

Filler

Down there—you know . . . whatchamacallit!

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Effective participation in “vagina dialogues” requires more than health practitioners no longer beating around the bush.

According to Berry¹, female patients frequently use all sorts of euphemisms to describe their genitalia, implying some sense of shame associated with the anatomically correct terms. The author asserts that medical specialists in obstetrics by avoiding to use appropriate nomenclature actively contribute to the taboo and undermine the empowerment of women.

I could not help thinking that there exists a long history of euphemisms regarding activities that refer to our body's hygiene. For example, while the word “dining room” clearly identifies what we actually use the room for (i.e., to have dinner), virtually no language refers to a toilet by the activities it is commonly used for. The list of euphemisms to refer to what is nothing more and nothing less than a “pee and poop room” is endless, featuring words such as “lavatory” (from Latin *lavāre* meaning “to wash”), “bath room” (most toilets in public places do not even contain a bath), or “rest room” (most people do not visit the place to take naps). Some languages contain even more flowery terminology, such as, for example, “keshōshitsu” in Japanese, of which the literal translation would be “powder room”.

The use of euphemisms in language has been the focus of several research studies. Goffman⁴ developed the “face-work theory” of which the underlying ratio is that people are living in a society and strive for saving their face rather than losing it. Because the “face” in this context is so fragile and can easily fall prey to injury or damage by others, members of society in the process of communicating with each other are in charge of maintaining not only their own face, but also the face of the protagonists they interact with⁴. “Face” in this sense then becomes the positive social value which a person effectively claims for himself through the position that others assume she or he has taken during such conversation. In other words, “face” is an image of the Self, delineated in terms of approved social attributes⁴. That which we commonly refer to as “politeness” really is nothing else than something that intends to reduce the threat of causing the other to lose face⁴. These dialectical tensions are also very present in the consultation room, to the extent that they are even anticipated to occur rather than that are merely hitting by surprise.

Going back to Berry's assertion, in my opinion the issue of terminology is perhaps somewhat more multi-facetted than we are led to believe. The genitalia fulfill the ambiguous double role of being at the same time organs responsible for the removal of waste and organs of lust. Our society historically seems to be concerned with attempting to maintain a clear separation between the two, probably because conflating them might easily escalate towards threatening the boundaries of the family entity as well as other people's individual private borders. Waste control is primarily an individual function, but lust is a function that very frequently is not delineated by the Self, but extended to another person of interest with whom one desires to share and satisfy that lust. The patient visiting a health practitioner is conditioned to emphasize the separation

of those functions and so does the health practitioner himself or herself to avoid awkwardness, confusion and every consequence —legal or professional— that comes with it in case confusion prevails.

Professionally also being a sexologist, I would argue that in that role, women tend to use far less ambiguous terms with me to describe their problems or organs involved when seeking help than when visiting a family physician or perhaps an obstetrician. There are two likely reasons for that. Firstly, when they seek help from a sexologist they do not need to make any qualms about the role of lust for lust is now implied in the context of which their medical problem needs to be considered. Secondly, there is the issue of specific competency and trust. Women do not consider every health provider or physician as an appropriate professional to discuss their sexual concerns with.

Yulevitch et al.⁷, using multivariate regression analysis, found that genital self-image was the major significant predictor of women's comfort level with discussing sexual problems with a gynecologist. Furthermore, Fahs et al.² showed that, overwhelmingly, women used strong emotional language when discussing their genitals, often evoking descriptions of anxiety, excess, and need for control. The same authors also observed fusions between sexuality and body image, and connections between "genital panics" and internalized racism, sexism, and homophobia². This suggests that the major issue is not the term that is used to refer to their genital organ, but what any reference to their genitals emotionally evokes in them. Because of those strong emotions, not only is the professional competency of the health provider at issue, but the connection the health provider is able to establish with the women. In other words, women seem most inclined to discuss sexual health if they perceive that important patient-provider conditions, such as trust and rapport, were in place⁵. Hughes et al., in a theory-based qualitative study observed that despite situational obstacles and perceived norms, women hold strong beliefs about their abilities to discuss sexual health topics with providers⁵. None of these studies suggest that women per se would have anymore objection against using specific terminology (provided that they are familiar with the term) than against using more flowery language.

Additional problems in health provider/patient communication that involves the topic of genitalia may be encountered when dealing with "special populations", i.e. people with various types and degrees of linguistic and learning difficulties, such as those where the patient (or physician) is a not native speaker of the language they use, has limited education, has mental limitations, or is child. In particular, all communication with children and adolescents with disorders of sex development must be age-appropriate and tailored to their developmental levels and needs⁶. A characteristic pattern tends to arise in which both educator/health provider and addressee jointly produce only a superficially correct response when verbal prompts involve long sentences and abstract concepts³. Nordenström and Thyen⁶ point out that communication is as much about information concerning the factual nature of the medical or sexual situation as it is about listening to the individual's thoughts, questions and anxieties. When dealing with the very young, these are best reached through the parents. Additional awareness should be devoted to eventual ethnocentric attitudes exhibited by the health provider, whether subconsciously or not, and which might raise additional barriers that prevent effective communication with the patient, particularly about delicate topics.

In conclusion, I believe that choice of terminology is a multi-factorial issue. Effective communication requires that the patient is central rather than the health-provider, or that which the anatomy textbook dictates.

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