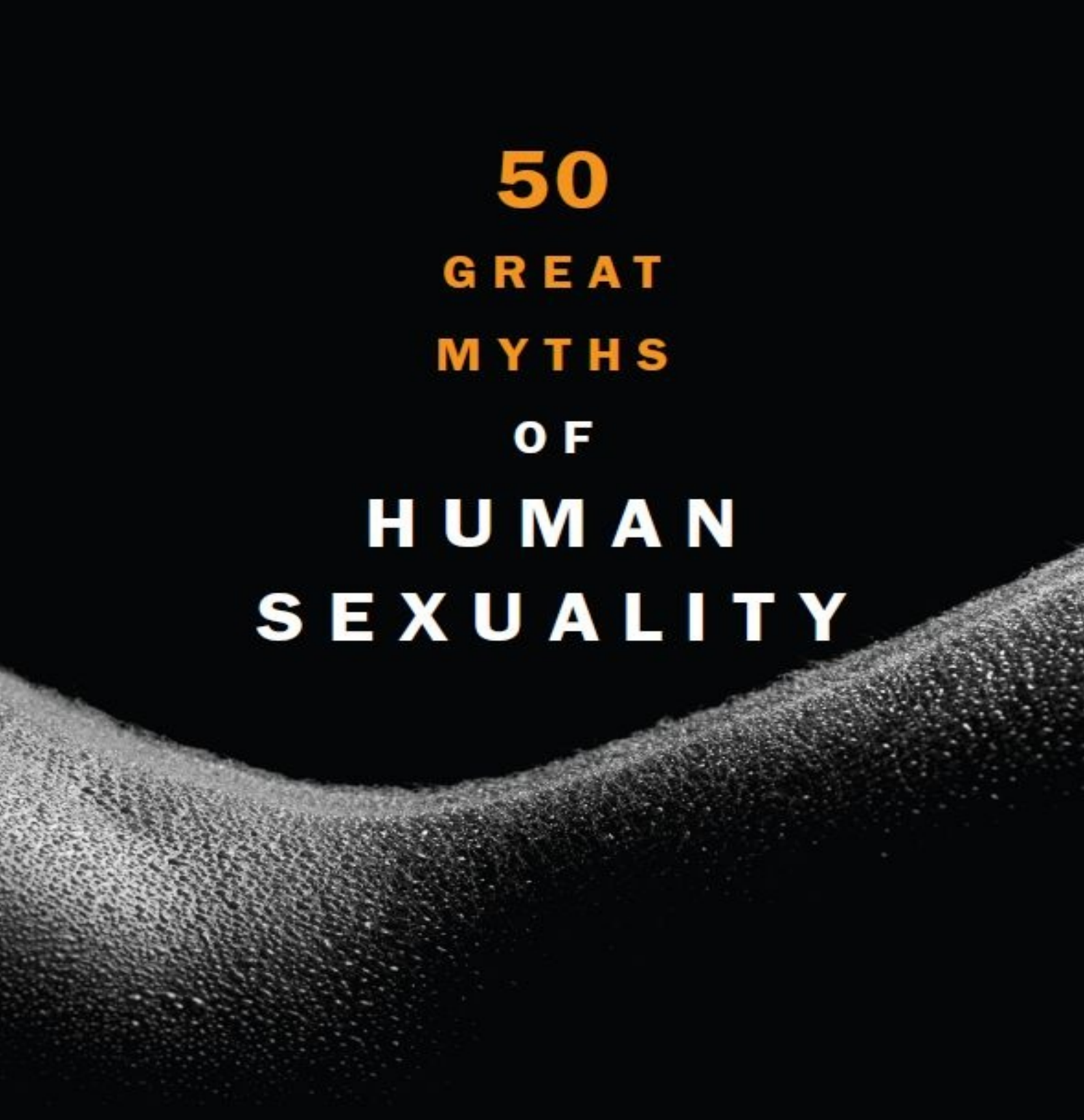
50 GREAT MYTHS OF HUMAN SEXUALITY



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50 Great Myths in Human Sexuality

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Preface

Not so long ago, a member of the US House of Representatives said that he knew that a woman could not get pregnant if she was raped against her will. He explained that there was some sort of organic process in the body that would prevent conception under "legitimate rape" conditions. We can't imagine where he learned this. He claims doctors told him but unless they were lying or joking we can't imagine anyone who had gone to medical school actually believing it. It so ridiculous that it would never have occurred to us to include it as a myth in this book. And yet a grown, well-educated man—a member of Congress, no less—believed it firmly enough that he was comfortable repeating i as fact to a television reporter.

We don't think that this myth is sweeping the nation but it reminds us that there are some amazing misconceptions about human sexuality out there, many of which are certified by self-anointed "experts" and passed on as gospel, and some of which are even taught in our schools. Some are so misleading as to be dangerous while others may cause needless worry and anxiety.

We are all victims of swallowing a myth or two during some point of our lives; nobody gets all the right information, and sometimes early information sounds right until we learn it was actually quite inaccurate, but possibly not before we've told others what we first thought.

During Pepper's freshman year of college, she was in a suite with a number of women, most of whom were virgins when they arrived. One by one, most of the young women acquired boyfriends or entere into an intense dating relationship, and got physical. One of the girls got pregnant the first time. She was shocked. She was sure that "you could not get pregnant the first time you had sex," or that the odds against it were so great that she didn't need to worry. Like there was a sex-freebie, and after tha things got serious. (That myth was very common in those days and still tossed around often enough that we did include it in the book along with the much newer myth that the soda Mountain Dew could prevent pregnancy when drunk in large quantities or used as a douche (see Myth # 25).

Myths have consequences. If we believe that a woman can't get pregnant the first time or during her period, some of us won't bother with contraception at those times. Even seemingly innocuous myths can change our behavior. If we believe, say, that red-haired girls are naturally hornier, some shy redhead is going to get come-ons that she doesn't like, and feel like she has to live up to expectations that she can't, or doesn't want to, fulfill.

It gets even more difficult because many beliefs about sexuality are based on personal or societal values and not scientific fact. And values changes. A couple of generations ago, mothers would tell their daughters to stay virginal until marriage because, as the saying went "He's not going to buy the cow if he can get the milk for free." That may not have been bad advice before the sexual revolution started to change women's behavior in the late 1960s and 1970s. It might not even be bad advice now but it doesn't reflect today's reality in which virginity, not sexual experience, is often more of a cultural burden to women. Despite this reality and the fact that today's teens have sex earlier and get married later, the abstinence-only-until-marriage movement of the 1980s, 1990s, and early 2000s tol young people in no uncertain terms that premarital sex was harmful. While some may continue to value premarital virginity and should be allowed to act on their beliefs, it is inaccurate to say that not doing so is harmful.

Other myths were just never true. Sometimes the facts are distorted because of political agendas. For

example, some antiabortion activists have literally made up physical and emotional consequences for abortion (see Myth # 29) because they want to scare women enough so that they will not have an abortion. And still others have some basis in historical fact but are no longer true today. It is no longe true, for example, that young women and teens should avoid IUDs out of fear of their future fertility. The newest versions of this contraceptive method are safe for women of all ages.

For this book we picked 50 myths about sex. We admit it was hard to narrow them down. We picked them first if we thought that a lot of people believed them and might never know the truth unless we put them in this book. Second, we picked ones that had misinformation that was so dangerous that we were worried that people's reliance on them could seriously hurt them (emotionally or physically) or others (through discrimination). Finally, we picked ones that had good research to the contrary; we didn't want to be guilty of the same thing our book is trying to address! You can probably think of a lot more. And we'd be delighted if you wrote us and suggested others (there's always the second edition!).

We do want to address a few things before we delve into correcting misinformation. For the most par we focused on research from the United States and the cultural issues that are specific to this country Attitudes about human sexuality are so different around the world that it would have been impossible to address each myth on a global scale. That said, we do include comparisons with other countries an cultures in some of our myths to help explain how variable beliefs can be and how societies can influence perceptions.

We also tried to be inclusive of same-sex couples wherever possible. Obviously, certain myths—like those about getting pregnant—are exclusive to heterosexual couples. Others are dedicated to correcting misunderstandings about gay, lesbian, bisexual, or transgender individuals and couples. Many myths, however, like those about faking orgasms or the importance of simultaneous orgasms, probably originated with heterosexual couples but can be applied to anyone. In these myths we tried t include research on same-sex couples wherever possible. Unfortunately, for many aspects of sexualit and sexual behavior, there has not been nearly enough research done on lesbian and gay couples. We are hopeful that as same-sex marriage and relationships become more open and accepted in our society, more researchers will begin to look closely at same-sex couples. (Perhaps that second edition we were talking about can include more information.)

Finally, we want to make sure that our readers understand that because beliefs on human sexuality ar so often grounded in personal values and opinions, some of what you read will reflect our beliefs. Ou opinions are grounded in science and we present that science to you throughout the book. Of course, we think it is only fair that you know that our opinions are also grounded in our collective years of experience working in the field of human sexuality, writing, researching, and teaching. And given thi experience, sometimes we just couldn't help adding a little advice into our entries.

Ultimately, we hope these pages clarify, enlighten, and entertain you. Just because these are serious matters doesn't mean we can't have a little fun with them.

1
Body Parts
Who Has What and How It Works

Myth #1 Bigger Penises Are Better

How many jokes have we all heard about how much "size matters?" And how many retorts "It's not the meat, it's the motion?" There are so many penis jokes and so much bragging, it isn't funny. No, it really isn't. Because the fact is that men with smaller penises worry that they will not be virile enough, it may make them avoid sexual interaction or even peeing in a public urinal, and, even more importantly, some of those men will buy various fake products that will supposedly make them longer, stronger, or wider. Distraught men may even opt for surgery, and these implants can cause nerve damage and even impotence. Even if successful, these are serious operations which include cutting the suspensory ligament, followed by weeks of traction that include hanging weights on the penis (Vardi *et al.*, 2008). This results in added length, but only in the flaccid state! (So who is this operation really for? Could it be really to see other guys enviously ogle the longer penis in the men's room?) Attempts to add girth have even more problems, often resulting in uneven distribution of the added fat tissue which can have an overall lumpy effect. Most men who have the procedure are not happy with the result (Li *et al.*, 2006).

So How Big Are They Usually?

There are differences in penis size. There are wide ones that are short, long, and in between. There ar long ones and short ones of different girth. The best study on penis size (Wessells *et al.*, 1996) found that the mean size of flaccid penises was about 3.5 inches and about 5.1 inches erect. When they measured against the pubic pad, it was about 6.2 inches. Mean circumference of the erect penile shaf was about 4.8 inches. Two-thirds of the men were within 1 inch of these measurements. Other studies also arrive at similar measurements (Templer, 2002). Interestingly, these studies found no correlatio between the flaccid and erect state, so next time you sneak a glance at the guy at the next urinal just remember—you don't really know much.

There have been quite a few studies searching for whether a man's height has any positive correlatio with penis size. Taller men certainly *think* their penises are bigger. An internet survey of 52,031 heterosexual men and women found taller men estimated they were larger while shorter men estimated they were smaller (Lever *et al.*, 2006). They may be right. Researchers in Iran actually studied the external genital dimensions of 1500 men and concluded that length had a significant positive correlation with height (Mehraban *et al.*, 2007). A study from the Department of Urology through the Athens Naval and Veterans Hospital measured 52 men under 40 and found that the penile shaft length, and total length, was correlated positively to height (Spyropoulos *et al.*, 2002).

Body mass also has had some correlation with penis size but most researchers feel that the correlatio is because the penis of obese men retreats under the belly and so seems smaller than it is. Ultimately researchers conclude that "fat level is a good predictor of when a man rates his penis as small versus large" (Lever *et al.*, 2006, p. 135).

People often joke that the larger the hand and feet the larger the schlong, but that doesn't seem to be

the case. Urologists at St Mary's Hospital and the University College Hospital in London studied the stretched penile length of 104 men and found that there was not a "statistically significant relationshi between stretched penile length and shoe size" (Shah and Christopher, 2002, p. 586). No one else has found such a link either.

While hands might not tell us anything, it turns out that the index finger can. The study of Iranian me found a positive correlation between the parameters of an index finger and the size of a man's penis (Mehraban *et al*., 2007). Another study on a small sample of men found the same thing (Spyropoulos *et al*., 2002). Voracek and Manning (2003) offered an explanation for this: "Homeobox (Hox) genes regulate limb development, including fingers and toes, as well as urogenital system development, including the penis. Therefore morphological patterns of the fingers may be related to morphological patterns of the external genitalia" (p. 201).

So there may in fact be some physiological continuities that can predict larger penis length. We think the better question, however, is why is everyone so interested? Are there really any differences between big penises and small when it comes to sexual satisfaction?

Does Size Really Affect Pleasure?

Well, there are two ways to look at this: what's in your head, and what's in your body. Physiological research refers to how effective different sized penises might be in terms of women's likelihood of orgasm and enjoyment of sex. Psychological factors refer to how mentally or emotionally or even aesthetically important size is for a woman's pleasure and/or likelihood of orgasm. A number of studies have taken a look at both. Let's look at heterosexual data first.

Masters and Johnson, the famous sex researchers whose work on sexual functioning in the late 1960s and 1970s jump-started the whole field of sexology and sex therapy, looked at hundreds (maybe thousands) of heterosexual sexual acts and concluded that size was irrelevant or a minor factor in women's sexual pleasure. Their research has been replicated numerous times (Masters and Johnson, 1966; Zilbergeld, 1999; Fisher *et al*., 1983). The main reason they felt sexual arousal and orgasm wer unrelated to penis size was because the vagina is such an accommodating space that, in general, the walls of the vagina grab the penis and conform to its size. The authors do note that women and men might not feel this grabbing at all times during sex because during the excitement and plateau phase the sexual arousal cycle the bottom part of the vagina "balloons" (perhaps to capture semen more efficiently). At times of extreme arousal, the vagina could feel looser or the penis not quite as fulsome.

Though the popular media may suggest that women want bigger and wider penises, the research tells different story and points to men being a lot more worried about penis size than women are. A large academic internet study found that while 55% of heterosexual men were happy with their penis size and/or girth, 84% of heterosexual women were happy with their partner's penis attributes. Only 14% wanted something bigger (Lever *et al*., 2006). An older study by Zilbergeld was particularly conclusive about women's subjective opinion: out of 426 non-virginal women, not one mentioned tha penis size was important (Fisher *et al*., 1983).

More recent studies have also gathered some interesting results. Eisenman (2001) asked 50 women about the importance of penis size; 45% felt more width felt better, while only 5% responded positively to greater length. A European study asked a number of new mothers about their partner's penis size and sexual satisfaction and only 1% of them mentioned length as a positive addition to the enjoyment. The majority found penis length either unimportant (55%) or totally unimportant (22%).

number of women said that they thought length was less important than girth, but only 1% mentioned girth. On the other hand, an additional study by the same researchers did find that one out of three women mentioned size and/or length as being important (Francken *et al.*, 2002). In a 2006 article based on a 1998 study of 556 women in Croatia, girth was found to be more important than length bu still only 12.8% of the sample rated either girth or length to be very important to them. However, when the authors limited their analysis only to the most sexually experienced women, a different sto emerged as more of these women thought that penis size was important (Štulhofer, 2006).

Interestingly, how a penis appears was important to women in this study as 26.9% of sexually experienced women said that the appearance of their partner's penis was very important to them and 44.9% said that it was somewhat important. In fact, only 18.2% said aesthetics of the penis were totally unimportant. It is interesting that in these studies women have strong aesthetic preferences bu lesser physiological ones.

Where does that leave us? Well, heterosexual men are clearly getting feedback that makes them wor about their penises. But, despite the pervasiveness of this myth, it seems rare that this feedback is truly based on size. Most importantly, there is certainly no credible information that penis size determines satisfaction in heterosexual relationships.

Is This Different for Gay Men?

Male sex workers advertise their wares according to size and gay male models in sexually explicit material seem to be chosen for the size and girth of their penises. In sexy gay cartoons, the guys are always hung. No wonder gay men worry about penis size—it seems to be a particularly widely held obsession in gay America. But does it matter in gay relationships?

Well, to some extent, what people believe to be real, is real in its consequences. (A saying first noted by W.I. Thomas, an early sociologist.) The aesthetics of penis size in the gay world has been so extolled that it would be odd if it didn't affect how a gay man felt about his equipment! But does it really make a difference in sexual satisfaction?

Certainly some men think it does. But are gay men who have partners with small penises more likely to stray or more likely to be sexually unfulfilled? We did not find any data on this topic in same-sex relationships so we are not sure if there is any consequence in a relationship one way or the other.

Why Do We Confuse Bigger Penises With Better Penises?

We think there are two reasons. First, the whole world seems to think bigger is better in just about everything from a hamburger to a house. Certainly, there are status points for having a big house—w know that it cost more and the person who builds or buys an elaborate estate is definitely trying to te the world they are a big deal. Whether or not that house is pleasant to live in may be an entirely different matter. Bigger penises come from the same thought pattern. Of course we know that bigger isn't always better in everything. Look at the extraordinary weight gain that has accompanied larger bagels, enormous steaks, and super-sized French fries. In fact, a big penis may be painful to some women, dangerous in vigorous anal sex to either a homosexual or heterosexual partner, and may actually be softer because very big penises can have some problems distributing enough blood to be "rock hard."

The second reason we think bigger has been confused with better is because for the most part only huge penises are used in porno movies. We think they are used so that the male watcher can identify and feel powerful by association. But of course, another comparison may lurk in his head: "My penis

doesn't look anything like that—maybe I am not capable of being that sexy!"

Obviously, individuals will have their preferences but the data swerve sharply toward penis size bein irrelevant except for a small proportion of women who like the aesthetics of a larger penis and those gay men who are hooked on size as an erotic trigger. Most of us, however, are fine with the penis in front of us and get all the sexual satisfaction we need from other elements of our partner and our relationship.

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Myth #2 Vaginas Are Dirty, Ugly, and Smell Bad

In the 1980s there was a series of television commercials that all began the same way; with a mother and her 20-something daughter going through some daily activity—like walking the dog or driving in a car. The daughter would suddenly become very serious, look at her mother intently, and say "Mom, do you ever get that not-so-fresh-feeling?" Despite the fact that the daughter never mentioned that th vague feeling had anything to do with her vagina, her mother would recommend a Massengill douche (or maybe it was Summer's Eve, we don't quite remember). The daughter would look relieved and invariably the clouds would part and the sun would shine. That "not-so-fresh-feeling" became the punch line of jokes for many years.

We haven't seen these ads for a while but there are certainly still commercials that advertise douches special soaps, feminine hygiene wipes, and vaginal deodorant sprays. And maybe we haven't come that far as many of the current ads talk about embarrassing odors and the need for special products to take care "down there." These commercials are designed to sell products (products that nobody needs but we will get to that later) but in doing so they perpetuate the idea that the vagina is dirty and smell bad. Moreover, in doing so without ever using the words vulva or vagina, these ads perpetuate the ide that this is an area of the body that is so embarrassing, we can't even name it. (Unfortunately, in som ways this is true, many people—both men and women—can't name it because they don't know the right words or mix up which part is which.)

The end result of an industry that sells unneeded products and a society that can't or won't use proper language is that many women feel ashamed of their genitals, which can negatively impact their sex lives. Women have also begun to alter the appearance of their genitals; some by removing all or som of their pubic hair and others by undergoing painful reconstructive surgery to "normalize" the appearance of their genitals.

What's Where and What to Call It

Before we can successfully debunk the myriad of myths that surround the female genitals, we have to start by talking about the female genitals themselves. Forgive us if this is a repeat of something you've learned in an anatomy class or a human sexuality course (or, if we had our way, a fifth grade puberty class) but we think this bears repeating. The external female genitals are made up of a numbe of different parts. The *mons* or *mons pubis* is the pad of fatty tissue that covers the pubic bone and is naturally covered in pubic hair after puberty. The *labia majora* and *labia minora* are the outer and inner lips, respectively. The labia majora are also covered in pubic hair. When these lips are pulled apart they reveal the *clitoral hood*, the *clitoris*, the *urethral opening*, and the opening to the vagina. All of these parts together are referred to as the vulva (Kelly, 2011, p. 31).

The *vagina* is actually part of the internal reproductive anatomy as it is what connects the uterus (or womb) to the outside of the body. Though many people think of the vagina as like a tube or a tunnel– always open, just waiting for something to go in or come out—it is not. The vagina is made of muscles that can open up if something (like a tampon, a penis, or a sex toy) is inserted into it or something (like a baby) is being pushed out of it, but most of the time the walls of the vagina are

touching each other. It is important to note that the walls of the vagina are very elastic and though they can stretch to accommodate a full-size infant during childbirth, they do not stay stretched out (Kelly, 2011, p. 34).

Taking Care of Vulvas and Vaginas

Though the marketing world seems to want women to believe that the vulva requires special lotions, soaps, and salves, and that the vagina must be frequently cleaned out—the truth is that the same soap and water techniques you use for the rest of your body are exactly what you need for your genitals.

The vulva has a lot of blood vessels and can get warm easily which is why it also has a lot of sweat glands; sweat helps the body cool off. Sweat also has smell and it is true that most vulvas do have a particular scent. Though they don't all smell the same, some people think the smell is a little salty, a little yeasty, or kind of like sour milk (Herbenick and Schick, 2011, p. 48). This is all normal and doe not require any special deodorant soaps or sprays. As Martha's college professor, Dr. Goodenough, once said: "There is no reason that a woman's vulva should smell like a field of wild strawberries." Women should take note of the smell of their vulva because if it changes or becomes significantly stronger at any point this could be the sign of an infection, but other than that there is nothing to wor about. In fact, some people find the smell of a woman's vulva to be an integral part of sex and arousa

As for the vagina—the internal part which can't be reached with soap in the shower—the good news that it cleans itself. Yep, the vagina has self-cleansing mechanisms and a delicate balance of microorganisms that keep it healthy (Kelly, 2011, p. 35). Though the practice of douching—forcing water or other liquid into the vagina to clean it out—has been around for thousands of years, it has been proven time and time again to be harmful to women, increasing their risk of getting sexually transmitted infections (STIs) and other infections. A review of literature by Martino *et al.* (2004) found research confirming that douching has been associated with increased risk of pelvic inflammatory disease (PID), bacterial vaginosis (BV), cervical cancer, recurrent yeast infections, and HIV transmission. Douching has also been associated with infertility and having low birth weight or preterm infants. Several studies have also found an association between douching and chlamydia (a common STI) though others have not (Martino *et al*., 2004, p. 1053).

Martino *et al.* do add a caution about seeing this as a direct cause and effect situation. They note that douching is more common in certain populations—African-Americans, people with low income, thos with less education, and those who have more lifetime sex partners—who are already at higher risk f many of these outcomes including PID, BV, and STIs (Martino *et al*., 2004, p. 1053). Still, douching unnecessary and clearly risky.

The need for douching is one of the most stubborn myths about the vagina because, despite years of research showing that this is not healthy, many women still believe it is important and good for them Ness *et al.* (2003) conducted a multisite study on douching habits and found that 66.5% of women wh douched said it was to feel clean after menses, 43.6% said they did it for general hygiene reasons, 35.7% did it to cleanse themselves before or after sex, 26.9% did it to reduce vaginal odor, and 19.4% did it because they thought it was normal to douche (Ness *et. al*., 2003, p. 72).

In their study of douching, Grimely *et al.* (2006) found that 70.3% of women who douched agreed with the statement "Douche products are safe to use; otherwise they wouldn't be on the market," Martino *et al.* looked at this very issue in their study and concluded:

> The FDA's [Food and Drug Administration's] role in regulation of the many vaginal douching products on the market is complex, as these products can be classified as drugs or cosmetics, depending on the type of claim made for the product and the type and strength of ingredients in th product. Although both cosmetic and drug products are required to prove safety, cosmetic product do not need to prove effectiveness as drug products do. The FDA also assesses the design and safety of any devices used to apply the douching solution. Our review suggests that current douching regulatory approaches are confusing at best and merit critical reassessment.
>
> (Martino *et al.*, 2004, p. 1054)

Additional oversight of these products seems wise as 90% of the women in Grimely *et al.*'s (2006) sample who douched had no intention of stopping (p. 303). Moreover, the women who douched were more likely to use other feminine hygiene products such as sprays (24% compared to 5.7% of nondouchers), cleansing wipes (30% compared to 14.5%), powder (21.5% compared to 6.6%), and cleansing bubble baths (20.5% compared to 6%). Interestingly, women who did not douche were mor likely to use deodorant suppositories or tablets (19% of nondouchers compared to 12% of those who douche) (Grimely *et al.*, 2006, p. 307).

The myth that women's genitals need special attention and products in order not to smell bad is truly problematic. It has allowed industry to prey on women's insecurities and sell products that are not ju unnecessary but potentially dangerous to their health.

Feeling Good About Girl Parts

In addition, it has perpetuated a cultural perspective that female genitals are something to fix and hid which has psychological implications for women as well.

Research has suggested that women who feel bad about their genitals are less likely to enjoy sex and more likely to participate in risky sexual behaviors. Morrison *et al.* (2005) found that more than one five college students, for example, expressed dissatisfaction with the odor of their genitals. In an earlier study, Reinholtz and Muehlenhard (1995) found that negative perception about the smell and taste of one's genitals was linked to lower participation in various sexual activities (both as cited in Schick *et al.*, 2010, p. 401). More recently, as pornography has become more accessible, researchers have started to question how women feel about the appearance of their vulvas.

In a 2010 study, researchers at George Washington University used three separate measures to determine how young woman's perceptions of their vulvas impacted their sexual behavior and enjoyment. First, they measured "vulva appearance satisfaction," then they measured "genital image self-consciousness," and finally they measured "motivation to avoid risky sex, sexual esteem, and sexual satisfaction." As the authors had expected, the results indicated that "genital appearance dissatisfaction may have harmful consequences for both sexual satisfaction and sexual risk among college women due to its detrimental impact on genital image self-consciousness and self-esteem" (Schick *et al.*, 2010, p. 400). In a small study of older women, Berman *et al.* (2003) similarly found that "positive genital self-image was found to negatively correlate with sexual distress and depressio and positively correlate with sexual desire." However, they found "no correlations between genital self-image and relationship health, perceived stress, overall sexual function, arousal, lubrication, orgasm, satisfaction, or absence of pain" (Berman *et al.*, 2003, p. 16).

Schick *et al.* go on to point out that genital appearance dissatisfaction is particularly disturbing amon college students, many of whom are engaging in their first sexual experiences: "Reduced sexual satisfaction during these formative years may impinge upon the development of healthy sexual self-

concept and set the stage for future difficulties and concerns." Moreover, they note that decreased motivation to avoid risky sex could leave this population even more vulnerable to STIs, including HIV/AIDS (Schick *et al.*, 2010, p. 400).

Vulvas Get (Unneeded) Makeovers

In our society it has become somewhat acceptable to change the appearance of body parts that we don't like. Women (and men) smooth out the natural wrinkles of old age with Botox, remove excess fat with liposuction, and use rhinoplasty to even out bumps and hooks and create that perfect ski slop nose. We also should not forget about the popularity of breast augmentations as an instant way to get the double D's that some members of our society seem to value. In their essay on the "Designer Vagina," Braun and Tiefer (2009) point out that, "Although genital distress is nothing new for wome women's genitalia were, until recently, largely excluded from the intense self-surveillance and improvement imperatives that cosmetic surgery culture mandates" (p. 1).

Today, there are a number of elective plastic surgery procedures that women can use to change the look and feel of their genitals. Some, such as "vaginal rejuvenation" and "revirginization" claim to tighten the vagina to make sex more pleasurable. Another procedure, called "G-spot amplification" is supposed to make it easier for women to take advantage of their G-spot, an area in the vagina said to have heightened sensation (see Myth #4 for a discussion of whether the G-spot exists in all or some women). Another procedure, called labiaplasty, changes the appearance of the vulva most often by reducing the size of the labia minora so that they do not extend beyond the edges of the labia majora. Some suggest that when a woman's labia minora are too long they can interfere with daily activities such as walking, wearing certain types of clothing, and exercising. Miklos and Moore (2008) argue that many women who seek to have labiaplasty do so because they are experiencing discomfort. They surveyed 131 women who had the procedure at one clinic over a 27-month period and found that 37% had strictly aesthetic reasons for it, 31% had strictly functional reasons for it, and 31% had a combination of functional and aesthetic reason for seeking the surgery.

The American College of Obstetrics and Gynecology (ACOG), however, says that these procedures a rarely if ever medically necessary. In its committee opinion on the topic, ACOG states:

> These procedures are not medically indicated, and the safety and effectiveness of these procedure have not been documented. Clinicians who receive requests from patients for such procedures should discuss with the patient the reason for her request and perform an evaluation for any physical signs or symptoms that may indicate the need for surgical intervention. Women should b informed about the lack of data supporting the efficacy of these procedures and their potential complications, including infection, altered sensation, dyspareunia, adhesions, and scarring.
>
> (ACOG, 2007)

Miklos and Moore also argue that most women (93.1%) sought the surgery for purely personal reaso while only a few (6%) were influenced by their male partners (2008, p. 1493). Some feminist theorists, however, would argue that we have to look at the context under which such choices are mad to determine if they really are purely personal. In her article on Brazilian waxing, Piexota Labre (2002) points out that women may take pleasure in or even feel empowered by activities that objectif and sexualize the female body but this does not mean that they are actually in the position of power (2002, p. 127).

Tiefer describes two feminist arguments when it comes to the issue of choice particularly around cosmetic surgery. The first, she says, highlights the physical and psychological harms of cosmetic

surgery and believes that participation in the beauty culture inevitably adds to the already oppressive environment and makes it that much harder for the next women to resist that intervention. These scholars believe that even if something, such as cosmetic surgery, is a solution for one individual it might still be wrong to allow it on a societal level because it increases gender inequality and limits th options of all women in the future. On the flip side, some feminist theorists suggest that all women have to live in our culture that is saturated with images of perfection and that sufferers deserve relief even if it takes the form of something as extreme as cosmetic surgery (Tiefer, 2008, p. 474).

Taking It (Pubic Hair, That Is) All Off

Cosmetic surgery on one's genitals is extreme and the question of whether women have, or should have, the choice to change a perceived problem with the appearance of their vulva may be harder to answer when dealing with something so drastic, painful, and permanent. We doubt that many of our readers will ever even consider elective plastic surgery on their genitals. We bet, however, that most of our readers (especially the women) have already considered removing—and many have already removed—some or all of their pubic hair. This is not all that drastic (hair grows back) but it can be painful and it does alter the natural appearance of the vulva—which, post-puberty, is meant to be covered with hair.

A recent study of adolescents at a Texas health clinic found that 70% routinely shaved or waxed their pubic hair (Bercaw-Pratt, *et al.*, 2012). In a larger study, Herbenick *et al.* (2010) surveyed 2451 women about their pubic hair grooming practices and found that overall most women had some hair on their genitals but this varied by age. Among the youngest participants, aged 18–24, 20.1% reporte being typically hair-free in the previous month compared to 12.1% of those aged 25–29, 8.6% of thos aged 30–39, 6.5% of those aged 40–49, and 2.1% of those aged 50 or older. The percentage of women who had removed all of their pubic hair at least once in the past month was slightly higher for all age 18–24 years (38%), 25–29 years (32.2%), 30–39 years (23.2%), 40–49 years (16%), and 50 or over (9.1%). Even more women partially removed their pubic hair one or more times during the past month. Still, the authors conclude that the majority of women typically have some pubic hair (Herbenick *et al.* 2010).

These findings contradict other findings in research as well as mainstream media reports that suggest that hairlessness is the new norm for vulvas. In her article, "The Brazilian wax: New hairlessness norm for women?," Peixota Labra, a native Brazilian, discusses this purely American phenomenon and fears that women are getting sucked into a practice that is not necessary, in part because of the media's fascination with and lack of criticism for this technique. According to Peixota Labre (2002), the Brazilian wax—which involves removing all (or almost all) of the hair from the mons and the labia as well as any hair a woman has, well, between her butt cheeks—started not in Rio but at a New York City salon. The procedure became a darling of women's magazines which often featured first-hand accounts by reporters, and was made infamous by an episode of *Sex and the City* which brought the expression "landing strip" (to describe one stripe of hair artfully left behind) into common parlance. The media acknowledges that waxing hurts (we can still hear the screams of Steve Carrel when he waxed his chest in *The Forty-Year-Old Virgin*) but few conclude that it is not worth the pain

Peixota Labre notes the gradual social acceptance of removing body hair from other areas such as the underarms and legs. She writes "most women first started to remove body hair to conform to social norms but later continued to do so for reason related to femininity and attractiveness" (p. 116). She suggests that "the removal of female body hair, particularly in the genital area, can be viewed as a component of the objectification of women and construction of women as objects designed to attract

male attention and provide men with sexual pleasure" (p. 124). She, too, blames advertising and othe media for perpetuating the idea that women in their natural state are less than ideal: "As a result, bod hair, which is both natural and normal, has been constructed as a revolting enemy against which women must continuously wage battle" (p. 124).

Interestingly though, Herbenick *et al.* found that even after controlling for other factors, those wome who were typically hair-free or sometimes hair-free in the previous month scored significantly highe on their genital self-image scale, meaning that these women had more positive images of their own genitals than the women who had not removed any or all of their pubic hair in the previous month (Herbenick *et al.*, 2010, p. 3325).

It is possible that these women were more comfortable with their vulvas before taking off the pubic hair which is what allowed them to put in that effort to begin with or it is possible that they felt bette about their genitals at the time of the study because they had "conformed" to a new societal standard

We are not going solve the ongoing debate around how women's beauty choices get made and wheth they can ever be truly personal in our society, especially when it comes to issues of the vulva. What we can tell you is that neither genital surgery nor removing pubic hair is medically necessary and as such should not be done without giving it careful thought (and in the case of surgery discussing it wit one or more health care professionals).

We also want to throw in one word of caution from a study that came out while we were writing this chapter. It found that the incidence of pubic hair grooming accidents that are bad enough to land people in the emergency room are going up. It seems almost comical, but the report by scientists at the University of California, San Francisco found that cuts, scrapes, and burns to the urogenital area increased fivefold between 2002 and 2010 with an estimated 2500 injuries in 2010. The majority of these injuries (57%) were in women but no small number (43%) occurred in men. And these figures are likely an underestimate given how many people may not seek help. The primary culprit was the razor (83%) but scissors factored into 22% of injuries and hot wax into just over 1% (Glass *et al*., 2012). We are not taking a position on whether anyone should wax, pluck, tweeze, shave, or grow some kind of pubic hair Mohawk; just be careful.

A Do Nothing Policy

To wrap up our rant on vulvas here, we just want to make sure that everyone understands the basics which are simple: the vulva is outside, the vagina is inside. The vagina cleans itself and the vulva jus needs regular showers with soap and water to stay fresh. Neither part needs to be deodorized, powdered, made smaller, made bigger, or in any other way altered. Instead, we suggest enjoying then the way they are.

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Myth #3 Male Circumcision Is Dangerous and Completely Unnecessary

Despite the fact that this is only the third myth out of 50—and many issues in sexuality are the subje of debate—we are going to make a prediction that this will be the most controversial entry in the whole book. Public opinion of male circumcision—an age-old practice of removing the foreskin (or prepuce) from the head of the penis—has swung wildly throughout history. While it was once primarily a religious practice for Muslim and Jewish men, it became an accepted medical procedure that was more common than not in the United States and parts of Europe during the twentieth century In recent years, however, the percentage of male infants who are circumcised has been dropping and heated debate has been taking place between those who believe this is a medically beneficial (or even a medically necessary) procedure and those who see it as an immoral form of bodily mutilation without consent.

The debate is so heated that even the science becomes controversial, with those who want to see an end to circumcision casting doubt on the research methods and even the motives of the researchers.

We don't believe that we can solve this debate within the confines of this entry, nor is that our goal. Instead, we will attempt to explain it thoroughly so that you have the best information and thinking o the topic. Our aim is to fairly represent all sides of the debate. That said, we are not neutral on the topic, as sexual health educators we naturally put a lot of weight on the science of public health—especially those studies that show circumcision reduces the risk of contracting and/or transmitting STIs, including HIV. We believe that as of now the scientific evidence on the benefits and risks of male circumcision is strong enough to suggest that this practice is neither dangerous nor completely unnecessary.

The Scientific Debate Over Circumcision

Medical science has been in favor of male circumcision since the Victorian era though the earliest rationales for it were less scientific and more, well, ridiculous. (This is no doubt part of the reason th some people are suspect of today's research.) At the end of the nineteenth century, doctors suggested that circumcision would cure everything from "masturbation to epilepsy to bed-wetting" (DeLaet, 2009, p. 418). By the mid-twentieth century, however, medicine was focusing on more reasonable benefits such as a reduction in certain kinds of cancers.

Interestingly, Dr. Abraham Ravich, Martha's great grandfather, was among the physicians who began making these arguments. Ravich was a urologist in Brooklyn starting in the 1920s. Many of his patients were Jewish immigrants from Eastern Europe who were circumcised because of their religio He noted that these men had fewer incidences of penile cancer, prostate cancer, and venereal disease (VD , or what we now refer to as sexually transmitted infections, STIs). He published his results in a book, *Preventing V.D. and Cancer by Circumcision*, in the early 1970s. In our research, we have foun that some anticircumcision activists (who like to call themselves intactivists) refer to Ravich as a zealot who invented his research to advance the practice of circumcision.

There are similar complaints about even the most recent research. Some say that the studies are unreliable because of their retrospective design, the small sample sizes, the indirect approach to obtaining data, and the reliance on self-report to determine if participants were, in fact, circumcised. Others argue that the results of studies about HIV in Africa are irrelevant to babies born in the United States because the HIV epidemic here (not just the incidence of HIV but the ways in which it is commonly transmitted) are so very different.

The American Academy of Pediatrics (AAP) released a new committee opinion on circumcision in 2012. In order to develop this opinion, AAP created a task force of experts to review the research tha

had been published between its last review in 1995 and 2011. The task force assigned each article an evidence rating of "excellent," "good," "fair," or "poor" based on the methodology used and how wel it was applied. In writing their review of the research—and ultimately developing the committee's decision—the task force took these ratings into account (AAP, 2012, p. e761). Though we understand that some in the medical world do not agree with the task force's findings, we believe that the technical report represents a comprehensive and thoughtful look at the research and are relying on it our summary of what the research says.

Low Risk Procedure

In determining the cost–benefit of an invasive procedure, the first thing to understand is whether the procedure itself has risks or complications and how serious those are. The AAP points to two large hospital-based studies with good evidence that the risk of significant acute complications is very low 0.19–0.22%, and most were not serious. Acute complications mean those that happen right away: bleeding, infection, and penile injury. There are other complications that can happen later, such as adhesions, but these are also quite rare (AAP, p. e771). The complication rate may be slightly higher the procedure is performed by a traditional or ritual provider outside of the hospital but there are few data about this. The complications are also higher when circumcision is performed after the newborn period (AAP, p. e773).

One of the complaints that those opposed to circumcision have is that the procedure is painful and th it has historically been carried out with no pain medication. In the past, infants were just given a sugar-covered pacifier. The AAP acknowledges that this is not sufficient pain management, even for an infant, and suggests that "adequate analgesia" be used (p.770).

Health Benefits of Circumcision

According to the AAP, the current research suggests that newborn circumcision can help prevent urinary tract infections (UTIs), penile cancers, HIV, human papillomavirus (HPV), and other STIs.

- *Urinary tract infections:* there is good evidence from two studies that the task force describes as "well-conducted" that newborn circumcision reduces the incidence of UTIs in boys under the age of 2 years. The results of another study suggest that 7–14 out of 1000 uncircumcised boys will develop a UTI during their first year of life compared to 1–2 out of 1000 circumcised boys. UTIs are not usually serious though they are uncomfortable and can require a visit to a physician, medication, and possibly even a hospital stay or an invasive procedure (AAP, 2012, p. e767).
- *Penile cancers:* there is some evidence that circumcision prevents penile cancer and even more evidence that it prevents the most invasive form of penile cancer. However, penile cancer is so rare in the United States that it would take 990 circumcisions to prevent one case of penile cancer (p. e767). Some would argue that this negates any prevention benefit when it comes to penile cancer because 990 circumcisions would likely lead to two complications.
- *HIV:* some of the best evidence on the health benefits of circumcision comes from studies in area where HIV rates are high. The AAP task force states: "Review of the literature revealed a consistently reported protective effect of 40 percent to 60 percent for male circumcision in reducing the risk of HIV acquisition among heterosexual males in areas with high HIV prevalenc due to heterosexual transmission (i.e. Africa)" (p. e764). There is less research on the protective effect in the United States where the overall HIV rate is lower and transmission is more common among men who have sex with men. A recently released study from the Centers for Disease

Control and Prevention (CDC), however, put the findings from these African studies into mathematical models and suggested that male circumcision before sexual debut would reduce the lifetime risk of HIV transmission by 15.7% for all males (Samson *et al*., 2010). This projection takes into account that circumcision seems less likely to protect men who have sex with men (MSM) from HIV transmission. The task force explains: "It is not known to what extent circumcision may be protective against HIV transmission from MSM who practice insertive sex versus for those who engage in receptive sex" (p. e765).

Researchers also offer an explanation of how circumcision protects men against HIV. One possible reason is that the inside surface of the foreskin is easily torn especially during sex and this could provide an entry point for HIV (and other germs). The foreskin also contains "a high density of HIV target cells (i.e., Langerhans cells, CD4 T cells, macrophanges) which facilitates HIV infection of host cells." And, finally, germs may get trapped under the foreskin giving them more time to replicate (p. e764).

- *HPV and cervical cancer:* this last explanation has been shown to be a possibility in HPV infectio as well. As a reminder, HPV is the virus that causes genital warts. It also causes cervical cancer i women. HPV is one of the most common STIs in the United States. The task force found two studies with good evidence of 30–40% reduction in risk among circumcised men. There are four other studies that provide fair evidence of risk reduction. A study by Australian researchers found that the foreskin can provide a reservoir for HPV cells (a place for them to collect) (Ladurner Rennau *et al*., 2011). However, the authors of that study caution that just because those cells are there does not mean they're transmissible.

  Still, there is good evidence that circumcision reduces the rate of male-to-female transmission of high risk HPV (the types of the virus that are most likely to cause cervical cancer) from men who were not infected with HIV. Moreover, there is some evidence (rated as fair) that male circumcision has a protective effect against cervical cancer for female partners as well if the man has multiple female partners (AAP, 2012, p. e768).

- *Other STIs:* finally, there is evidence that circumcision is protective against syphilis, herpes, chancroid (a rare bacterial infection), and BV (a bacterial infection of the vagina that is not necessarily sexually transmitted). The evidence suggests that circumcision provides no protection against chlamydia or gonorrhea.

Impact on Sex

One of the claims of those who are opposed to male circumcision is that it negatively impacts sexual function and reduces sexual pleasure. As most males are circumcised as infants (long before they become sexually active), it is hard to measure the direct impact of the procedure on sensitivity or function.

Some studies have looked at the impact on sexual satisfaction for men who are circumcised as adults. The AAP task force found two good quality studies of these men. In the first study of 5000 Ugandan men, circumcised men reported significantly less pain on intercourse than uncircumcised men and 2 years after the procedure the men's sexual satisfaction remained the same as it had been at baseline (98.4% compared to 98.5%). Interestingly, the satisfaction level in the control group went up from 98% at baseline to 99.9% 2 years later. The second study looked at men in Kenya and found that 64% reported greater sensitivity after the procedure and that 55% of circumcised men reported having an easier time reaching orgasm than they did before the procedure (though this change was not statistically significant; AAP, 2012, p. e769).

According to the AAP, a study of Korean men found fair evidence of decreased pleasure from masturbation after adult circumcision. For the most part, though, studies have failed to show any evidence that circumcision decreases sexual sensitivity compared to uncircumcised penises. Most evidence suggests that there is no difference in sexual sensation and satisfaction for men regardless o whether they are circumcised (AAP, 2012, p. e769).

As with the task force's conclusion on health benefits, many disagree with its conclusions on sexual pleasure and function. Christopher L. Guest, the co-founder of Children's Health & Human Rights Partnership, writes in his rebuttal to the AAP report: "the foreskin is richly innervated, erogenous tissue which enhances sexual pleasure and it also provides a unique, linear gliding mechanism during sexual intercourse." He points out that, in 2009, the College of Physicians and Surgeons of British Columbia stated "the foreskin is rich in specialized sensory nerve endings." In 2010, the Royal Australian College of Physicians stated "the foreskin is a primary sensory part of the penis, containir some of the most sensitive areas of the penis" and, in the same year, the Royal Dutch Medical Association concluded "the foreskin is a complex erotogenic structure that plays an important role in the mechanical function of the penis during sexual acts" (Guest, 2012).

The Ethical Debate over Circumcision

It is clear that the debate over circumcision is very heated and growing more so. Georganne Chapin, the executive director of the anticircumcision group Intact America, said this about the practice: "About a million people a year, newborn babies, lose a normal, healthy, functional, pleasurable, protective body part without their consent" (Bristol, 2011, p. 1837).

Chapin and other anticircumcision activists dismiss the AAP task force's report as being biased and profit-driven. She suggests that the report represents "a trade association agenda that desperately seeks to justify and secure reimbursement for a medically-unnecessary surgery that harms children and violates their basic human rights" (Chapin, 2012). She further dismisses the science suggesting that the African studies on HIV are being used as "an after-the-fact justification for a custom that is increasingly being rejected by those who see it as violating children's rights to bodily autonomy and their own future freedom of religion" (Chapin, 2012).

After dismissing the current science, those who oppose circumcision frequently argue that the procedure is unethical because infants cannot give informed consent, infants are not at immediate ris if they do not get circumcised, and as such parents are unfairly imposing their cultural values on children in a way that cannot be revoked. They also suggest that those in the Western world who support circumcision—including the medical community—are blinded by their own cultural values that see female circumcision as an abhorrent, primitive ritual but see no moral parallels when boys a subjected to a similar procedure.

Informed Consent and Immediate Risk

One of the basic premises in the practice of medicine is physicians cannot perform any procedure on patient without first getting his/her informed consent. To do this, health care providers must clearly explain the risks and benefits before getting the patient's explicit permission. There is widespread agreement that children are not capable of giving consent and as such their parents or guardians are i charge of their health throughout childhood and adolescence. Those who oppose circumcision, however, argue that parents should not have the right to permanently alter their child's body unless it is immediately necessary for their health and well-being.

Certainly, many people would agree that it would be inappropriate for a parent to consent to a nose jo for their 10-year-old; that since the procedure is not immediately (if ever) medically necessary, the decision should be deferred until the child is old enough to decide for him or herself. The issue is not as clear-cut when children are born with facial deformities or even large birthmarks in visible areas– many parents find it morally acceptable to consent to certain plastic surgery procedures (even those that are for purely aesthetic reasons) if they feel it will improve their child's quality of life.

Circumcision presents an additional complication because the procedure cannot necessarily be postponed. Delaying circumcision makes it more complicated, more painful, more risky, and more psychologically difficult. So, while ideally surgical procedures would wait until the infant grew and was able to make his own decisions, this is not really possible with circumcision.

Moreover, the health benefits of circumcision, though not immediate, may only be seen if the procedure is done at an early age. From a public health perspective it is important that protective measures against STIs, such as vaccines for HPV and hepatitis B, be given before an individual is sexually active and subject to exposure. Chapin and others argue that even if the studies of HIV in Africa are scientifically valid, they are irrelevant to infants in the United States who are not and will not be sexually active for more than a decade. While this is true, parents make decisions not just for their children's current health, but for their future health as well. Vaccines are actually a good example; children may not be at risk for the measles at the moment they receive the measles, mumps and rubella (MMR) inoculation but parents choose the shot anyhow to protect them throughout their lives. Moreover, parents vaccinate infants in order to protect not just their own children but their communities as vaccinations are most effective when the majority of the "herd" is vaccinated (Benatar and Benatar, 2003). The same may be true of circumcision as widespread circumcision is being promoted as a way to reduce HIV in areas with a high prevalence of the disease (Wamai *et al.*, 2011).

In truth, even the ethical arguments about circumcision hinge on the science and research. If you believe the science that finds circumcision to be low risk and high benefit, then these arguments abou informed consent are not issues—parents have always been allowed to consent to medically necessar procedures for their minor children. If you do not believe the procedure is beneficial, or worse you think it is harmful, then your answers to these ethical questions will likely be different.

Role of Culture, Religion, and the Comparison to Female Circumcision

Male circumcision began as a cultural and religious ritual rather than a medical procedure. Many people continue to choose it for their boys not because of the medical benefits but because of the cultural significance. In fact, some argue that male circumcision is morally acceptable simply becaus of its cultural and religious roots. However, this is not sufficient reason to justify any practice. Benatar and Benatar point out that "simply because a practice is culturally valued does not mean it is morally acceptable" (2003, p. 43). If the procedure is harmful, for example, then the cultural value is morally overridden. The case in point for this side of the argument is actually female circumcision which is often called female genital mutilation (FGM).

FGM refers to a wide range of practices which the World Health Organization (WHO) has put into four categories. The first is the removal of the prepuce or outer skin of the clitoris. This procedure is the least invasive and most common form of FGM worldwide and is the most similar to male circumcision. The second involves the removal of the clitoris and may also involve the removal of al or part of the inner vaginal lips (the labia minora). This procedure is much more invasive than male circumcision. Moreover, it prevents clitoral stimulation and may prevent all orgasms in many wome

The third category is called infibulation and is the most extreme and invasive form of FGM. It involves the total or partial removal of the external genitalia as well as stitches in the vagina to narro the vaginal opening. Infibulation is common in two countries (Sudan and Eritrea) but not common in the rest of the world though it is often what we think of when we hear the term FGM. Finally, the fourth category is labeled "unclassified" by the WHO and encompasses some of the least invasive forms of FGM (such as ritual nicking of the clitoris) and the most damaging forms (such as putting a caustic substance inside the vagina) (DeLaet, 2009).

The argument over FGM pits those who say these procedures are integral parts of certain cultures and that women who don't have them will be shunned by their communities against those who say FGM impinges on basic human rights (DeLaet, 2009 p. 414). Though some women's rights advocates suggest that certain minimally invasive forms of ritual FGM should be acceptable, there is a large worldwide campaign to eradicate the practice completely.

Many opponents of male circumcision question why there is not the same moral outrage to this procedure. DeLaet acknowledges that "male circumcision as typically practiced is not the physical or moral equivalent of infibulation, and it is not difficult to understand why either defenders of male circumcision or critics of female genital mutilation would resent the comparison" (p. 415). The most common form of FGM, however, involves the removal of the prepuce which is analogous to the foreskin on the penis. The procedure is not all that different from male circumcision but the reaction to each procedure is worlds apart. DeLaet notes that, "Critics of the disparate treatment of male and female circumcision argue that it reflects a "Western" double standard in which human rights activis in the West disregard sexual mutilations performed on boy children in their own societies" (DeLaet, 2009, p. 414).

This is an interesting double standard and we agree that people see the world through their own cultural lenses. It is likely that our opinion on circumcision is colored by our own backgrounds and b growing up and raising our own children in a culture and a religion that supports male circumcision and condemns the practice on women.

Ultimately, however, we believe that everything comes down to whether the procedure is harmful or beneficial. There is no research to suggest that FGM is beneficial and a great deal of research suggesting that especially the more invasive forms are harmful. Though disagreements remain, today's research suggests a certain degree of benefit from male circumcision.

Conclusions

As of now, no major medical organizations are suggesting that all newborn infants be circumcised fo health reasons. Instead, the view is that the procedure should be available to any family that wants it and should be reimbursed by insurance. Both AAP and the CDC suggest that parents need to be carefully educated about the benefits and risks of the procedure and the ways to make it as safe and painless as possible if they choose it.

We agree that more education about circumcision is necessary as parents should understand the existing science (including the criticisms of this science) and make the best choice for their child. W understand that this is an area that people—both in favor of and opposed to newborn circumcision—feel very strongly about and we hope that a healthy and respectful debate continues.

References

American Academy of Pediatrics (AAP) Task Force on Circumcision. (2012). Male Circumcision.