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## INSINUATION

### *A Biocultural Condition*



The worst name anybody can be called.  
—Germaine Greer, *The Female Eunuch*

In the spring of 2003, the *Journal of the American Medical Women's Association* published a study entitled “A Population-Based Assessment of Chronic Unexplained Vulvar Pain: Have We Underestimated the Prevalence of Vulvodynia?” At seven pages, the article concisely reports the findings of a telephone survey of over three thousand Boston-area women who were asked about symptoms that the authors defined as “chronic vulvar pain”:

- a) burning in the genital area for 3 months or longer with or without chronic itching,
- b) knifelike or sharp pain in the genital area for 3 months or longer with or without burning or itching, or
- c) excessive pain on contact when inserting tampons, during sexual intercourse, or during pelvic examinations that lasted for 3 months or longer. (Harlow and Stewart 2003, 83)

The survey was part of a larger project conducted by the Harvard School of Public Health, nestled between pilot research

demonstrating an 18 percent prevalence rate for vulvar pain and a clinic-based follow-up study intended to correlate women's reported symptoms with objective evidence of disease. The authors of the study (an epidemiologist and a researcher-physician) reported that "the pathophysiology of these conditions [and] . . . the magnitude of this problem . . . [were] largely unknown" (82), but that "the true incidence of generalized and localized vulvar dysesthesia" could not be determined "without a complete medical history and physical examination to rule out *other causes* of genital discomfort" (83; my emphasis).

For these researchers and their clinician audience, "other causes of genital discomfort" include vulvar dermatoses, malignancies, inflammatory conditions, postoperative or postinjury neurological complications, and recalcitrant or atypical presentations of yeast or bacterial infections of the vagina and vulva. Although etiologically and pathologically varied, what links these causes of genital discomfort is the medical certainty that they are physiological and that a resolution of the pain can and should be achieved through pharmacological or surgical means. Reasons for distinguishing between chronic vulvar pain and its possible look-alikes are, in this framework, related not to the nature of its source (i.e., physiological) but rather to the project of constituting and delineating a distinct category of genital disease. Noting that this "highly prevalent condition . . . is associated with substantial disability" (87), the authors conclude with the hope that suitable prevention strategies can be gleaned from a better understanding of chronic vulvar pain's distinct "etiological pathways" (87).

This book investigates the contemporary landscape of vulvar pain in order to illuminate a distinctly faceted set of causes and prevention strategies. Chronic and unexplained vulvar pain is indeed an increasingly legitimate medical condition. Though exact causative mechanisms remain unclear, researchers have postulated a wide range of possible factors—including neurological injury, genetic susceptibility, and altered hormone expression—and have developed an expanding array of variably effective treatment options (Bachmann et al. 2006; Danby and Margesson 2010; Haefner et al. 2005; Leclair et al. 2007; NIH 2012). This book argues that vulvar pain is also, and perhaps

primarily, a bodily *experience*, mired in discourses of pollution and taboo that severely restrict a woman's ability to accurately describe her symptoms. In the words of one informant, vulvas are virtually "off-limits," including to the women whose bodies they distinguish. Women with vulvar pain bow to the weight of censoring social discourses as they struggle with language, postpone and avoid clinical consultations, and refuse treatment options that necessitate physical encounters with their genitalia. Rooted in a "highly prevalent" social genital dis-ease, these behaviors index a "disability" no less "substantial" (Harlow and Stewart 2003, 8) than the painful conditions described by Harvard's researchers.

In this book, I treat vulvar pain as a condition that is simultaneously clinical and cultural, an approach reflecting my training in both feminist anthropology and gynecological medicine.<sup>1</sup> Medically, it is an affliction severe enough to preclude vaginal penetration, sitting down for longer than a few hours, and wearing pants or other forms of fitted clothing. Because the etiology of genital pain remains unclear, the diagnostic experience is a protracted one: clinicians attempt to identify the source and best course of treatment for symptoms they don't fully understand, while affected women's lives are irrevocably altered (Ventolini 2013). Vulvar pain is a cultural condition in that most women in the contemporary United States<sup>2</sup>—including symptomatic ones—lack an idiom or sufficient vocabulary through which to name and describe the parts of their body that are in pain. Frequently severe, this limitation is coassembled with a host of cultural institutions and practices through which frank descriptions of female genitalia are contaminated, erased, or otherwise muted.

I argue that distaste toward female genitalia is socially conditioned—neither natural nor inevitable; in Butler's words (1993), it can be regarded as a "regulatory schema that produce[s] intelligible morphological possibilities" (14). In the chapters that follow, I explore the cultural and clinical conditions through which this dis-ease condition is achieved, how it "produces and vanquishes bodies that matter" (14); I also elaborate some of the risks with which it is associated and describe strategies through which alternative female genital bodies might

be recuperated. In this introduction, I insinuate the contours of female genital dis-ease by positioning it within the symbiotic fields (Bourdieu 1993) of phallogentric and biomedical heteronormativity—discourses and practices that prioritize and assume the routine and penile penetration of female genitalia. Following this, I discuss the importance of feminist analyses that foreground the *intra*genital dynamics of the female sexual body—that is, the important and often hierarchical differences between vulvas and vaginas—and caution that failing to make these distinctions risks missing fundamental insights regarding how female bodies are culturally imagined. Furthermore, I argue that labial anatomies, thought by many to figure only marginally in heteronormative sexual scripts, have the capacity to profoundly disrupt and reconfigure them.

In the final section of this chapter, I offer three concepts without which I do not believe vulvar pain conditions can be properly analyzed: *genital dis-ease*, *unwanted genital experience*, and *genital alienation*. Unpacked in turn, these concepts demonstrate what medical anthropologists often label *bioculture* (Wiley and Allen 2009) and what “new materialists” refer to as *entanglement* (Barad 2007; Coole and Frost 2010): that events and ideas thought to be exclusively social are registered *and* reflected by material bodies, and that disease conditions are constituted by this multidirectional process. In the case of vulvar pain, the paradoxical narratives of excess and inconsequence shape a bodily imaginary in which genitalia are a problem to be avoided rather than confronted. Feminist and anthropological attention, I argue, can complement the clinical strategies of vulvar experts, reorienting symptomatic women away from the former and toward the latter.

## FIXING THE PROBLEM

The way he is, I have to fix the problem.  
—Sharon, Vulvar Health Clinic patient

Sharon<sup>3</sup> uttered this statement to me as we talked over coffee one afternoon, engaged in a formal interview about her vulvar

pain. Though symptomatic for over five years, Sharon had been neither properly diagnosed nor adequately treated until the month prior to our interview, when she had finally secured an appointment with the Vulvar Health Clinic (VHC), where, in 2004–2005, I conducted ethnographic fieldwork in order to better understand how symptomatic women and their providers negotiated the difficult “cultural” encounters that talking about genitalia required. For thirteen months, I observed and transcribed patient visits at the clinic and then followed these women through other aspects of their treatment regimens, including surgery and physical therapy sessions. This was in addition to formal interviews and informal conversations designed to glean as much information as possible about the wider contexts of vulvar pain. Sharon was emblematic of many of the women I came to know that year: having just consulted with an expert, she was newly optimistic that her symptoms would eventually resolve. But her buoyancy lay over several years’ worth of sexual and bodily despair, indexed most poignantly by her report of having “shut down,” both emotionally and sexually, a long time ago.

The “he” in Sharon’s remark was her husband, and her observation that the problem was hers to fix speaks to one of vulvar pain’s most onerous realities. The inability to engage in penetrative intercourse, one of the more notable hallmarks of this disease, engenders a unique set of stressors for patients’ intimate relationships. Almost always heterosexually identified, most women adapt to their symptoms by closing off connections to their genital bodies (sometimes for years at a time), participating in painful sex, or engaging in sexual activities that one informant explained were “more about him.” I argue that these limited coping strategies are elements of a pernicious and heteronormative social structure from which many straight-identified women must labor to discern their erotic sensibilities.

Immersed in the notion that vaginal-penile penetrative coitus constitutes “real sex” (Kaler 2006), women and couples affected by vulvar pain enact a set of seemingly natural implications: rather than exploring the nonpenetrative or nonvaginal dimensions of their sexual bodies and desire, they defer an active or generative sex life until symptoms can be wholly

resolved (Labuski 2014). Sharon's sense that it was *she* who needed to "fix [her] problem"—in other words, be able to "have sex" again—indexes the limited range of options through which many couples live their heterosexuality. In short, her husband's phallogocentric desire is the rule, rendering women who cannot comply with routine intercourse the exception. For both members of this couple, Sharon's pain functions as little more than an obstacle in that, rather than providing a motive to learn about what (other) parts of their bodies they might *also* enjoy, it drives them further away from physical intimacy. As I elaborate in subsequent chapters, neither partner is able to perceive the coexistence of vulvar pain *and* a heteronormative sexual relationship. Rather, both believe that they must choose what Sharon's body can tolerate: *either* the pain *or* her husband.

The situation in which Sharon and her husband are embroiled creates a space for what some scholars would call the queering of their heteronormativity. Arguing that radical sexuality need not be solely the province of so-called sexual minorities, Beasley (2010) calls for a "transgressive heterosexuality" that "reject[s] . . . simplistic accounts of sexual modes" by "refus[ing] to inculcate socio-political determinism" (208). Stevi Jackson (2006) furthers this analysis with a discussion of meaning, concluding that while such determinisms may govern the intelligibility of (sexual) norms, meaning "is also negotiated in, and emergent from, the mundane social interaction through which each of us makes sense of our own and others' gendered and sexual lives" (112). Here, a "'natural attitude'" (113)<sup>4</sup> toward penetrative intercourse can be called into question through beliefs and behaviors in which couples like Sharon and her husband might choose to engage, thus widening the parameters of what it means to be (hetero)sexually "normal."

For Cacchioni (2007), such practices constitute "sexual lifestyle changes":

Rather than working towards mastering, strategically mimicking, or carefully avoiding sexual practises, sexual lifestyle changes . . . involve challenging normative definitions of sex and even the overall importance of sexual activity. [They] might involve . . . privileging sexual

activities typically deemed as foreplay, and/or valuing non-goal-oriented masturbation as an acceptable sexual activity on par with intercourse with another person. They also might entail questioning the overall importance placed on sexual relationships, institutions and practices. (310)

In this analysis, pain can become a catalyst for two kinds of shifts, the first being in one's sexual repertoire, toward a set of more comfortable behaviors, and the second in the broader gender dynamics that structure a couple's relationship. As Kaler (2006) argues, vulvar pain produces a category of "unreal women" (50) whose gender identity is threatened by being unable to engage in "an action which makes people into heterogendered men and women" (58). Likewise, Kempner (2014) has shown that this brand of gender transgression extends to the condition of migraine. Women whose debilitating headaches make it hard to care for their children, maintain a household, or participate in sexual activity are pathologized for failing to comply with these gendered norms, particularly by pharmaceutical companies that market remedies that enable them to return to the roles of wife and mother. I want to underscore that both types of pain confound women's gendered identities by thwarting the aims of patriarchal masculinity; the conditions to be cured are defined as much by the (gendered) work in which symptomatic women cannot fully engage—vaginal intercourse and child care—as by the pain itself. Because of this conflation, and as my ethnography makes clear, sexual relationships that are (re)defined in terms of what *her vulva needs* rather than what *his penis expects* can facilitate the reconfiguration of gender norms in other areas of a heterosexual couple's life.

And though these interpersonal tensions take their toll on vulvar pain patients, the struggle in which most of these women are even more intimately engaged is the one with their own bodies. It is these bodies—female,<sup>5</sup> genital, sexual, and in pain—that are the protagonists of this book. I believe that the *intrapersonal* efforts of women afflicted with vulvar pain should be of concern to feminists for two important reasons: first, because their recuperative efforts locate them on the

cutting edge of a radical and nonphallogocentric sexuality; and, second, because they provide a uniquely embodied perspective on how female genitalia are lived in the contemporary United States. As anatomy and physiology—as skin, muscles, blood, and nerve endings—the genitalia of women with vulvar pain are “bodies that matter” (Butler 1993) apart from the erotic behavior in which they might or might not engage. But as I demonstrate throughout this book, this singular bodily fact is routinely undermined, in ways both astonishing and ordinary, by the erasure and muting of female genitalia.

### MY BIRTH IN THE CLINIC

It’s tricky to physically inhabit a part of the body from which you have been otherwise taught to disassociate, through, for example, the “shaming words and dirty jokes” to which Gloria Steinem refers in her introduction to *The Vagina Monologues* (Enslar 2001, xi). Throughout this book, I use the term “dis-ease” to convey the awkwardness of encounters with the vulva, as well as to underscore the role this awkwardness plays in not only our general understanding of vulvar pain but also in its rates of complication and severity. It is the mutuality of these dimensions to which I refer when I use the phrase “Vulvar Disease,” which I capitalize in order to provide increased analytical weight to this relationality. As a formal theoretical concept, Vulvar Disease emphasizes the biocultural nature of a physiological pain saturated with gendered meanings and expectations, a real disease shot through with beliefs and sensibilities that contour its progression.

Freud’s notorious assertion that “the sight of female genitals gives . . . rise to ‘horror, contempt, or pity’” (Gatens 1996, 34)<sup>6</sup> speaks to only one of the more explicit legacies through which women encounter dis-eased genitalia. These affects of disgust are compounded by what Harriet Lerner describes as the “persistent misuse” and substitution of the word “vagina” for “vulva,” a practice that “impair[s] a girl’s capacity to develop an accurate and differentiated ‘map’ of her . . . genitals” (2005, 28). When symptoms arise in this unmentionable (and therefore



unspecified) place, the familiar act of uttering the words necessary for a focused medical history (“It hurts when I breathe”; “The itching seems to be much worse at night”) requires a delicate and difficult set of negotiations among the woman, bodily ignorance, propriety, and the urgency of her painful situation. “Having accurate language to distinguish the vulva from the vagina is crucial for every girl,” continues Lerner. “Inaccurate labeling . . . increases shame and complicates healing” (2005, 28; see also Frueh 2003).

It was through my work as a gynecological clinician—working first as a nurse and then a nurse practitioner in Planned Parenthood and other so-called sexual health clinics—that I initially came to speculate about the vulnerability of genitalia from which my patients seemed to be detached. As a health care provider, I was initially concerned about the disease-related outcomes of this detachment: the malignant progression of an undetected vulvar lesion, for example, or the potentially life-threatening complications of a sexually transmitted infection (STI). My fellow clinicians and I routinely lamented that our patients couldn’t *talk* about the very same sexual bodies that they physically shared with their partners (Braun and Kitinger 2001; Devault 1990), and I began to wonder about the wide gaps that existed between what I taught my patients to do and what they later (at times sheepishly) told me they actually did. And though I am not suggesting that these problems are not shared by other areas of medicine, I am saying that genital health matters occupy a distinct cultural sphere, and that both clinicians and patients are challenged to invest in a bodily realm from which the rest of their worlds are often—and actively—*disinvested*.

What I couldn’t see, however, during my clinician days, was that I had been taught to assume far too much about the bodily integrity of my patients. A conventional program of college nursing, combined with an emerging feminist consciousness (a decidedly second-wave one<sup>7</sup>), had convinced me that patients simply needed more education to make “healthier” decisions (Metzl and Kirkland 2010), and that the cultural context of their lives—though interesting—was ancillary to their medical situations. In many ways, *It Hurts Down There* is the

handbook that I would offer to that young and eager nurse, whose politico-professional stance was chronically at odds with the clinical realities before her. Though she still has plenty to learn, I want to tell her that her instincts were right—that there *is* something amiss and that her patients often can't (or won't) use contraception effectively because they are unable to confront their sexual and genital bodies. I also want her to know that despite her ability to effectively intervene, at least at times, the discomfort and alienation shaping her patients' unwanted sexual situations were far more insidious than her individual efforts could address.

While I was conducting fieldwork, my friend's high school-age daughter called one afternoon to tell me about an academic conference she had just attended at a local university, the focus of which had been sexual assault and domestic violence. Though she had loved the conference, she found herself troubled by a "feeling" she had never before been aware of, one that surfaced as she listened to stories and feminist analyses of these two painful social realities. "It's in my stomach somewhere," she told me. "I don't know; it's this *feeling*." In response, I tried to share with her my own version of that *feeling* and how it had emerged for me during those early and trying years as a nurse. We spent some time commiserating about the other feelings it generated: anger, disgust, helplessness, inspiration (to intervene), vulnerability, and a grim and abiding acceptance of what it (sometimes) means to be a female body in the contemporary United States. As a clinician, I had never been able to properly address this feeling, given that my time with patients typically ranged between five and fifteen minutes. And though I chose to channel it into increasingly creative levels of prescriptive and supportive advice, I continued to notice that my patients' relative (in)abilities to be at home in their bodies almost always ended at their genitalia.

Undaunted by—and eager to account for—this collective reticence, I refocused my efforts toward feminist anthropology, so that I might investigate this genital reluctance through a less individualistic frame. My questions about bodily integrity, when posed in collective terms, lead me to further questions about the cultural sources of our bodily understandings

and about the corporeal “maps” through which we do or don’t connect with various parts of our anatomy. From this perspective, missing vulvas became both neuropsychological events as well as material instantiations of female sexual inferiority. I see these two dimensions as mutually obliged and, in the following chapters, I analyze them as both separate and interactive phenomena. In widening my anthropological lens to include the physiological functioning of the bodies in question, I not only return to some of my medical roots, I also offer a more complete rendering of how the vulva is made both present and absent through cultural disavowal.

My analysis of vulvar pain is positioned squarely within a feminist politics and in the service of a critical anthropology of the body (Karkazis 2008; Lock and Kaufert 1998; Manderson 2011; Martin 1987; Wentzell 2013). The discursive and material disavowals of female genitalia are structured and routinely sustained by the cultural institutions of patriarchy, heterosexuality, and gynecological medicine. Long disciplined and disparaged (Braun and Tiefer 2010; Muscio 1998), the vulva, I argue, is in need of recuperation at all three levels of bodily experience: individual, social, and political (Scheper-Hughes and Lock 1987). With this book, I begin that project, offering an attention to this genital flesh—in all its vulnerability, alienation, and inconsequence—through which new modes of identification might be possible. In these chapters, I create a space for the vulva to exist for and as itself—as an anatomical, neurological, erotic, vascular, and functional element of a body—and, in this way, contribute to the longstanding feminist project of reimagining female sexuality on its own terms (Braun and Tiefer 2010; Irigaray 1985a, 1985b; New View 2000).

## GENITALITY

Sorry your vagina looks like a grenade went off at a deli counter.  
—Text of a circulating e-card/meme<sup>8</sup>

Based on the largest existing collection of ethnographic and qualitative data regarding vulvar pain, this book constitutes

an important layer of recognition for a condition about which most people know very little. A feminist engagement with vulvar pain is important not only for the patients and clinicians whose stories resonate with those of my research informants but also for sex and gender scholars who share my interest in the critical study of genitalia. As the students in my Sexual Medicine course have discovered, even defining the term “genitals,” particularly after one gains an awareness of the variability through which people and bodies live the term, can be a protracted affair. Are uteruses genitalia? Cervixes? Prostate glands? If my relationship with these organs is sexually recreational rather than procreative, are they still “reproductive” organs? What about pubic hair? Do people have more and less genitalia if and when they alter them? (In the first iteration of this exercise, we settled on the definition “what’s between our legs,” though many of us continued to harbor reservations.)

Many of the questions that vulvar pain raises—regarding sex, gender, and genitalia—are being actively investigated by scholars of transgender identity and intersexuality (Fausto-Sterling 2000; Kessler 1998; Reis 2012; Stryker and Whittle 2006; Valentine 2007). Katrina Karkazis (2008), for example, in an ethnography of surgeons and parents who confront infants with various intersex conditions, demonstrates that both groups recruit genitalia in order to shore up the reality of binary sex. Surgically altering these genitalia, the *Fixing Sex* of her title, enacts a certainty about not only the mutually exclusive nature of male and female bodies but also about the permanence of this distinction. Karkazis convincingly demonstrates that sex is literally constructed via surgical instruments and procedures, and that gendered assumptions about the capacity for penile intromission and vaginal receptivity undergird medical decision making. The narratives of women with vulvar pain complement and extend these arguments by evincing the iterative and evolving nature of the gender-genitals-sex triad. In other words, the genitalia that surgeons presume to have fixed will remain so only if they continue to function; genitalia that are not “usable,” in the words of one of my informants, illustrate the ongoing role of gendered praxis in shaping sex. “Real women” (Kaler 2006,

50) and men, in other words, have genitalia that interact with one another in procreative and heteronormative ways.

Though feminists have long paid attention to the female genital body as a site of cultural discourse (Bordo 1993; Irigaray 1985b; Moore and Clarke 1995), a sustained analysis of genitalia as both social *and* biological entities is lacking in the social sciences. Biological vulvas “matter” (Butler 1993) in that they make plain some of the important differences between women, differences that can be elided through other forms of collective organizing (Carrillo Rowe 2008). Women whose vulvas have eroded or been excised, for example, due to disease conditions like those examined in this book, understand their genitalia through body images distinct from those of women whose vulvas have been acquired or enhanced, either through gender affirmation treatment<sup>9</sup> or cosmetic alteration. Though the degree to which female genitalia have been socially disciplined has been well documented, as has the importance of representing and affirming genital diversity (New View 2000), biological variations among women remain undertheorized.

Though based on the experiences of a relatively narrow spectrum of female bodies, this book—a theory of the intra-genital dynamics of the female (sexual) body—represents a first step toward such an analysis. A more thorough investigation into the relationships among the vagina, clitoris, labia, perineum, and vulvar vestibule in a feminist sexual politics and practice can frame useful questions such as why women overwhelmingly claim their vaginas over their vulvas, and how these external and internal aspects of female genitalia have become so easily conflated. What, in short, are the implications of a vaginal rather than a vulvar politics? I offer several hypotheses throughout this text, but a great deal of work remains to be done regarding these identification practices, particularly in the context of cosmetic vulvar surgery. Vulvar (self-)censorship is perniciously embedded in popular culture, and it is unclear why feminists have left this practice largely unexamined. My own reaction to the relative dearth of vulvar scholarship has never been one of rebuke. But I remain puzzled by the fact that for every feminist who matter-of-factly reminds us that “it should go without saying that the vagina is not the vulva” (Frueh

2003, 138), there is an equal if not greater number of vulvar “refusals,” well characterized by this recent—and particularly exasperated—post on a prominent feminist blog: “I don’t care about your stupid vulva, it’s all vagina to me” (West 2012).

Additionally, a more thorough engagement with female genitalia, including their biology, allows for more careful analyses of how genital bodies intersect with sexual ones. Though this relationship has rarely been posited as one of neat correspondence, the contexts of trans, intersex, diseased, asexual, and surgically altered genital bodies should render it even less so. The state of one’s genitalia does not constitute the bulk of an individual’s erotic identity: genitals can be sick, ignored, acquired, aesthetically pleasing, or even absent in ways that cannot always be reduced to a person’s “sexual” self. Similarly, erotic sensibilities are not confined to the genitalia and are often distributed across and among a wide array of affects, objects, people, and anatomical locations; as my research informants demonstrate, vulvar pain patients can learn to extend their genital imaginaries to other bodily locations. The degree to which our body maps—or schemata—are biologically inherited remains an open question, but the fact that they are malleable, dynamic, and influenced by experience has now been well established (Berlucchi and Aglioti 1997; De Preester and Tsakiris 2009; Knoblich et al. 2006). Reducing genitalia, therefore, to their reproductive, sexual, or even functional dimensions can blunt both the meaning and associated affects that might otherwise accompany genital anatomy. Shaped from birth, when “what’s between our legs” determines which of two extant gender categories will structure the majority of our lived experience, our personal genital imaginaries are as rich and varied as they are impoverished, owing to a wide range of individual and collective experiences through which vulvas, vaginas, and penises are culturally available.

## CRITICAL HETEROSEXUALITY

This book contributes to the literature in critical heterosexuality studies by providing ethnographic evidence of a coital

imperative—that is, the narratives through which heterosexual couples prioritize penetration in their sexual repertoires. This evidence, gathered not only through medical consultations and formal interviews but also through intensely personal physical therapy sessions that often included patients' partners, unpacks heterosexual practice in novel ways. By elaborating how the practice of heterosexuality is enabled by both bodily function and compliance, as well as by routine gynecology, I denaturalize the institution itself. Moreover, the stories of my informants provide alternative routes through which male-female sexual relations can be reconfigured, including sexual imaginaries that foreground the vulva.

In the following chapters, I analyze the sexually discursive work done by women with vulvar pain; I use my ethnographic data to suggest that symptomatic women's "interpretation" (Jackson 2006, 113) of routine heterosexuality contains notable amounts of ambivalence. Unable to participate in routine penetrative intercourse, my informants demonstrated a range of problem-solving behaviors, most of which were performed in slow, cautious, and erratic fashion: refusing or deferring physical therapy, missing clinic appointments, using prescribed medication improperly, not talking with their partners, and sexually "shutting down," that is, disengaging entirely from solitary or partnered sexual affects and activities. Moreover, their not infrequent disclosures that they "wouldn't even be at the clinic" if it weren't for their husbands suggested that women with vulvar pain bring a mix of desire (including for normalcy), verbal reticence, and bodily refusal to their (hetero)sexually disrupted situations.

To the extent that vulvar pain is a physiological realization of "actual distaste" (Frueh 2003, 139) and disparagement toward the vulva, it is possible to theorize penetratively prohibitive pain as the instantiation of a female (hetero)sexuality unsatisfied with commonly available sexual situations. Exhorted by the media—as well as their clinicians—to move beyond penetration and explore what else their genital and sexual bodies might enjoy, my informants routinely encountered male partners uninterested in such novelty. Vulvar pain patients normalized these interactions by keeping their own clinical focus on

a restored tolerance for easy penetration, but it is here where I locate an unstable and inchoate ambivalence: stated desires were frequently not followed by problem-solving behavior, and patients who were able to engage in “successful” penile-vaginal intercourse sometimes described subsequent feelings of anger and resentment toward their partners (“Okay, you got what you wanted!”). Faced with disrupting the penetrative narratives through which their bodies are typically interpellated, many of these women maintained active investments in reproducing *and* resisting these narratives, rendering the option of sexually shutting down a sensible and perhaps more manageable one.

In exam rooms and in interviews, women described expectations and disappointments around sexualities that were constructed and overdetermined by mainstream discourses. Gynecological discourse and popular rhetoric compete and conjoin in writing so-called healthy sexual scripts that normalize a penetratively based heterosexuality, one that is serviced by a compliant vulva. But a vulva that doesn’t “work,” one, that cannot function as an enthusiastic (or at least tolerant) receptacle for heteronormativity, performs the cultural work of manifesting the female genital body in its entirety. I suggest that *this* sexuality remains inadequately theorized by feminist researchers—that its singularity is missed by theories dominated by both phallic and queer perspectives. A vulvar-based “sexual imaginary” (Gatens 1995, xiv) opens a space in which female genitalia can exist in all their corporeal potential—as labial, clitoral, perineal, and pelvic floor anatomy and sensation. Such an imaginary is not available to missing and alienated vulvas, locating women who recuperate their genitalia (e.g., through physical therapy) on the cutting edge of alternative female sexualities.

*This* sexuality is infused with possibility, with the carnal potential of a profuse, expansive, and largely untapped source of pleasure and female corporeality, with a “sex” that Irigaray (1985b) insists can never be just “one.” One imaginary among many (Gatens 1996; Grosz 1995; Potts 2002; Segal 1994), a vulvar-based sexuality is one that women with vulvar pain are in a distinct position to inform. Queered by their marginal relationship to penetrative coitus, but materially and discursively



invested in heteronormality, the bodies of many of my informants were sexually paralyzed by the impossibility of these contradictions. But feminist and critical theory that makes space for their experiences can unseat the assumptions upon which this stagnation rests, transforming an ambivalent vestibular refusal into a recoded and generative orifice, a window into the routine violence of heteropatriarchy. If we read the pain and burning of *vulvodynia* or VVS-afflicted genitalia as a way in to the conflicted desires, anger, and disappointment of (some) heterosexual women in the contemporary United States, we have established a new opening in sexuality studies through which to analyze the apparent investment that straight women make in penetrative coitus.

### THEORIZING GENITAL PAIN

My body in need of treatment and the productive society  
surrounding me are cast from the same mold.

—Barbara Duden, *The Woman beneath the Skin*

#### *Other Causes*

I'm not convinced that a woman in the contemporary United States can escape the mediated and pernicious “blob” (de Zengotita 2005) of discursive contamination that I call genital dis-ease; indeed, if there is a clean or unpolluted cultural space in which the labia and vulva can take up residence, I remain unhappily unaware of its existence. Indeed, as recently as June 2012, Michigan state legislator Lisa Brown was ousted from her state's legislative chambers when she “failed to maintain the decorum of the House of Representatives” by using the word “vagina” in an abortion debate (Roberts 2012); and in 2014, a Japanese artist nicknamed Rokudenashiko (loosely, “good-for-nothing girl”) was arrested on obscenity charges for distributing data from which 3-D models of her vulva could be printed.<sup>10</sup> When I interviewed women—in booths at Denny's or in bustling coffee shops—I sometimes asked them to ponder the physical space in which their words were being spoken, not just

into the tape recorder on the table between us but into the air itself, the “open expanse” that Irigaray defines as “that [which] unfolds indefinitely and gathers all things together” (1993b, 40). I did this because I wanted us to imagine that our conversations—our public utterances of words and ideas too unsettling for legislative chambers and 3-D printers—were perfusing the space around us, seeping into the collective (un)conscious, by way of waitresses, menus, customers, and ambient noise. If the vulva needed to remain invisible in order for it to be culturally palatable, I thought, then perhaps our deliberate and unapologetic voicing, of both its existence and precarious state, might settle like so much dust onto the objects and people in its discursive and material circuits. Or that, like pheromones, our conversations could be naïvely absorbed through fluid and porous corporeal boundaries, influencing the instinctive behavior of those who were inadvertently exposed to them.<sup>11</sup>

Talking about their genitals is a behavior that is uniquely, though not exclusively, constrained for women with vulvar pain. Many patients told me that they had not discussed their symptoms with anyone but their partners and doctors. Others had confided in their mothers or another trusted intimate, but all agreed that their symptoms remained largely undisclosed to friends, coworkers, and relatives. In this section, I propose three “other causes of genital discomfort” (Harlow and Stewart 2003, 83) that structure the silence through which symptomatic women live their disease: genital dis-ease, unwanted genital experience, and genital alienation. Though each has the potential to exacerbate the severity of a woman’s disease process, particularly if it keeps her from seeking treatment, they are also social processes capable of generating their own deleterious effects. I understand these “other causes” to affect women with and without vulvar symptoms, and I argue that their cultural and bodily impacts both precede and transcend the individual experience of pain. As social conditions contingent upon a particular set of historical and cultural variables (including patriarchy and heteronormativity), however, these “other causes” are also preventable, amenable to a host of cultural and political interventions that can help women rewrite the genital rules they have been handed.

*Genital Dis-ease*

In their important article “Clitoral Conventions and Transgressions,” sociologists Lisa Jean Moore and Adele Clarke (1995) trace the clitoris’s visual presence in—and absence from—anatomy textbooks from the twentieth century. Sampling a dozen books published between 1900 and 1991, these researchers demonstrate that graphical representations of the clitoris adhered to prevailing cultural discourses regarding female sexuality, with the clitoris disappearing (i.e., not being drawn) during periods when vaginal orgasms and penetration were prioritized in the medical and popular literature. Moore and Clarke’s tracking of clitoral representation invites us to examine the relationship between social and medical discourses, as well as the role of representation in constructing anatomical—and therefore clinical—reality (Prentice 2012); how, in other words, “aesthetic and scientific paradigms, not empirical or experiential facts, determine understandings and even illustrations of genital anatomy” (Frueh 2003, 139). “Anatomies matter to feminists,” Moore and Clarke insist, because they “create shared images which become key elements in repertoires of bodily understanding” (1995, 255). Bodily erasures, we can conclude, do not occur in a vacuum: if my genitals are missing from my doctor’s textbook, they are likely missing from a wide variety of cultural locations with which that book intersects.

My own tracking of female genitalia has taken me to numerous field sites, including women’s restrooms, popular television and film, physical therapy sessions, clinical and academic conferences, sexual health websites, exam rooms, undergraduate classrooms, feminist workshops, the local Planned Parenthood board, fiction and other literature, surgical suites, sex shops and in-home sex toy parties, political protests, and—most recently—the Texas House of Representatives during the 2013 antiabortion hearings that brought then–state senator Wendy Davis to international attention. In between these various sites, my fieldwork also takes place in conversations with other people, be they diagnosed informants, friends, students, or professional colleagues, and it is these dialogues and exchanges from which I discern the habitual and commonsense ways in

which vulvar dis-ease is lived. Most recently, this involved an exchange with a longtime colleague who, after talking with me about some of the ideas in this book, suggested that maybe it wasn't "that big of a deal" for women to say "vagina" instead of "vulva." When I asked him why he didn't just call his wrist his hand or his thumb, given their anatomical proximity, he acknowledged that perhaps I had a point.

Inhabiting and observing these cultural spaces reveal that female genitalia are the subject of numerous forms of attention and intervention: "va-jay-jays" populate female-centric blogs and other forms of media; women get "vajazzled" by having their pubic hair replaced with patterned Swarovski crystals;<sup>12</sup> lists of the "Top 9 Most Amazing Vaginas"<sup>13</sup> and "10 Movie Vaginas Scarier Than the One in *Teeth*"<sup>14</sup> serve as clickbait for a number of pop culture websites (and only occasionally confuse vaginas with vulvas); and a variety of products target and commodify women's genital shame and insecurity, allowing them to sanitize their otherwise problematic privates in increasingly inventive ways. In 2010, consumers witnessed the debut of My New Pink Button, a temporary dye whose ad campaign, with its promise to "restore the 'Pink' back to a woman's genitals,"<sup>15</sup> renders anomalous any woman—particularly women of color—for whom rose-colored labia are not the norm. Once attuned to the implications of these diminutions and disappearances, it becomes almost impossible to ignore their importance, an orientation to pop culture that can attenuate one's enjoyment of otherwise female-friendly forms of entertainment. Indeed, this sensibility now extends to much of my social media circle, who fill my Facebook wall with vulvar-centered stories, most recently apprising me of an episode of the prison drama *Orange Is the New Black* in which a group of cis female inmates learn the details of their genital anatomy from their trans female peer.

These disavowing discourses, through which female genitalia are simultaneously named, disparaged, and erased, can also be tracked across numerous historical registers, "from Galen . . . through contemporary feminism" (Frueh 2003, 139). Aristotle, for example, equated bodily asymmetry with social hierarchy: women's "inverted" genitalia symbolized