CHAPTER 3

ANALYSIS AND DISCUSSION

In this chapter, analysis and discussion of the material are presented together. The chapter is divided into sections based on pre-determined categories of analysis. The transcripts have been analysed in their entirety, however, only certain quotes have been presented in the analysis. These quotes have been selected because they were felt to be representative of the themes introduced. Quotes that were felt to be redundant were not included (Banister et al, 1994). When quoting, abbreviations will be used, for example participant 1 will be referred to as P1.

Prior to commencing, it is necessary to provide the reader with a background of the participants, as well as impressions gained by the researcher during the interview. This will provide a contextualisation of the analysis to follow.

3.1 THE PARTICIPANTS

Participant one is a twenty four year old business women diagnosed with secondary vaginismus. At the time of the interview, she was about to commence treatment at the clinic. She was attractive and dressed smartly. The interviewer found her friendly, as she maintained eye contact and smiled a lot during the interview. She was receptive to the questions and her answers were lengthy and detailed. However, at times she was experienced as guarded and appeared to want to minimise negative aspects of her relationships. She did not display much emotion during the interview. She had been in an intimate relationship for over three years, and had been married for seven months. She had not been able to have sex with her partner for the last three years.

Participant two is a twenty six year old woman diagnosed with primary vaginismus. At the time of the interview she had recently started treatment at the clinic. She was attractive, slightly overweight, and dressed casually. The interviewer found her friendly, as she too maintained eye contact and often smiled during the interview. She was
experienced as being humorous and she made jokes throughout the interview. She was receptive to the questions, and her answers were lengthy and detailed. She did not display much emotion during the interview. Participant two had been in several intimate relationships throughout her life, but had not been involved in a romantic relationship for two years at the time of the interview.

Participant three is a twenty-four year old black woman who had been diagnosed with primary vaginismus. At the time of the interview, she was about to commence treatment at the clinic. She was attractive and dressed smartly. The interviewer experienced her as being friendly and co-operative. Her answers were detailed, and she was felt to be very disclosing of personal information as well as feelings. She exhibited much emotion during the interview. She had been in an intimate relationship with her boyfriend for two years, but had been unable to have sex.

Participant four is a twenty-two year old woman who had been diagnosed with secondary vaginismus. She had also been diagnosed with vulvodynia* at eighteen, a sexual dysfunction whereby pain is experienced during intercourse. She was attractive and dressed casually. At the time of the interview she had been in treatment at the clinic intermittently for approximately two years. Participant four reported that she became aware of the problem at eighteen, with her first boyfriend. She came to the clinic for treatment nine months later while dating her second boyfriend, who subsequently died in a car accident. She returned to the clinic for treatment a few months prior to the interview, as she has recently re-united with her first boyfriend and wanted to overcome the condition. Participant four was experienced as friendly, yet guarded. She smiled at times, but maintained a rigid composure throughout the interview. She did not display much emotion during the interview.

*Vulvodynia is a chronic, unremitting sensation of burning of the vulva. The cause of vulvodynia is unknown, and there is no proven mode of treatment. Women can experience the disease throughout their lifetime but it most commonly occurs during the reproductive years. The possibility of a psychological component has not been confirmed (Turp, M, 2001).
In summary, the age range of the sample was twenty two to twenty six. All of the participants, with the exception of one, were in relationships. All of the participants were experienced as friendly and co-operative, yet three were experienced as guarded. It is acknowledged that this may have been due to the sensitive nature of the topic, rather than being reflective of a general personality trait. Only one participant displayed significant emotion during the interview.

3.2 ANALYSIS OF DATA

3.2.1 PERCEPTIONS OF THE CONDITION AND ITS AETIOLOGY

A) GENERAL UNDERSTANDING OF THE CONDITION

When asked about their general understanding of the condition, most of the participants were unable to provide answers. Participants 1, 2 and 3 suggested that they found it difficult to understand their condition.

P2: Its not really the kind of thing one can make sense of… finding the cause is …so obscure and so difficult.

Participant two was the only participant to suggest a reason for this.

P2: Its not as though I have cancer or AIDS, something where one can see an obvious cause and effect…you know finding causality isn’t easy… I think they’re very layered, there’s layers which have to be unpacked.

The condition therefore appears to be experienced as complex and incomprehensible. This is consistent with the literature. Despite a long history of speculation about the nature of vaginismus, the precise cause is still unclear (Barnes, 1986, Jeng, 2003). Thus, perhaps it is not surprising that the participants themselves do not appear to have a good understanding of their condition. However, it is important to note that this question was
given at the beginning of the interview, and the scarcity of information may be partly reflective of the participants’ anxiety and lack of rapport with the interviewer.

Participant four was the only participant to offer an explanation of the condition. However, her answer was impersonal and medical in nature.

P4: I’ve been explained medically that umm sort of the muscles contract and that this is the reason I can’t have sex… but I have vulvodynia with vaginismus, so that’s actually caused from sort of pain.

It is interesting that participant four had been in treatment for the longest period. She suggested that she had no knowledge of the condition prior to commencing treatment. This may explain the distinction between her and the other participants.

P4: I wasn’t aware of vaginismus until my gynecologist said that I had it and she said I must come here… I think I’m much more educated now than I was when I first got it.

Participant one implied that she believed that treatment may increase her understanding of the condition.

P1: I haven’t really started treatment…so I think it’s a bit difficult for me to say.

The notion that treatment may provide or enhance understanding of the disorder was therefore introduced. However, this highlights the possibility that perceptions expressed by the participants may be coloured by those of the clinic from which information was gained. However, it is important to note that most of the participants had just begun treatment at the time of the interviews.

Despite the suggested lack of comprehension, Participants 2, 3 and 4 indicated the importance of having an understanding of their condition. Participant two emphasised how essential this was for her on a personal level.
P2: Any little chink that allows me a little…insight into the condition is always something to grab hold of and explore…because it is so obscure. Its like a wall there. So when you see a hole in that wall, to look through it and try grab what you can.

Participant three and four suggested that more research needed to be done in order to increase understanding in general.

P3: I feel that its so important to do research and find out more…They must just make it easier for us.

Participant two and three emphasised the significance of merely knowing that their condition had a name.

P3: I was so excited that at least when I speak about this problem, I could actually have a name related to it… because there are women out there… who suffer from this, some who don’t even know that there’s something called vaginismus.

The importance of having awareness and an understanding of the disorder was therefore highlighted by most of the participants. However, participant one did not express this sentiment.

B) PERCEPTIONS ABOUT AETIOLOGY

Various psychological factors have been suggested in the literature as possible causes (Jeng, 2003). Many of these themes were also explored by the participants, despite the fact that they had suggested not understanding their condition. However, it was felt necessary to differentiate between those who merely introduced the themes and those who identified them as being causal or contributing factors in their condition.

B1) PERCEPTIONS OF A PSYCHOLOGICAL ORIGIN

Three participants suggested a psychological component to their condition. However, this notion was emphasised to varying degrees. Despite the fact that this theme was
introduced by participants 1, 2 and 4, they did not engage with the concept in much
detail.

Participant one indicated that she felt the disorder had a psychological origin.

P1: The condition itself, I think its purely psychological, obviously the physical coming from that.

Participant four expressed the notion that the condition has a psychological component.

P4: …sort of a psychological thing, coupled with a, physical thing.

Participant two intimated that she felt vaginismus was more complex than a mere
physical disease, but did not suggest a psychological element directly.

P2: Its not as though I have cancer or AIDS, something where one can see an obvious cause and
effect…unlike a plain old physical disease.

This theme was not introduced by Participant three.

The prevailing view in the literature, and possibly in the clinic where the women were
receiving treatment, is that vaginismus is a psychogenic disorder (Barnes, 1986, Jeng,
2003, Silverstein, 1989). Despite this, this theme was not emphasised or discussed in
detail by the participants. This may reflect the fact that most of the participants had just
begun treatment.

B2) MISINFORMATION AND IGNORANCE ABOUT SEXUALITY

Misinformation and ignorance about sexuality has been identified in the literature as a
possible etiological factor in the development of vaginismus. This theme was introduced
by participants one and three. However, neither participant suggested this as a causal
factor in their condition.
P3: We never spoke about sex…all that information I got from outside, I never got if from my parents…it’s all new to me, like I said earlier on with L, his penis.

According to Silverstein (1989), misinformation and myths about intercourse may lead to painful first attempts. Consequently, a lack of information may result in the fear of pain and ultimately withdrawal from intercourse. This may have been the case with participant three, however this is merely conjecture.

Participant one suggested that it had not felt appropriate to discuss sexual issues with her parents.

P1: I think it’s a whole respect issue like you know like you’re not meant to talk about stuff like that with your parents.

However, participant one did not indicate if or where she had obtained information about sexuality from. This does not necessarily imply that she did not learn about sex in an accurate manner from another source. Nevertheless, participant I did imply that being a physically small woman may have contributed to her difficulties in having sex.

P1: I’m generally quite a small girl as well so…

It is interesting that she refers to herself as a ‘girl’, implying female child. Participant one may unconsciously view herself as a child for whom sexual intercourse is not appropriate. However, this is merely conjecture.

The literature suggests that sexual ignorance may lead to beliefs that the vagina is too small and vulnerable for coitus or that penetration is harmful (Gindin & Resnicoff, 2002). Hiller (1993) proposed that because females are unaware of the anatomical changes inside their bodies, they are not cognisant of the internal expansion of the vagina (Hiller, 1993). Participant one does not appear to have been accurately informed with regard to her anatomy and sex. Thus, paradoxically, it may have been misinformation that contributed to her difficulties.
By contrast, participant four suggested that her parents had informed her about sexuality at an early age, and that they were comfortable with the topic. However, she suggested the topic was never emphasised.

P4: They sat my brother and I down together, decided that we were going to have the birds and bees talk….You know obviously they weren’t like overly graphic and we didn’t discuss it like all the time but they wanted us to sort of know about it…they didn’t want us finding out half the story from like a friend or something at school.

This theme was not introduced by participant two.

B3) SEXUAL GUILT AND RELIGIOUS ORTHODOXY

All of the participants introduced the theme of sexual guilt. This is consistent with theorists such as Ellison (1968) and Silverstein (1989) who proposed that sexual guilt may play a causal role in the development of vaginismus. This guilt is believed to lead to a fear of punishment resulting in the physical ‘defense reaction’ that characterises vaginismus (Silverstein, 1989, p.687). Participants 1, 2 and 4 related this in some way to messages they had received from parents or family.

P2: I’m reassessing as they come to me, all of the preconceived notions and ideas and morals I suppose cause they are morals, umm that have either been deliberately instilled in me by my family or that have been received by me whether they intended them or not.

P1: When I was going to be sexually active and I think it just started, beliefs that everybody else instilled in me became my own.

Participant three mentioned experiencing sexual guilt related to not being married.

P3: One of the reasons why I close up is that somewhere in my head, its somewhere there that you can’t do this until you marry someone.
Whilst she did not relate this directly to her parents, she later suggested that her parents may have portrayed a distorted and perhaps negative view of sexuality.

P3: Umm, I started menstruating … I told my mother… she said to me… now you’re menstruating and if you have sex with a boy you’ll be pregnant. That’s the only thing she ever said.

Research has suggested that vaginismic women may feel that sex in general is distasteful or immoral (Ward & Odgen, 1994). As a result, such women may feel guilty about sex, often experiencing feelings of shame and rejection (Robinson, 2003, p.101). It is therefore possible that the participant’s families’ reactions to sexuality may have resulted in their guilty feelings with regard to sex.

Feelings of sexual guilt have been related to the experience of a religious or conservative background (Barnes, 1986; Jeng, 2003). Participants 1, 2 and 3 suggested having had conservative upbringings.

P1: The whole religious, you don’t have sex before marriage, if you come from a good home you would never … let the family be seen in that way, if you fall pregnant.

Masters & Johnson (1970) proposed that vaginismus may result from a childhood that is characterised by excessively severe control and attempts to instill high moral expectations (Masters & Johnson, 1970). None of the participants, however, identified this as a possible cause of their condition.

B4) SEXUAL VIOLATION

Participant two was the only participant to introduce the theme of sexual violation. She described being molested by one of her cousin’s friends at the age of thirteen.
He knelt down next to me and, he didn’t do anything violent, but he groped me and he put his tongue in my ear, his hands down my… and I was incredibly uncomfortable and very nervous… This was not at all something that I wanted. But as I lay there, I thought, oh my god… I don’t remember feeling anything but absolutely horrified, and numb and dumbstruck.

It has been argued that experiencing or witnessing sexual trauma may also be a causal factor in the development of vaginismus. Vaginismus is therefore conceptualised as a protective mechanism against expected intrusion (APA, 1994, Biswis & Ratnam, 1995 Silverstein, 1989). However, participant two suggested that she did not believe that this experience had caused her condition.

I don’t think what T did to me caused vaginismus, I think that it probably started much earlier…

Despite her assertions, this experience appeared to have impacted substantially on subsequent sexual relations.

Apart from T, I’ve never met anyone who sought to do me harm and to be honest I don’t think meant me harm either… but, I can’t shake that perception that suddenly here is this person who’s going to hurt me and that’s terrifying.

According to Silverstein (1989), vaginismus may reflect passive anger towards a partner as the representation of an aggressor, as well as representing a wish to maintain the integrity of the self. Participant two’s account is suggestive of this. She appears to perceive penetration as a potentially violent act. Gindin & Resnicoff (2002) highlight this perception as a potential aetiological factor in the development of vaginismus.

However, participant two added another dimension to her experience of sexual violation – the impact of subsequently not feeling protected by her family.

No one in the family has ever come back to me and said, ‘are you okay’, no one’s ever bloodied T’s nose… they still embrace this person who did this frankly abhorrent thing, umm to the family bosom.
Participant two suggested that she had experienced her family’s lack of response as an approval of what had happened. This had resulted in her subsequent quest to ‘win over’ her family’s protection, which she believed she had not previously deserved. Her family’s reaction was therefore also identified as a causal factor in the development of her condition.

P2: If I could just be a better girl, if I could just not have sex, if I could just be you know this virtuous, chaste person they want me to be, then they’ll forgive me for whatever transgressions I’ve made or committed in the past, for which I’m being punished… ‘We’re going to protect you, you’ve earned our support and our protection and our love’.

Participant two indicated that the presence of a support system may allow her to relinquish control. She suggested that she may be able to take risks, both emotionally and physically, if she felt protected.

B5) FEAR OF PAIN

Participants 1, 3 and 4 introduced the theme of being afraid of the pain associated with sexual intercourse and/or penetration.

P1: Because the experience was so painful and everything I think I, when he came near me, had a mental black against it… it was all happening because of my fear of what’s what’s to come.

Fordney in Jeng (2003) highlights one of the dominant emotional states of vaginismus as fear and anxiety, specifying that these emotions are related to confrontations with coital attempts or vaginal examination. Theorists such as Dawkins & Taylor (1961) suggest that the fear of pain is merely a symptom of vaginismus. In other words, once a woman has experienced pain due to the condition, she becomes afraid of repeating the experience. Similarly, participants one and three perceive their fears around sexual intercourse as having a maintaining role in their condition.
However, participant four suggested that the fear of pain itself may have caused the condition initially. She reported experiencing the pain both during and after intercourse. She identified her fear of pain, related to the vulvodynia, as a causal factor in her development of vaginismus.

P4: That’s a pain you have always. Yah, its all the time. So I’m feeling this pain everyday, so its kind of like a daily thing re-inforcing thing saying to me like don’t bring anything near me because its going to hurt me even more…

This account is consistent with theorists such as Ellison (1972), Blazer (1964) & Silverstein (1989) who suggested that a fear of pain may in fact play a primary causal and maintaining role in the disorder. Anxiety concerning penetration may be expressed physically via the involuntary vaginal muscle spasm that characterises vaginismus. Consequently, when the pain does indeed occur with the vaginal spasm expectations become self-fulfilling prophesies. In this way, vaginismus is believed to be characterised by a pattern of fear and pain (Silverstein, 1989).

So in terms of this sample, the fear of pain related to penetration is certainly prevalent and was identified by three of the participants. The pain was conceptualised as playing a maintaining role for some. For participant four, the pain she experiences as a result of suffering from vulvodynia is believed to have caused her disorder. The interplay between her two conditions, and the subsequent role of pain is unclear and complicates findings.

B6) FEAR OF PREGNANCY

Participant one was the only participant to introduce the theme of falling pregnant. She suggested that she developed the condition as a result of these fears.

P1: I think the reason I developed vaginismus was a fear of pregnancy… I became very neurotic about possibly falling pregnant. So when I first met my husband, we could have intercourse and it wasn’t a problem, and slowly, I think it just played at my mind all the time and one day it couldn’t happen.
Kabakci & Tugrul (1997) have identified the fear of pregnancy as a possible factor contributing to the development of vaginismus (Kabakci & Tugrul, 1997).

Participant one suggested that these fears began before she was married, and were linked to her not wanting to shame her family.

P1: It just became more I think like adult like you know, you don’t want to get caught or disappoint anybody…

However, she maintained that despite the fact that she is now married, the condition has persisted. Nevertheless, she reported still not being ready to have children. She identified two reasons for this.

P1: You want to be married, enjoy each other’s company first, not have kids yet, its too like demanding of your time and you’re trying to build yourself as a couple… I’m still young, I think I wouldn’t like to have a child now.

According to Kabakci & Tugrul (1997), women suffering from vaginismus were often found to have fears of pain, physical harm or death during coitus and delivery (Kabakci & Tugrul, 1997). Participant one’s fears may incorporate these factors. However, this is merely a hypothesis. Nevertheless, participant one indicated that she would like to have children in future.

P1: I see myself with other people’s kids, I love kids, so I think its because I love being with kids so much.

In fact, she indicated that this was one of the reasons she had sought treatment.

P1: I think its also one of the reasons that I actually woke up to come and get help because I want to enjoy having sex and enjoy sex in order to have my child… I want to know that it was pleasurable, and that our kids came out of love.
This paradox with regard to her condition is consistent with literature that suggests that it is often not sexual dissatisfaction but the desire for a child that brings such a woman or couple to therapy (Gindin & Resnicoff, 2002).

B7) STRESS

Participant one identified increased stress levels at the time she developed the condition, implying that this contributed to her development of the condition.

P1: I think that was the peak, that was when it all, it just happened one day, I think it was at my most stressed time.

Certain research has suggested that one’s sexual health may be connected with one’s daily interactions and stressors. Increased stress levels are believed to hinder both sexual desire and performance (Graham in Hunt, 2002; Hunt, 2002). Research pertaining specifically to vaginismus could not be found.

B8) DISCHARGE

Participant three introduced the theme of having a discharge, a theme not found in the literature. Whilst she did not identify this as a causal factor in her condition, she described not wanting her genitals touched as a result of the discharge.

P3: Maybe, sometimes I think its because of, because I have a discharge…maybe that’s one of the reasons that I don’t want anyone there. Its not a nice thing to look at.
Table 1: Table of relevant factors identified by participants

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<thead>
<tr>
<th></th>
<th>Misinformation/ Ignorance about sexuality</th>
<th>Sexual Guilt</th>
<th>Sexual Violation</th>
<th>Fear of Pain</th>
<th>Fear of Pregnancy</th>
<th>Stress</th>
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E = identified as an aetiological factor with regard to vaginismus.

M = identified as a maintaining factor with regard to vaginismus.

I = identified as impacting on sexual activity, or attitude towards sexual activity.

H= mentioned as part of their history.

C) CONCLUDING COMMENTS

The exploration concerning participants’ perceptions of the etiology of their condition revealed a number of issues. The first notion that was introduced was the differentiation between factors perceived as originally causing the condition, and maintaining factors which resulted in the continued experience of vaginismus. It is interesting to note that what was suggested as a causal factor for some was identified as a maintaining factor for others. In addition, some factors were described as impacting on sexual activity but were not related directly to vaginismus. Sexual guilt, for example, was expressed in this way by participant three. Given the fact that vaginismus prevents sexual activity, one may assume that the two are nevertheless associated.
An examination of Table 1 also suggested several patterns. The theme of sexual guilt appeared to be found amongst all of the participants. This is suggestive of a strong, possibly causal, association between the experience of sexual guilt and the development of vaginismus. The condition may therefore operate as a protective mechanism against intra-psychic guilt, or what has been termed the ‘superego’ by psychoanalysts (Christie, 1980). It should also be noted that all of the participants introduced the theme of their sex lives having been affected by experiences or messages from parents or family. However, given the nature and size of the study stronger assertions could not be made.

All of the participants described fears related to possible consequences of sex, including the fear of pain, of becoming pregnant, or of being violated against one’s will. The interplay between the vaginal spasm and these fears is unclear, and conclusions could not be made in this study. The participants, however, displayed very different trends with regard to the causal factors, and no further patterns could be elucidated. This is consistent with the literature, in which various theories about the aetiology of vaginismus are promoted but with little consensus.

3.2.2 PERCEPTIONS OF SELF - CHARACTERISTIC FEATURES OF WOMEN SUFFERING FROM VAGINISMUS

A) EMOTIONAL RESPONSES

The condition of vaginismus is accompanied by a range of negative emotions. All of the participants identified negative emotions associated with the condition.

P2: The thoughts can be positive but the feelings…overwhelmed, terrified.

P3: The feelings are… all negative…I feel so bad, really bad.

Participants one and two indicated that guilt was a prevailing emotional response, guilt related to their inability to provide their partners with sexual intercourse. Guilt was also expressed about avoiding or being unable to be physically intimate with their partners.
P1: The guilt that you suffer is the worst thing because when he’s coming near and you know there’s nothing wrong with you, and you’re lying and you’re saying I’ve got a headache.

P2: There is such a huge amount of guilt attached to it. I don’t want to hurt anyone...

Participant three also introduced the theme of feeling guilty. However, unlike the other two participants this point was not emphasised.

P3: Sometimes I will start kissing him but then I will feel so so bad, like why am I starting this if I know where its going to end…

Participant two also identified this emotion in another context. She suggested feeling guilty about other factors in a previous relationship, and wanting to make up for this with sexual intercourse.

P2: D badly wanted to have sex and I felt… incredibly bad about the advantage I was taking living with him, … I thought this is one thing I can give him.

The theme of guilt as a result of the condition is not explored in the literature. However, sexual guilt is emphasised in previous research, and was in fact found to be present in all four participants (Refer to Section 3.1). The tendency to experience guilt and internalise blame may therefore be characteristic of women suffering from vaginismus. However, given the nature of the study, this is merely conjecture.

Participants three and four also identified feeling embarrassed about their condition.

P4: I think in the beginning I was sort of… embarrassed, I didn’t want people to know about it…

The emotions of guilt and shame, to varying degrees, both involve accepting responsibility for something negative. Both imply a feeling that one has done, or perhaps is, something ‘bad’ or shameful.
Participants three and four also conveyed feelings of sadness and dysphoria as a result of the condition. Participant three related this to not being able to provide her boyfriend with sexual intercourse.

P4: It makes me depressed in a way … its very upsetting, and again you feel like you’re the only person who’s not having sex on the face of the planet.

P3: This guy is giving me everything, he understands so much about me, and then I’ll get so upset that I can’t even give him anything in return.

According to Robinson (2003), feelings of sadness are prevalent in women with sexual dysfunction. Christie and Mellet (1981) proposed that the experience of such a condition may produce a dysphoric mood as a result of combined physical and psychological stressors. In addition, the presence of such a mood is associated with lower levels of tolerance of the pain, possibly worsening the experience for such women. The exact nature of these feelings for the participants could not be elucidated in the current study.

Whilst participant two did not allude to sadness specifically, she suggested that she had been mourning for what she experienced as a loss- the inability to have sex.

P2: I think at that time I was grieving…I felt a profound sense of loss.

Participants 2, 3 and 4 identified feeling alone with their condition, as if they were the only women who suffered in that way.

P3: I felt very alone, I didn’t think there was anyone else…

Participants two and three suggested that discovering about the condition, and the fact that other people suffered from it had alleviated this feeling somewhat. This knowledge was not sufficient for participant four, as she had never met other sufferers.

P2: I had just begun to put a name to it and realise that I wasn’t alone in the world.
P4: You feel like you’re the only person who’s not having sex on the face of the planet, you know but there must be other people out there… I’m still waiting to meet one.

Participant three also found that being able to talk with people at the clinic was helpful in lessening her feelings of isolation.

P3: I hate being alone but right now I feel alone but then I know that I can get help. If I need to talk I call G or E and I tell them that this is the story. But back then I couldn’t and I would just cry, sometimes I would sit down and I would cry, cry and feel that why, why me, what have I done?

Fordney in Jeng (2003) proposed that fear and anxiety when confronted with coital attempts or vaginal examination is in fact the dominant emotional state of vaginismus. Whilst participants did not identify this as a central feeling, it was identified by the majority of the participants. This has been explored in section 3.1

All of the participants identified feeling hopeless at times about overcoming their condition.

P1: It makes you feel a bit… almost helpless, because you think you can’t do anything about it.

P2: Nothing was the slightest bit different from any of the other times that we tried, and I just thought, ‘D, you poor poor bastard.’ Nothing is going to change…

However, despite this, all four participants suggested that coming to the clinic had given them some hope.

P1: At least there is treatment, and at least if you do it properly and you work on it together its something that there is a cure to. You know and then it won’t come back ever again. I almost believe that it will happen.

P3: I felt so hopeless and so useless… even now I still feel that. But I think there’s hope because I came to E and I can see the light at the end of the tunnel. Something good is going to come out of all this.
Participants one and three appear to be hesitant, despite their suggestion of hope. This is suggestive of how despondent they feel about their condition. Despite her earlier assertion, Participant four suggested that stories of other people who had successfully overcome vaginismus had given her hope.

P4: You hear of other people’s stories and they have been able to get there so I think it does give you hope

The five dominant emotional responses suggested by the participants were those of guilt, shame, sadness, isolation and fear. This is consistent with various theorists who have suggested that emotional distress is linked to physical symptoms (Dersh, Gatchel & Polatin, 2002 & Miller, 1990). Beard (1998) suggested that patients suffering from vaginismus specifically may experience certain emotional states as a result of the condition. He identified emotional anguish as being prominent in women who suffer from vaginismus.

Participant four, however, described negative emotions which had not resulted from the condition. Conversely, these feelings appeared to have affected her disorder.

P4: It was very difficult especially after the car accident… I was extremely negative about life… I just became a bit despondent with everything… for the last few years I’ve been very negative about a lot of things, in terms of my condition…

Silverstein (1989) suggested that vaginismus may be a symptom of emotional distress, representing a defensive need to protect oneself and provide boundaries. It is significant to note that for participant four, her description of emotional turmoil occurred after the advent of the condition. These negative emotions, however, were felt to play a role in the subsequent experience of the condition.

The relationship between physical and emotional aspects was commented on by participants one and two.
P2: Physically it's like a wall and emotionally it feels like that as well.

The precise interplay between the physical symptom of vaginismus and one’s emotional state is unclear. In keeping with participant two’s comment, Silvertain (1989) proposed that such women do not feel safe to be open emotionally or physically. For this reason it is suggested that women suffering from vaginismus may be cut off from their emotions.

This idea was highlighted by participant two who suggested that feelings related to the condition are experienced as overwhelming and therefore she removes herself from her emotions, utilising the defense of intellectualisation.

P2: I intellectualise most things because especially with vaginismus just to allow myself to feel is terrifying, umm. I feel overwhelmed… the only way I can get any kind of handle on it or any kind of control on it is to intellectualise.

Participant one also identified feeling cut off from her emotions. However, she attributed this to the lack of intimacy in her relationship with her partner, rather than the condition itself.

P1: I don’t know so much because my feelings were starting to change... You feel like you become more aggressive, you feel like you become more hard, like almost emotionless, nothing phases you and you know sometimes you think its because you don’t have that affection, that intimacy.

The theme of being cut off from one’s emotions is also consistent with clinical impressions of participants 1, 2 and 4. None of these participants exhibited much emotion during the interviews. Participant four, in particular, was experienced as being emotionally guarded.

To summarise, there appear to be various trends related to the experience of vaginismus. The presence of negative emotions was highlighted by the participants, with all of the participants reporting experiencing emotional distress as a result of the condition. The possible effect of negative emotions on the experience of vaginismus was also introduced. However, there also appears to be the tendency to avoid the experience of
emotion. This is consistent with clinical impressions of participants 1, 2 and 4 as well as assertions made by the participants. This did not appear to apply to participant three. The implication of these inferences requires further research.

B) PERSONALITY

Certain research has suggested a relationship between several personality traits and vaginismus (Jeng, 2003). It was therefore felt to be important to explore whether certain personality dynamics were prevalent amongst the participants. It is, however, important to note that in a once-off interview one cannot make conclusions about the structure and functioning of participants’ personalities.

Dawkins and Taylor (1961) proposed that women suffering from vaginismus may reflect a personality type characterised by the refusal to accept or seek information about sex. In keeping with this idea, participant one suggested that she had not liked talking or being informed about sex. This theme, however, was not introduced by any of the other participants.

P1: That was something that was never really discussed, sex or anything like that cause they always knew the type of person that I was, I didn’t need reminders or and if someone attempted to tell me something, I was like, well do I look stupid…

Participants three and four suggested that they had investigated sexual issues, but only subsequent to the development of their disorders.

P4: I think I’m much more educated now than I was when I first got it. When I first got it, I didn’t even really know what was wrong with me. But umm, I’ve read so much on it and you know I’ve looked on the internet.

Since receiving treatment, participant three indicated being particularly anxious to receive and work with information regarding sex, in order to treat her condition.
P3: The only way for it to work out is if I, I’m willing to learn. I’m willing to listen to everything that I’m told. I don’t want to become…end up a virgin for the rest of my life.

Participant three’s previous lack of curiosity regarding sexual issues is suggested by her lack of previous knowledge about, or exploration of, her own genitalia.

P3: And then he said to me, do you sometimes look at yourself, sit in the mirror and look at yourself. I said ‘I never ever do that’…

This too appears to have changed following the advent of treatment.

P3: Since last week I was here … I went back home, I took a mirror and I looked at myself. I knew how it looked but opening everything and just looking at the detail and how it exactly, how it looks, where exactly is that hole? And then I felt so good… I’m discovering myself.

However, the trend of not being sexually curious prior to the discovery of vaginismus is not consistent for all the participants. Participant two described how she had been particularly curious and had actively sought out such information throughout her life.

P2: The irony is that talking about sex has never really been a problem for me. In fact…its kind of been an obsession… I have always found sex and sexuality absolutely fascinating.

Robinson (2003) found that many women suffering from vaginismus express the need for control in their lives. Participants 1, 2 and 3 referred in some way to the need for control. However, this theme was introduced in various ways.

Participants one and three implied that they viewed sex as an activity wherein they may lose control.

P3: Everytime I’m engaged in sex, I open up but at some point, I close up, I get so tense, I get so so scared that I just want to close everything and I, I, always focus there…

Participant two suggested that any form of intimacy introduced the possibility that she may lose control.
P2: I avoid intimacy because, to get into an intimate situation implies a contract… a choice that takes away my power to choose... I am relinquishing my right to then say no…

As suggested previously participant two’s need for control appeared to be related to her perceptions of a lack of protection from her family.

Participant three introduced the notion of feeling uncomfortable about not being in control, however in a context unrelated to sexual intercourse, namely that of her discharge.

P3: Sometimes you get a discharge… its not nice… its something that I can’t control it.

Participants 1, 2 and 3 also suggested a need for independence. The three participants described not wanting to rely on others for support. This too may represent a need for control, as perhaps relying on others involves a relinquishing of power.

P2: I want the cure to be about me, not about somebody else. And I want the righting of it to be entirely my responsibility, and my accomplishment, because then I know that I’m the one who made it better, not somebody else, somebody who may not be permanent, somebody who may not always be there.

It is interesting that the need for independence was not introduced by participant four, who also did not suggest a need for control.

However, participant three later suggested wanting to have sex when she was intoxicated, and therefore not in control. It would appear that she wished to prevent or overcome her need for control.

P3: I suggested that you know what, how about I drink, I take lots and lots of alcohol and then we have sex.

Participant one also contradicted her suggested need for independence, indicating that she wished her husband had taken more control.
P1: And I think that’s like one aspect where I want to say to him, ‘come on, just shout at me, what is wrong with you, you’re too calm… you must be more aggressive…sometimes the way I talk to you, I think that you’re a walk over.

These two participants therefore appear to be ambivalent about control and its relationship to responsibility. In summary, the need for control was prominent but the nature of this requires more exploration.

Barnes (1986) found that obsessive-compulsive personality types may be prone to vaginismus. Whilst it is not possible to measure this type of personality profile in a qualitative study, participant one did suggest dynamics typical of this personality type.

P1: I’m just, I’m a perfectionist…I do everything very much by the book, do everything properly, I pay accounts on time. I’m one of those people you know. So I think in terms of the bedroom it would have been the same thing.

Certain clinicians have also suggested that vaginismus sufferers may display neurotic, anxious or hysterical type personalities (Barnes, Doherty & Kennedy, 1995, Cooper in Kabakci & Tugrul, 1997). Robinson (2003) and Silverstein (1989) suggested that such women are often found to have other fears and phobias. However, the presence of this personality profile has been contested by other researchers (Barnes, Doherty and Kennedy, 1995, Duddle, 1997). As suggested in section 1.3, fear was experienced by the participants, but, only in the context of the condition and sexual relations. This is, therefore, not felt to be sufficient to comment on the presence or absence of the above-mentioned personality traits. The only other expressed phobia was that of participant one, who indicated a fear of falling pregnant.

P1: I became very neurotic about possibly falling pregnant….definitely, cause I wasn’t married at the time, when it started…I think I just became a paranoid person.

To conclude, several personality traits have been identified in the study. However, these were not present in all of the participants. In addition, certain personality characteristics shared no commonalities. This is consistent with much of the literature which suggests
that attempts to identify a specific personality type among vaginismus sufferers have consistently failed (Duddle, 1977; Kennedy in Jeng, 2003).

C) SELF-ESTEEM

The issue of self-esteem was prominent in the study. All participants suggested that they had low self-esteem. This may be linked to their tendency to internalise negative aspects as discussed earlier. This is consistent with findings by Robinson (2003) that women suffering from sexual dysfunctions such as vaginismus often have low self-esteem.

All four participants related their self-esteem in some way to the experience of vaginismus. This relationship was understood in various ways. However, all of the participants suggested that their inability to have sex resulted in a sense of failure.

P2: I suppose at the time if I tried to draw a conclusion it would have been, I’m a big wimp, he’s a big wimp, that’s why we can’t do this.

P4: It’s a difficult thing because you know you try and it doesn’t happen and you feel sort of like a failure…

This notion was implied by participant one, who incorporated the dimension of her relationship with her partner. The belief that she was disappointing him, as well as herself, contributed to a loss of self-esteem.

P1: its something I cannot fulfill my husband in the bedroom… it makes you feel a bit, I would say almost helpless, because you think you can’t do anything about it, and then well its like a letdown. You’re letting somebody down, including yourself.

It is interesting that participant one speaks in the second person in her description. This may reflect the fact that she needs to depersonalise her experience as it is too painful, an interpretation consistent with her tendency to cut off from her emotions.
Participant three also described a decrease in self-esteem as a result of the condition, but suggested that her feelings had resulted from or were worsened by what people had said to her.

P3: Because some people they don’t understand, they feel that you’re stupid…Cause when they see that you didn’t have sex yet, but you’ve got a boyfriend, how is that possible…and those were the type of things they said, and it felt, I felt so hopeless and so useless.

This is consistent with Jeng (2003) who suggested that self-esteem may be affected by unsuccessful attempts at having intercourse, which may induce a sense of failure. The resultant loss of self-esteem is believed to occur despite the fact that such women present as competent and confident (Barnes, Doherty & Kennedy, 1995). This pretense was highlighted by participant four.

P4: I think on the surface I have a very fine self esteem…

Participants three and four expressed feeling that they were not normal, or were alone in experiencing the problem. This in turn impacted on their self-esteem.

P3: Somehow you think that… she doesn’t work, she doesn’t go to school, but she’s able to have sex…I mean I’m qualified, why can’t I have sex… because sometimes I just sit and think that stupid people can have sex, why can’t I have sex.

The acknowledged reality of having a sexual dysfunction is believed to result in low-self esteem and self-critical thoughts. Women are reportedly often concerned about the abnormality of their condition. Robinson therefore asserted that such women begin to doubt themselves as well as their capabilities. Barnes, Doherty & Kennedy (1995) found that women suffering from vaginismus have a shaky sense of self, and doubt their own value relative to other women.

Thus the two main themes introduced by the participants regarding decreased self-esteem relate to feelings of failure as a result of not being able to have sex, as well as feeling alone and different from other women. Other theories related to self esteem in
vaginismus sufferers are introduced in the literature. It was felt important to explore these themes in relation to the participants, despite the fact that they did not directly introduce them.

Carosella & Lackner (1999) referred to the notion of control with regard to self-esteem. They suggested that weak convictions of control regarding the condition may contribute to a poorer self-esteem. The importance of feeling in control was emphasised by participants 1, 2 and 3. It is possible that not being able to control their ability to have sex may have contributed to their decreased self-esteem. However, this is merely conjecture.

Other research has focused on the issue of the pain that is characteristic of vaginismus in relation to self-esteem. Such research has suggested that the continuous experience of physical pain may be a causal factor in the development of a low sense of self-efficacy and self-esteem (Barry, Carrington Reid, Duong, Gou, & Kerns, 2003; Carosella, & Lackner, 1999; Christie, 1981; Estlander, Moneta, Kaivanto & Vanharanta, 1994). This type of continuous pain was described by participant four.

P4: That’s a pain you have always. Yah, its all the time.

It is therefore also possible that participant four’s unremitting pain may have also contributed to a decreased sense of self.

Bayer-Rots, Bekker & Peters (1989) proposed a relationship of a different nature. They suggested that low self-esteem may be somatised as pain, particularly in the pelvic region. Participant two was the only interviewee who introduced the idea of low self-esteem in a context separate from her experience of vaginismus.

P2: …at the time I didn’t think a hell of a lot of myself and I, yah, I kind of had the attitude that if you love me there must be something very wrong with you. You know umm, if if you could see value in me, you must be so empty of value yourself…
It is therefore possible that she may have been pre-disposed to having low self-esteem, which may have contributed to her development of the condition. It is also possible that the relationship was cyclical for participant two, as she had previously indicated the converse relationship. However, due to the nature of the study no causal conclusions can be made.

Participant three was the only participant to introduce the theme of feeling an increase in self-esteem. She suggested that treatment had increased her self-esteem to some extent and had resulted in feelings of achievement.

P3: I felt so proud of myself and eh I’m getting there. I know something is going to come of this.

D) FEMININITY

Participants two and three explored the topic of femininity with regard to the role of women. They conceptualised the role of a women as being able to engage in sexual activities. The fact that they could not have sex led to feeling less womanly.

P2: …because here I was depriving him of sex, which men expect when they get into a relationship…you know I’ve so often felt less of a woman because of it.

P3: I feel so less of a woman, umm right now I’m twenty three years and I haven’t had sex… Yah, why can’t I do the thing that every woman can, why can’t I have sex like every woman.

For participant three this was exacerbated by another factor, namely her discharge.

P3: Everything makes me different from other women, vaginismus … And then the discharge.

Participant two also introduced the idea of feeling less feminine as a result of potentially not being able to have children, which is perceived as a vital female function.

P2: I feel less of a woman and the idea that I may never be able to have children is the most horrifying thing.
This issue was raised as a concern for participants three and four, but was not linked to their sense of femininity.

P3: I have to give my mother and my parents grandkids…but he wants a baby, so I don’t know how is he going to get a baby with this problem.

Conversely, participant one identified a fear of having children.

Tyson & Tyson (1990) proposed different levels of conceptualisation of femininity, adding the dimension of unconscious manifestations of femininity. This viewpoint would obviously relate more to the psychoanalytic understanding of femininity. By its very nature, unconscious expressions are not recognised and therefore would not have been referred to directly by the participants. Nevertheless, it was felt important to explore latent content that came to the researcher’s attention. It is acknowledged that given the nature of the study, that these interpretations cannot be properly substantiated.

Participant two appeared to be quite defensive about her femininity being determined by a relationship with a man. Participant one made reference to having had certain male qualities, and in fact wanting to have male children. This may possibly suggest a conflict with regard to gender identity for both participants.

P1: I was an impossible child. I was very naughty, a little boy basically, that’s how I was... I want boys like my brother… girls are more demanding.

Another conceptualisation of femininity examines vaginismus within a socio-cultural context. The condition is believed to represent a feminine protest of sexual agenda (Reissing, 1999), or perhaps an objection against traditional female roles that require self-sacrifice and compromise (Barnes, Doherty & Kennedy, 1995; Dear and Roberts, 2002). This theme was introduced by participant two.

P2: ‘You can’t help yourself to be a women in every sense unless there’s a man in your life’, which seems to be such a contradiction. I also don’t want my sexual identity to be tied to one other person.
The story told by participant two of a powerful, unconventional woman is suggestive of her desire for a change in the power differential between men and women. This may possibly be related to the lack of power she experienced when sexually assaulted. It is possible that vaginismus represents a feminine protest for participant two.

P2: She’s completely this twenty first century woman, she had four husbands and you know from each of them she’s gained something and she’s left them by the way side… She can go into business, even though she is a woman in the fourteenth century, and she does, she preaches in church, which you know no other woman would dream of doing but she does because she’s open to new things.

This desire for a change in female role and power was not suggested by any of the other participants. However, Participants 1, 2 and 3 did suggest a need for independence. This too may represent a need for control, as perhaps relying on others involves a relinquishing of power.

3.2.3 INTIMATE RELATIONSHIPS WITH PARTNERS

A) QUALITIES OF INTIMATE PARTNERS

Various studies suggest that women suffering from vaginismus tend to choose partners of a particular type (Barnes, Doherty & Kennedy, 1995; Dawkins & Taylor, 1961; Masters & Johnson, 1970; Silverstein, 1989). However, this study found inconsistent trends with regard to the qualities of intimate partners.

Participant one identified her partner as being gentle in nature.

P1: He’s very nurturing…he doesn’t get upset, storm out the room… he’ll talk to me in a calm manner… he’s a bit softer…

Participant two described three of her five previous partners in this way, adding the dimension of passivity.

P2: J is a big softie…he lacks any kind of assertiveness, aggression, ambition…
These qualities were not identified by the other two participants.

This is consistent with literature which emphasises the ‘gentleness’ (Kennedy in Kabakci & Tugrul, 1997) and passivity (Dawkins & Taylor, 1961; Gindin & Resnicoff, 2002; Silverstein, 1989) of partners of vaginismic women.

Participant two suggested that two of her previous five partners exhibited stereotypically feminine traits and behaviour.

P2: Everything that could make someone excluded from the army is Jose, he’s completely sensitive…all his best friends are girls, umm he understands women better than just about any guy I know… these were all the things I loved about him

P2: P was lovely, yah P’s probably gay actually… P liked to wear make-up and girls clothes, so that was also fun and a little bit different.

Participant two appeared to have enjoyed these stereotypically feminine qualities in the men she dated. According to Dawkins and Taylor (1961), Gindin & Resnicoff (2002), and Silverstein (1989) women suffering from vaginismus often choose men who are afraid of their own aggressive sexuality. Participant two may therefore have chosen men with feminine qualities because they lacked aggressive sexuality, which she had previously experienced and now feared (Dawkins & Taylor, 1961, Silverstein, 1989, Gindin & Resnicoff, 2002). In addition, her choice in partner may have resulted from her desire for female dominance, as suggested in the previous section.

However, Participants three and four added a different dimension with their descriptions of their partners. They both suggested boyish qualities to their men, describing their partners as having a “naughty” element to their personalities.

P3: He’s charming, he’s fun, he’s bubbly, he’s not a boring guy. He’s so, he’s so comfortable with everything, he lives life, he lives free…he drinks a lot but he’s a good guy.
P4: If I had to describe him. Naughty, umm but fun. Umm, I think it’s the naughtiness in him that I actually like… I’m sort of like a sucker for guys that I think, not treat you badly but don’t treat you like a queen. I tend to like…love those guys.

Participants 1, 3 and 4 suggested that their partners were understanding and supportive regarding their condition.

P3: He’ll still support anything …he is understanding.

P4: He’s been very understanding through this whole thing…he always wants to help me, he’s very positive about my condition, he says that I’m going to come right, and then we’re going to get married and have kids.

This is consistent with Kabakci & Tugrul (1997), who suggested that such partners tended to be considerate and helpful towards the dysfunction, with almost one third of them showing no overt reaction to non-penetrative sex.

However, Participant four raised concerns that her partner would not always be this way.

P4: I need him…to be positive and I need him to support me and not be…judgemental, like he’s not but I worry that he would become like that.

Participant two suggested that while some of the men she had dated had been understanding there were many who did not support or encourage her with regard to the condition.

P2: Maybe I’ve also just been with a lot of men who made me feel completely rejected because I won’t do that one thing.

According to Participant two, this is not necessarily associated with how sensitive the men were.

P2: I have dated sensitive, kind, sweet, lovely men and every one of those relationships has ended horribly.
It is significant to note that participant two is the only one to suggest this lack of understanding in her partner. She is also the only participant not in a relationship at the time of the interview. One may hypothesis that the presence of an understanding partner is a pre-requisite for the continuance of such relationships.

Participants three and four felt that their partner’s support and understanding was essential in helping them through their experience of the condition.

P3: Exactly, and his attitude is making me feel… so at ease, so calm about this whole situation…if he didn’t understand, I wouldn’t be here today.

P4: Once you attempt it and it doesn’t work, you feel sort of like a let down but I need him to sort of pick me up again and sort of tell me that, okay it didn’t work there’s still other times to try it. So I think mainly, the supporting and understanding.

This description of what participant four needs appears to contrast with her previous assertion that she is attracted to men who don’t treat her very well.

However, by contrast, Participant one felt that her husband’s understanding and lack of assertiveness with regard to having had sex worsened the problem.

P1: And I think that’s like one aspect where I want to say to him, ‘come on, just shout at me, what is wrong with you, you’re too calm… for him just like keeping quiet I think it made my situation worse.

In summary, two trends were identified by participants. Partners were described as either having stereotypically feminine qualities such as gentleness and passivity, or more masculine traits such as being “naughty” and boyish. However, this differentiation did not appear to impact on how supportive partners were with regard to the disorder. The presence of a supportive partner appears to be crucial to the success of such a relationship. However, this quality, without appropriate assertiveness was experienced by one of the participants as exacerbating the problem.
B) THE RELATIONAL CONTEXT OF VAGINISMUS.

The literature is divided with regard to whether there is a connection between interpersonal relationships and sexual dysfunction in couples. When asked about their relationship dynamics, participants 1, 3 and 4 initially attempted to give idealised responses.

P1: We’re very easy going…So we’re very well balanced in terms of each other and our relationship is very well balanced…it’s just a really really good relationship.

P4: I think my boyfriend is the right person to be with … he literally knows everything about me, and I know all his secrets, we’re comfortable with each other so I think he’s the right person to try and tackle this with.

In addition, Participant one tried to minimise the impact that the condition had on their relationship.

P1: Its not really a problem cause it hasn’t affected anything really, well apart from the bedroom life but our relationship is still great you know, its not like we’re getting divorced tomorrow or something like that.

However, phrases like ‘seems to’, ‘think’ and ‘really’ appeared to suggest that the relationships were more complex than initially described. Later in the interview, several concerns related to their relationships emerged. The initial idealisation may have been due to a lack of optimal rapport towards the beginning of the interview. This trend may also reflect participants’ discomfort in discussing, and perhaps acknowledging, problem areas in their relationships. The fact that participant two did not follow this trend may be related to the fact that she did not need to be defensive as she was not involved in a relationship at the time.

After further inquiry, all of the participants suggested that the condition had impacted negatively on their relationships.
Most of my relationships have ended either directly or indirectly because of vaginismus, because you know in a real relationship people have sex.

Participants 1, 2 and 3 suggested that the condition had been problematic for both themselves and their partners. Consistent with Jeng (2003), the relationships were reportedly affected because the couples were unable to enjoy intercourse.

Participant four found that the condition was more problematic for her than her partner.

P4: I’m sure he would like to have sex but I don’t think its as big an issue to him as it is to me.

Conversely, Participant four also suggested that problems in the relationship may have contributed to the condition.

P4: There were a lot of challenging things in our relationship, like when we first were going out there was quite a lot of fighting… I think that also might have put me off having sex with him.

This is consistent with literature which advocates that problems related to attitudes, needs and responses within a relationship may lead to sexual dysfunction (Daya et al, 2001, Frandsen et al, 2002). Vaginismus specifically has been described as a protective mechanism or response to emotional pain (Silverstein, 1989). It is therefore possible that the condition may develop as a defense against an unhappy relationship. Due to the nature of the study, such conclusions with regard to participant four could not be made.

Some of the literature suggested that sexual dysfunction may exist in the absence of significant relationship problems (Metz & Dwyer, 1993). This was not found to be the case in this study.
B1) INTIMACY

PHYSICAL INTIMACY

Sexual intercourse for all of the participants was, given the condition, not possible. Participants three and four, nevertheless, suggested that they had been attempting to have sex but had not been successful.

P3: And then we decided to try it again and again and again, but there was no success...

The other two participants indicated that they were not attempting intercourse. Participant two had not been a relationship for some time, but even on initial dates explained to potential partners that intercourse was not a possibility.

P2: I’ve actually gone to the extent … I went on a second date with someone .., and I said, by the way this is our second date and I just want to tell you, so that there’s no confusion, I don’t fuck.’

The participants also appeared to differ with regard to other forms of physical intimacy.

Participant four indicated that other than sexual intercourse, she was able to enjoy all other forms of physical intimacy. She suggested that even a certain degree of penetration, was possible.

P4: I can do other things umm I think its mainly the sex part where… I have an issue, otherwise I’m all right… I can take umm a certain degree of penetration but when it gets to a certain point then I can’t.

This is consistent with Gindin & Resnicoff (2002) who found that sexuality was rarely completely absent in women with vaginismus, suggesting that many had a rich sexual life without coital penetration. Unlike this idyllic description, participant four emphasised that physical intimacy was still affected when they attempted intercourse.
Participant three indicated that she gave her partner fellacio as a substitute for intercourse.

P3: just imagine I’ve started to give him sex and then … I say no lets just drop it, I have to substitute it with something else. So I would just give him a blow job just to make him feel better.

However, it does not appear that participant three engaged in this physical activity for her own pleasure. In addition, she did not permit her partner to reciprocate.

P3: I don’t like him to go near my private parts, I don’t know why.

Participant one suggested that all forms of physical intimacy had decreased with the onset of the disorder. No form of penetration was allowed.

P1: Oral or whatever the case is but not penetration what so ever but… but again it wasn’t that often, I mean it was once or twice a month, which is very bad, I mean when you’re married it should be five times a week or five times a day or whatever the case is.

Participant one was the only participant to suggest that physical affection had decreased as well.

P1: He could have said something like… just come lie down here next to me or come cuddle with me, it’s genuinely what he wants to do and I wouldn’t.

These statements are consistent with the reports of Kabakci & Tugrul (1997), who found that women with vaginismus do not have frequent sexual contact in their relationships. As with participant one, Snyder and Berg (as cited in Cobain & McCabe, 1998) suggested that this may extend to an avoidance of physical affection as well. Participant two did not give much detail with regard to forms of physical activity she was
comfortable with. This may be due to the fact that she is currently not involved in a romantic relationship.

As with the literature, different trends regarding comfort with physical intimacy have been found in this study. Nevertheless, all four participants suggested that their physical intimacy had been affected in some way by their condition. Several reasons were offered for this.

Participants 1, 2 and 3 suggested worrying that physical intimacy might lead to the expectation of sexual intercourse, which is feared by all four participants.

P3: I feel tense when he started to get sexual, then I tense up.

P2: I’d go “okay he thinks this is going to lead to sex …”

Participant two suggested having felt comfortable with physical intimacy when there was no threat of intercourse.

P2: P and I had… a pretty good time of it because penetrative sex wasn’t the be all and end all for him. Umm, and once I realised that we actually had more fun together.

Participant two also attributed a decrease in physical intimacy to a loss of libido as a result of feelings evoked by not being able to provide her partner with sexual intercourse.

P2: I tend to start out enjoying myself because you don’t have to start out with penetrative sex, you can do other things and that’s great but then a few weeks into it I become acutely aware that it were, if I were anyone else in the world this guy would be having sex by now, and my sex drive just goes right down.

This theme was also introduced by participant four, who described having experienced this prior to her current relationship.

P4: I was going to have to face having sex and then …I would get upset you know if I couldn’t do it, I would feel bad.
It is therefore possible that physical intimacy is avoided in order to prevent the experiencing of such feelings. This avoidance of emotion appears to be prominent in the analysis. Nevertheless, despite expressing such feelings, participants one and three did not attribute their decrease in sexual activity to this.

Participant one also attributed the decrease in the type of physical intimacy enjoyed to her discharge.

Given the fact that the study focuses on the relationships of such women with their partners, it was felt necessary to explore how the partners reacted to the decrease in intimacy. The presence or lack of understanding in this regard has previously been explored, and thus the investigation will focus on the partners’ feelings as described by the participants.

Participant two described how many of her partners had lost interest and became bored with the relationship.

P2: Now, because our sex life went into this decline and just didn’t you know come back up for air, umm, G obviously lost a little interest…

Participant one and three suggested that the condition had evoked certain insecurities and anxieties. The decrease in physical intimacy appeared to effect the partners’ confidence in themselves sexually.

P1: He said… ‘I can’t even hug you or kiss you or anything like that, what do you want me to feel. He says naturally I feel you can tell me as much as you like that its not its not umm you its me or whatever the case is but somehow I’m going to feel like it is me. You know maybe you’re not attracted to me. Or maybe I don’t turn you on’

P3: He actually thought … I didn’t want to make love with him.

Participant three’s partner had become distressed about the fact that he could not reciprocate sexually.
P3: He said to me, I allow you to play with my penis however you want, but why can’t you let me do
the same thing, its one sided, why can’t it be both ways. He couldn’t understand, even now…

Participant three also suggested that the decrease in intimacy had evoked feelings of
frustration for her partner.

P3: He gave up at some point. He really was so frustrated, he wanted to give up, wanted to end the
whole relationship.

Participant four suggested that her condition had resulted in her partner becoming overly
anxious about hurting her.

P4: Cause I think sometimes he thinks that if we have sex I’m going to sort of like shatter like a
porcelain doll, so I think even he might be getting a bit scared.

These accounts contrast with the literature which suggests that partners of women
suffering from vaginismus were not particularly dissatisfied with the dysfunction
(Kabakci & Tugrul, 1997). It should be acknowledged that most of these partners
appeared to be reacting to a decrease in physical intimacy, not necessarily the lack of
sexual intercourse.

EMOTIONAL INTIMACY

Participants 1, 2 and 4 introduced the theme of avoiding emotional intimacy. These
participants related this, in different ways, to their experience of vaginismus.
Participants two and four associated emotional intimacy with the expectation of sexual
intercourse.

P4: I used to stay away from guys because I knew inevitably … if there was intimacy that would lead
to us having to have sex.

P2: I avoid intimacy because, to get into an intimate situation implies a contract, its an implicit
agreement, to behave in certain ways or to do a certain thing, in this case its penetrative sex…
However, participant four suggested that this changed with her current relationship.

P4: With my boyfriend now, I know him, he knows me, we’re comfortable with each other so the intimacy part is fine.

It is possible that her comfort with him allows to her feel more in control of the situation, despite the fact that this theme was not previously introduced by participant four.

Participant two provided two additional explanations of her avoidance of emotional intimacy. She suggested finding such intimacy too emotionally intense and therefore threatening.

P2: Intimacy to me is almost synonymous with intensity…that’s pressurised, that’s stressful, gazing into somebody’s eyes over a candle lit dinner is not a good way to get me to relax into a situation…

Participant two suggested that she was more capable of physical intimacy when there was no threat of emotional intimacy.

P2: We also weren’t in love with each other…the pressure was off. There was no ‘I have to fuck this person because that’s the only way I can express my love for them’.

Despite this, Participant two suggested that allowing emotional intimacy may put her in the position where she might be violated again.

P2: Truly watching the person I’m you know going out with having spent the evening getting along with or getting on brilliantly turn from someone charming and interesting and attractive and sexy into someone I can’t defend myself against…

The issue of both physical and emotional intimacy appears to be very threatening for participant two. This may be related to her experience of being violated. The interplay between the two forms of intimacy also appears to be complicated for her. This may explain why she had not been in a romantic relationship for two years.
Participant one suggested that she had begun to push her partner away, as a result of the condition, thereby decreasing the emotional intimacy. In addition, she indicated experiencing a numbing of her emotions for him as a result of the decrease in physical activity and affection. In this way, the physical intimacy appeared to be impacting on the emotional intimacy.

P1: …because my feelings were starting to change…You feel like you become more aggressive, you feel like you become more hard, like almost emotionless, nothing phases you and you know sometimes you think its because you don’t have that affection, that intimacy.

Participant three was the only participant to suggest that the experience of vaginismus may have had a positive effect on the emotional intimacy of the relationship. Her partner’s support and constant reassurance, once they identified the problem, appeared to have increased the intimacy and trust within the relationship. This contrasts with participant three’s initial description of her concerns related to her partner abandoning her.

P3: He said but I’m here to stay. I’m going nowhere, and then in the process that I realised that’s the truth. He said that he’s here to stay, that he’s not going to go anywhere until I’ve sorted myself out.

This is consistent with research that suggests that sexual dysfunction may intensify emotional intimacy (Gindin & Resnicoff, 2002).

B2) COMMUNICATION

The issue of communication was addressed by participants 1, 3 and 4. This category was not discussed by participant two, possibly because she is not currently in a relationship. Participants 1, 3 and 4 all suggested that they communicated well with their partners.

P1: He’s my best friend, I would say, I speak to him about everything. There’s nothing in my life that he doesn’t know about and the same on his side.
It is interesting to note that participant one and three emphasise their ability to speak to their partners. The mutuality of communication was only emphasised by participant four. Nevertheless, their accounts are consistent with a study by Hawton & Catalan (1990) that found that vaginismus couples demonstrated significantly better communication and improved over-all relationship ratings than a comparison group. This was, however, found to be dependant on the couple’s seeking treatment. It is significant that participants 1, 2 and 3 had just began treatment. It is possible that their accounts of the communication are idealised, which is a trend in this study.

Participants one and three reported later in their interviews that communication with their partners was not as idyllic as they had initially portrayed. Participant three suggested several topics, particularly sexual issues, that she had unable to discuss with her partner.

Participant one indicated that until she began treatment, she and her husband had not discussed sexual issues for approximately two years.

Participant four was the only participant who emphasised that she was able to discuss sexual issues comfortably with her partner.
Communication deficits, such as a lack of confidence in communication or difficulty in communicating preferences for various types of sexual interactions, have been demonstrated among sexually dysfunctional couples (Cobain & McCabe, 1998, Epstein & Metz, 2002, Kelly, Strassberg & Turner, 2004). This was found to be the case for participants one and three.

B3) CONFLICT

Different trends with regard to conflict were discussed by the participants. Participants one and four described having healthy conflict resolution in their current relationships. They also suggested that the disorder itself had not resulted in much conflict.

P1: We never argue, and if we do, we never go to bed angry. Its something that will be sorted out, which is another important thing from both sides. We’re both very much like that…we don’t like fighting but we’ll never just…if we’re fighting about something it means that there are issues…We’ll sort it out, find out what the problem is, and make up. And then its over. Its forgotten.

This account is consistent with literature that suggests that sexual dysfunction is not synonymous with conflict. Kabakci & Tugrul (1997) found that conflict, related to vaginismus specifically, was not prevalent. Some couples can reportedly manage the distress concerning sexual dysfunction, allowing themselves to sustain overall relationship satisfaction (Epstein & Metz, 2002). It is also possible that these descriptions are idealised, as appeared to be the case in this study.

The seeming lack of conflict related to vaginismus may be related to relationship dynamics created by the personalities of each partner. Participant one described her partner as being passive. This may result in him pacifying potentially conflictual situations.

P1: cause I’m I’m a bit, I’m more of the harder one, I would say in the relationship. He’s a bit softer…I’m the one who freaks out most times so he brings me back down to earth.
Participant four described her relationship with her boyfriend as having initially been very conflictual. However, the conflict did not appear to be related to her condition. Participant four attributed the current difference in the relationship to them being more mature.

P4: There were just issues around me being very possessive over him, and I didn’t like him hanging around his friends because they were all into drugs… I think there was a lot of fights about that so also me not trusting him because he was lying to me.

Participants two and three introduced the theme of conflict in the relationship as a result of the condition. Participant two attributed this to her partner’s lack of understanding of her experience.

P2: I had a huge screaming fight with G… I yelled at him and said can you not understand that I feel less of a woman and the idea that I may never be able to have children is the most horrifying thing… he had been flippant and blatant about something that to me was just a nightmare.

Participant three suggested that all their arguments ultimately ended in a fight about not being able to have sex.

P3: We’ll have an argument about something else but at the end of the day it will go down to sex so I would think that he’ll get an excuse to start an argument with me and then at the end of the day he will talk about not having sex, its its one of the biggest problems in this relationship.

This is consistent with literature suggesting that sexual dysfunction may cause or contribute to relationship conflict. In addition, such dysfunction may create a negative atmosphere for resolving conflicts in the relationship (Epstein & Metz, 2002).

According to Epstein & Metz (2002) relationship conflict can interfere with sexual desire, arousal and intimate behaviour. Thus, unhealthy conflict resolution can have an injurious effect on the emotional environment of sexual activity. This appeared to have been the case for participant two, whose relationships had ended as a result.
Conversely, participant four suggested that conflict with her partner had in the past contributed to her inability to have sex with him.

P4: I blame my boyfriend for a lot of things …I think that maybe also sort of perhaps contributed to it…there were a lot of challenging things in our relationship, like when we first were going out there was quite a lot of fighting… I think that also might have put me off having sex with him…

This accords with research indicating that conflict may cause or maintain sexual dysfunction (Hartman, 1980). Certain investigations have suggested that couple difficulties such as infidelity and conflict may result in or contribute to vaginismus specifically. Infidelity was described in the first attempt at this relationship, however participant four suggested she only discovered this after the condition had developed (Chisholm, Lamont, Shortle & Jewelewicz & Weiner in Reissing, 1999). The literature also suggests that sexual dysfunction may be symptomatic of larger relationship problems. Dickens & Strauss (1980) proposed that for certain couples, when the sexual dysfunction was successfully treated, a new problem developed (Dickens & Strauss in Epstein & Metz, 2002). As none of the participants had received prior treatment, it is not possible to make a comment in this regard.

3.2.4 EARLY PARENTAL RELATIONSHIPS

It should be noted that various themes with regard to parental and childhood influences on the development of vaginismus have already been explored. This section will therefore focus on the personalities of parental figures as described by the participants, and the quality of relationships established with their vaginismic daughters.

According to Ahvenainen et al (2003) a close, warm relationship with one’s mother is associated with the importance given to one’s sex life, the satisfaction experienced, as well as the ability to talk about sex in women. This aspect of the participants’ lives was therefore considered important to explore.
Participant 1, 3 and 4 emphasised that they currently had a close relationship with their mothers. Participants 2, 3 and 4 said that the relationship had improved as they had got older. Participant three attributed this to her father moving out. Participant two said she had discovered more commonalities with her mother.

P2: Whereas my similarities to my mother were less obvious, umm but I’m discovering them more and more now, as I’ve got older.

Participant four suggested that her maturation into adulthood had made the relationship easier.

P4: But, also as I’ve got older, our relationship has got better so I think we talk about things much easier than we used to when you’re older it gets easier, because they accept you as an adult and they talk to you like an adult, so yah but I have a really good relationship with her.

However, participants were vague as to what the earlier relationship had been like.

Participant one implied that she found her mother very needy.

P1: I get on very well with my mom but its like, say now for example I’m married and like she misses me so she’ll phone me like ten times a day, and I’ll say to her please stop phoning me you know I’m busy, and she’s like I just wanted to see what you’re doing in case you could meet up.

Participant three suggested taking contraceptives, despite not being sexually active, merely to please her mother. This may be suggestive of an intrusive style of mothering. However, this is merely conjecture.

P3: The reason I, okay, is that I use the tablets just for the sake of my mother because she thought I was having sex. So I decided that just to make her happy and better, so I’ll take the tablets just to make her feel at ease because she thought I was gonna get pregnant.

This is consistent with Hiller (1996), who described the possible impairment of sexual functioning that may result from a mothering approach that is over-intrusive with
daughters and characterised by a lack of clear boundaries. However, given the nature of the study and lack of detail given by participants, these conclusions cannot be reached.

Gindin & Resnicoff (2002) suggest that women with vaginismus may have had authoritarian mothers who imposed on them the belief that sex was sinful. Whilst the theme of sexual guilt has already been elucidated, it was felt important to explore the mother’s attitude towards their daughter’s sexuality specifically. This theme was not introduced by participant two.

Participant four said her mother had initially been angry about the fact that her daughter was sexually active, but has subsequently been understanding and supportive about her condition. She was the only participant to suggest that she had informed her mother about having vaginismus.

P4: When she first found out I was having sex, she almost hit the roof, umm… So, I don’t think she was happy to begin with, and I think she was also very judgemental of my first boyfriend, she I think she placed a lot of blame on him, which made me caused me to blame him as well.

Participant three suggested not being able to discuss sexual issues with her mother, particularly regarding her discharge and her condition.

P3: Uh, besides, I don’t even know what to…how to start telling her…I try to find the right time, but anytime when I find the right time to tell her, I decide not to, because somehow I feel that she wouldn’t understand…I couldn’t tell my mother that I had a discharge.

Participant one had described not being able to discuss sexual issues with either of her parents. Further, she did not believe her mother would understand or be particularly supportive with regard to her sexual dysfunction.

P1: She would probably tell me, go check yourself out, I don’t think she would take it as seriously as its cut out to be…
Jeng (2003) suggested that vaginismus sufferers may have seen their mothers as ineffectual when growing up, finding them helplessly dependant on the father. Having intercourse may therefore represent an identification with the mother which the daughter struggles to accept.

This is consistent with the account given by participant three, who suggested that her mother had been submissive to her father, and had never been able to be herself when he had been present.

P3: I didn’t know what kind of a person my mother was, until my dad left. Because, before, while we were living with my dad, my mother wouldn’t talk, she wouldn’t umm start a conversation, make a joke. She was always so umm, so tense…But after my dad left, I I started realising that you know what, I have lived with this person for so long but I didn’t know my mother could talk so much.

In fact, participant three suggested that her mother was so focused on attending to the father, and the problems in their marriage, that she never had much time for her children.

P3: You know she was so focused on the marriage, they were always resolving their own issues in the marriage that they couldn’t talk to us that much.

Participant one, however, suggested that her mother had been the dominant parent. In fact, her description of her parents dynamics mirrored that of her and her husband. The theme of parental dominance or submissiveness was not introduced by participants two or three.

The literature has also suggested that mothers of vaginismic women may have suffered from vaginismus themselves (Jeng, 2003). No evidence of this was found in the current study.
Participant 1, 2 and 4 described having good relationships with their fathers.

P1: I was just very close to my dad…even when I got married it was like sad to leave my dad….I think my dad’s just my weakness, my soft spot.

P 4: Yah, I have a good relationship with him…he’s always been there for me.

In fact, participants one and two describe being much closer to their fathers than their mothers.

P1: You know, so I think its like you know when you’ve just got a different love for somebody else I love my mom as well but it’s a different.

Both participants attributed this to similarities they believed they shared with their fathers. Participant four did not elaborate much on her relationship with her father. Participant three suggested that she had never been close to her father, as she had not felt able to talk to him.

P3: We never talked, we never talk even now. I just told him whatever that’s important, and that’s it…I’ll never sit and have a conversation with my dad. And its been like that for years.

There is not much available literature pertaining to the paternal relationship in vaginismic women. O’Sullivan (1989) suggested that that many vaginismic women grow up with threatening or aggressive fathers (O’Sullivan in Silverstein, 1989). Gindin & Resnicoff (2002) concurred, finding that fathers may even be abusive, dominant and violent (Gindin & Resnicoff, 2002). Silverstein (1989) proposed that the fathers of these women tend to be extremely critical and moralistic. Some are also found to be overprotective and not respectful of their daughters’ privacy or boundaries (Silverstein, 1989).

Participants 1, 3 and 4 introduced the theme of having protective or strict fathers. Participant one suggested that her father was protective of her with regard to men and sexuality. She, however, did not feel this was excessive or inappropriate.
I've been on holiday with him but my father didn’t allow it until he knew okay this ones the one, cause his whole thing is, you can go on holiday with every boy you meet, you know what does that say. And, even when we were engaged, we never slept at each other’s houses.

Participant two described her father as otherwise being calm and peaceful.

He’s very calm, he never used to shout.

Participant four suggested that her father was overprotective of her, but also did not appear upset by this.

I think he’s just one of those overprotective fathers… My dad’s just one of those people that I think would prefer me not to have a boyfriend. he doesn’t know about all these problems… and yah

Participant three felt that her father had been excessively strict and protective with regard to males and sexuality. She felt this had hindered their relationship.

He’s very strict. So, maybe, I guess that’s maybe one of the reasons why it wasn’t easy for me to talk to him…no sex before marriage, umm, you can’t get pregnant while you’re young. You have to get married first, I don’t want boys around, this and that, even now he’s that strict.

Further, participant three suggested that her father’s harshness might have contributed to her condition, by preventing her from discovering it sooner.

I think one of the reasons why I did not know why I have this problem is because that, when we lived with my dad, he was so strict.

However, there is not consensus in the literature concerning the significance of parental relationships. Cobain & McCabe (1998) and Leitenberg, Greenwald & Tarrun (1989) found that childhood events and relationships failed to have an impact on adult sexual functioning. It is perhaps significant that only participant 3 associated the development of her condition with a parental relationship. However, once again, given the nature of the study it is difficult to make conclusions in this regard.
All of the participants gave vague descriptions of their parental figures and relationships, particularly early childhood experiences with parents. Thus, it is difficult to make assertions regarding parental relationships. However, this fact may in itself be significant. Participants may be attempting to avoid certain issues by being vague, although this cannot be confirmed with certainty. Nevertheless, this hypothesis is supported by the fact that all of the participants initially gave idealised descriptions of their childhoods. The participants may have experienced these relationships in this way, however, this may also represent a desire to avoid acknowledging and discussing the painful aspects of their early experiences.

P2: Generally speaking I had a great childhood. I had an idyllic childhood.

P1: My childhood was awesome. Umm, we were a very very close family…very happy childhood.

P4: Umm, I had a very good childhood…my grandparents spoiled us rotten, and my parents were very good to us, and you know they were never divorced and there’s never been any abuse or anything like that, my family has always been very loving, and they’ve basically given me whatever I’ve wanted to do.

Participant three’s description was less emphatic.

P3: Okay, my childhood was okay, it was fine, you know you grow up as kids, and play with other kids outside, umm, just like a normal childhood…

She, in fact, emphasised not remembering much about her childhood. The significance of this cannot be established given the nature of the study. However, one may hypothesise that she may have repressed these memories because they were too painful.

P3: The only time I remember, its when I was in primary school…
3.2.5 SOCIAL INTERACTIONS

The relationship between vaginismus and the experience of social interaction was not initially considered as part of the study. However, as it was introduced spontaneously by the participants it was felt important to include. Participants 1, 3 and 4 said that they had not wanted to tell their friends and family about their condition.

P4: No, umm, only my boyfriend now and my mother know about it…I didn’t want people to know about it.

Participant one attributed this to not believing others would understand or empathise.

P1: You don’t want to tell people about it, you know sometimes people are, they are not accommodating to your needs, or your emotions or anything like that, so to them it might be, oh, funny, okay, whatever, yah sure, its not such a big problem. But they don’t know what it is exactly, what it entails. So you just rather not tell anybody.

Participant three suggested people would not believe her.

P3: Because, somehow, some people think that its normal to you know, already they concluded that you have had sex already. They’ll think I’m lying…Why must I tell them that I’m a a virgin, its my thing. And I just keep it to myself.

Participant four felt it would be too complicated to explain it to her friends.

P4: but its just easier not having to explain why you aren’t having sex while everone else is telling me what great sex they are having.

Participants three and four emphasised how this made them feel isolated and lonely.

P3: I feel so bad, really bad, I feel so alone. And they would ask me questions, how was it, how are you… how was your first time, how is the boyfriend? And I would just say, uch, you know what, lets not talk about it…
P4: …its sort of a very isolating problem because you think, you’re told that a lot of people have it but I don’t know anyone who has it, you know so I think you feel very isolated from everybody else because I mean all my friends have sex and have fine relationships, I don’t even think they know this problem exists.

Participant one suggested that the secrecy also made her feel as if she put up a pretense.

P1: You almost feel like you’re living a lie cause not that many people know about it.

Participants one and three suggested that this had impacted on their social interactions as they could not take part in conversations about sex.

P1: That’s it, it’s a complete secret that only yourself and your husband share. And that becomes a bit of a problem because when there’s jokes going around or you know we’re very close to all our friends, and that’s something that’s always discussed and we keep quiet…it cuts you out.

P3: Because every time when I, when I meet with my friends maybe at a party or something, you know how it is, they start talking about sex and then how they did this and that last night, how it was, how they, and I do, I make it a point…I’ll just leave the room and go somewhere else or maybe change the topic, change the conversation, talk about something different…

There is literature which suggests that the negative effects of medical conditions may be buffered, both directly and indirectly, by one’s family. The inability to discuss such problems with family or friends may deny sufferers this form of support, thereby worsening the experience of the condition (Flor, Turk & Rudy, 1989; Lorber and Moore, 2002).
3.2.5 CONCLUDING COMMENTS

The study was an explorative piece of research that identified various trends and themes with regard to the perceptions of women suffering from vaginismus. Paradoxically, the first trend that became apparent was the lack of consistency amongst the participants. Differences with regard to etiological themes, personality profiles, emotions as well as relationships with intimate partners and parents were found. This is coherent with findings in the literature, which are also inconsistent. This may suggest that there is no standard profile for women suffering from vaginismus, regarding their personalities, self-perceptions, relationships or the origins of their condition. However, it should be noted that whilst few aspects were found to be universal, most shared some commonality. Thus, patterns and trends were still established.

It would appear that participants did not have strong opinions regarding aetiology. This may be related to the fact that, with the exception of participant four, participants suggested not understanding their condition. The only factors highlighted as being causal were the fear of pregnancy, stress as well as fear of pain. It is unclear whether their perceptions regarding aetiology would have differed or become more emphatic following treatment. However, with regard to aetiological themes, as identified in the literature and mentioned by participants, a unified pattern could not be found.

All of the participants did, however, suggest that sexual guilt influenced their attitudes toward sexual activity. The emphasis of this factor in the study strengthens the hypothesis that vaginismus operates as a protective mechanism against intrapsychic guilt. However, the size of the study limits the potency of this conclusion.

Certain commonalities were found with regard to how the women perceived themselves. All of the participants reported experiencing emotional distress as a result of the condition. There also appeared to be the tendency to avoid the experience of emotion. This may be suggestive of a personality style or of how painful the emotions related to vaginismus may be.
Several personality traits were identified in the study. However, these were not present in all of the participants. In addition, certain personality characteristics shared no commonalities. Nevertheless, the need for control and independence was prominent. It is interesting that women who avoid passivity suffer from a condition which prevents them from having sex, an act which may be regarded as submissive by virtue of penetration. However, if there is such a mechanism at play, it appears to be unconscious. All of the participants suggested having low self-esteem as a result of their condition. This emphasises the enormous impact that having vaginismus has on one’s sense of self.

Differences were found, however, with regard to understandings of the construct of femininity. Those participants that associated femininity with the ability to perform stereotypically feminine roles appeared to feel less womanly as a result of their condition.

Two trends were identified with regard to choice of partner. Partners were described as either having stereotypically feminine or masculine traits. However, this differentiation did not appear to impact on the relationship dynamics, how supportive partners were with regard to the disorder, or whether partners were dissatisfied with the condition. Thus, the masculinity of the partner did not appear to significantly impact on the relationship. Rather, the presence of a supportive partner appeared to be crucial to the success of such a relationship.

With regard to relationship dynamics, patterns could not be discerned with communication or conflict. This may suggest that couples react differently to the experience of vaginismus. However, for the majority of the participants, vaginismus was found to impact on both physical and emotional intimacy. This is perhaps not surprising given the fact that vaginismus is a sexual disorder.

All of the participants gave vague descriptions of their parental figures and relationships. Thus, it is difficult to make assertions regarding these relationships. Participant three was the only one to relate her condition specifically to a parental relationship. However, all four participants suggested that childhood or parental experiences had impacted on their perception of sexual intercourse.
With regard to relationship dynamics, participant one and two suggested that they were closer to their fathers and participant three and four highlighted a closer relationship with their mothers. Interestingly, the group that suggested being closer to their fathers had chosen men with feminine qualities. This finding is consistent with literature that suggests parental relationships influence one’s choice in partner. The exact meaning of this, however, requires further research.

Several other patterns became apparent during analysis. One theme that was prominent in the study was that of avoidance. Participants were found to escape acknowledging or facing the condition by avoiding intimacy or even discussing sex with others. Avoidance of emotion was also prevalent. In addition, all of the participants described fears related to possible consequences of sex, including the fear of pain, of becoming pregnant, or of being violated against one’s will. Vaginismus may therefore represent an avoidance of having to deal with these consequences.

The tendency to idealise relationships was also found with all of the participants. It was only with probing that problems emerged. This may reflect participants’ discomfort in discussing problem areas in their relationships as a result of their unfamiliarity with the interviewer. However, this may also be related to a tendency to avoid acknowledging negative aspects of their lives.

The participants also appeared to make contradictory statements throughout the interviews. Changes in narratives as the interviews progressed may be reflective of an increasing comfort with the interviewer, following which they were more revealing and honest. However, the inconsistencies may also suggest that participants were unsure of their perceptions, possibly related to a lack of understanding.

The positive impact of being in treatment was also introduced. This was evident despite the fact that treatment had just began for most of the participants. The participants suggested it gave them hope, increased understanding, improved self-esteem. Treatment
also appeared to broaden perspectives on vaginismus. However, it was unclear whether it merely the idea of being helped that was powerful in this regard.

It is also felt important to acknowledge how participants differed from one another. Participant four appeared to have a particularly unique profile, as she differed markedly from the other three participants. This may be attributed to the fact that she suffered from vulvodynia as well, and had been in treatment for longer than the others. This may explain why at times, her outlook appeared more positive, particularly with regard to her relationships. However, it may also be significant that she was experienced to be the most guarded of the participants. Thus, she may have merely not expressed her concerns as openly as the others did.

Participant four was also the only one to introduce the notion her experience of vaginismus was impacted upon by factors such as emotions and intimate relationships. The other three participants appeared to focus on how vaginismus had influenced these aspects of their lives. It is possible that they had not contemplated the converse relationship, perhaps because they had just begun treatment.

Participant three was experienced as being different from the others as she displayed significantly more emotion during the interview. Participant three was also the only black participant. One may hypothesise a difference in cultural norms regarding the appropriateness of displaying emotion. However, this contrasts with participant three’s description of not being encouraged to express herself at home. Participant three was not otherwise found to be markedly different from the others in the way she perceived, understood or experienced her condition. This may suggest that there is no racial or perhaps cultural variation in the way women experience vaginismus. However, given the nature and size of the study, stronger assertions could not be made.

Participant two exhibited several unique features with regard to her intimate relationships. Certain prevalent themes, such as communication, were not introduced by her. This may be related to the fact that participant two was the only one not in a
romantic relationship at the time of the interview. This may suggest that one’s relationship status could influence what is considered relevant and important to comment on. Despite this, participant two’s experience of vaginismus did not appear to differ remarkably from the others.

Participant one did not have a particularly unique profile. She was also the only participant who was married at the time of the interview. The lack of marked differentiation, particularly with regard to relationship dynamics, may suggest that the experience of vaginismus may not differ remarkably depending on one’s marital status.

In conclusion, the experience of vaginismus appears to be stressful and impacts on one’s life regardless of one’s colour, marital or relationship status. Nevertheless, whilst there are commonalities, there does not appear to be one universal experience. However, these trends require further research and substantiation.