

The Vulva Dialogues: The Sexual-Bodily Experience of Cisgender Women

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Abstract: Sexuality is an essential part of our lives. Despite being personal, it is deeply impacted by our culture and social scripts. Thus, the sexual-bodily experience of the cisgender woman relates to her life experiences through her body. Nonetheless, the female body is often subjected to prejudice, stigma, and misconceptions, driving women into genital alienation. There is plenty of misinformation on the vulva and the clitoris, even within the scientific community, which not only contributes to many women's unawareness of their own bodies, but also puts their health at risk in the hands of poorly trained surgeons. Furthermore, the sexual-bodily experience of the cisgender woman is commonly observed from a phallogocentric perspective, which tends to override and neglect her agency. My research seeks to analyse the most relevant aspects of the sexual-bodily experience of Portuguese cisgender women who date mostly men, focusing on their relationship with their vulva, their clitoris, and their sexual pleasure. I also want to identify the role of medicine and health professionals in that relationship, within the Western medicine perspective of the female body. The fieldwork is being carried out by qualitative methods, divided into three parts: 1) a minimum of 15 semi-structured, in-depth interviews with health professionals (gynaecologists, gynaecological surgeons, and sex therapists) working in the Lisbon Metropolitan Area (LMA); 2) a minimum of 15 in-depth interviews via the Biographic-Narrative Interpretative Method (BNIM) with Portuguese cisgender women residing in the LMA who date mostly men; and 3) a review of how female genitalia are portrayed in anatomy books used in Portugal's top medical schools. Therefore, I aim to understand how centuries of control over the female body and decades of medicalization of female sexuality have impacted the corporeality and sexuality of Portuguese cisgender women, to contribute to an in-depth debate on such matters in Sociology.

Keywords: Clitoris; Female Sexual-Bodily Experience; Female Sexual Pleasure; Medicalization of Female Sexuality; Vagina; Vulva.

1. The Female Body in History

Since the beginning of Christianity, matters related to the female body's sexuality and reproductive cycles have been associated with impurity, temptation, and sin for awakening male desire (Federici, 2017). It was also perceived as "closer to matter" – ergo, further from God – than the male's because of menstruation, rendering a woman "a dangerous agent of Satan" (Delumeau, 2009: 462, 465). Hence, subjugating the female body meant mastering the danger and impurity contained therein. Even in science, the study of the female body was structured by direct comparison to the male's, perceived as the superior and powerful *standard* (Martin, 2001; Strömquist, 2018), whilst female sexuality was merely suited to social demands (Bourdieu, 2017; Strömquist, 2018). In the 16th century, the clitoris was finally noted by anatomists. But "what constituted the clitoris ... what characterized normal anatomy and whether having a clitoris ... was normal were controversial issues" at the time (O'Connell, Sanjeevan and Hutson, 2005: 1189). Up to the end of 1700, "a kind of unisex body model seemed to have dominated the European philosophical and medical thought", on the premise of the male body as "ideal", as the "normal" body standard and the woman's as "an imperfect copy ... and nothing more than that" (Aboim, 2013: 23).

From the 18th century onwards, the idea of two distinct bodies emerged and women came to be seen "as sexual beings, yet ... still... conceived as a womb" (Aboim, 2013: 23). After the Industrial Revolution, the growth of capitalism meant "the female body was appropriated by the State and by men, forced to function as a means for reproduction and accumulation of labour" (Federici, 2017: 34), which reduced the social relevance of women's bodies and sexuality to their reproductive capacity, removing them from productive activities (Aboim, 2012). Consequently, there was a separation between public and private life and between men and women: whilst private/domestic life was associated with motherhood and women, "the public sphere – of industrial production and political citizenship – remained linked to the masculine, reproducing its supremacy" (Aboim, 2012: 98).

The 19th century saw the drive for public health administration and birth control – from a normative and regulatory perspective (Bozon, 2004) – especially based on the 'normal' vs. 'abnormal' dichotomy. This meant medicine and social sciences put sexuality in the public sphere. At the end of the 19th and beginning of the 20th century, a "science of sex (sexology)" emerged (Aboim, 2013: 23). Freud's theory of sexuality made an association between sex and the pursuit of pleasure, whereupon the perspectives of sexual pleasure and female

orgasm began being considered and discussed (Bozon, 2004). However, Freud did a great disservice to female sexuality by claiming vaginal orgasm as superior and more mature than clitoral, completely disregarding the importance of the clitoris for women's pleasure (Enright, 2019) and sexual-bodily experience.

In 1901, the clitoris was included in *Gray's Anatomy* – considered a world reference in anatomy since its first edition in 1858 – only to be completely excluded from its 25th edition by Dr Charles Goss (Enright, 2019). There is no justification for Dr Goss's editorial choice, but "one theory is that Goss was influenced by Sigmund Freud's disparaging attitude towards the clitoris" (Enright, 2019: 55). Nonetheless, the possibility of this choice without any public objection from the scientific community says a lot about the importance given to women's genitalia.

In the 1960s, the so-called "sexual revolution" caused a "massive diffusion of medical contraceptive methods, which act on the female physiology (pill, intrauterine device or IUD, female sterilisation) and are controlled by women" (Bozon, 2004: 43). Such methods enabled greater female sexual agency, allowing women to have more control over their bodies, separating sex from reproduction, and altering women's sexual-bodily experience.

After centuries of oppression and control of the female body, women have overcome several obstacles to the fulfilment of their sexual-bodily experience, achieving greater social, economic, and political empowerment, since sexual agency is essential to other types of agencies (Hawkins, Cornwall and Lewin, 2011; Turner, 2008). Whilst all aspects of the cisgender woman's body play an important role in her sexual-bodily experience, the vulva and the clitoris seem to be the most neglected and controversial.

2. The Sexual-Bodily Experience of the Cisgender Woman

We mark our presence, distinguish ourselves as individuals, build and express our ideal or desired social identities through our bodies (Goffman, 2009; Turner, 2008), which are the object of our conceptions, apprehensions, and contemplations (Crossley, 2001). Our sexuality is a construct mediated by the creation of meaning between our bodies, the signs we associate with pleasure, and our other. It provides us with our history: however private and intimate, it reflects the time and the society in which we live (Merleau-Ponty, 1999; Young, 2005). Hence, the sexual-bodily experience of the cisgender woman concerns her life experiences resulting from her interactions with the world through her body (Young, 2005).

The vulva is one of the most important aspects of a woman's sexual-bodily experience. Like many other parts of her body, it also changes: the colouring, amount of subcutaneous fat and tissue of the vulva, and the amount of pubic hair change through a woman's life (Farage and Maibach, 2005). These changes are perceived by their medical functionality (Braun, 2000; Martin, 2001), and are socially treated as taboo; little is said and understood about them (Braun, 2005; Enright, 2019; Martin, 2001).

The word 'vulva' seems to be stigmatised – as it is rarely used – vis-à-vis 'vagina', often misused in reference to the vulva. Furthermore, it is uncommon to find a direct association between vulva, vagina, and sexuality, albeit vulva and vagina are female sexual organs. Even in medical dictionaries, such as the British Medical Association's (BMA, 2018), the word 'vulva' appears only with a physiological description – followed by an explanation of itching, dermatitis, and other infections that can affect the vulva – without any reference to female sexuality. However, in the same dictionary, the word 'penis' has a clear sexual association, making no mention of any physical symptoms that may affect the male sexual organ, despite them being possible to occur. These asexual descriptions of the female genitalia also appear in popular English and Portuguese dictionaries: Oxford's (2023) and Cambridge's (2023) make no clear reference to female sexuality in their definitions of 'vagina' and Porto Editora's (2023) makes no such reference in their definition of 'vulva'. The same dictionaries define 'clitoris' as if its *glans* were its *entire body*.

Similarly, the social sciences also offer misinformation about the female genitalia: in 2020, a search on EBSCOhost – one of the largest databases for scientific journals – for papers published between 2010 and 2020 which mentioned the word 'vulva' revealed that of the nearly 8,000 papers found, only three were in social sciences. However, the same search for 'vagina' found almost 19,000 papers, of which 51 in social sciences, but most of them used the word 'vagina' *in reference to the vulva*. Thus, one could argue that calling the vulva a vagina is *a choice* – whether conscious or not – to focus exclusively on the reproductive aspect of a woman's body (vaginal childbirth) and/or on male heterosexual pleasure (vaginal penetration), much to the detriment of a broader view on female sexuality (Braun and Kitzinger, 2001).

Expectedly, such confusion and misinformation about the vulva and the clitoris are also common to many women. The Eve Appeal, a gynaecological cancer research charity based in the UK, carried out a study in 2016 with 1,000 British women (O'Malley, 2018) between 16 and 75 years old (The Eve Appeal, 2016). Part of the

study consisted of asking these women to identify the parts in the female genitalia and reproductive organs. Forty-four percent of them “were unable to identify the vagina” and 60% failed to identify the vulva in the illustrations (O’Malley, 2018: 1). Additionally, 65% claimed to “have a problem using the words vagina or vulva, and nearly 40% of 16-25-year-olds resort to using code names such as ‘lady parts’ or ‘women’s bits’ to discuss gynaecological health” (The Eve Appeal, 2016: 1). It appears a level of shame surrounds these women’s relationship with their vulvas. The same can be said of many Portuguese women. According to Marta Cerqueira (2021), a Portuguese Sexologist, “there are 25-, 30- or 35-year-old women who have never seen their vulva” (Cerqueira, 2021: 1). The health professionals I have interviewed so far confirm these statements; many of their patients/clients had not previously seen their vulvas and did not use the word ‘vulva’ referring to their genitalia.

The vulva is subject to scrutiny because of its appearance, which impacts women’s acceptance of their bodies, leading them to “genital alienation” (Labuski, 2015: 29): on the one hand, some have never seen their genitals (Cerqueira, 2021) or can name its parts (El-Hamamsy *et al*, 2022; The Eve Appeal, 2016); on the other hand, some pursue infantile aesthetic ideals of the vulva (Plowman, 2010), resorting to permanent hair removal, bleaching, and labiaplasty, a surgical procedure that removes partially or completely the inner labia, and is analogous to Female Genital Mutilation (Shahvisi, 2023). Labiaplasty, like any surgery, involves risks, “including infection, pain during sex, scarring and lack of sensation” (Enright, 2019: 84), especially if the surgeon has not had access to the correct information on the neurovascular anatomy of the region.

According to the International Society of Aesthetic Plastic Surgery (ISAPS, 2023), 194,086 labiaplasties were performed worldwide in 2022, an increase of over 46% in comparison to 2018. In Europe, Germany was the country with the highest reported number of labiaplasties: 10,528. Notwithstanding, the ISAPS survey only covers 16 countries, not all plastic surgeons in those countries are members of the organisation, and their participation in the survey is voluntary. Furthermore, labiaplasties are also performed by gynaecologists. Therefore, the actual number of labiaplasties performed in the world every year is most likely much higher than what is shown in the ISAPS report. In the UK, doctors have reported their nine-year-old patients being bothered by how their vulvas look (Enright, 2019), and “in 2015-16, more than 200 girls under eighteen had labiaplasty on the NHS; more than 150 of them were under fifteen” (Enright, 2019: 84). In the US, some women opt for the complete removal of the inner labia: “A Californian gynaecologist called Dr Red Alinsod has introduced a procedure that removes the inner labia completely – it’s called the ‘Barbie’ and it creates a ‘clamshell’ look” (Enright, 2019: 85). As stated on Dr Alinsod’s website, his work was “instrumental in the development of vulvovaginal cosmetic surgery” (AIAVS, 2023: 1).

For some, labiaplasty can offer women empowerment of their bodies and improvement of their sexual agency when their vulva is a source of trauma and insecurity (Dodsworth, 2019). Nevertheless, we must consider the reasons causing such traumas and insecurities. Negative associations with the female genitalia must be contemplated as a contributing factor in the increase of female genital cosmetic surgeries (FGCS) (Braun, 2005). All the misinformation, taboos, and stigma still surrounding the vulva, the clitoris, and women’s sexual pleasure have a negative impact on women’s sex lives. The study “Differences in Orgasm Frequency Among Gay, Lesbian, Bisexual, and Heterosexual Men and Women in a U.S. National Sample” (Frederick *et al*, 2018) found that 95% of heterosexual men reached orgasm in all or almost all their sexual experiences versus 65% of heterosexual women. The researchers interviewed approximately 53,000 adults from 18 to 65 years old. One could question how the sexual politics (Millet, 1970) of the female body take place for women in heterosexual sex, how these women perceive the sexual role *expected* of them, whether heterosexual sex is socially perceived – and experienced – from a phallogocentric perspective, what these women understand by pleasure, how they materialise their sexual desire, and what model of sexual agency they experience.

Another aspect of female sexuality that is still very poorly understood and problematised (O’Connell, Sanjeevan and Hutson, 2005; Pin, 2018) is the clitoris, the main source of sexual pleasure for women (Strömquist, 2018). Although the existence of the clitoris has been known since the 16th century and its actual shape since the 17th century, the study of its anatomy has always been subjected to social issues and surrounded by controversy (O’Connell, Sanjeevan and Hutson, 2005). The precise physiology of the clitoris – information on its shape, size, and neurovascular anatomy – is still missing from most renowned anatomy books (Pin, 2018). The anatomy books I have reviewed so far *Anatomia e Fisiologia de Seeley* (VanPutte *et al*, 2016) and the first-ever Portuguese edition of an anatomy book, *Anatomia Humana: Manual para Estudantes* (Ferreira, Furtado and Neto, 2020) – do not have detailed information on the clitoris either but do for the penis. Misinformation about the clitoris puts women’s sexual pleasure and physical health at risk: plastic, gynaecological, and urological surgeries are performed by doctors who usually do not have full knowledge of the clitoris (Enright, 2019; O’Connell, Sanjeevan and Hutson, 2005; Pin, 2018), especially regarding its nerves (Pin, 2018). Thus, the average lay person does not

know the real size, location, and shape of the clitoris, especially since only the glans – approximately 10% of its length – is visible to the naked eye (Gross, 2020).

Despite all the progress women have made in their sexual-bodily experience, one must realise that heterosexual cisgender women's pleasure is still conditioned by a phallocentric hegemony: women's role is perceived as supporting to men's and is often described as *dysfunctional* (Alarcão, Machado and Giami, 2016; Tiefer, 2004). Consequently, there is a tendency for many more men than women to reach an orgasm in heterosexual sex (Frederick *et al*, 2018; Laan *et al*, 2021). When social factors are disregarded and sexuality is perceived in a health-disease dichotomy, women have their alleged dysfunction medicalised, for which 'treatment' is available (Alarcão, Machado and Giami, 2016; Hawkins, Cornwall and Lewin, 2011; Lupton, 2003).

3. Objectives and Methodology

I am researching the sexual-bodily experience of Portuguese cisgender women who date mostly men. Notwithstanding sex and gender being socially constructed (Butler, 2004), I wish to understand the reality of women who have been socialized and always lived in cisgender bodies, due to the repression and silencing women's bodies have endured throughout Western history (Strömquist, 2018; Weitz, 1998). My general objectives are to research:

1. the perception of health professionals (gynaecologists, gynaecological surgeons, and sex therapists) on Portuguese cisgender women's relationships with their genitals and sexuality,
2. these women's sexual-bodily experience, especially their relationship with their genitals and sexual pleasure,
3. the female genitalia, especially the neurovascular anatomy of the clitoris, in anatomy books used in Portugal's top medical schools.

My research question is: how is the sexual-bodily experience of Portuguese cisgender women, and what are the possible influences from health professionals on the women's perception of their genitals and pleasure?

The research is being carried out by qualitative methods divided into three parts. Firstly, I am conducting semi-structured in-depth interviews with at least 15 health professionals working in the Lisbon Metropolitan Area (LMA), using specific scripts per specialty. The use of semi-structured scripts allows me to compare interviews and have better control of the duration of each interview, being respectful of the interviewee's demanding schedule. The professionals are being recruited based on the visibility and scope of their work: their potential social impact, according to their places of work and possible presence in the media (newspapers, magazines, radio, TV, podcasts, and social media).

Secondly, I will conduct biographical narrative interviews, using the Biographic Narrative Interpretive Method (BNIM) with at least 15 Portuguese women residing in the LMA. To recruit the women, I will take advantage of various events focused on women's topics to approach potential interviewees, resort to recommendations from the health professionals I interview, and from my network. Additionally, I have set up a website (www.thevulvadialogues.com) to make the project publicly available to a wider audience, increase recruitment opportunities and, later, upload my thesis/the results of my research, giving feedback to all interviewees and any other parties who have contributed to my research, promoting a broader and more inclusive debate on this subject.

I will apply BNIM (Wengraf, 2001) associated with the semi-structured interview technique. Whilst BNIM will allow me to obtain a more spontaneous account of the interviewees' sexual-bodily experience, the semi-structured approach will allow me to collect sociodemographic data and apply a visual test on their knowledge of female genitalia. BNIM involves asking an open-ended question and letting the interviewee respond freely, without interruptions. The insights I am gaining from the health professionals shall help me elaborate that question. At the end of the interviewee's narrative, the interviewer asks follow-up questions, with keywords used by the interviewee. In my case, since I also want to test their knowledge of female genitalia, after applying BNIM I will provide the women with illustrations of a vulva (Figure 1) and a clitoris (Figure 2) and ask them to name as many parts as they can. The same illustrations will be shown to them afterwards, but with all parts identified (Figures 3 and 4), to offer them reciprocity and create an opportunity for the interviewees to become informed or confirm their understanding of their genitals. Next, I will ask the sociodemographic questions. Whilst BNIM will allow the women to spontaneously share what they consider most significant (Wengraf, 2001) to their sexual-bodily experience and their relationship with their vulva, clitoris and pleasure, the semi-structured part of the interview will enable a comparative analysis between the profiles. Therefore, I expect this association of

two different techniques to generate richer and more comprehensive research material. The next step of BNIM involves a follow-up interview after a preliminary analysis.

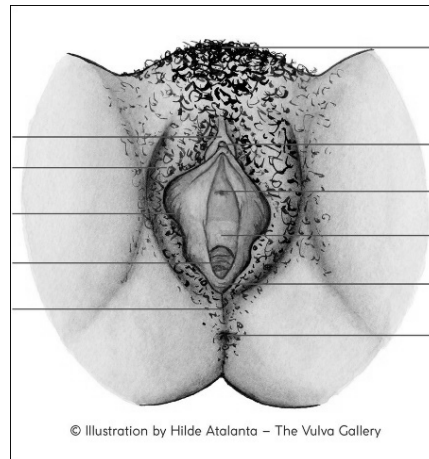


Figure 1: Vulva with no identification (Atlanta, 2023).

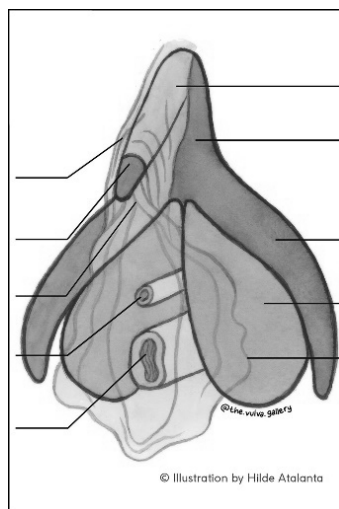


Figure 2: Erect clitoris with no identification (Atlanta, 2023).

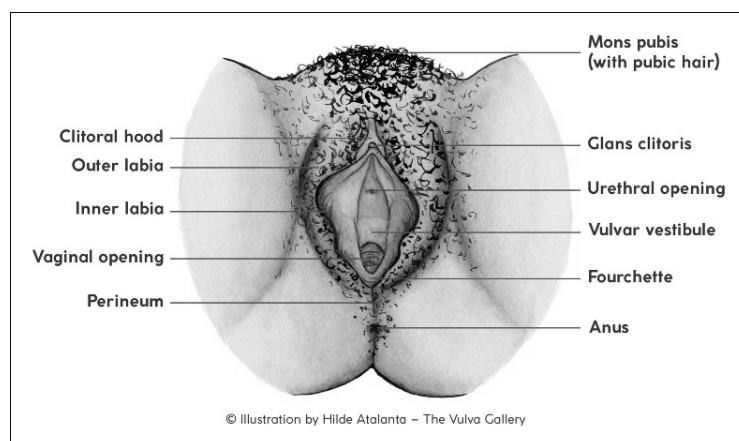


Figure 3: Vulva with all parts identified (Atlanta, 2023).

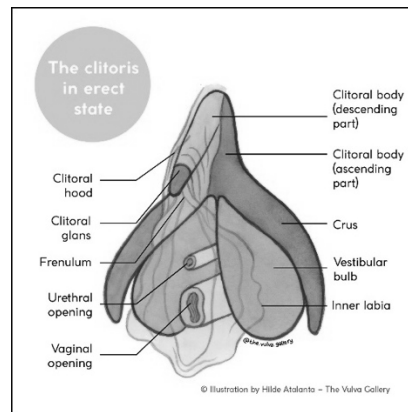


Figure 4: Erect clitoris with all parts identified (Atlanta, 2023).

At the end of each interview, I will make myself be available to the interviewees for additional conversations should they feel the need to add or change anything in their accounts. With the health professionals, I will also ask their permission for future contact for any clarification that may be necessary during my analysis. As for the women, I will inform them about the necessary follow-up to complete the BNIM interview technique, as well as make myself available to listen to them again between the first interview and the next, should they feel the need for additional contact. All interviewees will also be informed about the option to have their participation excluded from the study at any time between their interviews and the submission of the thesis.

All in-depth interviews are being conducted at private sites chosen by the interviewees to ensure their comfort, privacy, and convenience. The narratives of the health professionals used in the thesis will always be contextualized and duly credited, to avoid misrepresentation of their words and intentions in my interpretation. In the cisgender women's case, though their testimonies will be anonymous, I will give them the option to choose their aliases. Despite the anonymity, their narratives will also be contextualized.

Thirdly, I am carrying out desk research on the main anatomy books used in Portugal's top medical schools to verify how the female genitalia – especially the neurovascular anatomy of the clitoris – is portrayed in those books compared to the drawings procured by Jessica Pin (Figure 5), which contain details of such anatomy (Kelling *et al*, 2020). This part of the research aims to understand what kind of knowledge is being passed on to current medical students, bound to perform surgeries on female genitalia in the future.

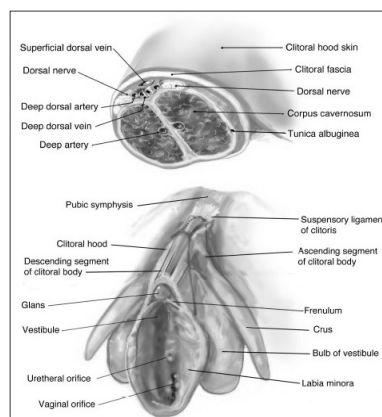


Figure 5: Detailing of the neurovascular anatomy of the clitoris currently missing from most anatomy books (Pin, 2020).

My research follows the best and current practices for conducting sociological research and reporting results, as well as the General Data Protection Regulation (GDPR) of 27 April 2016, and Iscte's Code of Ethical Conduct in Research (Iscte-IUL, 2016). The testimonies of the interviewees will be used exclusively for this study and any academic work derived from it. These guarantees will be formalized by an informed consent form signed by all parties involved. All material related to the study – the signed forms, my notes, the recordings, the transcripts, and any other documents related to the recruitment, interviews, and data analysis – is being stored on an external hard drive, without any backup in the cloud, to guarantee that only I have access to them.

Lastly, it is important to point out my position as an observer and speaker: I am a cisgender, heterosexual, feminist, and socialist woman, which will certainly bring a greater critical perspective in the observation and analysis of the data. I also aspire to raise public awareness of women's genitals – especially its correct name and the real shape and position of the clitoris – and advocate for its correct representation in medical literature being used in universities throughout Portugal. Therefore, my research aims to offer some contribution to the contemporary understanding of the sexual-bodily experience of cisgender women, as well as address aspects that are paramount to this topic and deserve greater prominence within the social sciences debates.

4. Conclusion

As stated thus far, the cisgender woman's body has long been oppressed and silenced. Part of this silencing involves misinformation in the educational and medical fields, being reinforced in the symbolic field, through our social discourse. Such oppression, silencing and misinformation puts women's health and sexual-bodily experience at risk. Albeit my fieldwork is just beginning, so far it seems Portugal follows suit in some of the same trends observed in other European countries and the in the U.S. Ergo, I intend to use the results of my research to shed more light on female genital alienation in Portugal, and thus contribute to deeper discussions and understanding of the sexual-bodily experience of Portuguese cisgender women.

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