

<http://somatosphere.net/?p=12079>

## Three Millimeters

2016-04-18 05:00:49

By Christine Labuski

The first time I encountered Judy I was with Dr. Erlich, gathering fact sheets about vulvar pain conditions. Dr. Robichaud, the other physician at the Vulvar Health Clinic (VHC)[\[1\]](#), and a new resident entered the pod in a white-coated blur—animatedly conferring, hastily scribbling on forms that they were pulling from file cabinets, and getting on the phone to arrange an obviously urgent surgery for the woman whose story they had just heard. Amidst the chaos, Dr. Robichaud told us that their patient—Judy—had one of the severest cases of lichen planus (LP) that she'd ever seen: her labia were so fused together that she was urinating through a three-millimeter vulvar opening. The procedure that Dr. Robichaud was scheduling would both surgically correct the problem and evaluate how much of Judy's vaginal patency it was possible to restore.

Judy was not the first woman I'd met whose genitalia were a source of distress. Prior to the fieldwork that I conducted in the VHC, I had been a nurse practitioner, and for almost fifteen years I managed the gynecological needs of uninsured and low-income women in several US cities. During those years, I observed that the majority of my patients knew little about their genital anatomy and I frequently attended to the repercussions of this: removing tampons or condoms believed by patients to be "lost" in their vaginas; excising vulvar warts for patients who struggled to understand their mode of transmission; and describing, often after the fact, the important differences between hormonal and barrier contraceptive methods regarding pregnancy and infection. I chose the VHC as an anthropological fieldsite because I wanted to know if and how the awkward relationships between my patients and their genitals were changed by the presence of life-altering symptoms. I wanted to know, in other words, if a pressing need for clinical attention, as opposed to a less immediate one for bodily awareness, made it easier to ask "Can we talk about my genitals?"

Genitalia pose multiple dilemmas for critical gender scholars. Aside from the ongoing project of destabilizing the sex/gender binary along which genital anatomy is frequently interpreted, feminist and queer sexuality scholars wrestle with definitional, behavioral, and classificatory questions in our analyses of genitalia, and we work both with and against efforts to medicalize and sexualize these overdetermined body parts. We also

recognize that advancing greater bodily and sexual self-determination (when that is a goal) may incite a “sexuality” whose construction Foucault cautioned us to interrogate. In investigating vulvar disease conditions like Judy’s, then, I think about the stakes involved in saying more about her labia rather than less: that my work will reify essentialist notions of “female” genitalia, or that Judy’s pain becomes a vehicle for ideas about her body that don’t resonate with her own experience. I also think about how Judy’s knowledge of her vulvar anatomy is cultivated by a broader cultural dis-ease with women’s non-reproductive genitalia, and how this can lead to material loss, by disease and/or excision. And when I assemble all of these thoughts, I settle on the side of saying more. A whole lot more.

Though perhaps more familiar to anthropologists via its role in female genital cutting debates,<sup>[iii]</sup> the vulva has been an erratic site of investigation for feminists, sexologists, and other gender scholars, including its relative role in sex assignment,<sup>[iiii]</sup> sexual deviance,<sup>[iv]</sup> and bodily aesthetics.<sup>[v]</sup> Composed of two sets of labia (outer and inner), a clitoris and its hood, urinary and vaginal openings, and several sets of secretory glands, vulvas have been both ignored and reclaimed by feminists, often in concert with broader political projects. In my own work, I posit that vulvas in the contemporary United States are best understood as disavowed. The concept of disavowal, in which objects are simultaneously brought to and erased from our attention, helps me to explain the ways that hyper-sexualized vulvas, stripped by cosmetic reduction procedures, contain increasingly less anatomical flesh. It can also explain how even physicians who specialize in vulvar disease conditions contour their definitions of “getting better” around the ability to engage in penetrative sex, i.e., transforming their object of care from vulvar sensation to heteronormative—and vaginal—behavior. As genitalia that are irreducible to procreative or heteronormative bodily capacities, as flesh that can be involved in but that ultimately exceeds vaginal penetration, vulvas are anatomy that compel us to “ask more”<sup>[vi]</sup> about whether and how “our genitals make us who we are.”<sup>[vii]</sup>

Though there are a host of issues specific to vulvar disease conditions, there were also commonalities between the patients I met as a nurse practitioner and the women I met at the VHC. In both sites, women were paralyzed by the embodied knowledge that while good patients compliantly reported their symptoms, nice women refrained from speaking about their genitals. That is, and despite the ubiquity of some forms of genital “talk” (e.g., pornography; waxed and manicured “va-jay-jays”) the disavowing nature of a word like *cunt* structures the ways that vulvas are lived. This dis-ease can extend to non-expert clinicians who encounter—and often fail—women like Judy. In this case, I argue that Judy’s labia suffer from impoverished definitions of genitalia, definitions

that exclude body parts that exceed penetrative sexual activities. I outline how Judy's fused labia tell a story about which bodies are sexual and which are not, and show how a three-millimeter opening in Judy's vulva indexed the myopic perspectives of providers who were charged with her care.

## **Loss**

*Lichen planus* is an autoimmune disease marked by an overproduction of inflammatory discharge that, if not interrupted, can contribute to permanent scarring, compromised patency, and decreased elasticity of the vagina. Due to anatomical proximity (and gravitational pull), LP can also lead to vulvar problems, including a loss of suppleness and contour erosion of the labia, and decreased flexibility and mobility around the clitoris and its hood. Narrowed vaginal patency thwarts the efforts of women and their partners to engage in penetrative sexual activity and, for many, this behavioral dimension of their condition – rather than ongoing discomfort or evident contour change – is the reason they ultimately seek care.

Judy told Dr. Robichaud that it was “taking [her] ten minutes to pee,” not knowing that medical professionals see vaginal discharge as the likely cause of her problem. Tellingly, Judy's understanding of her disease condition was organized around urinary problems rather than an inflamed vagina in need of treatment. Like other patients at the VHC, she had lived with (and normalized) difficult symptoms for quite some time before trouble emptying her bladder convinced her that something was wrong. What she learned at her first visit was that a “healthy” genital opening enables a variety of bodily functions, including but not limited to penile penetration; a constricted one, on the other hand, can make vaginal entry difficult as well as trap genital discharge.

The irreversible skin changes sustained by Judy's genitals made me incredibly sad and when I came home from the clinic that day, I told my housemate—a computer programmer who always listened to my stories with genuine curiosity—all about it. After I'd recounted the details, he asked me why and, more precisely, *how* this could happen to a woman with health insurance in the contemporary United States.

In my frustration, I replied “Because nobody gives a shit about a sixty-two-year-old woman's genitals,” a sentiment that I believed wholeheartedly at the time.

And though my assertion was woefully hyperbolic—many people care tremendously about and for the genitals of women of all ages, including women themselves—I nevertheless want to argue that in the case of vulvar

neglect, Judy's age compounds rather than causes the disavowal through which her genitalia were clinically apprehended. The compromised access that Judy and the VHC clinicians had to her (sexual) body on the day she came to the clinic resonates with the inadequate capacity of non-expert providers to properly attend to her disease condition.

### **Preservation**

Many autoimmune diseases are notoriously enigmatic, but LP is fairly easy to recognize and manage by knowledgeable gynecologists and dermatologists. To better understand the ways that Judy's vulva was both seen and not seen, however, it is helpful to know more about the drugs involved in her treatment regimen and, even more importantly, how they were deployed by the providers she saw before seeking treatment at the VHC.

Almost a year before Judy came to the vulvar clinic, she had secured a diagnosis for her condition from a dermatologist that I will call Doctor A. Doctor A was a friend of Judy's from her years of working in research hospitals. At the time that her symptoms began, she had just moved. Since she had not yet secured a local health care provider, she called Dr. A for what she hoped would be an easy consult about her genital irritation. Based on what Judy told him, Dr. A presumptively diagnosed *lichen planus* and prescribed a topical steroid, which Judy immediately procured and began using. Cautioning her about some of the more serious side effects of steroids, including immune system compromise, Dr. A encouraged Judy to use the medication sparingly, backing off when her symptoms were under control.

Judy complied with this regimen, but it was not long before the steroid could not control her symptoms. When she called Dr. A to report this, he referred her to a local colleague—Dr. B—who biopsied Judy's vulva and gave her a definitive diagnosis of LP. Dr. B switched Judy to a higher-potency steroid and an immune system modulator called *tacrolimus*. But despite the decreased risks associated with this second drug, Judy was encouraged to use the medications only when her symptoms were acute or troublesome.

The problem with this regimen, as the physicians from the VHC well knew, is that LP is an unpredictable and idiosyncratic condition, equally likely to flare in stressful and stress-free situations. For this reason, the vulvar experts at the VHC encouraged patients to use their medications liberally and regularly at first, in order to establish good symptom control; subsequent backing off would then be done under physician guidance and in order to establish whether particular stressors could be identified, predicted, and avoided. This seemingly small material difference—the

amount of medication prescribed by a physician—is in part a reflection of a provider’s clinical orientation, with conservative clinicians wanting to use fewer clinical interventions, including pharmaceutical ones. But in Judy’s case, the amount of medication prescribed by Dr. Robichaud reflected an acknowledgment that her vulva was relevant and worth preserving—materially and vitally. Here, a less “conservative” approach toward disease management is simultaneously a queerer stance toward non-reproductive genitalia.

Under Dr .B’s care, Judy’s LP became so severe that her labia fused together. Although not as clinically urgent as the day she presented in the clinic—she could urinate normally and her vaginal opening was technically patent—Judy’s labia were markedly flattened in contour and she could not accommodate any vaginal penetration. Significantly, and according to Judy, she and her husband were having “difficulties” at the time, and their sexual activity had more or less ceased. Judy shared this with Dr. B, who subsequently recommended that Judy just “leave it closed” (referring to her vulva and vagina) unless and until she “needed it” again. Unaware of alternatives, and in a relationship with her genitals that was penetratively circumscribed, Judy agreed to the plan. It was just over a year later, at the start of the more dramatic urinary problems described above, that Dr. B referred Judy to the VHC, aware that she now likely needed corrective surgery.

The now of Dr. B’s decision indexes the differences in kind (rather than degree) between the VHC physicians—Drs. Robichaud and Erlich—and more generalist providers through which women without access to specialty care might come to understand their condition. At the VHC, new LP patients were not only encouraged to use liberal amounts of steroids and immune system modulators (like *tacrolimus*) in order to achieve good symptom control, they were also taught to understand the nature of their affliction. Importantly, this included the knowledge that neither medication would halt the (over)production of LP’s vaginal discharge. In fact, patients were taught to expect regular exacerbations, even with good pharmaceutical control, and that all people diagnosed with genital LP [\[viii\]](#) were at risk for labial contour change, erosion, and vaginal scarring. VHC patients and clinicians also knew that in cases like Judy’s, where the vagina fuses into a “classic” apple-core shape, surgically cutting through the fused area was the only way to restore so-called normal vaginal patency.

Drs. Robichaud and Erlich, in the role of vulvar experts, consistently and actively worked against disease progression. And though I attribute this practice to their distinct orientation toward vulvar well-being, it is also good preventive medicine. Managing a patient’s chronic condition as if it could worsen at any time is standard clinical practice in any specialty area, and

most providers routinely do this with a wide variety of diseases (e.g., diabetes, hypertension). In this larger context, managing LP without planning for this kind of complication signals indifference towards the preservation of a symptomatic woman's external genitalia.

Since LP typically afflicts women in their fifties and sixties, decades often reported as a woman's "post-reproductive" years, an inflammatory obstruction of the vagina can become conflated with the allegedly unnecessary maintenance of robust labia and women like Judy can get to a point where doctors present "leaving [their vulvas] closed" as a reasonable option. In contrast, the physicians at the VHC encouraged patients to be proactive in maintaining their vaginal patency, or what they called "capacity." This could be done either through regular vaginal intercourse with a partner or, preferably, with the regular (daily) use of a therapeutic dilator; Dr. Robichaud, for example, typically recommended that her patients keep a dilator inserted in their vaginas for two fifteen-minute sessions per day. While consensual and desired intercourse was also encouraged, dilators were preferred because they could be used more predictably, with greater patient control, and with far fewer problems during the sometimes acutely uncomfortable flares of LP.

This treatment plan, in contrast to the one initially presented to Judy, was derived from an investment in the anatomical and physiological well-being of the vulva and vagina, without regard to the "need" for vaginal penetration or sexual activity. Liberal prescriptions and applications of medications, close monitoring for undesirable side effects, careful instruction about the nature of LP, and treatment strategies geared toward maintaining as much vulvar and vaginal anatomy as possible were the material contours through which a patient at the vulva clinic came to experience her disease condition. These material strategies were obliged to a female genital imaginary in which optimal vaginal patency and vulvar contour were more than simply options to be considered: they were anatomical ground to be preserved.

Although their tools, in the form of immune system modulators, were virtually identical to one another, the physicians described here wielded them with distinct agendas regarding the use-value of female genitalia. Non-expert physicians' lack of information about the condition and treatment of lichen planus evinces how the lines between ill-informed and substandard care often blur. In Judy's case, these unstable boundaries—between conservative clinical management, medical misogyny, and casual disregard—evince a pernicious breed of vulvar inconsequence. The vulva with which Judy struggled to come to terms was a bodily instantiation of overlapping discourses regarding female sexuality, excess, reproduction, heterosexuality, "health" (Metzl and Kirkland 2010), and genital normativity. Ethnographic attention to these dynamic



boundaries can reveal the disavowing and active nature of discourses that rob many women of a genital “capacity.” Without explicitly proclaiming that they “don’t give a shit” about the genitals of these women, institutionally located actors convey this sentiment in their everyday acts of evasion, erasure, and disparagement.

The last time I saw Judy was when she came to the clinic for a post-operative visit. She was bearing a mountainous basket of blueberry muffins, and thanking Dr. Robichaud for the genitals she’d “given back” to her. Of her (sexual) relationship with her husband, she told us, “We’re in a great spot; the best in thirty years.” But what I hope to have made clear is that Judy acquired far more than surgical correction from the vulva clinic physicians. She also acquired a vulva in which she was now invested. Through this novel imaginary, she could manage her symptoms as well as generate an expanding number of genital behaviors in which her vulva might engage. Her previous casual disregard for her genitalia, cultivated by at least two physicians and through an actively disinvested cultural milieu, had been replaced—at least for the time being—with the practice of getting up “pretty flippin’ early” for the dilator sessions that she knew would help to preserve her genital vitality.

Neurologist Wilder Penfield began mapping the somatosensory cortex in 1932, but it took almost twenty years before genitalia were included on his [homunculus](#), the term he used to describe the brain’s proportional representation of various body parts. And though female epileptics were among the patients whose brains he studied, vulvas and vaginas were not depicted in the maps that eventually contained genitalia. I wonder about the genealogy of this absence—how it can be tracked from dermatologists who recommend “leaving [a vulva] closed” to cosmetic surgeons whose [business models](#) depend on widespread vulvar dis-ease. Taking care of women like Judy requires rendering vulvas thinkable irrespective of the penetrative terms of medical and heteronormative discourses. It also requires that we include disregard and disavowal in our list of symptoms to be resolved.

[Christine Labuski](#) is an anthropologist and assistant professor of Women’s and Gender Studies at Virginia Tech, where she also directs the Gender, Bodies & Technology initiative. Her book [It Hurts Down There: The Bodily Imaginaries of Female Genital Pain](#), tracks the emergence and physiological realization of vulvar pain conditions in the contemporary United States.

## Notes

[i] The names of people and places in this essay are pseudonyms.

[ii] Shell-Duncan, Bettina. 2008. From Health to Human Rights: Female Genital Cutting and the Politics of Intervention. *American Anthropologist*, 110 (2): 225-236.

[iii] Karkazis, Katrina. 2008. *Fixing Sex: Intersex, Medical Authority, and Lived Experience*. Durham: Duke University Press.

[iv] Terry, Jennifer. 1995. "Anxious Slippages between 'Us' and 'Them': A Brief History of the Scientific Search for Homosexual Bodies." In *Deviant Bodies: Critical Perspectives on Difference*

*in Science and Popular Culture*, edited by Jennifer Terry and Jacqueline Urla, 129–69. Bloomington: Indiana University Press.

[v] Frueh, Joanna. 2003. Vaginal Aesthetics. *Hypatia* 18 (4): 137–58.

[vi] Fields, Jessica. *Risky Lessons: Sex Education and Social Inequality*. New Brunswick: Rutgers University Press, p. 168

[vii] Karkazis, p. 13.

[viii] Lichen planus can also affect oral mucosa.

#### **AMA citation**

Labuski C. Three Millimeters. *Somatosphere*. 2016. Available at: <http://somatosphere.net/?p=12079>. Accessed April 18, 2016.

#### **APA citation**

Labuski, Christine. (2016). *Three Millimeters*. Retrieved April 18, 2016, from Somatosphere Web site: <http://somatosphere.net/?p=12079>

#### **Chicago citation**

Labuski, Christine. 2016. Three Millimeters. Somatosphere. <http://somatosphere.net/?p=12079> (accessed April 18, 2016).

#### **Harvard citation**

Labuski, C 2016, *Three Millimeters*, Somatosphere. Retrieved April 18, 2016, from <<http://somatosphere.net/?p=12079>>

#### **MLA citation**

Labuski, Christine. "Three Millimeters." 17 Apr. 2016. *Somatosphere*. Accessed 18 Apr. 2016.<<http://somatosphere.net/?p=12079>>