of re-virginising, but also engage in collective looking and seeing practices. This does not mean looking at each other's genitalia but encouraging each other to look at their own. This is to see what has so far been neglected, which forms part of the online sisterhood, in an attempt to help fellow re-virginisers to make sense of their own bodies without the aid or authority of a medical professional who is deemed as an expert on the woman's body. An example is a re-virginiser who has trouble making sense of the appearance of her vulva following the operation. She asks another re-virginiser for help online, and receives it.

> I had never looked at it [my vagina] in the mirror, but for you, I got up and looked in there. Yes, it looks like it's closed but I didn't force it much. I pushed [out] just a little bit, but when I push [out] a bit more, [I can see that] there's a small hole. (Thread 33, October 2012)

What is noteworthy here is not whether women are making the 'correct' sense of their bodies or body parts, nor should we expect women to see their bodies in a way that mirrors doctors'

imagination or construction of their bodies. What requires attention is that women establish a new relationship with their bodies as a direct result of re-virginisation, one that they would perhaps not embark on had they not put themselves through this process.

Another layer of relationality is how men relate to the (in)visibility of the hymen and of virginity. On the one hand, Dr Jale suggests that there are men who bring their girlfriends to hymenoplasty before going to the military for the compulsory service. She says,

> 10% [of my patients] are brought in by their boyfriends before they join the military [for compulsory military service]. Some of these cases are so that the women would not be in a difficult situation if they don't come back [if they are killed]. Some of them [operations] are there to act like chastity belts. The boyfriends want to make sure she doesn't have sex until they come back. They don't want defective goods. (Dr Jale, Ankara, April 2017, personal interview)

As these men cannot see their girlfriends' virginity for themselves, they are utilising the medical gaze to give them comfort and security. What cannot be seen by the non-expert eye becomes transformed to be seen later through the blood. However, not all men resort to the institution of medicine for this purpose. The example below, as written by Dr Gökçen Erdoğan in her book *Things on the Quiet: The Notes in the Drawer of a Gynaecologist-Therapist* displays how men imagine the hymen, and form a relationship with it, even though it is not part of their own body.

> I comforted Merve, and when we came to the same point again, I saw shame in her tears. It annoyed me that the bleeding marks on her vagina, the holes, the wounds were multiple and not of the kind I'd seen before. But even I couldn't guess what had happened. Some parts had scabbed, others had been peeled off. An inhumane treatment was showing itself immediately.
>
> Now it was her turn [to tell me] why she wanted the [virginity] examination. A person who would do such harm to her genitalia could never have reasonable aims, but who knew what they were. It was unbelievable.
>
> The man she was in love with had deflowered Merve. They had both wanted it, but Merve had to be persuaded because she was unsure about it herself, but thinking she was going to get married, she was convinced. The result had not been as the young woman expected. He wanted to break up. He tried consoling his girlfriend who was crying after the loss of her virginity with another lovemaking. And afterwards, what a reasonable (!) solution he had found. What a thoughtful boyfriend…

> He had wanted to sew the ruptured hymen himself. Ah, that grand sense of ownership! He had pretended to be a doctor so that she wouldn't be touched by anyone else. The needle is the same needle, the thread is the same thread, why wouldn't he do it? Just like he was doing an experiment, like playing a game, like loving his beloved more than anyone else…
>
> He had let go of Merve after she passed out shouting and screaming in pain. He had dressed the wound in his way. We were lucky that Merve's twisted stitches had not been infected and that the man had not gone too crazy to leave permanent damage. (Erdoğan 2014, 64)

This quotation of a real-life incident that Dr Gökçen Erdoğan has narrated in her book is an epitome of the meanings attached to virginity, hymen and the woman's body. But more importantly, it illustrates the different layers of visibility in relation to virginity from a man's eye. The man assumes that what he does not see (the hymen) has been 'ruptured' due to his penetration into the vagina, symbolised by the blood. Even though the hymen is not seen by the man, this change in the woman's vagina is assumed. When the relationship is to end, the man takes on himself to undo the disappearance, or the ceased 'visibility' of the hymen, hence he attempts to create a new 'visibility' or a new visual on the vagina by stitching it together. This allegedly would 'undo' his penetration, yet would leave a different mark on the vagina. Therefore, via attempting to undo his visibility *in* the vagina, he makes himself even more visible *on* the vagina and the vulva.

Perhaps more important than what is being looked at is what is seen or what is desired to be seen, as well as whose eyes are seeing through which filters, which social constructions. Interestingly, the person who sees the hymen or who imagines the hymen in a vagina claims ownership over it. Dr Zafer stated that a woman with three kids had demanded vaginoplasty as his husband was not getting pleasure during sex due to the 'looseness' of her vagina. He did operate on her, and during the operation, he decided to give her a 'surprise' and reconstructed her hymen as well. He confessed that this was also to practice his hymenoplasty skills, as it was the early years of his practice (Dr Zafer, Istanbul, January 2017, personal interview). Here, it was the gynaecologist, followed by the husband who claimed ownership over the woman's vagina. In a similar manner, men who engage in sexual intercourse with women claim ownership through the hymen which they cannot see but desire it to be where it is supposed to be. This visibility and ownership take on further importance when blood enters the picture, as it is regarded as the only 'reliable' source through which virginity can be viewed, to which I now turn.

Fifty Shades of Red: The Blood on the Sheet

Blood holds a significant position within virginity and re-virginisation. I do not contend that blood is central to the discussions around these topics, however. Blood is usually a symbol for what is required from women, for the power relations in the re-virginisation industry, and for the gender inequality in society. Therefore, I do not argue that re-virginisation is just "for one drop of blood" (Ayuandini 2017a). Rather, it sits at the centre of complex social, political, legal, and medical relations. Nevertheless, this does not mean that we should disregard blood in its entirety. Blood in re-virginisation moves through bodies and things, evokes emotions and in this process, blood itself also *becomes*.

I have discussed Deleuze and Guattari's notion of becoming in Chapter 2 in more detail. However, I want to stress here that blood, as well as the hymen, can and should be thought with regards to relations of becoming. Bodies are "permeable to the influence (and imposition) of others, with porous borders and boundaries" (Renold and Mellor 2013, 33). The subject extends into others, including nonhuman and material others (Renold and Mellor 2013, 36). However, I would like to suggest that it is not only that the subject extends into nonhuman and nonmaterial others, but also that things become through their extension into human and nonhuman others. On the one hand, blood in all its actuality is directly affected by the operations done unto women, determining to an extent when and how much of it is allowed to flow. On the other hand, the image and imagination of blood, as well as what we see when we look at blood depending on where and when we see it, is also a result of its extension into us, and our extension into the blood. Hence, the blood becomes through its relationship with humans (women, doctors, families, partners) as well as things (the hymen, vagina, the sheet). Therefore, in this section, I will look at the materiality of blood and the relations and relationalities formed around its becoming.

As even gynaecologists, who claim themselves to be the hymen experts, require additional devices to be able to 'see' the hymen, and as GPs who act as forensic practitioners fail to pass 'correct' judgments on the intactness of a woman's hymen, hence virginity, what we are left with is blood. Blood becomes one of the two means through which a woman can prove her virginity to her partner (the other being tightness), and/or her husband's family in the absence of a virginity examination, or so that such examination does not take place. What gives hymeneal blood its meaning is who gets to see it. When it is seen by the husband (or to a lesser extent by the boyfriend), and in some cases by the mother-in-law, and/or sister-in-law, the blood takes on the meaning of sacredness and virtue, and its status is elevated. For blood to achieve this status, many re-virginisers attempt to create the ideal setting, for instance arranging that the intercourse takes place on a white sheet to create a contrast

between the redness of the blood and thus to increase its visibility. Hence, when and where the blood becomes visible, or available and accessible to the eye is key.

Many men and women believe that hymeneal blood should carry certain characteristics, unlike other types of blood. It is imagined to be 'different'; different in colour, in amount, in brightness. The imagination of this difference generates further fear among re-virginisers around the idea that their husbands or his family can tell the 'difference'. This is further strengthened by the belief that women are better at deciding whether the blood that is presented to them is hymeneal. One re-virginiser suggests that she tried to persuade her fiancé to not share with his parents whether she has bled or not on the nuptial night. However, this was met with resistance by the fiancé.

> I said it should be a secret. Let's say it [sex] didn't happen, will everyone have to know? "Oh, it didn't happen", "she was on her period", etc, why, I said "no one should know whether it happened or not", but women apparently can tell what kind of blood it is, that's why they look at it and they will arrive at a decision whether she is a girl [virgin] or not, oh my. (Thread 43, April 2012)

She further notes additional features hymeneal blood is believed to carry:

> Mine [my fiancé] said it should be light pink, I said, "see, you know it needs to be light pink, what more do you need?" But no, apparently, they [women in the family] need to have a look. At the end of the day, he's inexperienced. Also, when you wash it off, it shouldn't go away, is that correct? I wonder if they will take it [the sheet] and hold it under the water to see if it washes off or not. Ahh, I'm thinking about everything. But normal blood doesn't wash off either, right? (Thread 43, April 2012)

This instance illustrates how hymeneal blood is deemed sacred, but not secret. Furthermore, it is believed that it can be distinguished from other types of blood, and cannot be washed off. These additional and imagined characteristics make the hymeneal blood ideal even more difficult to attain. Dr Önem puts forth that she explains to her patients that all blood is the same, but they are not convinced,

> Dr Önem: For instance, they've had intercourse before, it [the hymen] was ruptured, [she] bled, etc. Just to show the sheet to the family on the nuptial night, there are couples who go through this process, have this operation, have hymenoplasty, because this blood needs to be seen there.
>
> Hande: So, the fiancé knows too?

> Dr Önem: Of course he does. I ask them, is it so important? Take [something], prick [your finger], wipe [the blood] on the bed. "No, they'll tell [the difference]." "No they won't", I say. That blood and this blood are the same anyway. Now do you understand this fear? (Dr Önem, Ankara, May 2017, personal interview)

This fear generates both from the idea that hymeneal blood is supposed to be different, but also from the necessity to display this blood to parents for some couples. However, it is not only the colour or shade of hymeneal blood that is considered a vital characteristic, but also its quantity. Mostly based on hearsay, individuals have different ideas about how much a woman should bleed during her first penile-vaginal intercourse, although the quantity of this blood depends on many factors including how much lubrication occurs, the shape of the hymen, the tightness of the vaginal canal, the partner's penis size, and how much force the partner uses. Despite the quantity being subjective and time-bound (I explain in Chapter 7 that a woman might bleed a small amount right after the intercourse but more afterwards), men and parents in-law tend to expect a certain amount of blood based on what they have heard from other men and women. Dr Jale, for instance, talks about the calls she receives from her 'patients' about this quantity

> Even people who have never had an operation like this and are really virgins, they might just get a few drops of blood after wiping it with a tissue. I had feedback like that. "I didn't bleed much, only when I wiped it, my husband is not convinced, why was the blood so little?" I tell them, "there's nothing to do, God created the hymen to be ruptured only once. We're doing something against God. You need to settle for it". (Dr Jale, Ankara, April 2017, personal interview)

It is important to point out that Dr Jale suggests that re-virginisers need to "settle for" less blood because they are going "against God". Even though as a gynaecologist she knows that not every woman bleeds, and that there is no 'normal' amount of hymeneal blood, she suggests that by way of re-virginising women lose the 'right' to bleed more. Through her interpretation of the quantity of hymeneal blood, Dr Jale perpetuates the assumption that 'real' virgins bleed more, as well as strengthening the association between virginity and blood. It is also curious to see these discussions around the quantity and quality of blood generating from the rupture of the hymen, but not from any other part of the body. How much or what colour a woman bleeds while she is menstruating or within the initial days following childbirth is not even a discussion, even though these bleedings happen through the vagina as well. The reason is that this particular blood is regarded as the only proof of chastity, virtuousness, and of being a 'good girl'. Wynn discusses the "horror of the contamination of a virgin's pure blood by the impure, false blood produced by hymenoplasty" (Wynn 2013, 40). This further underlines how it is not important where the

blood originates from, it is the cultural meaning ascribed to it which makes the 'original' hymeneal blood sacred.

The resemblance of the relationality that is created between re-virginisers in online communities through blood to that created by especially mothers-in-law requires attention as well. In some families, especially in rural areas, it is still a custom that especially the mother of the groom waits for the 'blood news'. In other words, it is expected that the groom will let his mother know via phone, or in person if they are in the same house that the intercourse has been successfully completed, and that the bride has bled (this is not necessarily followed by the display of the blood on the sheet). Mothers-in-law tend to anxiously wait for this information on the nuptial night. On the one hand, the receiving of the blood news gives confirmation of the prowess of the man that he has been able to have an erection long enough to penetrate the woman's vagina. However, as Dr Jale has pointed out, "men are not brought to a doctor if they haven't had an erection" (Dr Jale, Ankara, April 2017, personal interview), whereas many women are taken to a gynaecologist if they do not bleed on their nuptial night, as Nazlı's story leading to divorce has illustrated above.

In a very contrasting but at the same time similar manner, re-virginisers wait around online to hear the news that their friend has bled. In this eager yet anxious expectation, re-virginisers both form a sisterhood around blood and feed their hope by seeing examples of successful re-virginisation before them. Many women wait for their fellow re-virginisers to let them know of their 'blood news' before they embark on this process. The blood is encapsulated in expectation, anxiety, and hope. Where there is no news, re-virginisers express their anxiety, exemplified by the following quotation:

> Please honey, it's been a battle of nerves here. Please come back. Please come back with your good news. Don't you see us in your dreams, my friend? We are left here like orphans. (Thread 43, August 2014)

In the event of one 'bad' news, i.e. news of not having bled during or after penetration despite the operation, however, re-virginisers tend to go as far as attempting to cancel their doctors' appointments. One re-virginiser suggests to another, "Dear, cancel your appointment, I will too. I had put all my trust in this, I lost all hope" (Thread 43, November 2012). Re-virginisers rely more on fellow re-virginisers' experiences than the word of the doctors, as they fear that doctors might just be after their money. Hence, the blood news becomes the ultimate proof that they too can re-virginise and successfully overcome the nuptial night. One re-virginiser states, "the most logical decision is to rely on those who have had it done, that's what I believe from now on. I don't even believe the doctors, they are all marching to different tunes" (Thread 43, April 2012). This re-virginiser's fear is not ungrounded. As I was waiting for Dr Jale while she saw her patients, and interviewing her in

between the appointments, I witnessed a call from one of her hymenoplasty patients. The conversation took place between her secretary Irmak and a former patient who had received hymenoplasty. Even though I could not hear what the woman said, what happened for this woman on her nuptial night was clear to understand.

> Woman on the phone: …
>
> Irmak: Were you able to wipe it on the tissue and show it [to your husband]?
>
> Woman on the phone: …
>
> Irmak: [*curious*] No blood at all, is it?
>
> Woman on the phone: …
>
> Irmak: I'll arrange for you to talk to the doctor later, she's now seeing a patient. (Ankara, April 2017)

Before this conversation took place, I had asked Dr Jale whether she had had any patients who didn't bleed following hymenoplasty. After a pause, she had said no. This phone conversation, however, clearly illustrates that there are women who do not bleed following the operation. Therefore, the worries of re-virginisers are not unwarranted, which renders the 'blood news' and sisterhood even more significant as their re-virginisation process unfolds.

The Expert Websites

Apart from attempts to see the hymen, and looking at the sheet and hoping to see blood, the only other visual element that forms part of the re-virginisation process is the images one comes across on 'expert websites'. These websites are where either the working of artificial hymens is explained and where they can be purchased, or where hymenoplasty techniques are detailed by medical doctors. The images used on these websites play an important role in how we come to imagine virginity and the virgin body, given that re-virginisers, especially during their research phase are exposed to these images on a daily basis. Creating a re-virginisation market becomes possible only through attributing certain roles to women and making them believe that re-virginisation is the only path possible for women who do not have an intact hymen, or those who suspect that they might not bleed. Re-virginisation 'experts' accomplish this goal through the websites where they 'educate' women, where advertisement wears the cloak of education. Through images, as well as texts, they communicate their imagination of virginity, which then shapes women's imagination of their own virginity and bodies as well. In other words, re-virginisers become through these images, as well as the notion of virginity becoming through its relationality with the creators and audience of these images.

As women resort to these websites to get the 'expert' opinion, they get exposed to the "image world" of virginity first-hand. Deborah Poole describes the "image world" as follows,

> It is a combination of these relationships of referral and exchange among images themselves, and the social and discursive relations connecting image-makers and consumers, that I think of as forming an "image world". (…) The specific ways in which we see (and represent) the world determine how we act upon that world and, in so doing, create what that world is. It is here, as well, that the social nature of vision comes into play, since both the seemingly individual act of seeing and more obviously social act of representation occur in historically specific networks of social relations. (Poole 1997, 7)

Hence, the images of virgin women and of re-virginisers as imagined by re-virginisation experts are not sitting in a vacuum, and instead are part of an "image world", which determines how virginity and re-virginisation are viewed by re-virginisers themselves, as well as by other women and men. The images displayed on these websites create a public consciousness with regards to what virginity *looks like*, in addition to what virginity does and does not do. As will be detailed below, the images suggest that virginity and hence re-virginisation create happiness, both in the moment and for the future. Virginity is shown to cross temporal boundaries in instigating feelings of security and safety in the marriage as a result of which happiness is believed to be established.

Poole, in studying images in relation to modern racial discourse, stresses "the role of visual images in the structuring and reproduction of the scientific projects, cultural sentiments, and aesthetic dispositions that characterise modernity in general, and modern racial discourse in particular" (Poole 1997, 6). I contend that the images on expert websites, alongside the texts published by these experts, construct a discourse around gender that not only perpetuates the importance attributed to virginity but also encourages re-virginisation in an attempt to revert women back to marriageability. This medical and social project goes alongside the national project detailed in the previous chapter where I had put forth that the state is more preoccupied with women starting a family than their virginity, and that re-virginisation is believed to be a tool for the family unit to stay intact, which does not threaten the national ideals around womanhood and bodily integrity.

The main and common message conveyed through re-virginisation websites is that women have become victims of men's sexual desire. Almost all websites suggest that women have been lured into sex, and thus 'deserve' re-virginisation. One doctor puts this in the following words on his website,

> Ladies[25] who have had a sexual relationship due to men's pressure, or who have an elastic hymen resort to hymenoplasty as a solution to this problem.
>
> (…)
>
> Once they are on the verge of marriage, ladies who have previously been forced into a sexual relationship that they did not consent to, or those who have had a relationship they regret, think that their spouse will not accept that they have had a sexual relationship before. They think that they can be subject to psychological pressure by both their husband and his family, that they can lose their husband, or even have their life threatened. Hence, they intend to prevent these problems by having hymenoplasty.[26]

Few doctors and no retailers acknowledge that this is a social problem. Most suggest that women cannot have consented to pre-marital penile-vaginal intercourse, neglecting the possibility that women might have desired and/or enjoyed sexual pleasure or intimacy. When this discourse is read alongside women's online conversations and the interviews I have conducted with both parties, it can be clearly seen that ignoring women's sexual desires leads re-virginisers to create a subjectivity that is aligned with doctors' assumptions and expectations. As one of women's main sources of information on re-virginisation is doctors' websites, it is expected for them to fit the non-virgin ideal as described by the 'experts' and as perpetuated by the online forum as well, as discussed in the Methodology chapter. Women thus put on the victim mindset in order to access re-virginisation, and push their desires aside.

Even though hymenoplasty websites provide detailed information about types of surgery, and its aftermath, providing this information is only an advertising strategy for some doctors. Dr Levent, for instance, has this kind of information on his website, yet he does not believe that re-virginisers need to know what will be done unto their body.

> Dr Levent: Researching perceptions of virginity is different. Of course hymenoplasty is included within this topic. Whether it's short-term [temporary] or long-term [permanent], that shouldn't be of your [a researcher's] interest. These are technical issues. Am I clear? When we look at this sociologically, what is the thing we need here? How is virginity perceived in society? How is it among

[25] The word translated here as lady is 'bayan', which can be more accurately translated as Ms. *Bayan* is a title like Ms, generally used to avoid addressing someone based on virginity status, as the alternatives are loaded in relation to virginity (*kız* [girl] refers to a virgin, *kadın* [woman] refers to a non-virgin). Nevertheless, feminists detest this word, as the feminine equivalent of man is *kadın*, and the use of *bayan* is a derogatory attempt at overlooking the use of *kadın* in relation to virginity loss.

[26] Kardas Arslan, Burcu and Korkut Arslan. 'Kızlık Zarı Dikimi icin Doktor Secimi' [Choice of Doctor for Hymenoplasty]. Kadin Sagligi & Dogum, Estetik Jinekoloji. Accessed 1 November 2019. https://www.drburcu-korkutarslan.com/uygulama/kizlik-zari-dikimi-icin-doktor-secimi/.

doctors? How is this reflected in society? What are the psychological disorders, sexual problems that can happen as a result?

Hande: Hymenoplasty is a result of this too.

Dr Levent: [*gets angry*] That's the technique, how this and that happens, hymenoplasty is related to loss of virginity [*bozulması*] but it's a technical part, psychologically, whether you have done a flap operation on the girl, whether it's short-term or long-term, it doesn't matter, it's no use for your research.

Hande: There's very little research on this in Turkey.

Dr Levent: Very little around the world too, but there's already plenty [of information] on the Internet, there are 3-4 methods. That's not about the society, neither does the patient know about it, which method is used, nor does it help her to know that.

Hande: Your point about the patient not knowing?

Dr Levent: You don't go and explain the method. Do you[27] think that's needed? Let's say you see someone for rhinoplasty, they'll say they will do it with method x, another one will say they'll use method y, or method v. You wouldn't be interested in that, you'd say, what's important is, this is the problem with my nose, I want it to be aesthetically corrected. The technique doesn't matter much to us, right? Because that's sort of, let's say you're flying to London from here, the pilot will say to you I'm not gonna fly over Budapest but Serbia. That's not important to you.

Hande: But if it changes the time I will arrive… [Dr Levent interrupts]

Dr Levent: When am I gonna arrive, what's my goal, that my nose is changed, I want my nose to be changed, that's it. But you can't say [to the pilot], don't fly over Serbia, fly over Hungary. (Dr Levent, Istanbul, March 2017, personal interview)

This interview illustrates a stark contrast between the information provided on the websites and how doctors view this information. Of course, it's not possible to generalise this doctor's views to that of all gynaecologists on the matter. However, it is striking that even though general information is shared online, Dr Levent is not necessarily interested in a woman learning about what will be done unto her body, as long as she gets the 'desired' result. Ownership of the body requires attention here again, as well as how the operation is seen as

[27] This is the point where Dr Levent started addressing me with the informal you [*sen*] instead of the formal you [*siz*] which he used until that moment.

a technicality by the doctor. With no explanation to the woman, the doctor claims space and time over, and authority to alter the woman's body. Even though he opposes the idea that re-virginisation techniques need to be studied, the very idea of his that it shouldn't be shows that it indeed is necessary to do so.

In both artificial hymen and hymenoplasty websites, experts make use of a wide variety of stock images. Even though these images are not specifically created for these websites, the selection of these particular images is noteworthy. On the one hand, the images of 'white' women perpetuate the 'Western' idea of the body. On the other, these images contain certain common elements that complement the 'information' provided by text and allow us to unpack the messages conveyed to women and society in general with regards to what virginity means and who a re-virginiser is. Most images in these websites are white or pastel in colour, in line with the 'softness' of the woman, or more specifically, of the virgin woman, even if she is re-virginised. This sentiment is perpetuated and further expanded by three common elements on websites, which are how (i) vulvas, (ii) flowers and (iii) wedding dresses are depicted.

(i) *Vulvas (see Figures 1-3)*: Most of the images on re-virginisation websites portray women, either their faces or genitalia. However, women's genitalia are never shown explicitly and are covered with clothes, hands, or more commonly, flowers. The covering of the vulva through a variety of means conveys the idea that this is a part of the body that should not be seen or touched by another, unless one is married, of course. This portrayal perpetuates the idea that pre-marital sexual relationships are wrong, through a compulsory invisibility of the virgin vulva.

(ii) *Flowers (see Figures 2-4)*: Even though the Turkish language does not have a phrasing similar to defloration to refer to 'virginity loss', flowers are a recurrent imagery on re-virginisation websites. They are not only used to cover vulvas but also portrayed as a symbol of happiness and freedom, especially in images where women are running happily and freely in a field of flowers. On the one hand, flowers are used as symbols of women's innocence, i.e. lack of sexual experience, even if the lack is constructed through re-virginisation. On the other hand, re-virginisation is presented as a method of liberation that running through the fields suggests. The woman is liberated from the psychological pressure due to not being a virgin, or due to having an elastic hymen, through re-virginisation. This kind of imagery perpetuates the idea that re-virginisation brings freedom, which underlines and re-produces the importance attributed to virginity, while subtly implying the pressure that norms create on women.

(iii) *Wedding dresses (see Figures 5-8)*: Re-virginisation websites make frequent use of images of women in wedding dresses. Sometimes these are women who look happy with their husbands, other times and more frequently, they look distressed, desperate, or are even in chains. Not only does the 'desperate bride' warn the women against marrying as a non-virgin, as this would be unacceptable, but also the images with wedding dresses reinforce the idea that having an intact and blood-generating hymen is a necessary step to getting married, making virginity an intrinsic precondition of marriage.

Expectedly, a medical language is used to persuade women to re-virginise at the advertised clinic or by the advertised doctor. However, it is not only hymenoplasty websites that employ a medical language but also artificial hymen websites that do so. As discussed in detail in the Introduction, the use of the artificial hymen does not involve any medical parties. However, as hymenoplasty is the most common method of re-virginisation women resort to, artificial hymen retailers employ a medical language to persuade women that their product is as reliable and effective as hymenoplasty. This can be seen both in the imagery, where one of the websites one can see a team of people in white coats and statoscopes creating the idea that doctors recommend or are involved in the development of the product, as well as texts, such as the statement, "Recommended by dermatologists and plastic surgeons" (see Figure 9).

It is unclear which dermatologists and plastic surgeons recommend the artificial hymen, and why a recommendation has been allegedly sought from dermatologists instead of gynaecologists or plastic surgeons. Furthermore, most of the doctors I have interviewed had not heard of the artificial hymen, and both the ones that have heard of them and the ones that learned about it through me stated that there was no way of knowing how effective using the product would be, especially when the contents of the artificial blood are unbeknownst to the women, as well as the retailers themselves. Thus, the validity of the medical support given to artificial hymen is highly dubious. Furthermore, one website states, "it [the artificial hymen] has been approved by the German Ministry of Health, and it has been proven that it is suitable for all age groups and body compositions/physiques".[28] Another retailer has suggested in our interview that the artificial hymen they were selling was approved by the Ministry of Food in Turkey. At the time of the interview, there was no Ministry of Food. What used to be the Ministry of Food is now the General Directorate of Food and Control under the Ministry of Agriculture and Forestry. More importantly, however, is that there is no proof of either approval on the side of the ministries in Germany or Turkey. By

[28] *Yapay Kızlık Zarı* [Artificial Hymen]. 'Yapay Kızlık Zarı' [Artificial Hymen]. Accessed 1 November 2019. https://www.kizlikzari.biz/yapay_kizlik_zari_hakkinda_soru_ve_cevaplar.html.

Photo of woman covering the vulva removed for copyright reasons. Copyright holder is Op. Dr. Rohat Kutlay.

Figure 1

Photo of woman with a flower in front of her vulva removed for copyright reasons. Copyright holder is Op. Dr. Nurettin Ersoz Ince.

Figure 2

Photo of woman with a flower in front of her vulva removed for copyright reasons. Copyright holder is Op. Dr. Suleyman Eserdag.

Figure 3

Photo of woman in a garden removed for copyright reasons. Copyright holder is Op. Dr. Korkut Arslan.

Figure 4

Photo of bride in chains removed for copyright reasons. Copyright holder is Op. Dr. Korkut Arslan.

Figure 5

Figure 6

Figure 7

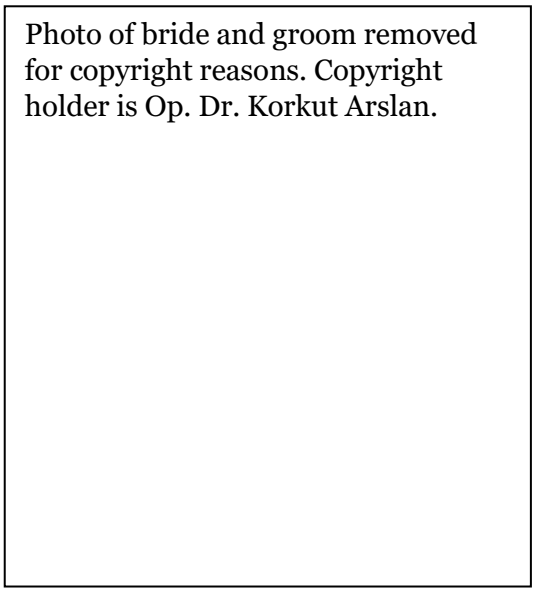


Figure 8

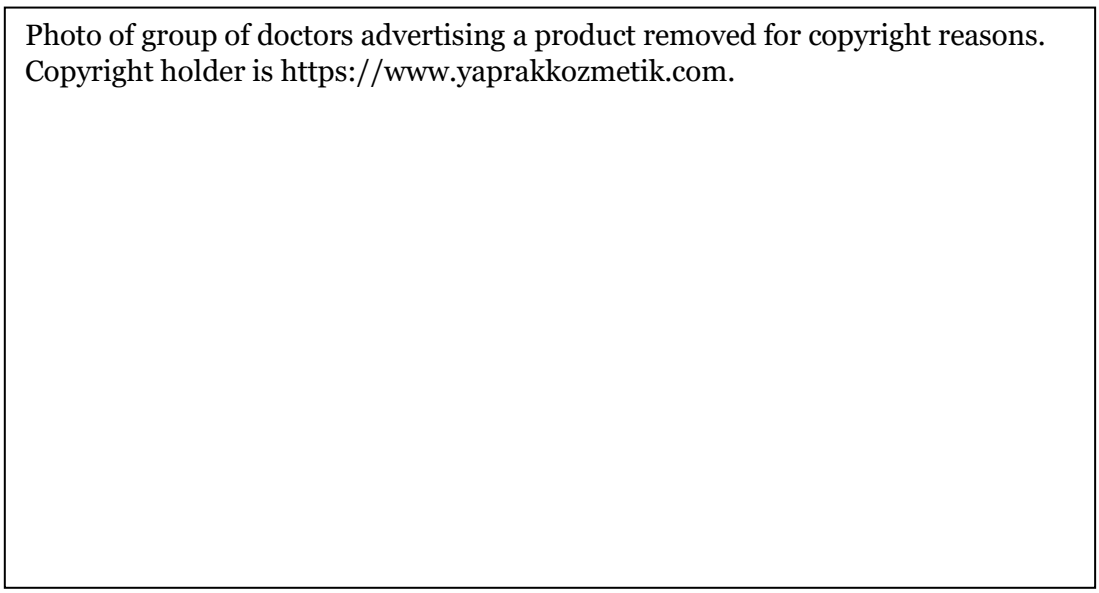


Figure 9

suggesting that these products are approved by government authorities, retailers are attempting to create a feeling of safety and security with regard to their products. However, there are no regulations regarding the sale of artificial hymens. Therefore, this is a false feeling of safety as it has no ground.

The idea that the artificial hymen is suitable for all kinds of physique also deems attention. One artificial hymen website states, "As the artificial hymen is produced from herbal materials, it causes no allergic reaction in the body whatsoever. And that it doesn't have any toxic [materials] has been proven by clinical trials" (Yapayzar n.d.). In the interviews that I conducted and the webchats that took place between the customer representatives and me, none of the interviewees were able to respond to the question, "What materials are in the artificial hymen?". Here's one of the webchats I experienced with a customer representative:

> Hande: Hi, I'm curious about the exact ingredients of this product, to make sure it doesn't cause any allergic reactions. Could you provide me with some information?
>
> Customer Representative: Hi.
>
> it's artificial blood.
>
> doesn't have the slightest harm or side effect
>
> Hande: What is the exact content of the artificial blood? I'm asking because my body is a bit allergic.
>
> CR: Ask logical questions.
>
> Hande: I believe I have asked a logical question, at the end of the day it's an artificial material. I talked to a gynaecologist, and she told me that we cannot be sure about allergy unless we know the exact ingredients.
>
> CR: They are herbal mixtures
>
> all in all there is NO blood
>
> would they make something that would cause harm
>
> who would take that responsibility
>
> Hande: Yes, it's stated that it's herbal on the website as well, but every body is different, if one can have an allergic reaction to strawberries, one can have to this too.
>
> CR: Let's do it this way
>
> if you want to give an order

do it through the website

the officers will call you and confirm it anyway

have a good evening (Yaprak Kozmetik, February 2017, online chat)

This is the reaction a woman faces when she tries to find out what materials she is suggested to put in her own body. When this conversation is thought together with the views of Dr Levent, it is possible to see that re-virginisation experts are mostly keen on remaining as such, while they claim authority over women's bodies. They claim this authority by denying information to women.

Circling back to the relationship between seeing and ownership, I have unpacked how women's hymens and blood are claimed by the people who see them, especially their doctors, partners, and partners' families. Through the images and texts on the websites, it is women who look at bodies that represent their own. However, seeing happens through the lens of re-virginisation experts, who filter the images to be circulated through social norms around marriage and gender. Therefore, here, more than the act of looking, our attention needs to be drawn to what is made available to be looked at. With blood and the hymen, the act of looking and seeing is more important than what is available to be looked at. Here, on the contrary, the object and the subject of the act are central to the discussion, and these objects and subjects have a significant impact on the act of seeing, and on what is being looked at.

Conclusion

Throughout this chapter, I have portrayed how notions of visibility and invisibility are imbued in re-virginisation practices, as well as demonstrating how looking at re-virginisation through this lens provides us with insights into gendered forms of oppression and the hierarchy within the medical institution. As a result of power relations formed around gender, sexuality, and the body, some body parts are made visible to certain eyes. The blood and the hymen are in particular made visible to doctors, nurses, partners and families, as well as to women themselves. Furthermore, I have stressed that images from 'expert' websites, which form the other visible side of re-virginisation play a significant role in how re-virginisers *become* from a Deleuzian perspective, as their interrelationality with these images has an important impact on how they come to imagine virginity and the normal-ideal re-virginiser.

While hymen and the blood play with our understanding of what is visible and what is not, there is a significant phase of re-virginisation that tends to be neglected and invisibilised, which is the pain women undergo throughout this process. I will tend to the affective side of re-virginisation in Chapter 7. However, before that, I will shift the focus to the physical pain

women experience and what this pain can tell us about the body and sexuality, as well as how it can challenge the common understandings of what pain is.

6. Healing the Body, Desiring the Pain: The Embodied Experience of Re-Virginisation

Parts of this chapter have been published as Güzel, Hande. 2018. 'Pain as Performance: Re-Virginisation in Turkey'. *Medical Humanities* 44 (2): 89–95. doi.org/10.1136/medhum-2017-011414.

> *Wounds don't heal very fast. Normally, you should wait for 2-3 months just to see if the sutures stayed in. If the man in front of you insists on seeing the blood, then you should have the flap operation [permanent hymenoplasty] 2 or 3 weeks before [having sex]-alongside [vaginal] tightening. And then you'll see how much you'll bleed! It will hurt a lot, but bleeding will happen for sure as well.*
>
> Re-virginiser, posted online (Thread 33, October 2012)

Even though blood seems to be central to virginity and re-virginisation, vaginal tightness (and hence difficulty to penetrate the vagina) is seen as one of the proofs of virginity as well. Just like the common myth that every virgin woman possesses a hymen that covers the vaginal entrance, the myth that a woman who has not had sex should feel tight persists. And while the existence of the hymen is to be proven via blood, tightness is to be proven via pain. As a result, pain is a central experience in re-virginisation. Even though it is not possible to differentiate between emotional and physical pain women go through, and even though both of them are illegitimate hence invisible, here I will focus more on the bodily sensations that are experienced as part of this process, which are frequently overlooked in the literature, while turning to affect in the next chapter. Although this division is artificial, analytical purposes render it necessary. However, as a result of embodiment always already being affective, emotions will come up in this chapter, and bodily experiences will do so in the next one.

In this chapter, I argue that pain in the process of re-virginisation (i) is desired and sought-after, and (ii) is a gendered and temporospatial performance. Within this performance, pain manifests itself as a functional experience as well, especially as a marker of having been operated on, of having had a successful operation, as a reminder of this operation, and finally as an experience around which a community can be formed. Although pain can be functional at most stages of re-virginisation, when, where and how it can be performed is determined intersubjectively. Within the discussion on pain, I will also discuss the "technologies of the self" (Foucault 1988) that women employ on themselves as they go through hymenoplasty

and demonstrate how the neoliberal understanding of the body generates solidarity simultaneously with distrust in doctors.

Pain in the Literature

Since the 1990s, social scientists have focused on rescuing pain from being contained to the medical realm, and have started to bring attention to the narratives of pain by those in pain, rather than by medical staff (Bendelow and Williams 1995). This has made it possible to conceptualise pain not as an objective, but as a subjective experience, whose perception is not free from cultural or social construction (Bendelow 1993; Honkasalo 1998; Williams and Thorn 1989). The subjective nature of pain has brought up discussions around the communication of pain. Elaine Scarry's seminal work on this topic has drawn attention to the difficulties in expressing pain, and how the world of the one in pain can never be fully understood by the listener (Scarry 1985). Nevertheless, as has been noted by other researchers as well (Good 1994), I argue that pain *can* be communicated, and the focus needs to be shifted from whether or not pain can be expressed to how it is expressed. The online forum discussions that this thesis and this chapter in particular draw from are significant examples of how pain is communicated. This calls for studying the myriad ways pain can be communicated, as well as the consequences of communicating (or not) this pain. This entails considering through which means pain is shared with others, and which expressions are used to illustrate pain. Online forums create a relatively safe space for women for this purpose, while they cannot express their pain elsewhere. In these forums, pain experience takes "a collective form" (Gonzalez-Polledo and Tarr 2016). Hence, it is necessary to acknowledge that the experience of pain is always intersubjective (Kleinman et al. 1994). How much pain one feels and how much of this pain one is willing to express always depends on one's interaction with other beings, and to this, it is possible to add things, such as medical devices and the artificial hymen. Gonzalez-Polledo calls for a "reimagining of pain through intersubjective, temporal, and material and knowledge ecologies", which she conceptualises as "painscapes" (Gonzalez-Polledo 2017). Re-virginisation is one of these painscapes.

Despite the overarching acceptance that pain is something to be gotten rid of, many scholars make a distinction between "good pain" and "bad pain" (Rivera et al. 2012; Thomas and Tarr 2009). Within this categorisation, the latter usually refers to pain that hurts and is rather difficult to endure, whereas the former is seen as necessary or is believed to have a function in the body. Pain that is necessary can be the result of bodily work such as exercising and dancing, as the pain in this case is the proof to oneself that the body has been put under the necessary stress to progress. However, how this pain is interpreted by the one in pain and by its immediate community is not necessarily the same, which blurs the lines between good

and bad pain (Cavallerio, Wadey, and Wagstaff 2016). Bendelow and Williams refer to good pain as the "constructive use of pain", where pain is "an ally" (Bendelow and Williams 1995) rather than the enemy. Authors have also stressed that pain has a "signal function" (Bendelow 1993) and functions as a reminder (Leder 2016). Although pain is referred to as good, constructive, or creative as well as destructive or bad, this definition of pain is still based on a division between pain and pleasure. However, this dichotomy falls short of making sense of the experience of pain, especially when the focus is shifted from chronic pain to acute pain. As Bendelow suggests, "pain as an emotional experience, the obverse of pleasure, is in fact a much older conceptualisation than of pain as a purely physical sensation. The pain/pleasure dichotomy developed by Aristotle is constantly evoked and reinforced throughout the history of social thought" (Bendelow 2000, 11). However, as this chapter will illustrate as well, this dichotomy is constructed as a result of the over-emphasis on chronic pain, and by overlooking the intersection between the two sensations. When the focus is shifted away from medically-induced pain, the elusiveness of the lines between pain and pleasure can be seen even more clearly, as in the examples of physical exercise (Cavallerio, Wadey, and Wagstaff 2016), sado-masochism (Taylor and Ussher 2001) and tattooing (Klein 2014). Similarly, Amy Chandler addresses the elusiveness of the line between pain and pleasure by referring to self-injury, and puts forth that "pleasure and pain became amorphous, fluid entities" in her participants' accounts (Chandler 2013, 722). Re-virginisation allows us to see this fluidity as pain becomes the desired end, rather than only having a signalling function, or being otherwise generative. Pain and pleasure intertwine in re-virginisation also through the pleasure of passing as a virgin and the pain that is involved in this process. Chandler also refers to pain as the end rather than the means, as she argues that "pain in some cases appears to be framed as a primary aim of the practice of self-injury, rather than a (generally unwanted, if not always negative) side-effect" (Chandler 2013, 717). Although pain is given a multiplicity of meanings by re-virginisers, ultimately, it is a sought-after experience. However, the relationship between pain and re-virginisation has been rarely touched upon in the literature so far. The only link that has been drawn between the two has been the possibility of having a painful wedding night following hymenoplasty (Kopelman 2014; Wynn 2016). Nevertheless, as this chapter will illustrate, pain and re-virginisation intersect at many more points.

Pain in Re-Virginisation

For the re-virginiser, pain is desired, as it is regarded as the marker of having had an operation. Due to not being able to share their re-virginisation with friends or family, many women visit the gynaecologist or plastic surgeon on their own, which creates a feeling of insecurity. Added to this is the fact that the operated area cannot be seen by the naked eye,

and not having control over one's own body under anaesthesia or sedation. Therefore, re-virginisers fear that they have not been operated on at all. Dr Önem argues in our interview that there are many "charlatans" in the field of hymenoplasty. She states,

> Of course, it is uncustomary to call my colleagues that. They [the doctors] say they have done the permanent [hymenoplasty], she [the patient] comes [to me] for an examination, for the control [appointment]. She didn't go to them [the doctor who operated on her], because they didn't accept her, they didn't answer her calls after the operation. In other words, they didn't stand by the patient. That's one [issue]. You have to stand by the patient. Secondly, I look at it [the vagina], they haven't done anything, it hasn't even been touched. What is that? If you like, we can call this not charlatanry, but fraud. (Dr Önem, Ankara, May 2017, personal interview)

These stories find their way to patients as well, and as a result, they look for a marker of having had the operation, which manifests itself in the form of pain. When women do not feel pain following the operation, they question whether they had the operation. One woman states, "I don't have any pain at all. When I look at it [the vagina], there are no stitches visible either. It's as if nothing has been done. I don't understand it" (Thread 17, January 2015). Similarly, another woman states, "I don't understand it. Pain, [a] burning [sensation], nothing happened. It's as if the doctor said they sutured it [the hymen], but fooled me" (Thread 43, December 2012). As Dr Önem has affirmed, women's worries and fears are not unfounded and point to a problem of trust between the doctor and the patient. As a result, women prefer to trust their own bodies, rather than doctors' statements pertaining to the operation. This is crucial in the way pain is conceptualised, as most scholars point at pain as a threat "to core identity", and argue that "pain can disassemble self, leaving a state of panic, which by definition is uncontainable and requires social negotiation and social management" (Aldrich and Eccleston 2000). In the case of re-virginisation, however, lack of pain following hymenoplasty creates a state of panic that needs to be resolved, as for women, it might mean that they have not been operated on after all. Pain, then, has a control function for women to ensure that they have been operated on. Women's trusting their own bodies rather than the doctors also demands attention, as it endangers the authority of doctors. However, women find it possible to trust their bodies only through the collective, rather than the individual. They read about other women's experiences of pain following the operation, and look for the same marks of having been operated on.

Re-virginisers perceive pain not only as the marker of having had an operation but also of having had a *successful* operation. The success of re-virginisation operations is measured in two ways. The first one is the follow-up visit, which usually takes place one month after the

operation. In this appointment, the doctor examines whether the new sutures have stayed in to form a tissue that makes it difficult for the penis to penetrate the woman's vagina. This is possible only in permanent (enduring) hymenoplasty, as the sutures in temporary (transient) hymenoplasty are not supposed to heal, as described in the Introduction. The second one is bleeding following intercourse. In the time period between the operation and the follow-up visit, women do not have the means to tell whether their operation has been successful. Therefore, they again rely on pain to determine this. Re-virginisers perceive the lack of pain following the operation or a fast healing process as an unsuccessful operation. One woman states, "Feeling good and relaxed started to disturb me as well. I wonder whether it [the sutures] stayed in? We won't feel relief until the wedding day" (Thread 43, March 2012), while another asks a fellow re-virginiser, "Did you have any sense of tension, stinging, or bleeding? I don't have any of these. That's why I'm feeling very nervous. But the doctor didn't do tightening on me-said it was already tight. I'm wondering if that's why I'm not feeling any tension. I don't have the courage to call the doctor either" (Thread 20, December 2011). As these examples illustrate, women expect to have pain especially following the operation, and see this as an indispensable part of a successful re-virginisation.

The *anticipation* of pain after the operation also marks a successful operation for re-virginisers. As discussed in Chapter 4, many women travel to bigger cities to have the operation, rather than seeing a doctor in their city for fear of running into an acquaintance at the clinic or hospital, or into the doctor after the operation outside the medical space. As many re-virginisers live with their parents, they schedule a day-trip to the city where they will have the operation. While it is important to not be in so much pain so that they cannot travel back, the anticipation of pain that might preclude travel is thought to signify a more successful operation. A woman seeking re-virginisation shares her thoughts on this as follows,

> A friend has been operated on by Dr Ahmet, hers was very painful and it was really difficult after the operation as well. With [Dr] Ufuk, it is all so easy, he says you can even travel back by bus. That means there is a difference between the operations and I think the operation by Dr Ahmet is more serious and detailed. (Thread 1, March 2015)

Although many women decide not to be operated by gynaecologists like Dr Ahmet due to difficulties in travelling, doctors whose operation requires longer healing processes are acknowledged and appreciated. Nevertheless, the same cannot be said for pain during the operation. This pain is categorised as 'bad pain' by re-virginisers, and doctors who ignore their patients' pain during the operation are frowned upon. The initial pain felt by the needle to anaesthetise the vagina, or in some cases, from the waist down is expected and

accepted. This pain is the entry point to hymenoplasty. However, any pain after this is unacceptable. One woman who has experienced 'too much pain' narrates her experience as follows,

> I had hymenoplasty several days ago, (…) but I wish I hadn't. Is it possible for an operation to go this bad? I can't tell you how much pain I was in. I cried so hard. I guess he did not anaesthetise that region of mine. Just like you, I had this happen to me when I was dreaming of getting married. (…) I was compelled to [have this] operation, but I wish I had been to a better doctor, I went [to him] because it [his clinic] is close to the city I live in, but I regret it. I guess my sutures did not stay in, everything was perfunctory, the doctor kept scolding me. I couldn't ask a single question, and I paid a lot of money. Should I feel sorry for this incident [virginity loss] happening to me, or for the way I was treated? The man [the doctor] chopped me up like a butcher. (Thread 43, July 2012)

This example illustrates the stark contrast between what is acceptable pain, and what is not. Although pain during operation could also signify having had an operation, it is regarded as 'bad pain', while pain during healing is not. This distinction can be explained by the space in which the pain is felt. Within a medical setting, pain is still regarded as something that needs to be gotten rid of, as a threat that "creates panic" (Aldrich and Eccleston 2000), while outside this realm, pain is attributed a new meaning, that of having had a successful operation. This meaning making process is significant, as it takes place in the online platform only, and hence becomes a collective meaning making process. Although women consult their doctors as well to make sense of the pain, they are usually told that pain might be expected following the operation, and painkillers are the solution to them. The medical realm falls short of addressing the subjective nature of pain, as a result of which women turn to their online communities to produce a new meaning, and to look for meanings already produced that can explain their subjective experiences. Through these mediums, women selectively share their experiences and rely on fellow re-virginisers to make sense of their pain. Here, it is possible to describe women seeking re-virginisation as 'prosumers' (Newhouse, Atherton, and Ziebland 2017) who both produce and consume the medical and non-medical experience of pain. This fine line between the roles of the expert and the patient (Ziebland 2004) is more blurred online than in other settings, and the elusiveness also brings up questions such as whose pain is acceptable or respectable, not only with regards to gender as Bendelow and Williams have pointed out (Bendelow and Williams 1998), but also with respect to the forming of an online subjectivity that is accepted by other re-virginisers, as discussed in the Methodology chapter. Only then is it possible to share one's pain, share it to others and with others. It is also important to see who gets to share

their pain experience, as there are more women who read the online posts than the ones who post. This may cause some women's voices to be heard more loudly, and these voices may be treated as false representatives of a varied experience.

The subjective nature of pain makes it difficult for re-virginisers to make sense of their bodily sensations or lack thereof. On the one hand, there is no uniform experience of hymenoplasty, and of healing afterwards. Therefore, it is expected that women have differing levels and/or experiences of pain in the process. However, as women are able to share their experiences online only, this gives them limited access to the realm of pain in re-virginisation. Therefore, they compare their lived experience to those of other women who post online, where they draw conclusions about the relationship between their pain, or lack thereof and their re-virginisation process. As feeling pain also becomes an experience that brings re-virginisers together, it can be expected that pain following hymenoplasty is the acceptable form of experiencing re-virginisation. This way of thinking denies the subjective nature of pain and expects that every woman will go through the process in the same way, despite the differences in thresholds of pain and in women's bodies overall. Therefore, online communities are on the one hand generative in terms of meaning making, but are also questionable in which meanings they tend to make, and which ones they disregard, albeit unintentionally.

The Performance of Pain

Re-virginisers are allowed and encouraged to share their pain and make it visible in their online communities. In fact, pain becomes an anchor for re-virginisers, around which they can form a community. This holds true for both the emotional and physical pain re-virginisation generates, although it is not possible to separate the two. Nevertheless, the performance of pain during the healing period is compulsorily invisible. It is denied from re-virginisers in their private offline settings, especially in their workplaces and homes, as most of them are living with their families. As most re-virginisers do not share having had hymenoplasty with their co-workers or family members, they need to downplay their pain, while in the online communities, pain is over-emphasised especially to 'brag' about the difficulty experienced during penetration. Having had premarital sexuality takes away from women the permission to perform their pain during the healing period, no matter at what level it is manifested, or the performance needs to be masked as the pain coming from a different source. A woman who seeks re-virginisation shares her indecisiveness about having hymenoplasty for fear of performing her pain offline. As she addresses another user who has recently had a hymenoplasty, she states, "a lot of time has passed, but you say that you still have stinging and burning. I fear a lot that if I cannot go back to my normal routine, people around me will detect [that I had surgery]. I am concerned" (Thread 19,

March 2015). The pain in the healing period causes women's bodily movements to change significantly. Many re-virginisers report difficulty walking and sitting down, and those who work in the service sector where they need to work for long hours standing up suggest that re-virginisers should take at least 2-3 days off following the operation because of their pain. Those women who have no choice but to perform their pain use and suggest the use of alternative explanations for this performance. One frequent alternative is pretending that one has haemorrhoids, as one user claims following her hymenoplasty, "Everyone notices [the change in your movements]. I told them I had haemorrhoids, I had no other option" (Thread 1, July 2016). Similarly, another woman who had the operation during wedding preparations talks about the difficulties she is experiencing as follows, "'I'm in a hustle and bustle. We are shopping for furniture. Families are around, I spend time with them. I have great difficulty walking and sitting down. People notice. I told [them] I was on my period, but it really hurts. My movements are limited" (Thread 17, June 2015). People 'noticing' their pain is one of the main problems re-virginisers face. While they try to make their pain unnoticeable offline, they make it visible by posting online. This is different from making people believe that they are in pain that is frequently discussed in the literature, as re-virginisers are by default devoid of the right to perform their pain due to the confidentiality of the operation. By not performing their pain, re-virginisers are performing the "virginal facade" (Ozyegin 2015). Selectively performing pain depending on temporal and spatial dimensions is how gender is performed by re-virginisers. Rather than being performative, this decision can be understood as "a strategy of survival within compulsory systems", where "gender is a performance with clearly punitive consequences" (Butler 1999, 178). As will be discussed below, women are encouraged to perform pain during the intercourse at the nuptial night, in stark opposition to pain during the healing period. The conditions of the performance of pain are intrinsically linked to the performance of gender, as which pain is allowed to be performed and where are dictated by norms around virginity.

While the performance of pain is not allowed offline following the hymenoplasty operation, it is *required* during the first penetrative sexual intercourse after the operation. For most women, this refers to the nuptial night, although some prefer to have sex a few weeks or days before the wedding, as they find it very stressful to withstand wedding preparations with the risk of not bleeding during intercourse. The pain during intercourse is indispensable to passing as a virgin, as it is thought to signify virginity, alongside blood. Pain felt by the woman during intercourse is associated with a tight vagina, which is associated with limited or no sexual experience at all. On the other hand, "a slack vagina, then, is specifically associated with (negative) judgements about sexual promiscuity" (Braun and Kitzinger 2001, 267). Therefore, pain is sought after during the intercourse, which is believed to be made possible by the vaginal tightening operations women usually have

alongside hymenoplasty, or via the regular use of vaginal tightening cream alongside the artificial hymen.

As tightness is thought to signify virginity, women not only perform pain during the first sexual intercourse following the operation but also overemphasise this experience in their online community. The following quotation summarises this as follows,

> When that moment arrived that night, I dreaded having sex with my husband. It hurt, he had difficulty [penetrating me], but bleeding happened too and I relaxed. Because my husband had difficulty, and because it hurt, he did not doubt anything and everything got resolved smoothly. That day, a new page was turned for me. (Thread 43, July 2012)

Similarly, another user shares her post-intercourse feedback as follows,

> I slept with my husband last night. Let me describe it for those of you who are curious. We tried unbelievably hard to do it. It was really difficult, friends. We tried for about an hour and my husband used a lot of force to do it. But this could be because of my anatomy, because when I went to the doctor they told me it [my vagina] was too tight. In conclusion, I bled about 2 spoonfuls of blood and I cried because of the pain. I can't quite sit now, it is painful. (Thread 1, July 2016)

On the one hand, women experience a significant amount of pain that limits their movement and causes them to cry. On the other hand, this physical pain brings about happiness, as they believe that they have been able to prove that they are virgins. Within the scope of re-virginisation, the hymen and the blood become "happy objects" (Ahmed 2010). Ahmed defines happiness as "an orientation toward the objects we come into contact with. We move toward and away from objects through how we are affected by them" (Ahmed 2010, 24). Whether the hymen and blood are "happy objects" depends on when and how women come into contact with them. When this contact takes place within a premarital sexual relationship, women move away from them, whereas when the contact happens within marriage and following re-virginisation for re-virginisers, women move toward the hymen and blood, making them "happy objects". Although being happy as a result of proving one's virginity is socially determined, re-virginisers take back their right to be happy via re-virginisation. One user states, "I got hurt, but that was the point. An enormous burden was lifted from my shoulders" (Thread 8, May 2016). The pain, therefore, is the means through which a woman sheds the weight of not being a virgin.

In some cases, pain is valued so highly that bleeding is thought to be replaced by pain. A woman who considered re-virginisation, but decided not to go through with it, for fear of being uncomfortable during the intercourse, prefers to rely on pain to pass as a virgin, as

she claims to have had one sexual encounter only. She puts forth her thoughts as follows, "My concern is not whether it bleeds. Won't he say, 'this girl was a virgin' when he has difficulty [penetrating me]? Maybe I will bleed as well, you never know" (Thread 20, December 2011). In this context, pain is desired even more than blood, as the feeling tightness gives to the man allegedly proves that the woman is a virgin. Here, the tactile sensation overrides vision, as lack of blood is not reprimanded by the user. On the contrary, some users contend that men enjoy seeing women in pain, as one woman suggests, "You should have [hymenoplasty], and I hope it will bleed. It [the operation] serves them right. All they think about is [sex], they like it when we are in pain" (Thread 43, September 2011). This gendered perspective on the experience of pain requires particular attention. On the one hand, it is expected that women endure pain so that men have a more pleasurable experience during sexual intercourse via increased contact between the penis and the vagina. On the other hand, re-virginisers always already endure pain as a result of not only hymenoplasty but also due to the feelings of shame and guilt. Therefore, the emotional labour and the physical pain become burdens on women's shoulders, or shall we say, vaginas, throughout the process of re-virginisation.

The expectance of women's enduring the pain goes hand in hand with the belief that women have "a 'natural' capacity to endure pain lacking in boys and men" (Bendelow and Williams 1998, 423), and that women are "thought to be more able to cope with pain, as in the young man who reckoned that pain was something that women were attuned to in their everyday lives from puberty onwards whereas 'all we do is shave'" (Bendelow 2000, 107). Due to this view, it feels part of the everyday life routine to ask the woman to endure the pain, and expect the man to take physical and/or emotional pleasure via this pain. If we recall Dr Zafer, who had confessed to having 'surprised' her patient with a new hymen when she had only consented to vaginal tightening, the picture becomes clearer. Although having two operations instead of one is sure to cause more pain for the woman, the doctor saw it as his right to modify the woman's body without her consent. This has its roots in, on the one hand, the medical profession's claiming ownership over women's body, and on the other, the assumption that women can tolerate pain, especially those who have given birth.

Healing and Bleeding

When re-virginisation is conceptualised as a *process*, rather than a moment, it is possible to see how the healing process seeps into the everyday life of the re-virginiser, and how it becomes a determining factor in the success of the operation. Although almost all doctors initially guarantee that the woman will bleed as a result of the operation, soon after the operation takes place, women find out that there are a variety of measures they need to take in order to bleed. Re-virginisers are promised a full and easy recovery following their

operation, yet find out soon thereafter that they need to be moving and not moving their bodies in a certain way in order to get the desired result. They employ certain "technologies of the self" (Foucault 1988) per their doctor's instructions, as well as the measures that they hear have worked for other re-virginisers through online communities. "Technologies of the self" are defined by Foucault as the technologies "which permit individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality" (Foucault 1988, 18). Women employ a wide variety of operations to attain the "purity" of virginity and to be the "perfect" marriageable woman in the Turkish context with the "help" of doctors and fellow re-virginisers. The measures advised by doctors range from not taking a shower for several days, to walking in smaller footsteps, from not swimming, riding a bike, or a horse, to not lifting heavy weights. As women are expected to employ these "technologies of the self" (Foucault 1988) on their bodies, they are made to bear the emotional burden of ensuring that the operation is successful, a burden that is delegated to the patient from the doctor.

The measures to be taken post-operatively are not only for pain management but also to recover from the operation without causing harm to the stitches to make sure that bleeding will occur. The reason is that even though most doctors give full guarantee prior to the operation that the operation will be successful, there is a good chance that they might not bleed unless women take the 'necessary care' and follow the guidelines. The interviews with doctors and the online conversations of re-virginisers paint different pictures regarding this guarantee. Many re-virginisers put forth that they have heard from the doctors a full guarantee that they will bleed, with expressions such as,

> "He told me it would bleed 1000%." (Thread 20, December 2011)
>
> "Honey I talked to Dr Banu, and she's giving 1500% guarantee." (Thread 20, April 2012)
>
> "The doctor said, 'You'll be like you are 14 after the operation. Don't worry about it, and re-start your life'." (Thread 43, February 2012)
>
> "He said, 'you'll have a hymen like you have just been born' [*anadan doğma zar*]". (Thread 12, July 2014)
>
> "Even if you visit another gynaecologist 2 months after the operation, they won't be able to tell. I guarantee it." (Thread 7, December 2014)
>
> "You can take a virginity report from forensic medicine [after the operation]." (Thread 33, October 2012)

Although these statements are reassuring for many re-virginisers, it is not uncommon for women to question doctors' motives and their claims' medical accuracy. As re-virginisation processes are imbued with emotions including trust, women try to do their best to not be 'fooled' by doctors, one of the means around this being online communication with fellow re-virginisers. One re-virginiser shares her experiences that led to doubt and mistrust as follows, "I'm doubtful of what doctors say, because I had permanent [operation] twice, and it didn't work, the tissue didn't heal. I lied on that table with the guarantee [that it would bleed], you see?" (Thread 43, November 2016). Similarly, other re-virginisers question the distinction made between temporary and permanent hymenoplasty, and try to understand why doctors encourage the latter, arguing that the former has a better chance of initiating bleeding, "Doctors say online that the permanent flap method has a 90% guarantee of bleeding, whereas the temporary one has 100%. How can we risk it then? Why do all doctors recommend the flap method if there's a risk [of not bleeding]?" (Thread 12, June 2014) is a question asked by a re-virginiser online. I have discussed the alleged distinction between temporary and permanent hymenoplasty in the Introduction, and have stressed that most women's experiences point towards the fact that it is the temporary operation that initiates and/or guarantees bleeding. Nevertheless, these operations are portrayed by doctors in a way that elevates the status of permanent hymenoplasty and downgrades temporary hymenoplasty. In relation to this distinction, permanent hymenoplasty is generally accepted to be the operation that women who want to heal from their past resort to, whereas the temporary one is for those who want a 'quick fix'. Among the re-virginisation community, it is more acceptable to want to heal, to regret the 'mistake' and move on to a virtuous life rather than resorting to a last-minute solution, which leads most re-virginisers to go through the permanent operation. Of course, there are other concerns for women, such as the trouble of finding the time and space to have the operation around the time of marriage, which also moves them away from the temporary operation. However, as the priority is the guarantee of bleeding, many women go through a much more painful healing period as a result of the recommendation of having the permanent operation by doctors.

While the information that women can access only through doctors' websites about the operations is conflicting at best, interviews I have conducted with doctors reveal other concerns that are not necessarily shared with re-virginisers. Dr Jale, for instance, shared with me the groups of women that have a lower possibility of bleeding following hymenoplasty, "Especially with diabetics, infected patients who do not pay attention to their hygiene, obese patients, overweight patients and people with loose connective tissue, the chance of success for these operations may not be 100%" (Dr Jale, Ankara, April 2017, personal interview). Dr Mehmet, on the other hand, believes that 'real' hymenoplasty is much more complicated than the operations advertised by popular doctors and that it

requires hospitalisation for one or two days. He further suggests that "the downside of this is that just like you cannot promise that every hymen will bleed, you cannot promise that this [the reconstructed hymen] will bleed either" (Dr Mehmet, Istanbul, December 2016, personal interview). This is a more accurate way of discussing the guarantee that can be given for the result of hymenoplasty. However, it is dubious whether this information is shared with re-virginisers themselves.

The intersection between not being able to perform pain offline and not being given full information on potential complications is bound to create a risky platform upon which re-virginisation rests. Although most doctors abstained from sharing stories with me where the outcome was far from what was expected, online forum data and few interviews show the other side of re-virginisation. Dr Ünzile was one of those few doctors, and shared with me the following:

> Dr Ünzile: I had this one patient, we repaired her hymen. She came back 3 days later saying she has bleeding. I checked her [sutures], there was nothing. 5 days after the operation, she had excessive bleeding. She said she didn't do anything [to initiate the bleeding], but I'm not sure [that she told the truth]. Her relatives called me to say that she passed out. It was really bad, I picked up the patient and checked her into the hospital. I re-sutured the bleeding areas. All of her relatives were there. It was a very difficult process, both for me and for the patient. I told her relatives that she has polycystic ovary syndrome. "I had removed her abscess. The sutures where I did that bled-we fixed that", I said. It was really bad. She was in a village far away, she called me at night saying, "I am bleeding, I am bleeding a lot". I said, "come here", and she said, "How? There are no cars here". After this, for a long time, I didn't do [hymenoplasty]. I said [to myself], "these [girls] don't listen to me, they're doing something [wrong]".
>
> (…)
>
> Hande: What did you tell the hospital?
>
> Dr Ünzile: At the hospital, we recorded it as "Bartholin's abscess", as "Bartholin's abscess drainage". It was ok, because she didn't have to stay there overnight. It was a private hospital. (Dr Ünzile, Ankara, April 2017, personal interview)

This narrative depicts many layers of secrecy involved in re-virginisation. On the one hand, the secrecy between the re-virginiser and her family makes it difficult for Dr Ünzile to medically intervene at a critical point. On the other, the medical institution needs to be part of the secrecy so that the operation can be kept off the record. As suggested in the Introduction as well, it is very common among doctors who conduct hymenoplasties in

private hospitals to record the operation as “Bartholin’s abscess”. In addition to secrecy, this narrative shows the mistrust of the doctor in the patient. Dr Ünzile assumes that her patients “don’t listen” to her, and hence decides to not operate on them for a time period. At the same time, she expects the re-virginiser to be responsible for any complications that might occur, putting the burden of healing on her. This powerful narrative packs into it many aspects of re-virginisation that make the process difficult for women.

Even though doctors provide some instructions about how to take care of the body following the operation, re-virginisers create their own ways of bodily movement or non-movement in order to cope with the post-operative period and to minimise their pain. Their online communication makes it possible to compare the guidelines given by different doctors. Following this, women refine these guidelines and employ “technologies of the self” on their bodies based on this discussion. Here is a list of precautions one woman took following her operation, which she shared with her fellow re-virginisers,

> I didn’t sit down for 10 days, I lied down the whole time.
>
> I didn’t use pads, I ironed and used old undershirts.
>
> I ate 2 cloves of garlic and 1 onion per day. (This is the most important point that helps the stitches to stay in.)
>
> I slept on my side for one week and I didn’t even lift 2 kgs of weight.
>
> I consumed a lot of liquids and every morning I ate a dried apricot so that I wouldn’t get constipated
>
> It’s gonna be rude but while defecating I always made sure to bring together the two labia with my hand. (Thread 1, July 2016)

These lists of techniques are deemed very valuable by other re-virginisers, and this is one of the strengths of forming an online community around re-virginisation, given the public and offline silence regarding the operation, and the difficulties women face when they need to communicate their concerns with medical personnel as they fear stigmatisation. However, just like other online medical communities, these forums run the risk of generalising one person’s experience to others, even though their bodies may require different types of treatment due to differences in sensitivities, and/or differences in the methods used by their doctors. As Newhouse et. al. suggests, in online platforms, “if experiences are presented powerfully yet are not typical or are biased or inaccurate in some way, optimal decisions may be missed or trust broken. Vivid or partially extreme experiences may not be representative of the unremarkable majority, whose voice may be lost” (Newhouse, Atherton, and Ziebland 2017). This becomes a central issue especially when online resources become the most

important means of obtaining information for patients, as in the case of re-virginisation. Another re-virginiser has taken more extreme measures to ensure that her stitches stay in. She advises another re-virginiser the following, “Do not open your legs. When asleep I normally spread my legs a lot, so I tied a belt around my hip for a month. Thank God there was no opening [of stitches] and no bleeding [in the healing period]. Just some throbbing and tingling-that’s it” (Thread 43, March 2013). Far from being a recommendation by a doctor, this re-virginiser has devised her own method to keep her legs from spreading to ensure her hymenoplasty produces the desired result. Even though this might be a very painful experience that lasted for an entire month and added to the pain from the operation, the woman limited her own mobility. This might have been as a result of her physical mobility’s coming after the social mobility that her technical virginity is expected to provide her in order of importance.

The very fact that women need to take control of their own bodies as a result of a misrepresentation of the potential outcome of their re-virginisation is parallel to a neoliberal understanding of the individual. The doctor, despite providing a full guarantee in the beginning, puts the responsibility on the woman to reach the desired outcome following the completion of the operation and the payment for the operation. Therefore, the woman has to devise her own methods to accomplish what the doctor promised to, and take on a serious emotional and physical work for this purpose. However, when we consider the ownership of the body, we can also argue that this leads the woman to own her body despite it being shaped by social norms, the institution of medicine, and all the other actors that enter her life. This is a minor silver lining. However, it has the unintended consequence of leading women to decide what to do with their bodies (i.e. deciding to re-virginise) even though the outcome they are hoping to achieve may not necessarily be in line with their individual desires. The neoliberal approach of making the woman responsible for her body unintendedly leads to claiming ownership of the body, which would perhaps not happen if this critical process did not trigger re-virginisers.

The emotional burden of having to take care of their own bodies is somewhat eased via pain functioning as a reminder for many women, as lack of pain might cause forgetting the measures one must take in order to heal in a way that will ensure bleeding later on. For instance, a user shares her experience as follows, “I got really scared on the first day. It is so painless that one forgets one had an operation. I dropped my earring, and abruptly leant over and picked it up, only to remember after I got up [that I had hymenoplasty]. I ran to the bathroom but there were no problems” (Thread 43, August 2011). As the first week following the operation is assumed to be the most important period in terms of taking care of yourself, the pain felt during this week has been found to be helpful albeit hurtful for re-

virginisers. However, feeling acute pain for a long time also erupts similar feelings in women. Another woman suggests, “Girls, today is the fifteenth day [following the surgery]. Yesterday I felt severe pain, today the [vaginal] discharge, which was over, started again and I bled one drop. I believe [the sutures] did not stay in. I will call the doctor tomorrow and will get examined by a doctor who does this job [hymenoplasty]. I am very depressed, I’m re-living the pain and the stinging from one week ago” (Thread 19, February 2016). As this quotation displays, the ideal duration of the pain is highly arbitrary, if it exists. However, as doctors have varying opinions on the matter, and as dialogues among doctors on re-virginisation are limited if not absent, women turn to other re-virginisers on the online platforms and compare their own experiences to other women. Hence, if it is a more commonly shared experience to feel pain for a week and then to heal, women who fall outside this spectrum self-diagnose with an unsuccessful operation. On the one hand, being in a community of women with similar experiences is supportive, while on the other hand, it might be generating ungrounded fear and anxiety due to the subjective nature of pain, and not everyone being able to share their experience. The offline silence regarding hymenoplasty is the main cause of this situation.

Once a woman engages in intercourse following hymenoplasty and shares her experience of pain therein, she reaches a new stage in her re-virginisation process. At this point, she is no longer like her peers, but has become more of a mentor to those who still seek re-virginisation, or to those who have had hymenoplasty, or bought an artificial hymen, but have not yet had sexual intercourse. The pain experienced during the intercourse starts a new process for re-virginisers that involves moving on from re-virginisation. For this reason, many re-virginisers deactivate their profiles following the intercourse, either by providing a brief statement about the final result or by sending a private message to one of the members to be disseminated to all members. In this context, the final physical pain becomes the point that separates the re-virginised from those seeking re-virginisation. Pain, which brings re-virginisers together at the beginning of their process, marks the end of the same solidarity. However, some women decide to stay on the forum for a few more days or weeks to answer any questions their fellow re-virginisers might have. Here, pain does not end the solidarity but moulds it in a way that creates a hierarchy between re-virginisers. Those who have felt the pain of the sexual intercourse rank higher among re-virginisers, not only as a result of having gone further in the process of re-virginisation, but also for having endured more pain, and for having created the right conditions for pain to be felt.

Conclusion

While the hymen, blood and online images discussed in the previous chapter form the visible side of virginity and re-virginisation, there is an invisible side thereof as well. It is

particularly the post-operative period that is imbued with healing and pain that women go through that is compulsorily invisibilised. As women do not get to perform their pain, suffering, or healing during their post-operative phase, their sensations and feelings become invisible to the outside. In order to attain a visible outcome, that is blood, women are required to go through an invisibilisation of their process of re-virginisation and of their pain. The illegitimate nature of re-virginisation forces women to go through their emotional and physical work beyond what can be seen. Hence, in this chapter, I have portrayed the embodied pain women undergo throughout their re-virginisation process. Re-virginisation is a perfect display of how the experience of pain is gendered and temporospatial. Contrary to the existing literature, I have argued that we need to focus on how, when and where pain can be communicated. Within re-virginisation, pain has many functions that intersect with the emotions re-virginisers experience. Due to mistrust in doctors, pain becomes a signifier of having had an operation, and/or having had a successful operation. Even more importantly, pain is a desired experience as it becomes one of the proofs that one is a virgin, as pain is associated with a tight vagina, hence lack of sexual experience.

It is important to note that pain is never discussed alongside women's desire, pleasure, or lubrication. These concepts are almost non-existent in women's discourses around pain, and around sexuality in relation to re-virginisation. This fact needs attention, as it demonstrates how women's engaging in sexuality for the pleasure of it is actively neglected by women themselves, in line with the discourse of "mistake" as discussed in the Methodology chapter. Seeking sexual pleasure is seen as a sign of promiscuity, and hence is hidden from discourse. In the next chapter, I will unpack the affective relations of re-virginisation further, the starting point of which will be hymen as a "happy object". Chapter 7 will expand further on how emotions roam through bodies and the process of re-virginisation.

7. Affective Hymens, Affective Times, Affective Spaces

I don't know how to explain my emotions, my feelings, my disappointment. While my hands are trembling, my eyes are filled with tears, there is no one beside me to let it all out to.

Re-virginiser, posted online (Thread 43, March 2012)

The process of re-virginisation is imbued with emotions. As re-virginisation is a process with various stages as discussed in the Introduction, each stage evokes different emotions in re-virginisers based on not only their personality and personal history, but also doctor-re-virginiser relationship, social expectations, and norms. In this chapter, I argue that the hymen, in its physical, re-created, or imagined form, is the object of all emotions in the re-virginisation process, and that it is the hymen's being *the* affective object that makes re-virginisation possible. Furthermore, I provide a roadmap into reading and understanding re-virginisers' emotions. In doing so, I focus on what these emotions "do", rather than what they are (Ahmed 2010). However, by arguing that a single object can be *the* affective object, i.e. the object of a multitude of emotions, if not all, I take Sara Ahmed's work further.

In travelling through what emotions do during re-virginisation, I will also provide a reading of times and spaces affectively. In other words, I will provide an exploration through which the constant interaction between emotions and times and spaces will be legible. This is an important and indispensable task to undertake not only because re-virginisation cuts across a variety of times and spaces, but also because it is a gendered and temporospatial experience which is characterised by what the emotions do to re-virginisers throughout the process, as well as what they do to me as a researcher in my process of studying re-virginisation. The affective reading of time will allow us to gauge the conceptualisation of time by re-virginisers against the "time norm", and how time is suspended, shared, and re-imagined in the process. The affective reading of spaces, borrowing from the literature on emotional geographies will illustrate not only the spaces re-virginisers roam as they experience re-virginisation, but also how bodies as spaces are affectively shaped. This latter approach will also be an attempt to close the gap between the emotional versus bodily sensation, or the emotional versus physical body divide via conceptualising the body as a space that interacts with other spaces affectively. The stages that speak to the physical body, such as the operation done unto the body, the physical pain women undergo at different stages of re-virginisation, or the blood that is released from the body during the penile-vaginal intercourse cannot be separated from the emotions that are interwoven throughout the process. I will bring to the fore these emotions, even though this may require at times to relay the analysis of the two components of the embodied self, emotions and the body

separately for analytical purposes. However, by treating the body as a space, it will be possible to analytically regard the body as an affective body in and of itself.

The Affect Theory

The last couple of decades have seen an increasing amount of research focusing on affect and emotions, with the affective turn being re-initiated in sociology and anthropology (Clough and Halley 2007), as well as in political science (McCalman and Pickering 2010), especially in relation to feminist and queer studies (Hardt 2007), among many other academic fields. The revival of this research strand has been dominated by debates around whether to distinguish emotion from affect. Sianne Ngai, in her seminal work *Ugly Feelings*, suggests that

> My assumption is that affects are *less* formed and structured than emotions, but not lacking form or structure altogether; *less* "sociolinguistically fixed," but by no means code-free or meaningless; *less "*organized in response to our interpretations of situations," but by no means entirely devoid of organization or diagnostic powers. (Ngai 2004, 27; emphasis in original)

In making this argument, Ngai points to the relative differences between emotions and affect, yet at the same time, she points at the grey areas and how the two are intrinsic to each other. The potential difference between affect and emotions is further discussed by Elspeth Probyn, in her work *Blush: Faces of Shame* as follows,

> It could be convenient to say that emotion refers to the social expression of affect, and affect in turn is the biological and physiological experience of it. To an extent, this is an apt description. But it also seems that disciplinary pride keeps the camps separate when what is needed is a radical cross-fertilization of ideas. (Probyn 2005, 25–26)

I agree with Probyn that "a radical cross-fertilization of ideas" is what is necessary in relation to the study of affect and emotions. More importantly, even though radical social constructionism is not what I'm arguing for as I have drawn attention to bodily becomings in the previous chapter, I do argue that what is physical or biological cannot be separated from the social. These two supposedly separate camps feed into and shape each other, and how one experiences emotion or affect, if we are to separate them, is not independent of the other. Another dimension of difference between emotions and affect that Ngai points at is feelings and their containment. She argues,

> At the end of the day, the difference between emotion and affect is still intended to solve the same basic and fundamentally descriptive problem it was coined in psychoanalytic practice to solve: that of distinguishing first-person from third-

> person feeling, and, by extension, feeling that is contained by an identity from feeling that is not. (Ngai 2004, 27)

What is most striking here is the discussion on feelings that are not contained by an identity. I contend that it is not possible to argue the existence of such feelings as they take on an existence and meaning only insofar as they move through, or touch upon an identity, a thing, a time, or a space, all of which are in constant interaction. Therefore, it is neither possible nor useful to make a distinction between emotion and affect along the lines of containment, or subjectivity and objectivity. To conclude this debate, although I acknowledge that the body might have physiological reactions to emotions in addition to psychological ones, I do not distinguish between these two, as they bear each other. Hence, I do not distinguish between emotion and affect either, and use the two terms interchangeably throughout the text.

In this text, I follow Sara Ahmed's conceptualisation of emotion, as she defines them as "social and cultural practices" (Ahmed 2014, 9). This perception makes it possible to move away from theories that see emotion as an individual, isolated response (cf. Plutchik 1994) and to draw attention to political, social and cultural norms and practices that shape emotions or that bring them into existence. For Ahmed, emotions are interwoven within power relations, as she suggests that "emotions show us how power shapes the very surface of bodies as well as worlds" (Ahmed 2014, 12). In re-virginisation, as in every other social situation or process, which emotions are experienced and by whom are shaped by social norms, power structures, and social and personal histories. The hierarchy between the doctor and the 'patient', the retailer and the customer, the parents and the daughter, the boyfriend and the girlfriend, among others, shape and are shaped by emotions. Hence, "emotions are relational" (Ahmed 2014, 8) and they produce relations between bodies and bodies, as well as bodies and objects. How an emotion relates to its object, or how the host of the emotion, in this case the re-virginiser relates to the object of her emotion is the key to understand the re-virginisation process. "Contact involves the subject, as well as histories that come before the subject. If emotions are shaped by contact with objects, rather than being caused by objects, then emotions are not simply 'in' the subject or the object" (Ahmed 2014, 6). Instead, emotions are in-between and in constant flux as subjects and objects interact.

As we study what emotions do, rather than what they are, it becomes more significant to pay attention to the objects of emotion, in addition to, or even more than its subjects. Emotions may reside in, or go through a variety of objects. The central object of emotion in the re-virginisation process is the hymen. The contact re-virginisers get into (or remember getting into) with their hymen generates emotions that will be further looked into below. However, it

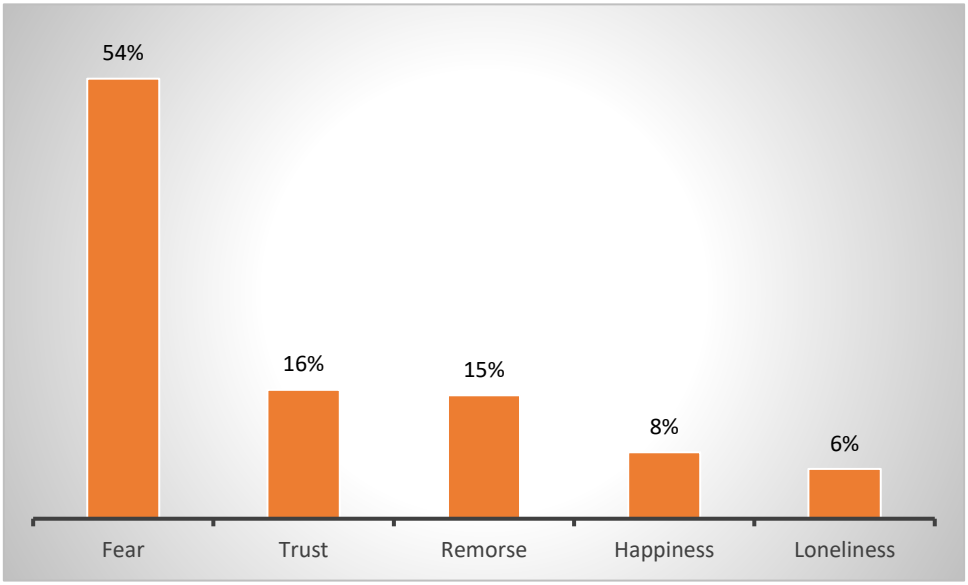
is crucial to determine that an object of emotion does not need to have a "material existence" to be the object of emotion for re-virginisers, but it "can also be imagined" (Ahmed 2014, 7). The hymen as the central object of emotions in re-virginisation is not necessarily the physiological existence of the hymen, or the hymen women are assumed to be born with. It encompasses the re-generated hymen by doctors, the artificial hymen, as well as the imagined hymen, the memory of the hymen and the very absence of the hymen, as each of these creates a unique relationship with the re-virginiser, as well as with people she is in interaction with.

This is not to say that the hymen is the only object that generates emotions in the re-virginisation process. On the contrary, there are many objects that come into contact with the subjects of re-virginisation, especially with re-virginisers. Some of these are the family, the gynaecological bed, the vulva, the penis, and the imagined future. However, while these objects shape the body and emotions sporadically, the hymen is always at the centre of these encounters and emotions. Every emotion in the process of re-virginisation "moves through the movement or circulation of" (Ahmed 2014, 11) the hymen. The hymen then "become[s] sticky, or saturated with affect, as [a] site of personal and social tension" (Ahmed 2014, 11). It is this stickiness that the first section of this chapter will explore, alongside objects other than the hymen. It should be noted that the hymen being the central object of affect, i.e. *the* affective object of re-virginisation also stems from the social construction of the hymen and of virginity, which makes it so that all emotions are supposed to have the hymen as their object. The "affective economy" (Ahmed 2014) of re-virginisation is made to revolve around the hymen based on social norms around virginity and the re-virginisation market that prioritises the hymen, as well as the blood and the vagina above all else. As a result, the hymen becomes the indispensable object of all re-virginisation. Here, I move away from Sianne Ngai, who, referring to Ernst Bloch argues that "'expectant emotions' like anxiety, fear, and hope 'aim less at some specific object as the fetish of their desire than at the configuration of the world in general, or (what amounts to the same thing) at the future disposition of the self'" (Ngai 2004, 221). I argue that the "future disposition of the self" and the object cannot be separated from each other. Furthermore, fear, anxiety and hope (or hopelessness) cannot be reduced to the future self, they are much more complicated, and are generated and re-generated at the intersection and constant becoming of the past, present, and the future. The "future disposition of the self" is not independent of the past or present, and this becoming primarily cuts across, lodges temporarily in, and moves through the hymen.

Circulating through the contact with the hymen as the affective object, the most common emotions that re-virginisers express during the re-virginisation process are fear, trust,

happiness, and loneliness. Based mostly on online forum data, this commonality can be measured by the frequency of expression of these emotions by re-virginisers as they go through the various stages. My data analysis was not quantitative, therefore I will not present the number of times the word, e.g. "trust" [*güven*] came up in the online forum. However, as I was coding the forum discussions using Atlas.ti, I coded every time a new way of expressing an emotion came up. In other words, I did not code the expression "You should never trust men" (Thread 20, January 2011) twice. Instead, after coding this once, I used the code again for the statement "I would not trust going to the doctor on my own" (Thread 20, January 2012). Therefore, the number of quotations per code gives an idea about the importance of the particular emotion for re-virginisers. In addition, a closer reading and coding of the data instead of auto-coding an emotion has allowed me to identify expressions of an emotion outside the use of specific words associated with it, and to gauge the meaning and emotions underlying every entry as a whole. Based on this analysis of online data, fear has been expressed in at least 239 different ways, while trust has been voiced in 70, remorse (including feeling like one committed a mistake) 67, happiness 36, and loneliness in 27 different expressions. These numbers give an idea about the intensity of the re-virginisation process at the affective level, and display the emotional work women undertake in the process. Therefore, sharing one's re-virginisation story is much more complicated than finding the right doctor, city, or operation. Below is a figure illustrating the emotions intrinsic to the process of re-virginisation based on the intensities (Figure 10).

Figure 10: Intensity of emotions in online data



N= 439 (total number of new expressions of emotions in the online forum)

The hymen, as the affective object of re-virginisation, also has its own agency. I borrow from Bruno Latour's Actor-Network Theory (ANT hereafter) in integrating the agency of non-human objects into the discussion. In *Reassembling the Social: An Introduction to Actor-Network Theory*, Latour expands on the meaning of 'social' and extends it to both human and nonhuman "actants" (Latour 2005). Latour posits that "social, for ANT, is the name of a type of momentary association which is characterized by the way it gathers together into new shapes" (Latour 2005, 65), associations which take place not only among humans but also among humans and things, as well as other nonhuman actants, to use the ANT vocabulary. I do not take on the ANT approach in this text and do not argue that ANT and networks are *the* way to make sense of re-virginisation processes. ANT has been criticised for neglecting gender, race, and class categories at the very least (Corrigan and Mills 2012; Lagesen 2012). However, I do contend that the 'original' hymen, the artificial hymen, and the re-generated hymen have agencies that need to be taken into account. The hymen may generate bleeding, or not. When and where this blood will be generated is also not pre-determined, be it through re-virginisation or not. What is imagined to be the hymen has its own clefts, and as it hides from plain sight, it has the space to act on its own (inter-relational) agency. Therefore, as we trace emotions and how they go through or reside in objects, it is necessary to keep in mind that these objects have their own agency as well.

In the introduction to 'Gilles Deleuze: Beginning from the Middle', Yücefer reminds us that "beginning from the middle means beginning with the dynamic, with the movement, 'settling in becoming'" (Yücefer 2016, 6). This "middle", dynamism, and movement point at the flux of the hymen, the times, spaces, and emotions. Yücefer also argues that "we should always begin from the middle, as everything that is interesting, salient, and worth thinking about is happening in the middle, in between, in the cracks of static structures, alongside the escape lines leaking from these structures" (Yücefer 2016, 6). In attempting to move through these cracks and leaks, I now turn to the emotions that re-virginisers and the hymen move through.[29]

The Happy Hymen

The main reason why re-virginisers engage in re-virginisation practices in the first place is that they envision a happy future for themselves, one in which they are not regarded as a 'secondary citizen' because of having had penile-vaginal intercourse prior to marriage. Hence, the hymen is a "happy object". While the lack of the hymen, or the expectation that one will not bleed is unhappy, an artificial hymen, or the pseudo-hymen constructed through surgery are happy objects. The hymen provides "a shared horizon of experience" (Ahmed

[29] The emotion of remorse/feeling like one committed a mistake will not be re-visited, as it has already been discussed in the Methodology chapter.

2010, 32), as well as an anticipation of such experience. Hymens are high in 'affective value', and thus re-virginisers attach the feeling of becoming a whole [*tamamlanmak*] to happiness. Many re-virginisers consider themselves 'less than' in the absence of a hymen, and state that they want to become a 'whole' through re-virginisation, as a result of which they will be happy. This can be exemplified by the following quotation,

> Do you think everything can really be alright? Will I be able to experience what I couldn't and give to my husband what he deserves [to have]? Will I be able to sexually feel how I'm supposed to, and have my first experience with my husband, the man I love more than anything? (…) Will I be happy? Will I be free from feeling lacking [for my husband]? (Thread 16, June 2014)

This re-virginiser is seeking re-virginisation despite her fiancé knowing that she is not a technical virgin, as her virginity loss was due to sexual assault. Her feeling of lack versus feeling whole in the presence of the hymen is what prevents her from feeling happy, whereas what drives her towards re-virginisation is the belief that she deserves to be happy. It should be noted that happiness is measured against the husband in the quotation above. Similarly, family and marriage take a central role as happy objects throughout re-virginisation. The hope that a family can be raised as a result of re-virginising, and that a happy ending can be reached through marriage, and having children (that can only follow re-virginisation) become salient in re-virginisers' accounts. In the discussion forum, as well as interviews with re-virginisers and medical doctors, it is possible to see that getting married, followed by having a child is seen as proof that the re-virginisation process has been successful. Therefore, for re-virginisers, marriage and having children become ultimate "happy objects". The hymen as a happy object draws women closer to other objects such as family and marriage, in an attempt to multiply happinesses. However, there is a constant re-direction of other happy objects back to the hymen as *the* happy object, as a result of the norms surrounding virginity, as well as the advertisements of re-virginisation products and services by doctors and artificial hymen retailers.[30]

Many studies in psychology argue that getting married makes one happy, therefore marriage is a means to happiness (Ahmed 2010, 7-12). On the contrary, re-virginisers posit marriage as proof that they too can be happy. Marriage in this case becomes a performance of happiness. Even though it is typical that very few people would know that one has re-virginised, it is a performance especially for themselves, the fellow re-virginisers on the forum, as well as their previous partners that they deserve to be happy as well. In the earlier stages of their re-virginisation, especially at the time leading to the surgery, women discuss

[30] Please refer to Chapter 5 for further discussion on this.

how they cannot believe that their previous partners have moved on despite 'taking' their virginity. Here, it is possible to talk about how re-virginisers are not happy with the way happiness is distributed, as they find it unfair that they have to do the emotional and physical work to overcome the consequences of virginity loss, whereas men can just move on. Hence, re-virginisation rests on the idea that happiness is a right for all women, even for those who have 'made a mistake'. Here is what a re-virginiser states online on her right to happiness, "Why should I not get married? Happiness is my right too, our right too. There is no other way than this operation" (Thread 43, July 2015). By framing happiness as a right, re-virginisers are making a political claim in that even though having pre-marital sexual intercourse is not approved by many in this society, as well as many in the forum, and even by women themselves, happiness becomes a place anyone and everyone deserves to go to, and this is ultimately marked by marriage and having children. This attainment is underlined as a contrast to being promiscuous, as exemplified by the following quotation,

> I don't have the slightest happiness to keep me going, no joy for life at all. I haven't been able to overcome this period for 3 years, and I am scared that it is going to take even longer, and I'm trying to get a hold of life from its edge, to be happy even if it's a little bit. I want people to see me not as a walking vagina, but as a mother. (Thread 20, May 2011)

This re-virginiser reflects her discontent with the dichotomy of "a walking vagina", a woman who is ready to have sex any time, versus "a mother", whose body is sacred and not desired, while at the same time she accepts that the only means to not be seen as a "walking vagina" is to be seen as a mother. Therefore, the happiness that one is supposed to lack due to pre-marital sexual intercourse can be attained via becoming a mother. It should be pointed out here that happiness following sexual intercourse is rarely mentioned by re-virginisers. Therefore, it is necessary to draw a distinction between happiness deriving from pleasure versus happiness as a result of conforming to social norms around virginity. Re-virginisers might have felt happiness deriving from pleasure following their pre-marital sexual intercourse, and might feel a similar sense of happiness and/or pleasure following the sexual intercourse within their marriage. Nevertheless, these are rarely mentioned, because women are trying to prevent people from seeing them as a "walking vagina", and are suppressing their sexual identities for this purpose. This is especially true when we consider women's 'online subjectivities' as discussed in the Methodology chapter.

As Pedwell and Whitehead argue, "feminist engagements with feelings (…) tell us most about the affective workings of contemporary power when they illuminate the complex and shifting co-constitution of emotional subjectivities and encounters and socio-political and economic structures and relations" (Pedwell and Whitehead 2012, 122). Re-virginisation is a vivid

example of how power seeps into the affective world of women and plays a central role in determining their feelings towards particular objects. On the one hand, the re-virginisation market creates a supply of a bleeding hymen as a "happy object", while on the other, the construction of the ideal woman eligible for marriage feeds into the loop which shapes women's feelings towards their own bodies. Of course, this is not only structurally defined, but also inter-subjectively, as women's online and offline interactions play a key role in their conceptualizations of happiness as well.

Fear

Having a happy object is the way to combat fear, even though both emotions travel through the same object. The hymen is not just a happy object, it is also an object of fear. Any fear that re-virginisers feel during the process roams through the hymen, or the idea thereof. Ahmed argues that

> fear does not simply come from within and then move outwards towards objects and others (the white child who feels afraid of the black man); rather, fear works to secure the relationship between those bodies; it brings them together and moves them apart through the shudders that are felt on the skin, on the surface that surfaces through the encounter. (Ahmed 2014, 62–63)

Fear is productive and generative. It re-establishes relationships between bodies, as well as bodies and things. Fear comes in many shapes and forms for re-virginisers, as it is the emotion that dominates their re-virginisation process. One of the primal fears is the fear of being exposed, the fear that their families or social circles will find out that they are no longer virgins, or that they have re-virginised. This fear creates different proximities and distances. It brings re-virginisers together, in order to combat the loneliness that is generated by this fear. It brings women closer to doctors, clinics, and to new hymens so that women can be relieved of their fear. This fear is usually cotemporaneous with the fear of upsetting the current boyfriend or fiancé for not being a virgin. This fear potentially moves women away from their partners if they haven't yet re-virginised. Ayşe, whom I introduced in the 'Inside the Operating Room' section states, "someone asked for my hand in marriage before, but I didn't want to [because I wasn't a virgin]. And then I got engaged [to another man], and started to look for options [for re-virginisation]" (Ayşe, Istanbul, January 2017, personal interview). The fear that she wouldn't be accepted as she is moved Ayşe away from her previous potential partner, and her fear had to cut across her new hymen for her to get closer to her new partner. This is a typical trajectory fear takes on in re-virginisation, as it initially draws potential relationships apart, and at the point where re-virginisers decide that happiness is their right, it works to draw a potential relationship close. Therefore, as soon as the hymen becomes a happy object alongside being an object of fear, it works to draw people

closer. In other words, re-virginisation becomes possible not when the hymen is the object of *an* emotion, but when it is the object of all emotions involved, exemplified here with the cutting across of happiness and fear.

The direction of fear is not necessarily one way at a time. As discussed before, women embark on hymenoplasty hoping that the surgery will bring an end to their non-virgin status. Nevertheless, despite the guarantee doctors give to re-virginisers prior to the surgery, the scenario changes afterwards. Women are given a list of things they should or should not do in order for the stitches to stay in, and in order to 'keep it'. This generates an instant fear that draws women both towards and away from doctors. Towards, as women try to find out the methods through which they can heal their wounds without compromising the new hymen, and away, as they feel deceived by doctors in addition to feeling more responsible and vulnerable than ever. This responsibility doubles their emotional work but brings them closer to other re-virginisers because of the shifting of trust in doctors.

Fear causes a constant movement between bodies, and bodies and things, as women move around their hymens or imagined hymens throughout the relations described above. As Ahmed argues, "fear may also work as an affective economy" as "it does not reside positively in a particular object or sign. It is this lack of residence that allows fear to slide across signs and between bodies. This sliding becomes stuck only temporarily, in the very attachment of a sign to a body, an attachment that is taken on by the body, encircling it with a fear that becomes its own" (Ahmed 2014, 64). Although I agree with Ahmed, this constant sliding is true for not only fear, but all emotions, and the sliding takes place across emotions as well. This is especially true when a particular affective object, in this case the hymen, is the object of multiple emotions, or all emotions. Sara Ahmed, in her work on objects of emotion, does not study one object across emotions, which makes it impossible to see how one object can be the affective object and how it can journey through multiple emotions. The hymen shows how this works.

Loneliness and Lack of Trust

"I really would have liked someone to hold my hand at that moment, but the only thing I could do was to hold onto the iron bars of the [gynaecological] bed…" (Thread 43, July 2011) says a re-virginiser on the online forum. It is no secret that women feel lonely in their process of re-virginisation. This loneliness emanates from the 'absence' of the hymen and not being able to communicate this absence. Even though a re-virginiser might have other women without hymens around her, the fear of being exposed to others prevents women from creating a bond around the lack of the hymen offline. That is why online interactions become more sustainable, as discussed in the Methodology chapter. Another re-virginiser shares her feelings about being on her own during re-virginisation as follows,

> A word of advice, don't go [to the doctor] on your own, that's what I did, and I felt so terrible. I cried all the way there. I've never felt this lonely, this weak. Now when I look back, I think maybe I should have told someone, at least to my best friend, and go with her, but I was too embarrassed to tell anyone. That's why this site is empowering me, I feel like writing more and more. You know what they say, only the one who falls off the roof can sympathise with the one who falls off the roof. (Thread 33, August 2012)

The emotions of loneliness, lack of trust, and fear are interwoven in the process of re-virginisation, making it difficult and redundant to draw lines between these emotions. The lack of trust between the doctor and the patient is a source of fear that many re-virginisers experience. Many re-virginisers warn each other about the risks of having surgery under general anaesthesia. It is already assumed that one will be treated as 'less than' due to their lack of hymen. Even more fearful are re-virginisers when especially a male doctor suggests conducting the surgery under general anaesthesia, as the rumour is that some doctors may say, "she is already open [*açık*], let's open her up a bit more" (Thread 43, February 2012). As discussed in Chapter 5, in everyday slang, 'open' is used to refer to women who have lost their technical virginity, whereas 'closed' are those who have their hymen intact. Interestingly, the same words are used to refer to women with or without a headscarf, closed (covered) referring to the former, open referring to the latter. Both connotations are based on the woman's body and are means to construct stereotypical categories and stigmas from which deductions can be made. Being 'open' in both senses of the word means that women are feeling vulnerable as a result of their 'openness', based on other people's perception of their relationship with their bodies. The emotions of trust and loneliness, alongside others, pass through the hymen, the clinic, the gynaecological bed, and the Internet. They even bounce back passing through the hair, as it is re-vitalised in discourse through the open and closed/covered dichotomy. In this context, emotions, objects, and subjects are constantly becoming in relation to each other.

Re-Virginisation as Affective Performance

By taking affect into the centre of re-virginisation, I argue that re-virginisation is an *affective performance*. Ayuandini proposes the concept "performative virginity" to distinguish hymenoplasty from "normative virginity" (Ayuandini 2017a, 75). Unlike the re-virginisers in her research, my fieldwork has demonstrated that women are not just interested in proving virginity via blood and tightness/pain. Even though this is a significant part of the performance of virginity, affect plays perhaps an even more important role throughout re-virginisation. Women are not just interested in changing the technicality of their virginity, but also claim that they want to rectify their 'mistake'. Many women struggle throughout the

process of re-virginisation, because their emotions are involved in their becoming. It is also the acknowledgment that re-virginisation is a process, rather than a moment that makes it imperative to define it as an affective performance. It should be underlined that I do not contend that women are necessarily performing the emotions required to be accepted as a virgin. On the contrary, women are going through a turbulence of emotions as they processually perform virginity. Framing re-virginisation as affective performance draws attention to the very existence of these emotions, and to realise that a momentary bodily performance does not equal re-virginisation as such.

As finding the right doctor is also part of the re-virginisation process, how women arrive at being eligible to receive hymenoplasty is also fundamental to this affective performance. One of the main roles the institution of medicine plays in the re-virginisation industry is the selection process prior to deciding whether a woman qualifies to be a 'patient' in the doctor's eye. Although it is not possible to talk about a uniform selection process for all doctors, there are layers of qualification across doctors, which reflect how they perceive virginity, re-virginisation and the role of women in society. Based on the interviews I have conducted with gynaecologists and plastic surgeons, it is possible to say that there are four tiers of qualification. The first tier is the doctor who accepts any woman who requests a hymenoplasty surgery. Although the doctor might have differing opinions about different groups of patients, they do not deny service to any. These doctors usually advertise their service of hymenoplasty as well. Thus, many popular doctors fall into this category. The second tier of doctors denies service only to those women who ask for surgery as a fantasy, as a gift to usually their husbands for their anniversary. These doctors usually see hymenoplasty for these women as redundant, and as a misuse of their medical services.

The most intricate tiers in qualifying as a patient are the third and fourth ones, as they are the most subjective ones. Doctors, mostly after seeing the woman in person, decide whether she deserves to be a patient on entirely arbitrary terms. The most common qualification sought after in a woman for this purpose is 'innocence' and 'victimhood', referring to third and fourth tiers respectively. Dr Ezgi, for instance, states that she operates on 'innocent' girls only. When asked how she evaluates a woman's innocence, she suggests that "her manners, how relaxed she is while talking [to me]" give it away (Dr Ezgi, Istanbul, November 2016, personal interview). The distinction between a woman who is innocent and who is not is determined less by what a woman says, and more by her manners, the way she sits and talks. The more insecure a woman looks, the more 'innocent' she is believed to be, and the more qualified she is to be accepted as a patient. Dr Hasan makes a similar point and claims that one of the few patients he operated on "has kept her innocence after [virginity loss]", and that he would not operate on a woman who "has done it with this man

and that, with many partners" (Dr Hasan, Istanbul, December 2016, personal interview). Dr Hasan's referring to having sex as 'doing it' demands particular attention. Through this wording, he belittles the act of sex as something to be ashamed of, especially if it has taken place premaritally. Furthermore, having sex with more than one man is seen as a sign of promiscuity and loss of innocence.

Like many other doctors, Dr Ezgi claims to be very good at reading people's manners and making a 'diagnosis' based on how they talk and walk, as she states,

> When the patient sits across us and starts to talk, we can understand at what level she is. I've been face to face with people for years, since I was 18. I'm now 46, after 5 to 10 minutes, sometimes I'm wrong, but we usually diagnose correctly. (Dr Ezgi, Istanbul, November 2016, personal interview)

This 'diagnosis' helps doctors to determine whether the woman is innocent, or *different*. Dr Ezgi sees women who have had sexual intercourse with multiple men as 'different', as the following excerpt displays:

> But some[times] my conscience doesn't allow me to do something like this [hymenoplasty], because sometimes you don't know the person in front of you. Maybe he's been through the mill, maybe he's been with 30 different people before marrying the girl, or he can be a man with no sexual experience. When a young girl who has lived a *different* life came, I tended to reject them. I was disturbed by them because it is obvious, the mood of the girl is obvious. She won't stop even when she gets married. She has the potential to do *different* things. There have been cases like that which I didn't want to get involved in. (Dr Ezgi, Istanbul, November 2016, personal interview; emphasis added)

For Dr Ezgi, having had more than one sexual partner means being a 'different' woman, which is not acceptable. To enter the institution of medicine for re-virginisation, she invites women to not be different, as being 'different' also means that the woman will not make 'good use' of the operation. If they operate on a woman who looks relaxed, she is prone to having premarital sex again, and she might come back for hymenoplasty once again. Furthermore, premarital sex is associated with a higher possibility of cheating on the husband. Therefore, Dr Ezgi claims that "she [the woman] won't stop even when she gets married", as she has premarital sexual experience, she will also have extramarital sexual relationships, a concern raised by doctors and men alike. Doctors also mention tactics such as setting a very high price for the operation or setting the next appointment for a very distant future to indirectly reject patients that "irritate" them, as Dr Onur states, in the same way (Dr Onur, Gaziantep, November 2016, phone interview). A similar finding has

been presented by Wynn, as she shares from one of her interviews, "'Don't get me wrong', he continued, 'I won't do it for just anyone. The woman who wants this surgery has to demonstrate that she has repented.' (…) 'I have to know that she's not going to make this mistake again', he argued. 'I don't want to do this surgery and then she goes out and sleeps with another guy she's not married to, and she destroys my world.'" (Wynn 2013, 45). As this quotation also supports, doctors go through many conflicts themselves, including protecting their prestige as discussed in Chapter 4, their moral values, and financial earnings, as well as seeing the 'misuse' of the operation as an attack on their profession.

Although the lines between the third and the fourth tier are rather blurred, doctors in the latter group use the terms 'victim', 'miserable', or 'sufferer' to refer to the women they accept as patients. Those who were raped, or those in danger of being killed due to not being a virgin fall into this category. Dr Zerrin states, "I'd operate on her if I thought that she would be killed, if she was miserable" (Dr Zerrin, Ankara, April 2017, personal interview) while Dr Emine suggests, "I'd help her if she was suffering, if she didn't consent to it, if she was a victim, if she would get hurt even more [if she was not operated on]" (Dr Emine, Istanbul, February 2017, personal interview). Although doctors see this as a way of 'helping someone who is suffering', who suffers is not only arbitrarily defined, but also may force women to embody this ideal patient to receive service. Similarly, Ayuandini puts forth that "it can be said that the Dutch doctors themselves pick and choose which woman can then be a patient or a candidate for hymenoplasty. By choosing only women who are in distress to be patients, Dutch doctors firmly cast women in the context of hymenoplasty in the position of inferiority" (Ayuandini 2017a, 110). Doctors assume the role of the moral gatekeepers of society, as they employ their own definition of virginity. On the one hand, they do not openly criticise women for engaging in a premarital sexual relationship. On the other hand, they believe that women who were not 'fooled', who were not made believe that they would get married, or who were not raped do not deserve hymenoplasty, as they do not display the characteristics of an innocent woman. Hence, for many doctors, women who have lost their virginity pre-maritally can still be virtuous or innocent as long as they are weak.

As women interact with other healthcare staff on the phone before visiting the clinic, and as they come face-to-face with the doctor in the consultation, they get an understanding of what kind of a non-virgin woman is seen as 'virtuous enough'. This is made possible through not only their personal interactions but also how hymenoplasty is described on doctors' websites and through the online forum discussions. As a result of the picture drawn by doctors, re-virginisation becomes both an affective and an embodied performance in order to access hymenoplasty. Women control their bodily movements, gestures, speech,

and their discourse in order to be able to continue their re-virginisation process. Hence, re-virginisers' bodies become an object of emotion. Ahmed argues that "the objects of emotion take shape as effects of circulation" (Ahmed 2014, 10), as they circulate through subjects and objects. I will now turn to how these circulations take effect across times and spaces.

Affective Times: Hymen Round the Clock

"There are ruptures at 4 and 9 o'clock".

When a woman seeking re-virginisation visits a gynaecologist or a plastic surgeon to have her hymen examined, what she hears is where 'on the clock' her hymen was 'ruptured' or 'torn'. In other words, the hymen is imagined to be a circular shape or a round clock, and the location where bleeding has been caused to occur is articulated via the numbers on the clock. With this imagination in mind, it is important to visualise how the clock has fixed intervals that cannot translate into the non-circular and continuous structure of the hymen, especially when doctors use only integers to describe one's hymen. However, the clock metaphor is not only a misrepresentation of the hymen but also a call to unpack the relationship between time and re-virginisation. This is the task I will undertake in this section via a reading of times and re-virginisation through affect.

The rupture of the hymen as a clock symbolizes the rupture of "public time" (Wright 2009; Zerubavel 1979). This concept has been used in different ways by different authors. Eviatar Zerubavel differentiates between public and private time in relation to public and private sphere and argues that "rather than view given time periods as either private or public, we ought to consider every moment of an individual's time as some combination of private and public elements, that is, as being located somewhere along that continuum" (Zerubavel 1979, 41). Stephen Wright, on the other hand, views public time as "a time without qualities", which he defines as "an available time, an undisciplined time, a public time, whose ideological and moral density is tolerably low" (Wright 2009, 130). I suggest using the term "public time" in a similar vein to "time norm", where I refer to a public dictation of how time needs to be spent as opposed to an individual's own perception of time and own preference of spending this time. This takes on significant meaning especially in relation to sequencing. Sequencing can be defined as "the order in which transitions are experienced over the life course" (Settersten and Hagestad 1996, 252). Within societies where pre-marital sexual relationships are highly discouraged, penetrative vaginal sex is supposed to follow the marriage contract. However, when this sequencing is disrupted, it causes distress and unrest in society and in women who disrupt it, causing them to battle with emotions such as regret, fear, and loneliness and to re-virginise. The sequencing of the life course in which virginity loss follows marriage also dictates a heteronormative time. Women are expected to marry only men, with whom they should have sex only after they get married and procreate within

the institution of marriage. Therefore, not only is re-virginisation a very heteronormative practice, but so is the sequencing of time. This conceptualisation of time directs our attention also to which parts of the body are allowed to be used in a certain way within norms. The hymen, then, can be 'put to use' only after a heterosexual marriage takes place. Any action on the side of the hymen other than this is considered a rupture in heteronormative time, symbolized in the rupture of the hymen as a clock.

At the same time, hymenoplasty has its own temporality. The two types of hymenoplasty - permanent and temporary- that are claimed to be offered by medical doctors are named after the amount of time they offer the woman to stay as a virgin, as discussed in the Introduction. Temporary hymenoplasty grants virginity temporarily, i.e. for a short-term which is at most a week, whereas permanent hymenoplasty leaves it to the woman to cease being a virgin in long-term. The artificial hymen promises an even shorter-term virginity to the re-virginiser. Therefore, re-virginisation is overall a temporal experience. Not only is it a process, but also it is time-bound. The hymen also has its own temporality. Even though women may be expected to prove their virginity as soon as the penile-vaginal intercourse takes place, it is quite often the case that the hymen may generate bleeding a couple of hours following the intercourse, which might go on for a few days as well. Some of this blood may be produced as one urinates -in a similar way to menstruation, which makes it unfeasible for the woman to showcase the blood to the interested parties. The temporality of the hymen is of course not isolated either. It is intermingled with the type of operation a woman has, temporary or permanent hymenoplasty. The temporality of the operations in relation to women's bodies and how they take on the operation play significantly into the temporality of the hymen. The timing of when the artificial hymen is inserted into the vagina plays a significant role in the temporality of the hymen and of blood, be it artificial or generated by the body itself.

As re-virginisers are disrupting the sequencing of the time norm or the public time, they look elsewhere to find those with whom they can "share" their time (Baraitser 2017, 10). This is where online communities enter the picture. It is not only suggestions, problems, or successes that are shared; fundamentally re-virginisers share their time, their temporality and their new trajectory with fellow re-virginisers. What it means that this happens in a shared space will be discussed in the next section on affective spaces. However, it is important to note here that in this shared space, women compare and contrast their timelines, which diverge from that of non-re-virginisers'. Once women lose their virginity before marriage, they are no longer on the same timeline as women who stick with the sequencing that is dictated by public time. This puts them on a new timeline, which is assumed to be not on the same path as the rest of society. In addition, as women continue to reflect on their re-virginisation processes, they create new times, as Brockmeier argues, "the

autobiographical process does not follow chronological time but creates its own time, narrative time" (Brockmeier 2000, 31). Hence, I argue that online communities morph re-virginisers' perception of time, as they may help women's time to be re-enacted, or re-animated. As a space held for re-virginisation, the online forum holds the space for time to be suspended, so that it is not suspended in a vacuum, and has a space to morph into. Therefore, online spaces take the shape of re-virginisers' sense of temporality, while at the same time morphing them into a new understanding of time as it is shared, hence making it possible to suspend the suspension of time, and eventually re-enact time via either creating a new timeline where virginity is no longer seen as a concern, such as the case of Emine (which will be discussed below) or via being integrated back into the time norm following re-virginisation. Of course, the latter does not follow a smooth transition, and it might very well be the case that re-virginisers are perceived to be back on the same timeline as their virgin counterparts, yet they may feel like they will always be on a different temporality. This temporality links back to re-virginisation being experienced as a process, rather than a moment, and how for some women it is a process with no end, as exemplified by the following re-virginiser,

> Friends, you know what? The only thing I now see is if I had it done two months prior to [the wedding] it would be more comfortable. I think there is no benefit of having it [the operation] earlier, because one can never say that it's over, that [you're] free of it. (Thread 43, January 2012)

This re-virginiser shares her temporal experience for other women to benefit from it. However, sharing time online often does more than that. In particular, re-virginisers in online communities rely on each other's timeline in order to determine when to re-virginise. One re-virginiser suggests the following,

> Honey, my advice to you is that if there is no wedding [in the near future], wait, and have [the operation] based on my result. All the other ones who had the operation had two months until their wedding. I have 6 more months. Don't take a risk, if mine goes flawless, then you can get it too. I now think that maybe I should have waited. (Thread 43, February 2012)

Instead of sticking to their own timeline, women start to operate on shared time, which is shared online, but enacted offline. Even though these timelines do not intersect with each other offline, shared time trajectories cause women to act based on other women's timelines. This is different from changing your schedule based on the needs of others, or based on responsibilities, as fellow re-virginisers only share their time and space online. However, this exchange makes it possible for women to take on other women's timelines as their own.

Emine, with whom I conducted a phone interview, is a woman who had been raped by a police officer. During her visit to a clinic for an abortion, the gynaecologist offered to give her a hymenoplasty as well. She started to consider the operation.

> I hadn't started my undergrad yet. There was social pressure, they asked me when I would get married. How could I get married like this? How would he [the future husband] accept me like this? I thought to myself, even if he did, he would hold it [not being a virgin at the time of marriage] against me later. (Emine, Diyarbakır, May 2017, phone interview)

Despite her initial reaction, Emine found herself in a different environment during her undergraduate studies, which eventually shifted her ideas about re-virginisation.

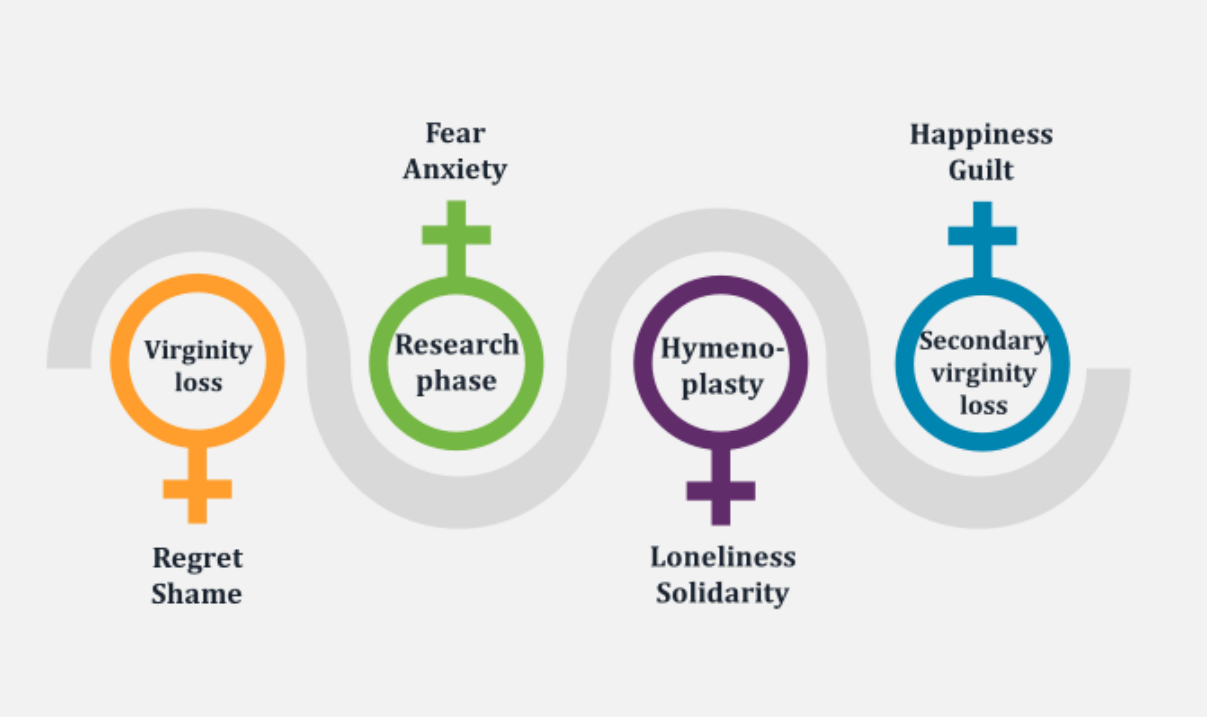
> Facebook contributed [to learning about feminism]. I joined [Facebook] groups like "The Woman Has No Name",[31] "Campus Witches". I hadn't read any books about these topics before. I was just reading what was being posted on Facebook. I was wrong [in my thinking] as well. I thought if he didn't let me work, if he was jealous, that showed that he loved me. "Virginity, saving yourself is important", I thought. And then I started reading books, I read [the works of] Duygu Asena, [Forough] Farrokhzad. When I started my undergrad, everything changed, I got in a social environment. I joined a women's studies group. (Emine, Diyarbakır, May 2017, phone interview)

By opening a new way for herself via reading Facebook posts, feminist studies, and joining groups, Emine started a new timeline for herself. Instead of joining the trajectory of the re-virginised, she chose to stay outside the time norm, the heteronormative time, and follow a different timeline. Despite the doctor's offer, she decided to not go through with re-virginisation, hence she did not get back on the time norm or the public time. Contradictorily, having access to re-virginisation also works for a similar purpose. Even though pre-marital sexual relationships are outside the time norm, hence thwarting women outside the public time with such an experience, re-virginisation allows women to establish authority over time. Even though losing their virginity might place them outside the time norm due to a disruption in sequencing, re-virginisers get to say which timeline they would like to be on, and what emotions they choose to feel and express on this timeline. One re-virginiser states, "now is the time to be happy, for all of us" (Thread 43, October 2012), where she determines the dominant emotion the re-virginisers should feel, depending on the act of engaging with re-virginisation. This is a moment of reclaiming not only virginity, but also claiming rule, power, and dominance over time.

[31] This is the title of a famous novel by Duygu Asena, first published in 1987. The book addresses gender inequalities, and was seen to be revolutionary for its time.

Reading online spaces through affect allows us to see which emotions come to the surface at which moments of the process. As women write online, they "reshap[e] the way [they] materially experience and perform their past, present and future selves in relation to others" (van Doorn 2011, 540). More important here, however, is that these emotions are intertwined and co-existent, which calls us to re-think how we define time in relation to re-virginisation. To illustrate this co-existence, please see Figure 11.

Figure 11: Emotions according to phases of re-virginisation based on a linear understanding of time



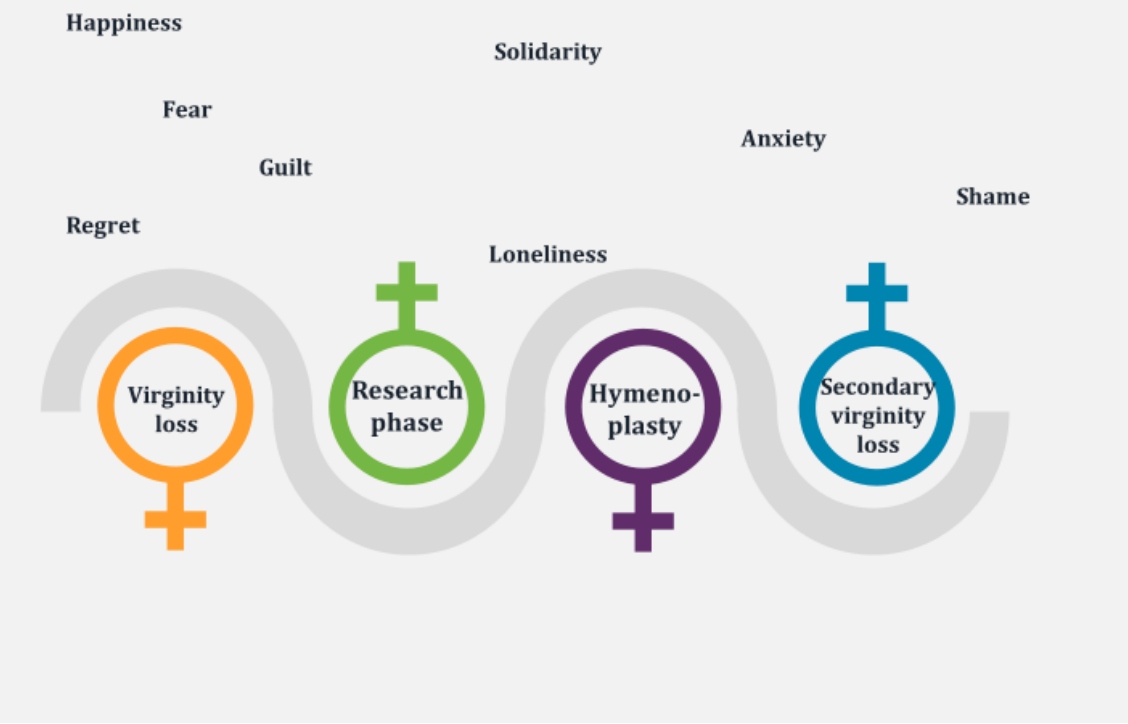
Although this figure takes a first step at illustrating which emotions are expressed at which stages of the process of re-virginisation, it would be simplistic to say that there is a linear continuity in when these emotions are expressed and how they affect re-virginisers' lives. For instance, even though solidarity may peak at the time of hymenoplasty, it cuts across all stages, whereas fear and anxiety also come up following hymenoplasty. In turn, the happiness felt following the 'successful' virginity loss after hymenoplasty allows re-virginisers to look at the period immediately following the original virginity loss from a different perspective, and the emotions of regret and shame might transform into happiness being a right for all. This constant transformation, or becoming of emotions is a reminder that time is not linear. As Coleman suggests,

> Understanding the past as "the condition of the present" does not suggest that the past is the pre-condition of the present; the past does not determine the present. Rather, the relations between the past and present involve a "co-existent"

> connection; the past and present are the conditions of each other. The 'whole of the past' is this past of this present, it is the virtual of the actual. (Coleman 2008, 96)

Therefore, virginity loss, re-virginisation, and its aftermath mingle and get involved in the becoming of the body when one takes them outside of objective time. Past, present, and future are simultaneously re-created within the endless process of becoming. Such an approach to time is significant in understanding women's experiences of becoming in order to see how re-virginisation is not necessarily a single moment of change, but one that is in constant relationship with women's past, present, and future. A close look at the emotions provides us with an understanding of this constant becoming. Even though "modern time renders the past old and obsolete in order for the new to emerge, precisely through its radical separation from the past disparaged *as* past" (Baraitser 2017, 6; emphasis in original), an affective reading of time displays how past, present and future overlap, and reconstruct each other within each other simultaneously. Figure 12 displays how emotions cut across and are sprinkled and spread over different phases of re-virginisation.

Figure 12: Emotions according to phases of re-virginisation based on a non-linear understanding of time



Throughout the re-virginisation process, time flows at different speeds for women. Time might speed up, slow down, or be suspended, sometimes all at the same time. Although it varies from re-virginiser to re-virginiser, there are some common trends in terms of time perception vis-à-vis re-virginisation. The process of re-virginisation has an ever-changing

rhythm. As women are burdened with the emotional and physical work of being responsible for their own re-virginisation as discussed in Chapter 6, the time between the operation and the follow-up visit for permanent hymenoplasty patients gets extended, imbued with fear and anxiety. Some women, on the other hand, prefer to, or feel obliged to do this extension deliberately. One re-virginiser states, "I have adapted my life to slow-motion, I'm not rushing any of my movements or actions" (Thread 43, August 2011). In a similar vein, the time period between the operation and the day of the intercourse also feels extended for many re-virginisers, as they wait for the day to arrive so that the fear and anxiety can dissipate. One re-virginiser puts this waiting into the following words, "It's like I'm dead now, it feels like I will be re-born on [date redacted]. I mean, I have waited for other important days all my life, but I pray every day for [date redacted] to arrive" (Thread 43, August 2011). This push and pull between death and (re-)birth dominates many re-virginisers' relationship with life throughout this process, hence shifting their time perception based on re-virginisation. Time gets suspended during death (virginity loss), until re-birth through re-virginisation becomes possible. This is experienced as a time when all else stops, and when life does not move forward. Going back to the re-virginiser who compares herself to a "walking vagina", which I mentioned in the section 'The Happy Hymen' in this chapter, it is possible to understand the experience of time in this period.

> I don't have the slightest happiness to keep me going, no joy for life at all. I haven't been able to overcome this period for 3 years, and I am scared that it is going to take even longer, and I'm trying to get a hold of life from its edge, to be happy even if it's a little bit. I want people to see me not as a walking vagina, but as a mother. (Thread 20, May 2011)

With the suspension of time, this re-virginiser's happiness has been suspended too. Here, the vagina becomes an unhappy object, whereas motherhood is a happy object, standing opposite the "walking vagina". The discussion here, however, is more complicated than a woman suspending her own time. Even though suspension of time may seem to be an individual process, it takes place only inter-relationally. In this case, the re-virginiser's time is suspended, arrested, or stopped, only based on her relationship to her vagina, her hymen, the man or men she has had sex with, the man or men she is intending to have sex with, as well as her family and doctors. Therefore, it is not an isolated experience, and the experience of time and temporality are shaped in relation to other people and things. This quotation also shows that happiness and time are intermingled. Seeing the family or marriage as a "happy object" as discussed above, not having reached this happy object leads re-virginisers to want to turn back time, or erase time. In other words, they perceive the past as a time of regret, while the future where they have re-virginised is filled with happiness. A re-virginiser

states, “we want to feel as if something like this never happened, we want to be like our friends. We don’t want to feel a bittersweet happiness days or months before our engagement, or our wedding. We want to experience happiness entirely like the others do” (Thread 17, June 2015). Many gynaecologists and plastic surgeons posit this perception of time as the main rationale behind seeking re-virginisation, exemplified by Dr Kerem,

> [Permanent hymenoplasty] is preferred by young girls who have been raped or who have been abandoned by their fiancés, who have not been able to deal with the issue with the hymen psychologically, who couldn’t overcome it, and those who don’t have any plans to get married [at the moment], who don’t have a relationship in sight, and these are ones that we operate on based on the recommendation of psychotherapists and psychiatrists. It’s not clear when they will get married, it’s just to renew themselves, in other words, to convince themselves that they made a mistake, but this is how they’ve been able to come back from the mistake, [to say] “I am now who I was before making this mistake”. And of course, the ones who have been raped, they get the operation done because they feel they’ve been stained, spoiled, because they can’t get over it, “No, he hasn’t been able to stain me, he couldn’t destroy me, I am who I was before the rape”. (Dr Kerem, Izmir, August 2017, personal interview)

Here, we have a difference in discourse, as turning back time and turning back the body to its state prior to the sexual assault are perceived in a similar manner. Hymenoplasty, then, is believed to reverse the body to a prior state, whereas the operation does not serve this purpose, as all it does is to attempt to make the body bleed. Instead of turning back the body to a prior state, it adds to the body, or it morphs the body to prepare it for the future. However, in seeing the hymen and marriage as happy objects, re-virginisers perceive this morphing of the body as a reflection of the past, hence creating a new timeline where they have not had penile-vaginal intercourse.

In her book *Enduring Time*, Lisa Baraitser refers to Roland Vazquez who discusses the

> politics of time; one that affirms the west as the present, and the present as the only legitimate site of reality. Modernity, he argues, produces an amnesic surface where reality and the present coincide, negating the possibility of relations between the self and the (non-European) other who is by definition ‘behind’ the times. In contrast, relational temporalities drawn from indigenous philosophies, Vazquez argues, “decolonize” modern time through their radical critique of the confinement of experience in the empty present. (Baraitser 2017, 4)

A modern and 'Westernised' understanding of time focuses on the present as the real and ignores the relationship among the past, present, and the future, which constantly shape each other. Such a perspective would be restrictive and lead to concluding that re-virginisation is a moment, rather than a process, as well as perceiving re-virginisation as a practice that is carried out by those who are 'backward' in all senses of the term. This has been more widely discussed in the Historical Background section of the introductory chapter. Nevertheless, it is important to underline here that how we perceive time and temporality in relation to gender and re-virginisation is in direct relation to our perception of modernity and tradition.

Affective Spaces

We can and should read not only times and temporalities through affect, but also spaces. Spaces, like times, call for an affective reading both because they are infused with emotions, and because this infusion is always already gendered, racialised, and classed. The spaces that re-virginisation travels through effectively mould re-virginisers through their emotions, while the spaces are in turn moulded as they become through the interactions they enter into with re-virginisers. The process of re-virginisation roams through many spaces, which can be categorised into four groups: The first one is the micro-spaces, which are the clinic (or the hospital), re-virginiser's home, and workplace. The second one is the macro-space, which refers to the cities or countries that re-virginisers travel to during the process. The third one is the online spaces, in particular online forums, and the websites where re-virginisation products and services are advertised. The final category is the corporeal category, which refers to bodies as spaces. Each of these spaces has their unique dynamics that evoke a variety of emotions in re-virginisers, as well as in other subjects that are involved in the re-virginisation process.

There is an increasingly expanding literature on "embodied space", or "lived space". Borrowing from Thomas Csordas and Maurice Merleau-Ponty, Setha M. Low discusses "embodied space" as "the location where human experience and consciousness takes on material and spatial form" (Low 2009, 26). It is this triad of experiences, bodies, and spaces that I am focussing on in this section. Each space, and each interaction with the space moves through different emotions. Harvey distinguishes between three types of space; absolute, relational and relative, as he discusses urban space,

> If we regard space as absolute it becomes a "thing in itself" with an existence independent of matter. It then possesses a structure which we can use to pigeon-hole or individuate phenomena. The view of relative space proposes that it be understood as a relationship *between* objects which exists only because objects exist and relate to each other. There is another sense in which space can be

> viewed as relative, and I choose to call this relational space — space regarded, in the fashion of Leibniz, as being contained *in* objects in the sense that an object can be said to exist only insofar as it contains and represents within itself relationships to other objects. (Harvey [1973] 2009, 13; emphasis in original)

Although Harvey bases his theoretical elaborations on urban spaces and does not necessarily refer to emotions, I contend that this categorisation of spaces can be extended to other geographies, in particular to "geographies of health and illness" (Davidson and Milligan 2004, 525), where one should integrate the gendered, embodied and affective experience of geographies, which cannot be separated from one another. "Space is neither absolute, relative or relational *in itself*, but it can become one or all simultaneously depending on the circumstances. The problem of the proper conceptualization of space is resolved through human practice with respect to it" (Harvey [1973] 2009, 13; emphasis in original). Agreeing with Harvey, I contend that regarding space as absolute strips it away from any relationship it has with people or things, and it is merely impossible from a sociological perspective. On the other hand, space should always already be studied as relational and relative. However, what needs to be integrated in the embodied, relative and relational space idea is the affective space. Davidson and Milligan put forth this discerning argument as follows,

> Our attempts to understand emotion or make sense of space are, thus, somewhat circular in nature. We can, perhaps, usefully speak of an emotio-spatial hermeneutic: emotions are understandable—"sensible"—only in the context of particular places. Likewise, place must be felt to make sense. This leads to our feeling that meaningful senses of space emerge only via movements between people and places. (Davidson and Milligan 2004, 524)

To make sense of places and spaces affectively, it is necessary to study geographies of re-virginisation both as "geographies of health and illness" (Davidson and Milligan 2004, 525) and as "geographies of consumption" (Mansvelt 2005). As discussed in the Introduction, re-virginisation is not restricted to medicalised processes, it is highly commercialised at the same time. However, it is not only the places that re-virginisers go to that are medicalised and commercialised, but also re-virginisers' bodies at the same time. Therefore, in this section, not only will I be discussing the affective experience of spaces in relation to re-virginisers, but also how re-virginisers' bodies as spaces bring new insights to the meanings of virginity and the hymen in the re-virginisation process. Reading the body as an affective space is key to both overcoming the body/emotion dichotomy, and to understanding which emotions roam through bodies that are medicalised and commercialised throughout the re-virginisation process. Low argues that "the body (and bodies), conceptualized as embodied space(s), incorporates metaphors, ideology, and language, as well as behaviors, habits, skills,

and spatial orientations derived from global discourses and far away places — especially for the migrant — and yet is grounded at any one moment in a specific geographical location" (Low 2009, 22). Although I agree with Low, I propose to extend beyond the body as a discursive space, conceptualising it as an embodied space. Bodies are spaces that leak, bleed, that intersect with other bodies through sexual activity. Therefore, bodies are both spaces around which power mechanisms are enacted, but also spaces that take up space, and spaces that are taken up in other spaces. An example here is the relationship bodies as spaces have in the presence of fear. Building on Liz Bondi, Nina Held argues that

> feminist geographies, especially geographies of women's fear, are one of the geographical traditions (besides humanistic geography and nonrepresentational geography) that have laid important inspirations for the development of emotional geographies. Geographies of women's fear have explored emotions as generated by and expressive of wider social relations. (Held 2015, 34)

As re-virginisation exemplifies, women's bodies can be conceptualised as "geographies of fear". Fear has a particular relationship with space. Ahmed argues that fear "re-establishes distance between bodies whose difference is read off the surface, as a reading which produces the surface (shivering, recolouring). Fear involves relationships of proximity, which are crucial to establishing the 'apartness' of white bodies" (Ahmed 2014, 63). A similar dynamic exists in relation to gender. Fear, as discussed above, brings women's bodies together and apart based on where they are in relation to the time norm. Furthermore, "fear works to restrict some bodies through the movement or expansion of others" (Ahmed 2014, 69). This is especially true with regards to re-virginisation. Re-virginisers, or women who are outside the time norm are made to be restricted to clinics and their homes unless they re-virginise, or in other words get back on the time norm. Ahmed states, "such shrinkage is significant: fear works to contain some bodies such that they take up less space. In this way, emotions work to align bodily space with social space" (Ahmed 2014, 69). However, at the same time, doctors and clinics expand into re-virginisers' homes and workspaces through "technologies of the self" (Foucault 1988). As a result of the fear that their non-virgin status will be found out or will be rejected by their families and/or their (future) partners, women's bodies shrink, and only expand as far as they can extend a new hymen and can expand onto the sheets via blood. This expansion becomes the only means through which bodies can overcome the shrinkage. As Low argues, "the space occupied by the body, and the perception and experience of that space, contracts and expands in relationship to a person's emotions and state of mind, sense of self, social relations, and cultural predispositions" (Low 2003, 10). The same is true when we conceptualise the body as space as well.

Doors, Gates, Gateways

Doors are entry and exit points between rooms and worlds, literally and figuratively. They have special significance in "geographies of health and illness" (Davidson and Milligan 2004, 525), as well as in bodies as spaces, especially with regards to re-virginisation. As one of the myths around the hymen is that it covers the vaginal entrance completely, it is imagined almost like a door by women and men, and even by doctors alike. It is a door to sexuality, regret, guilt and shame, or it can be a door to innocence, success and happiness. This meaning the hymen takes on is temporally and socially determined.

Conceptualising the body as space allows us to understand the meaning assigned to the hymen by society more clearly. Doctors have varying views on the function of the hymen. Although many doctors argue that it has no function at all, some disagree. Dr Hasan, for instance, argues that "virginity is a sacred thing for the woman. The hymen is something that protects against sexual contact, against sexual illnesses. [It is] the woman's most precious treasure, both for herself and for her health" (Dr Hasan, Istanbul, December 2016, personal interview). In a similar vein, Dr Aysel states, "There is no such thing as the hymen. There is, but there isn't. It has a vaginal bleeding function. An opening of approximately 2 centimetres. A tissue of 5-6 millimetres. It works as a barrier for pathogens to not enter-can be around 1-2 millimetres too" (Dr Aysel, Izmir, September 2017, personal interview). These descriptions foster the idea that the hymen is indeed a barrier, a gateway against disease and against sexuality. Within this perspective, the hymen also becomes a door that opens to infidelity and promiscuity, discussed in relation to "affective performance" earlier in this chapter. As exemplified by the statements of Dr Deniz below, it is feared that the woman will roam through different bodies once the door to sexuality is opened via initial penile-vaginal intercourse:

> Let me tell you this, in consequence, virginity is basically about fidelity in the next step. If a person does not associate themselves with the concept of virginity, they may not associate themselves with fidelity in the future. That's the basic thing that people are refraining from. If this person is not a virgin, she may not be faithful and may cheat on you, cheat on you more easily maybe. If that's the case, many people think there might be a trouble in future projections. And because of this association, virginity becomes something that is sought after. (…) In fact, what is needed is to separate these two, virginity may not be important with someone who will be faithful. Shouldn't we distinguish between the person who is mature enough to make up their own mind with the foresight of "I've married this person, or I haven't gotten married, I'm living with them, I should be faithful to them", and someone who could think, "I wasn't a virgin before either, i.e. when I

married this person, I think it's ok if I cheat on them"? (Dr Deniz, Istanbul, April 2017, personal interview)

This collective fear that the woman's body is not only open to infections as a result of 'losing' the hymen, but also being open to other bodies returns us to the dichotomy of the open versus closed women discussed in the previous section, where women are categorised according to their 'virginity status' based on the lack or the existence of their hymen. An open door is hence an open body that is always already available for sex, "a walking vagina" as one re-virginiser suggested. The hymen as a door, or an entry passage is also reflected in forensic medicine. An elastic hymen is called *duhule musait*, which literally means "available for entry". Dr Ceren explains this phenomenon as follows,

Dr Ceren: You know, there is this thing, with some hymen structures, there is something called completely *duhule musait* in forensic medicine. *Duhule musait* hymen structure. Some hymens do not tear or bleed even if there is a sexual relationship.

Hande: Is this the elastic hymen?

Dr Ceren: Yes, they are too elastic. This is actually a problem. A person can go through their first sexual experience with no bleeding at all. But you cannot explain it to anyone in Turkish society. I've always thought, what are we debating, what are we doing? It's very stupid for people who know the anatomy to discuss this.

Hande: Was it called *duhule musait*?

Dr Ceren: Yes, we've always laughed at this expression. A hymen structure that's entirely available for entry. There are such things. The patient might be completely honest, but you'll never know. (Dr Ceren, Izmir, August 2017, personal interview)

That a particular type of hymen is named after whether a penis or any other thing can enter the vagina without resistance displays how the woman's vagina and body in general are imagined. It becomes a site that needs to be conquered, invaded, and 'opened'. The opening of the body or the vagina is a task that doctors undertake as well. Dr Kerem states, "Sometimes, in patients that we need to do a biopsy on and who are virgins, we may have to open [break] the hymen" (Dr Kerem, Izmir, August 2017, personal interview). This opening of the hymen, or of the woman's body, when done on medical grounds is more socially acceptable, as it does not necessarily make the woman available for sexuality and promiscuity. However, it still bears this risk, hence causing most women to ask for reports from doctors proving that they have been 'deflowered' for medical purposes only.

The constructed dichotomy between the desexualised woman before marriage and the hyper-sexual woman in marriage as discussed in Chapter 5 causes women to 'close' their legs, as they do not feel ready for sexuality, or they create a psychological and physiological reaction to being sexually available. This is the root cause of the 'disorder' called vaginismus. Dr Ünzile talks about one of her patients with vaginismus as follows,

> They get vaginismus, young girls who have been raised under pressure come to us with vaginismus. Because we treat vaginismus here, I had one patient, she never came for a follow-up appointment either. She is from Azerbaijan. Her mother was an ob-gyn. Every time the kid [patient] would play outside and come home, the mother would examine her daughter's hymen. She would tell her that it would get damaged, so she should not open her legs, nor ride a bike. She would always examine her hymen and at every examination, she would tell her that her hymen is microperforate, "You will bleed a lot at your first intercourse, you will hurt a lot, how will you have intercourse?" The mother raised her like that and when she got married, she had vaginismus as a matter of course. She wouldn't open [spread] her legs, no way. (Dr Ünzile, Ankara, April 2017, personal interview)

This fear makes it difficult also for women to have hymenoplasty. However, which space the operation will take place in is also determined on how open a woman can be with her body, or with how much she can spread her legs open, as Dr Onur shares,

> The number of my cases [hymenoplasty patients] can be a bit less than other colleagues, and the reason is that I prefer to do [the surgery] at the hospital, for the patient's safety. Because the patient gets stressed out, because she cannot lie down comfortably, it is necessary to anaesthetise her a bit. Anatomically, it is a very stressful part [of the body] for the patient. Few patients can have it in the clinic-only if she can be very comfortable, very relaxed, can lie on the table, open her legs comfortably. (Dr Onur, Gaziantep, November 2016, phone interview)

While doctors open or close new doors for women through hymenoplasty, in the case of artificial hymens, it is the woman who should be able to spread her legs open and insert the product into her vaginal canal. This also implies that the woman is available and ready for sexual activity, as she is able to open her body easily. This is one reason why in the online forum most women do not want to admit that they have bought or considered buying an artificial hymen. The online subjectivity that they create is usually one that has 'made a mistake' and has not necessarily enjoyed sexual activity, as discussed in the Methodology chapter. Being able to use the artificial hymen creates a persona that stands against the 'chaste', 'innocent' and 'virtuous' woman, encapsulated in the ease that the woman feels when opening her legs.

In addition to the hymen as the door, the physical door of the gynaecological clinic carries a significant meaning in re-virginisation, one that is beyond other geographies of health and illness possess. Here I repeat a quotation by Dr Önem from the Introduction that states this significance as follows,

> They [re-virginisers] don't want to have it [the operation] done in their hometown, because the doctor may turn out to be their aunt's cousin's neighbour. Let's say three people come from Konya on that day, we seat them in this room, we know where they're coming from. They can't-they shouldn't run into them [other women coming from Konya] at the door. They might say "I'm here for my cyst", but we won't even allow that. It's risky to enter through the gynaecologist's door. (Dr Önem, Ankara, May 2017, personal interview)

Despite this risk, re-virginisers enter through the door of the clinic, as re-virginisation is also seen as the door to happiness by re-virginisers, as it opens up a new world, or rather a way to get back to the world they were previously in, or to get back on the time norm. Re-virginisation is the limbo, the in-between of the two worlds. Hence, one re-virginiser states that she sees re-virginisation as the gateway to happiness, yet the time before that is a time stuck between doors, as she says,

> I'm just like you dear, as if I'm in a cul-de-sac, like a cat that got stranded there, like I'm clawing at all the doors, but can't find a door. I'm crying like crazy and then turning off the Internet, I ask the same questions, whether one day happiness will knock on my door too. (Thread 43, June 2013)

There are many spaces at once here. There is the absent space, or the stranded space, just like suspended time, where the re-virginiser feels stuck and cannot go on. Her expectation of happiness, which would "knock on [her] door" through re-virginisation also symbolises a transition between spaces, where the hymen and blood function as gateways to happiness. Similarly, Dr Ezgi describes women whose time gets suspended from virginity loss onwards as those who "lock themselves", as "one group of patients locks themselves, but then time passes, and their family insists on marrying them off, and then they come [to us]" (Dr Ezgi, Istanbul, November 2016, personal interview). Therefore, the time between virginity loss and hymenoplasty becomes a space that is stranded, a single-space setting, until happiness "knocks on the door".

Happiness cloaked as re-virginisation does not knock on every woman's door in the same way, at the same time. In order to be admitted to a geography of re-virginisation, women are required to own a certain level of economic capital. In the 'Inside the Operating Room' section, I had detailed my observation and interview during a hymenoplasty operation. How

I entered that space also requires attention. As this was a private clinic, further doors were required to be passed through. On that day, I entered through the big security gate guarding several other buildings. The clinic was located at one of the newly built 'business centres', clusters of which have become gated communities, where one cannot enter without a previous appointment. Once I was approved at this gate, I went through the reception at the upscale building, by exchanging my identity card for a guest pass. The main gate that separates the *Lebenswelt* of the more privileged from that of the ordinary is a solid reminder that economic capital is the means to access a particular form of re-virginisation, which is hymenoplasty. Those who cannot afford hymenoplasty tend to turn to either the artificial hymen, or more alternative methods such as engaging in sex during the later days of menstruation. The gate also reminds us of the temporal and local dimensions of accessing re-virginisation. As women do not tell their families or colleagues about their re-virginisation, arranging their time and travelling so that they can finally stand before the door through which they will access re-virginisation is critical. Therefore, even though many women save money in order to enter the door of such a clinic, not all of them are able to get in, and the door stands as the symbol of the classed structuring of this geography.

Doors signify not only socioeconomic classes but also hierarchies in healthcare settings. As I was waiting to interview a professor at a public university hospital in Ankara, I noticed that there were multiple doors that led to doctors' clinics. From the waiting room, it is possible either to go through a large gate, which leads into doctors' offices, or to go through one of the smaller doors that lead to a clinic. Patients are not allowed through the larger gate, but can only go to the clinics from the waiting room. However, doctors use the gate to go to their offices, and then use a hidden door between their office and clinic to see patients. The gate represents the different worlds of patients and doctors, and creates a hierarchy between the two, as patients are always already visible, while doctors can use doors at their own will, and can render themselves invisible to the patient's eye as they please. I was led to the doctor's office through the gate, which separated me from patients, but I also belonged to the waiting room, which positioned me at an interim position between the doctors and the patients.

Doors are not necessarily concrete. Especially in the case of online forums, it is possible to see rooms, walls, and doors being built, destroyed, and re-built constantly. If we consider an online forum as a building, every thread is another room in that building, where women who post enter and exit. However, it is not possible to talk about a free flow of people or ideas among rooms, as women seeking re-virginisation act as gatekeepers, as discussed in the Methodology chapter. Furthermore, guards, in other words, moderators walk around every now and then, making adjustments as necessary. Online forums, then, become a temporary space for women's emotions as they go through re-virginisation. However, as the Internet

and the forum store all of the entries that have been posted, these spaces are also permanent spaces for other re-virginisers. Hence, online spaces hold emotions across time, they become atemporal spaces of re-virginisation, while they are temporal and temporary for re-virginisers. Hence, unlike other geographies of re-virginisation through which emotions roam, online spaces store them for future re-virginisers.

Conclusion

Ahmed argues that "bodies take the shape of the very contact they have with objects and others" (Ahmed 2014, 1). I have argued in this chapter that bodies constantly change shape with regard to the contact they get into with emotions, objects, spaces, and times; all of which change shape simultaneously and constantly alongside bodies. This constant becoming is perhaps what makes re-virginisation a venture worth taking, and a bearable one. The potential change of perception of time for re-virginisers from its suspension to its sharing, and eventually getting back on the timeline of the time norm, or the promise of it makes it possible for re-virginisers to take on this process.

As we draw attention to the idea that "an anthropological theory of space and place needs to be process-oriented, person-based, and allow for agency and new possibilities" (Low 2009, 22), the new possibilities, and the person-based approach to space also calls for the integration of emotions into the discussion. As re-virginisers and their (imagined) body parts interact with other people and things, different emotions are evoked and they cut across each other in a constant flux that calls for a non-linear conceptualisation of times and spaces. Not only do emotions go through objects, but they also go through spaces, lodge in them, take their shape, and are shaped by them. Furthermore, conceptualising bodies as spaces enables us to see what parts of the bodies are opened, which doors are closed and opened for bodies and in bodies, as well as which emotions become through the process. Following this affective analysis, I now turn to the Conclusion.

8. Conclusion

Virginity, by being once lost may be ten times found; by being ever kept it is ever lost.

William Shakespeare, *All's Well that Ends Well*

Re-virginisation is a complication for feminism. On the one hand, it is a process that creates and feeds from emotional and physical pain for women, and perpetuates norms around virginity. At the same time, however, it is a process of liberation, both in the practical sense for women who are re-virginising and for challenging the notion of virginity in the grander scheme of gender relations. This thesis shows how intricate these dimensions and debates are on a seemingly straightforward topic.

It has been a unique experience to research this topic in Cambridge. In the many research group meetings, workshops, symposia, and conferences where I presented my research, I received a plethora of feedback from an academic audience. Two of the most recurring reactions were giggling, following the presentation of the artificial hymen I had bought, and questions directed on the relationship between re-virginisation, and religion and region. The giggling points at the difficulties that researchers of sexuality continue to encounter. Even in a context where re-virginisation is not a "public secret" (Tausssig 1999), the topic is received as awkward, unusual, and foreign. This feeling of foreignness is amplified when Orientalist responses are added to the picture, as the second group of reactions demonstrates. The audience of my presentations as well as the people I had short conversations with about my thesis were more interested in whether re-virginisation was being practiced outside of Turkey and how traditional Turkey should be given the prevalence of re-virginisation there than what it meant for a woman to go through this process, or the feminist debates that could enrich our way of thinking about virginity. These interactions show the necessity for change in our ways of thinking in academia in relation to Orientalism and sexuality research. I can only hope that my conversations and this thesis may have contributed to this critical transformation.

In some ways, this research has been an ambitious attempt to research re-virginisation in its entirety in Turkey. As the topic is understudied especially in Turkey, it has been necessary to first get a sense of the market upon which this industry is formed, and then move on to the experiences of women and the role of the institution of medicine and medical staff, as well as that of artificial hymen retailers. Hence, in many ways, this research aspires to pave way for more in-depth research in the field of re-virginisation in Turkey by laying the groundwork upon which further research can be built. In doing so, this thesis has focused on three research questions,

(i) How do women experience and embody re-virginisation?

(ii) How do re-virginisation providers understand and practice re-virginisation?

(iii) How is the re-virginisation industry shaped?

These questions have attempted to draw a framework for the re-virginisation industry (iii) and to grasp the experience of re-virginisation as understood by the providers of re-virginisation goods and services (ii) and, most importantly, by re-virginisers themselves (i). The data that I have collected and analysed has allowed me to answer all three of these questions. Firstly, the re-virginisation industry is shaped around the circulation of a variety of capitals (iii). Most importantly, the tug-of-war between symbolic and economic capital for medical doctors and artificial hymen retailers characterises the re-virginisation industry. On the one hand, they are key actors in making re-virginisation available and accessible to re-virginisers from a variety of backgrounds. On the other hand, they risk losing their prestige as a result of helping women to go against society's norms around gender, sexuality, and virginity. In this liminal state, re-virginisation providers perpetuate and/or create their own definitions of virginity, which also impact re-virginisers significantly, which brings us to (ii). Especially medical doctors have their own constructions of not only virginity, but also the hymen. This results in screening processes being employed on women in order to see if they are virtuous enough, or are promising enough to be virtuous to 'deserve' hymenoplasty. This further fuels the anxiety, fear, loneliness, and lack of trust that re-virginisers are already experiencing on a daily basis. In their collective discourse, however, all re-virginisation providers employ the concept of 'mistake' when explaining why a woman would need to re-virginise. As this is shared on their websites, women get an understanding of what emotions a re-virginiser should feel, which primarily neglects their desire. The data has also allowed me to explore the nation-state's own façade with regards to re-virginisation. The Turkish state has its own strategic silences that affects both re-virginisers and the industry at theoretical and practical levels.

The first research question has proved to be the most important one. Especially in understanding that re-virginisation is a process, women's embodied and affective experiences throughout have become an indispensable part of this research. The data has demonstrated how the process is never linear and that it is imbued with pain and a variety of emotions. Women's perception of time and space change as they re-virginise, their sense of solidarity gets mixed up with loneliness, and happiness becomes a scarce resource that is distributed unevenly. At the same time, pain becomes a shared experience, both subjective and intersubjective, and leaves women with the necessity to be responsible for not only healing their bodies but also to understand where and when it is acceptable and expected for the pain to be performed so that their lives can be deemed "liveable" (Butler 1999, xxii).

Key Concepts

This thesis offers many original, as well as existing yet improved conceptual tools for other researchers to use, be it researchers of re-virginisation or not. One of the major conceptual contributions has been the concept "becoming-virgin" as a re-direction of Deleuze and Guattari's becoming-woman towards making sense of experiences of and relationalities surrounding sexuality. Becoming-virgin invites us to think about power and structure as one becomes through their sexual identity. This concept has the potential to be useful for researchers of sexuality in particular.

Within the scope of methodology, two key concepts emerge. One of them is "re-virginiser". Even though it is a simple way of referring to women who have sought or are seeking any re-virginisation method, it is a useful addition to our vocabulary, as it provides us with a coherent way of analysing re-virginisers and their interactions with other groups of people. Re-virginisers go through a unique manifestation of norms around gender and sexuality, and this concept allows us to provide space for their experiences to be made more audible. "Amplified intimacy" is another concept that helps us to think about methodology in a new way, when it comes to online spaces that have unique dynamics that create certain forms and relations of intimacy. With this concept, I offer a new way of looking at online communities and argue that intimacy is amplified rather than being stuck at the 'virtual' realm when it is established online. I also provide an alternative definition of *mahremiyet*, as the gendered construct of intimacy to integrate the specificities that come with researching re-virginisation in Turkey.

For research on pain, my thesis argues that pain can be communicated, and that we should pay attention to where and when this communication is allowed to take place. This becomes important especially for pain that cannot performed in certain spaces, be it for reasons such as the fear of being exposed in the case of re-virginisation, or when the bearer of pain chooses to not perform it in certain spaces and times. This draws attention to the idea that pain is a performance, and that pain is performed temporospatially. The very performance of pain points at the communicability of it.

Within affective research, my thesis makes a fundamental contribution by introducing the hymen as *the* affective object. This conceptualisation is not limited to the hymen, however. In addition to tracing different affective objects, my research points at the possibility that one affective object can be the dominant or the single object in a series of relations. This framework creates further opportunities of unpacking affective relations. Furthermore, I posit the concept "affective performance" to advance my argument that pain is a performance. Re-virginisation is not only performed physically. Affects play an important part in this performance, as women take on a variety of subjectivities throughout the re-

virginisation process in online spaces, in medical institutions, as well as in their homes. Unpacking the role of affects in any performance should be fundamental to our research.

Other concepts that may enrich scholars' vocabulary include "hymenotechnology", to refer to all technologies that surround the hymen, as well as "compulsory invisibility" as an addition to Foucault's "compulsory visibility" (Foucault [1975] 1995). Compulsory invisibility draws our attention to the bodies, body parts, and/or performances that need to be invisibilised based on social norms. Finally, I suggest the conceptualisation of the body as space, which can be used not only as a compulsorily visibilised or invisibilised space but also one that is affective and embodied. By conceptualising the body as space, we open up to the possibility to use theories on space and geographies to understand the becoming of bodies further.

Methodological Limitations

As Marcotte (Marcotte 2015) reminds us, not engaging in the conversation of women's online exchanges limits the quantity and the quality of data available for collection. As explained in the Methodology chapter, my access to women who post on the online communities was prohibited as women feared that I was a man who could blackmail them, threatening them with sharing their sexual past with their families after getting close to them. As I have not been able to pass that barrier, not only could I not recruit participants through online communities, but also I have not been able to converse with women through the 'public' forums. This latter task was not initially on my agenda, as I also saw the online forum as a sacred place where women only wanted to read other re-virginisers' experiences. In collaboration with the moderators, they did their best to keep women who did not go through the same process as them away from the forum. Therefore, even if I were allowed to post, I would have preferred to respect their space and abstain from actively interacting with them, except for privately messaging them. This puts me in a position of not being an ethnographer but an observer, also because I have analysed entries posted as early as 2010, until 2017, when I concluded my fieldwork.

Engaging in conversations with women online would bring a different dimension to my research, providing insights into remaining questions, and getting a deeper grasp of their embodied and affective journey of re-virginisation. Another means to do this would be interviewing more re-virginisers. Even though I have been able to access more than 20 women who have re-virginised, this was not a process they wanted to re-live or risk confidentiality for. Hence, my offline data collection from re-virginisers has been more limited than I had planned. On the one hand, only after the necessity to overcome the challenges that I encountered with interviewing re-virginisers have I been aware of the abundance of online data. Hence, this obstacle has re-drawn my own route in re-virginisation research. However, online and offline narratives of re-virginisers can be

expected to inform the data in different ways. One of the ways that my data could be enriched is what happens to women who re-virginise. From the online data, it is possible to see several women posting that they are happily married with kids, and a few who have been stuck temporally at their virginity loss. A re-virginiser who had problems with bleeding shares the following,

> I paid a lot of money for this, but I did not bleed on our first night. I argued a lot with my husband, I almost got beaten up. My wedding night got sour, I didn't bleed a single drop. When my husband tried again the next day, I did bleed, but this time we couldn't stop the bleeding. We had to go to the emergency room, a lot of issues like infection came up. My husband found out that I had hymenoplasty. He didn't divorce me, but he hasn't been the same as before since then. (Thread 17, February 2015)

This quotation shows what kinds of consequences re-virginising can have other than the ones that are more readily visible or expected. On the one hand, the marriage did not fall apart, which makes it a success story in the eyes of some re-virginisers. At the same time, not bleeding at the right time and in the right amount has created irreversible problems for the re-virginiser's married life. Finally, we can see here a complication of the operation that is rarely mentioned by doctors. More data on the post-re-virginisation lives of women would be highly informative and enrich this data. Emotions become more palpable, and pain more visible when the interviewer and the interviewee can interact in person. My interview with Ayşe sets a layered example for this, by offering the much-needed windows to emotions of trust in doctor-re-virginiser relationship, meanings of confidentiality, intimacy, and virginity, as well as the lived experience of time and space. More interviews would open more windows.

I have sporadically scanned entries posted after my fieldwork, as late as October 2019. I have noticed that the themes I have observed are still being repeated, with advertisements that are cloaked as genuine posts on the increase. It has also been possible to identify entries posted to condemn certain doctors as an advertisement strategy by their competitors. Hence, as the demand for re-virginisation is increasing, the market is becoming more competitive, and the advertisement strategies becoming harsher. Since 2017, re-virginisers have also been recommending additional ways which they believe will help hymenoplasty to be sustained, such as taking more vitamins following the procedure. The tension between re-virginisers and those who are against these practices, as well as the intervention of moderators stand still. Including these new aspects would also enrich this research.

Men and Re-Virginisation

Although I have interviewed six men who are not directly related to re-virginisation as part of my research, men's voices have not been at the forefront of this thesis. However, re-virginisation gives us important insights into how masculinities are constructed, how masculinity is made more fragile by way of focusing on women's technical virginity, and how men's bodies are viewed. Further interviews and focus groups, as well as an analysis of men's online forums, would give us the other side of the picture. As I wanted my thesis to reflect women's experiences, I paid less attention to men's in relation to virginity and re-virginisation. Such further research would enrich what we already know about the topic.

I had set off this research by also asking the question, "What does re-virginisation tell us about how men's bodies are defined?" This question has been pushed into the background for a variety of reasons, including the abundance of data on women's experiences, my desire to put women at the centre of my research, and limits on space and time. However, I continue to insist on the idea that as bodies are interrelational, and their definitions are tied to each other, re-virginisation gives us significant insights into how men's bodies are imagined. The conceptualisation of men's bodies can be regarded as the opposite of women's bodies at the first glance, but further inquiries can show us how similarities are being overlooked in a pursuit to establish inequalities that facilitate the control over women's bodies. I have briefly mentioned male circumcision and penile enhancement surgeries and pumps to draw attention to these similarities. I believe this line of thinking bears a lot more potential to be tapped into.

Re-virginisation also points at a crisis of masculinity and makes us aware that masculinity as such can no longer be sustained. It threatens one of the pillars of patriarchy and forces it to redefine sexuality and virginity. Hence, it would be an exciting and insightful endeavour to collect more narratives of men in relation to virginity and re-virginisation to identify the relationship between re-virginisation and the fragility of masculinity. As an example, a woman who had hymenoplasty yet did not bleed, while also suffering from vaginismus, shares the following online,

> My husband didn't engage in foreplay, in case I got wet and didn't bleed. Imagine the pressure I was under. I couldn't help it, I was hurting too much, I couldn't have [sex]. My husband tried so many times, "it's enough if it [the hymen] is spoiled, we'll do [the rest] on the honeymoon", he said. In the end, he strangled me. Still, whatever I did, I couldn't do it, I was pushing him off instinctively. And then he couldn't get hard, got demoralised. He went to the other room and started crying. (Thread 47, November 2013)

This quotation demonstrates the violence women experience just so that blood can be made visible not only to prove the woman's virginity but also the man's prowess and virility. Not being able to penetrate the vagina creates anxiety in men, translated into both psychological pressure and physical violence, while women's pleasure is entirely neglected. This relationship, in particular, requires further exploration.

Technical virginity and re-virginisation rest on the assumption that all sex is heterosexual and penetrative. This was one of the first premises of this research. Interviews with non-heterosexual women would give us different definitions of virginity, and its relation to re-virginisation (or the lack of it). Technical virginity takes on a different meaning when it is not a man's penis that penetrates the vagina. How this relates to re-virginisation would also generate an understanding of where homosexuality stands in Turkey in relation to sexuality.

Desire and Love

Women's online narratives of sexual experience are generally shaped around men's desire, and how this desire has deceived women into making the 'mistake' of pre-marital penetrative sexual activity. As discussed in the Methodology chapter, this is in line with constructing an acceptable non-virgin subjectivity. What gets lost in this online subjectivity, however, is women's desire. In arguing that it was a 'mistake', women also tend to neglect the instances where they did desire sexual experience and pleasure. Few women say "I did it because I wanted to do it". However, not only is this the minority but also, as discussed in Chapter 4, there is a constant construction of a distance between one's identity and genitalia or sexual activity, by not calling it by its name. Women's desire's being in the background is in line with the Republican woman ideal, who is supposed to be de-sexualised until marriage and hyper-sexual after marriage, in a way that responds to her husband's desire. Needless to say, such a jump to being-woman without becoming-woman is not possible nor sustainable, and women struggle to find their sexual identities as a result of feeling stuck. Women's desire is absent in this formula. Hence, we do not know how a woman is supposed to curtail her sexual desire following hymenoplasty, as for many re-virginisers, there is a temporal gap between the operation and marriage. We also do not know how it is possible for a woman to not have any sexual desire until marriage, and how to immediately change this on the day of marriage. However, re-virginisation creates an alternative path of becoming in the world. Ahmed defines these alternative paths as "desire lines", which describe

> unofficial paths, those marks left on the ground that show everyday comings and goings, where people deviate from the paths they are supposed to follow. Deviation leaves its own marks on the ground, which can even help generate alternative lines, which cross the ground in unexpected ways. Such lines are

> indeed traces of desire; where people have taken different routes to get to this point or to that point. (Ahmed 2006, 19–20)

Re-virginisation is a path around sexuality and marriage. On the one hand, if the desired destination is marriage, it is a path that allows women to get to that point. There are, of course, other paths, such as not engaging in any sexual activity until marriage, preserving technical virginity via engaging in sexual activities other than vaginal penetration, or taking a path outside of the heteronormative understanding of virginity. In other words, not getting married, not marrying someone who demands a virgin bride, and/or being in a non-heterosexual relationship are other alternative desire lines that may or may not lead to a change in the desired point. However, re-virginisation is not only a path to marriage. It is also a path for sexuality. It is not necessarily a path towards sexuality, but a path that crosses it, as in the absence of re-virginisation, sexuality may not be a stop until marriage. Hence, re-virginisation makes sexual desire accessible to women by making virginity accessible. Finally, re-virginisation is a path through emotions and self-making, it is a becoming that involves roaming through trust, loneliness, fear, guilt, shame, and desire-which tends to remain in the background while the others take over the process. It would be an exciting journey to pull desire from where it has been pushed to hide and bring to the fore.

Besides desire, a reading of re-virginisation through love would bring a new angle to this research. This would perhaps be more possible in the presence of interviews with re-virginisers. The data I have collected is more interested in women's relationship with their own bodies. How does this relate to the men that they loved, or that they never loved? How does the woman who has been abandoned after revealing her sexual history to her boyfriend feel towards him? How does the girlfriend of the soldier-to-be feel as the boyfriend takes her to the gynaecologist to be re-virginised? It would be simplistic to assume that there is only hatred and anger here. When coming against family norms and one's love for family are integrated into the picture, there is no doubt that following love would uncover further intricacies in re-virginisation.

Generation Re-Virginisation

What will happen next? Where does having a generation of women who negotiate their sexuality through re-virginisation take us? Even though re-virginisation has been around for more than half a century now, the rapid increase alerts us to the fact that the growth in re-virginisation is exponential. Hence, the current generation of married women has perhaps the highest percentage of re-virginisers. How will this impact society in general, and gender relations in particular? From a more optimistic approach, we should remember that there are many women who re-virginise and at the same time are aware of the gendered inequalities that have led them to this decision. A re-virginiser says, "I'm angry at myself.

While he's living the way he wants to and talking about it [our sexual experience] the way he likes, I had to resort to other routes-because Turkey forces you to do that. In Turkey, 'justice' is always on the side of men" (Thread 43, June 2013). This discourse is aware that re-virginisation is a result of the patriarchal order and that women are subjected to unjust forms of control. Similarly, another re-virginiser states,

> If the doctor says the stitches have stayed in, and if the [other] gynaecologist doesn't understand [that I re-virginised], I won't go to the last appointment. I'll erase it from my mind, because after this point if there is no bleeding, I will bring to mind the ones who are virgins yet do not bleed. It's not our fault if our husband is a dick [*öküz*]. Whatever happens we'll stand tall girls. What am I supposed to do with a man who makes those kinds of accusations? (Thread 43, October 2012)

In a similar vein, many re-virginisers agree that it is a woman's 'natural right' to re-virginise. Even though they have had to re-virginise, these women do not blame themselves but the social order. I believe that there is hope between these lines. The next generation is being and will be raised by women who have gained an awareness of inequalities around gender and sexuality especially through their own experience. This can open up the way for this generation to be less obsessed about the hymen, and to start to define women's virginity in the same way men's virginity is defined. The goal is to attain a society where virginity is not a relevant concept, which might take more generations to be reached. However, re-virginisation can be a step towards this goal. Re-virginisation can be a form of micro-feminism that transforms families and in the end society from a micro scale, hence can be regarded as a "minor gesture" (Manning 2016).

For some men, the very existence of re-virginisation has made the demand for a virgin bride irrelevant. Gamze is a woman who has helped two of her friends to go through re-virginisation. One of her male friends has shared with her that, "I no longer look for virginity in my future wife. I look for honesty. It is very hard to come across a woman who hasn't had sex [before marriage] anyway. If she says she's a virgin, she has probably re-virginised. I'd rather be with a woman who tells me the truth" (Gamze, Istanbul, March 2017, personal interview). When thought about within this framework, re-virginisation's being more widespread and mainstream stands as a challenge to the idea of virginity, as it makes it malleable and atemporal. Society's norms around technical virginity get challenged, making the gender norms shaky and ungrounded. On these moving planes, it might be possible to build new structures that defy the current meanings or existence of virginity. This new build should focus on sexual experience as something that is gained, rather than virginity being lost. The current discourse focuses on *gain* to the extent that men are supposed to *get* the experience not only for a healthy sexual life, but also for their nation-state. Men are called

milli after their first penetration, which literally means 'national'. However, the presumed urgency for a man to 'lose' virginity, in his late teens or early twenties, still holds. Our goal should be eradicating the language of loss in relation to sexuality once and for all, and transcend into one of gaining experience, for all genders.

The feminist movement in Turkey has not yet paid re-virginisation the attention that it gave to virginity examinations. My limited interactions with feminist activists on the topic, however, have revealed that some feminists may not be able to fathom the complexities of re-virginisation, and may bluntly oppose it. Unlike virginity examinations, re-virginisation is multi-layered and requires one to accept and acknowledge the spaces and timelines it allows and opens for women, in addition to the ones it closes and obstructs. Women in Turkey would benefit from a feminist stance that argues against norms around virginity and sexuality while at the same time not fighting against women's access to re-virginisation practices.

I believe that one of the main impacts of this study is to raise awareness on the very existence of re-virginisation, which feeds into the challenging of our assumptions on virginity, and making technical virginity less of a value. If virginity can be acquired by anyone, it becomes a void concept. Furthermore, by witnessing the process women go through as they re-virginise, it can be possible to understand how far the concept of technical virginity has been taken. This has the potential to create a rupture or a crisis in a non-re-virginiser's life and to start questioning the norms we have taken for granted.

The Future of Re-Virginisation

It is highly likely that re-virginisation will be around for more years to come. However, I expect the demand for re-virginisation products and services to reach a plateau in the next few decades. Re-virginisation is taking its power from being a "public secret" (Taussig 1999). As it becomes more accessible and more mainstream, it will become more public and less secret. Re-virginisation will continue to be a viable option for women as long as this balance between public and secret is maintained. Until about a decade ago, "secret" outweighed "public", which meant that demand for re-virginisation was more limited. We are now approaching the optimum place for the balance, which will maximise the demand and supply of re-virginisation. However, as media coverage and scholarly research into the topic are increasing, "public" is bound to outweigh "secret", which will make re-virginisation as a less viable option for women. From a more optimistic point of view, if this happens simultaneously with more gender and sexuality awareness and with transformations of gender equality, it might eventually lead to a more liberal conceptualisation of virginity. At the same time, however, this might lead to more conservatist methods of 'measuring' and

proving virginity, and to the strengthening of the existing myths around it. I believe that in the upcoming decades, we will witness a mixture of these two scenarios.

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Appendix 1: Backgrounds of Healthcare Participants

Pseudonym	Specialty	Gender	City currently working in	Sector
Medical doctors				
Ezgi	Gynaecology	F	Istanbul	Private
Onur	Plastic, Reconstructive, Aesthetic Surgery	M	Gaziantep	Private
Hasan	Gynaecology	M	Istanbul	Public
Mehmet	Gynaecology	M	Istanbul	Private
Zafer	Gynaecology	M	Istanbul	Private
Eren	Gynaecology	M	Istanbul	Private
Çiğdem	Gynaecology	F	Istanbul	Public
Emre	Gynaecology	M	Kayseri	Public
Emine	Anaesthesia and Pain	F	Istanbul	Public
Levent	Gynaecology	M	Istanbul, Ankara, Izmir	Private
Tarık	Gynaecology	M	Istanbul	Public
Deniz	Plastic, Reconstructive, Aesthetic Surgery	M	Istanbul	Private
Ayşegül	Plastic, Reconstructive, Aesthetic Surgery	F	Istanbul	Private and public
Emel	Medical Ethics	F	Ankara	Public
Zerrin	Plastic, Reconstructive, Aesthetic Surgery	F	Ankara	Public
Ünzile	Gynaecology	F	Ankara	Private
Jale	Gynaecology	F	Ankara	Private
Önem	Gynaecology	F	Ankara	Private
Demir	Gynaecology	M	Istanbul	Private
Kerem	Gynaecology	M	Izmir	Private
Ceren	Plastic, Reconstructive, Aesthetic Surgery	F	Izmir	Private
Aysel	Gynaecology	F	Izmir	Private
Assistants and Secretaries				
Naz	Gynaecology	F	Istanbul	Private
Elif	Gynaecology	F	Istanbul	Private
Reyhan	Plastic, Reconstructive, Aesthetic Surgery	F	Istanbul	Private
Irmak	Gynaecology	F	Ankara	Private
Zeynep	Gynaecology	F	Istanbul	Private
Banu	Gynaecology	F	Istanbul	Private
Tülin	Gynaecology	F	Izmir	Private
Sibel	Gynaecology	F	Izmir	Private

Appendix 2a: List of Questions (for Medical Doctors, in English)

1. Can you tell me about your background in medicine? How did you decide to become a doctor? Where and when did you receive your education? Why did you choose to specialize in this area?
2. Is re-virginization discussed within the medical community? What do you think is the general opinion regarding it?
3. What should the role of medicine be in re-virginization?
4. Do you carry out re-virginization operations? Why or why not?
5. Do you accept to do hymenorraphy on all the women who request it? Or do you have standards? (cases of rape, prospects of honour killing etc)
6. Do you also provide certificates for the women you have operated?
7. Can you describe me different kinds of re-virginization surgeries? What are their differences and similarities? Which one(s) do you carry out? Why/depending on which circumstances?
8. How, where and when did you learn to do this operation?
9. What does it mean for a woman to be a virgin? What does it mean for a man to be a virgin?
10. Why do you think women come to you for hymenorraphy? What could be an alternative to recreating a hymen?
11. Can you tell me about the first patient who came to you for re-virginization? How was your experience? Had you heard or thought about this operation before?
12. Do you report to the hospital how many operations you make?
13. How much do you charge?
14. How many women have you operated for re-virginization purposes until now?
15. Do you follow your patients up after the surgery? Have they had any complications? What are the possible complications that may arise from this surgery?
16. What do you know and think about the artificial hymens? Do patients consult you on them? If yes, how do you respond?
17. Do you advertise this surgery? Why or why not?

18. Have you observed any class/educational/age pattern in your patients who come for re-virginization?
19. Are there any women who come from different cities, or countries to be operated? If yes, why do you think is the case? Do they get in contact with you beforehand? If yes, how and how do you maintain confidentiality during these contacts? Do you personally talk to them, or is there a nurse/someone else who talks to them before they get here?
20. With whom do women come to the operation and/or pre- or post-operative doctor visits?
21. Do patients come with background knowledge on the surgery? What kind of questions do they ask before the surgery?
22. Have there been any patients who came and decided not to have the operation? If yes, why do you think is the case?
23. Can you describe me one of your cases of re-virginization, perhaps the one that has left a mark for you?

Appendix 2b: List of Questions (for Medical Doctors, in Turkish)

1. Tıp alanındaki geçmişinizden bahsedebilir misiniz? Doktor olmaya nasıl karar verdiniz? Eğitiminizi ne zaman ve nerede aldınız? Kadın doğum alanında uzmanlaşmaya nasıl karar verdiniz?
2. Tıp çevrelerinde kızlık zarı dikimi veya bekâretin yeninden kazanımı konusu tartışılıyor mu? Bu konudaki genel kani sizce nedir?
3. Tıbbın bekâretin yeniden kazanımındaki rolü ne olmalıdır?
4. Kızlık zarı dikimi ameliyatı yapıyor musunuz? Neden?
5. İsteyen her kadına kızlık zarı dikimi yapıyor musunuz? Bu konuda sınırlamanız var mi? (örneğin sadece cinsel taciz vakaları ya da namus cinayeti ihtimali durumlarında gibi)
6. Ameliyat yaptığınız bu kadınlara bekâret raporu da veriyor musunuz?
7. Farklı kızlık zarı dikimi ameliyatlarını bana tarif edebilir misiniz? Farkları ve benzerlikleri nelerdir? Siz hangilerini yapıyorsunuz? Buna nasıl karar veriyorsunuz?
8. Bu ameliyatın nasıl yapıldığını nasıl ve ne zaman öğrendiniz?
9. Bir kadının bakire olması ne demektir? Bir erkeğin bakire olması ne demektir?
10. Sizce kadınlar neden kızlık zarı dikimi için doktora gidiyorlar? Kızlık zarının onarımı ya da yeniden yaratılması için başka nasıl bir alternatif olabilir?
11. Size kızlık zarı dikimi için gelen ilk hastayı hatırlıyor musunuz? Bu ilk deneyiminiz nasıldı? Daha önceden bu ameliyatı duymuş muydunuz ya da üzerine düşünmüş muydunuz?
12. Çalıştığınız hastaneye bu ameliyatları ve kaç ameliyat yaptığınızı raporluyor musunuz?
13. Ameliyatın ücreti ne kadar?
14. Şimdiye kadar kaç kadına bu ameliyatı uyguladınız?
15. Ameliyat sonrası hastalarınızın durumunu takip ediyor musunuz? Komplikasyonlar gelişiyor mu? Bu ameliyat sırası ve sonrasında olabilecek olası komplikasyonlar nelerdir?
16. Yapay kızlık zarı hakkında bildikleriniz ve düşündükleriniz nelerdir? Hastalarınız size bu konuda danışıyorlar mi? Evetse, ne yönde yanıt veriyorsunuz?
17. Bu ameliyatın reklamını yapıyor musunuz? Neden?
18. Size gelen hastalarda sınıf, eğitim durumu, yas gibi bir patern gözlemlediniz mi?
19. Farklı şehir veya ülkelerden operasyon için gelenler oluyor mu? Evetse, neden böyle bir durum olduğunu düşünüyorsunuz (Neden yaşadıkları yerde ameliyat olmuyorlar sizce?)? Gelmeden önce sizinle iletişime geçiyorlar mi? Evetse, onlarla olan iletişiminizde gizliliği

nasıl sağlıyorsunuz? Onlarla siz mi konuşuyorsunuz, yoksa bir hemşire ya da asistan mi iletişim kuruyor?

20. Kadınlar ameliyata ve öncesi-sonrasındaki muayenelerine kiminle geliyor?
21. Hastalar ameliyat hakkında arka plan bilgisiyle mi geliyorlar? Size ameliyat öncesi ne tur sorular soruyorlar? Siz onlara ne soruyorsunuz?
22. Size ameliyat için gelen ve vazgeçen hastalar oldu mu? Olduysa sizce neden vazgeçmiş olabilir?
23. Bir vakayı detaylı anlatabilir misiniz? Belki sizde en çok iz bırakan olabilir.

Appendix 3a: Consent Form (for Healthcare Workers, in English)

UNIVERSITY OF CAMBRIDGE

INFORMED CONSENT FORM

Research Project: Virginity Perception in Turkey

Researcher: Hande Güzel. PhD Candidate, Department of Sociology, University of Cambridge.

As part of a research project on perceptions of virginity in Turkey, I am conducting in-depth interviews with medical doctors working in Turkey. You will be asked about your views on virginity and relevant experiences. The participation in this research is voluntary. You may refuse to answer some/all questions and may withdraw at any time. The interview will usually take between half an hour to an hour, and will be recorded and transcribed if you consent to it. All your responses will be anonymised and used only for academic research.

For further information, please contact me at +905xxxxxxxxx or at xx@xx.

	Tick the box
1. I confirm that I have understood the instructions and have had the opportunity to ask questions.	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time.	☐
3. I understand that my responses will be anonymised and only used for academic research.	☐
4. I allow the researcher to record and transcribe the interview.	☐
5. I agree to participate in this research project.	☐

Name of Participant Signature Date

Name of Researcher Signature Date

Appendix 3b: Consent Form (for Healthcare workers, in Turkish)

UNIVERSITY OF CAMBRIDGE

AYDINLATILMIŞ ONAM FORMU

Araştırma Projesi: Türkiye'de Bekaret Algısı

Araştırmacı: Hande Güzel. Doktora Adayı. Cambridge Üniversitesi Sosyoloji Bölümü.

Türkiye'de bekâret algısına dair bir araştırma projesi kapsamında Türkiye'de çalışan tıp doktorları ile derinlemesine görüşmeler gerçekleştiriyorum. Bu görüşmede size tıbbın bekârete bakış açısı hakkındaki görüşleriniz ve deneyimleriniz hakkında sorular sorulacaktır. Bu araştırmaya katılım gönüllülük esasına dayanır. Yanıtlamak istemediğiniz soruları geçebilir ve istediğiniz zaman araştırmadan çekilebilirsiniz. Görüşmeler yarım saat ile bir saat arasında sürmekte ve izniniz olduğu takdirde ses kaydı alınmaktadır. Tüm görüşmeler isimsizleştirilecek ve yalnızca akademik amaçlı kullanılacaktır.

Araştırma hakkında daha fazla bilgi edinmek isterseniz, benimle 05xx xxx xx xx numaralı telefondan ya da xx@xx adresinden iletişime geçebilirsiniz.

Kutuyu işaretleyin

1. Yönergeleri okuduğumu ve soru sorma fırsatım olduğunu onaylıyorum. ☐
2. Katılımımın gönüllülük esasına dayandığını ve istediğim zaman araştırmadan çekilebileceğimi anlıyorum. ☐
3. Yanıtlarımın isimsizleştirileceğini ve yalnızca akademik amaçlı kullanılacağını anlıyorum. ☐
4. Görüşmelerin kayıt altına alınmasını ve kayıtların yazıya dökülmesini onaylıyorum. ☐
5. Bu araştırma projesine katılmayı kabul ediyorum. ☐

Katılımcının adı	İmza	Tarih
Araştırmacının adı	İmza	Tarih