

CHAPTER 1

LITERATURE REVIEW

1.1 UNDERSTANDING VAGINISMUS AND HOW IT DEVELOPS

There is a long history of speculation about the origin of vaginismus. According to Barnes (1986) and Jeng (2003) the psychosomatic nature of vaginismus has been recognised for many years. However, the exact aetiological mechanism, if there is such a thing, is still unclear. Despite this fact, there are several theories which attempt to explain the condition. Quantitative research dominates the literature, which has relied on self-report data of women suffering from vaginismus. The literature also includes theories based on clinical experience, rather than empirical research. The main themes, as directed by previous literature, will now be explored.

A) MISINFORMATION AND IGNORANCE ABOUT SEXUALITY

Misinformation and ignorance about sexuality have been identified in the literature as possible etiological factors in the development of vaginismus. According to Silverstein (1989), misinformation and myths about intercourse may lead to painful first attempts. Furthermore, a lack of information may also result in the fear of pain and, ultimately, withdrawal from intercourse. Sexual ignorance may also 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.

A lack of sex education has been noted in a number of studies of vaginismic women (Audibert and Kahn-Nathan, 1980; Ellison, 1968; Jeng, 2003; Silverstein, 1989). Ellison (1968), for example, reported that 90% of his vaginismus patients exhibited a higher degree of misinformation. However, this finding has not been consistent in all the literature. Certain studies have found no differences in the level of sex education between

a group of vaginismic women and a comparison group (Amsel, Binik, Cohen, Khalife & Reissing, 2003; Duddle, 1977).

B) SEXUAL GUILT AND RELIGIOUS ORTHODOXY

Theorists such as Silverstein (1989) and Ellison (1968) propose 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).

This view was corroborated by Basson (1996), who found that the majority of women in his study disapproved of or felt guilty about sexual activity before marriage. Kabakci & Tugrul (1997) suggested that such women may feel that sex in general is ‘nasty’. In an investigation by Ward and Ogden (1994), 50 % of the vaginismus sufferers identified ‘being brought up to believe sex was wrong’ as a possible causal factor (Ward & Ogden, 1994, p.56). A study by Robinson (2003) also suggests that women with vaginismus feel guilty about sex, often experiencing feelings of shame and rejection. She found that many young women had trouble in accepting ‘that God is going to forgive them’ (Robinson, 2003, p.101).

Feelings of sexual guilt are often related to the experience of a religious background. Barnes (1986) suggested that religious orthodoxy, of whatever denomination, which emphasises the importance of chastity may induce a sense of guilt about sexual behaviour, possibly resulting in sexual dysfunction. Masters & Johnson (1970) therefore proposed that vaginismus may result from a childhood that is characterised by excessively severe control and attempts to instill high moral expectations. Nevertheless, the notion of religiosity as a causal factor has failed to receive consistent support (Jeng, 2003).

C) SEXUAL VIOLATION

It has been argued that experiencing or witnessing sexual trauma may also be a causal factor in the development of vaginismus (APA, 1994; Biswis & Ratnam, 1995; Silverstein, 1989). Vaginismus is therefore conceptualised as a protective mechanism against expected sexual intrusion. It may also reflect passive anger towards a partner as the displaced representative of the aggressor, as well as representing a wish to maintain the integrity of the self (Silverstein, 1989). Women may therefore like to have sex, but perceive penetration as a violent act (Gindin & Resnicoff, 2002).

However, this assumption has been challenged. Barnes (1986), and Hawton & Catalan (1990) found no difference in prevalence of sexual abuse or violation between vaginismus sufferers and comparison groups. In fact, the study by Barnes (1986) indicated that only 4% of the sample in study of 53 couples claimed that they were victims of sexual abuse. However, this topic is extremely sensitive and many individuals may not wish to disclose their experiences. For this reason, prevalence of abuse in the above-mentioned findings may have been underestimated.

D) FEAR OF PAIN

Vaginismus has been identified as a disorder with a significant phobic element, and therefore the fear of pain has been suggested as a significant component of the experience of vaginismus (Jeng, 2003). However, one has to consider the exact nature of the relationship between the fear of pain and the development of vaginismus.

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 is afraid of repeating the experience. Kaplan (1974) elaborated, suggesting that once this develops, vaginismus becomes a reflexive reaction to the anticipation of pain, leading to the avoidance of intercourse (Kaplan in Kabakci & Tugrul, 1997). In addition, according to Dersh, Gatchel & Polatin (2002), anxiety has been found to decrease one's pain threshold, which may perpetuate the problem.

However, theorists such as Blazer (1964), Ellison (1972) & Silverstein (1989) suggest that the 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 the expectations become self-fulfilling prophecies. In this way vaginismus is believed to be characterised by a pattern of fear and pain (Silverstein, 1989). This notion was supported by Ward & Ogden's (1994) findings, in which 74% of vaginismic women reported fear of pain as the primary reason for their condition.

E) FEAR OF PREGNANCY

Kabakci & Tugrul (1997) have also identified the fear of pregnancy as a possible factor contributing to the development of vaginismus. Women suffering from vaginismus were often found to have fears of pain, physical harm or death during coitus and delivery. However, paradoxically, it is often not sexual dissatisfaction but the desire for a child that brings such a woman or couple to therapy (Gindin & Resnicoff, 2002).

F) STRESS

Certain research suggests 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 (Hunt, 2002; Graham in Hunt, 2002). However, Morokoff & Gillilliand (1993) found that life stressors may in fact have a positive impact on sexual functioning. They suggest that the experience of daily stressors may increase levels of sexual desire, which acts to distract oneself from daily problems. Research pertaining specifically to this theory in relation to vaginismus could not be found.

Amsel, Binik, Cohen, Khalife & Reissing (2003) assert that the etiological studies of vaginismus are methodologically flawed, and as such adequate conclusions concerning etiology have not been drawn. In addition, some have questioned the validity of theories based on clinical observations rather than empirical research. Conversely, given the

speculations about the unconscious mechanisms that may be at play in vaginismus, such observations have been argued to be the only means of understanding the condition (Jeng, 2003). As such, the lack of consensus about etiology may reflect not only research inadequacies, but also paradigmatic differences within the research community. However, the absence of a unified explanation of etiology may be indicative of another issue. None of the allegedly causal factors highlighted in this chapter have been unanimously endorsed, instead each has been both supported and criticised. It is therefore possible that there are a number of independent etiological factors, rather than one mechanism.

Despite these possibilities, the validity of previous findings and conclusions is not the focus of the current study, which aims to explore how women understand their own condition, taking into account the history of how it developed and progressed. However, in order to establish and elucidate thematic patterns, it is essential that these narratives be explored in relation to literature on more general predisposing and contextual factors.

1.2 CHARACTERISTIC FEATURES OF WOMEN SUFFERING FROM VAGINISMUS

In addition to etiological factors, the experience of vaginismus itself incorporates many psychological and emotional elements of an individual's life (Daya , Farad ,Lamont, Randazzo & Wilkins, 2001; Hawton & Catalan, 1990; Jeng, 2003; Robinson, 2003). This study aims to explore how women suffering from vaginismus perceive themselves. However, their reportings need to be evaluated in relation to available literature on the characteristic features of women suffering from vaginismus.

A) EMOTIONAL EXPERIENCES

According to Hiller (1993), human sexual interaction involves a series of physical changes that are intimately connected with both conscious and unconscious feelings. The interplay between vaginismus and emotions is felt to be particularly significant,

considering the fact that emotional distress forms part of the diagnostic criteria for the condition (Jeng, 2003). However, the exact nature of this relationship is controversial, and has been debated extensively in the literature.

Psychoanalysis provided one of the first approaches to the interplay between physical and emotional functioning. Freud argued that some physical symptoms are best understood in terms of unconscious mental conflict. He asserted that thoughts and feelings too uncomfortable to allow into consciousness seek an outlet and may emerge as physical symptoms (Turp, 2001). Other theorists have suggested that emotional distress is linked to physical symptoms through autonomic arousal, vigilance and misinterpretation (Dersh, Gatchel & Polatin, 2002). Regardless of the mechanism, Miller (1990) proposed that pelvic pain in particular may be the physical expression of unresolved tension and emotional problems.

Silverstein (1989) suggested that vaginismus may be a symptom of emotional distress, representing a defensive need to protect oneself and provide boundaries. This implies that women suffering from vaginismus do not feel safe to be open emotionally or physically. Vaginismus is therefore viewed as a defensive bodily response to emotional pain. For this reason it is suggested that women suffering from vaginismus may be cut off from their emotions. Friedman in Jeng (2003) also conceptualised vaginismus as a physical defense, but suggested that it arises from the inability to deal with conflicting feelings about sexuality.

Conversely, Beard (1998) suggested that patients suffering from vaginismus may experience certain emotional states as a result of the condition. He identified emotional anguish as being prominent in women who suffer from vaginismus. Fordney (in Jeng, 2003) concurred, proposing that fear and anxiety arising when confronted with coital attempts or vaginal examination are the dominant emotional states in vaginismus.

According to Robinson (2003) young women with sexual dysfunction also identify significant feelings of sadness. Christie and Mellet (1981) suggest two possible

explanations for this observation. They propose 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, worsening the experience for such women. Robinson (2003) also identified frustration as a prominent emotion highlighted by women suffering from sexual dysfunction.

Whilst there is much literature that supports a relationship, regardless of its nature, this finding has not been consistent in all the literature. For example, Amsel et al (2003) found that women with vaginismus do not demonstrate increased levels of psychological distress.

B) PERSONALITY

Personality may be described as ‘a person’s relatively consistent way of thinking, feeling, reacting and behaving’ (Davison & Neale, 1998, p. 15). Studies have shown a link between personality and health (Frandsen et al, 2002). In particular, several personality traits have been shown to play a significant role in influencing the severity of pain and associated behaviour. Consequently, certain researchers have attempted to establish a relationship between personality and vaginismus, a condition clearly associated with the experience of pain (Jeng, 2003).

Several personality types have been associated with vaginismus. Barnes (1986) found that obsessive-compulsive personality types may be prone to vaginismus. Certain clinicians have also suggested that vaginismus sufferers may display neurotic or hysterical type personalities (Barnes, Doherty & Kennedy, 1995). 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.

Cooper (1969) found high levels of general anxiety in women with vaginismus (Cooper in Kabakci & Tugrul, 1997). Robinson (2003) and Silverstein (1989) suggested that such

women are often found to have other fears and phobias. However, Barnes, Doherty & Kennedy (1995) as well as Duddle (1997) found that women with vaginismus fell within the normal range on aspects of personality associated with neurotic anxiety, albeit the extreme end of the range. Robinson (2003) found that many women suffering from vaginismus express the need for high degrees of control in their lives. She reported that such women may either struggle to be in control of their lives, or fear losing control over their feelings and behaviour.

However, it is not clear whether these characteristics are reflective of a personality type that is prone to vaginismus or rather is a consequence of the experience of such a disorder. Clement & Pfafflin (1980) suggest that serious sexual dysfunction impacts adversely on the general personality and emotional stability of the patient (Clement & Pfafflin in Barnes, Doherty & Kennedy, 1995). Despite much conjecture, attempts to confirm a specific personality type of vaginismus sufferers have consistently failed when investigators used standard personality inventories (Duddle, 1977, Kennedy, 1995 in Jeng, 2003).

C) SELF ESTEEM

According to Frandsen et al (2002), perceptions of self clearly incorporate self esteem, and thus it was felt necessary to consider this dimension in the study. Self-esteem refers to the degree to which people like or dislike themselves. However Frandsen et al (2002) suggested that in addition to thoughts about self, self-esteem incorporates feelings about one's capabilities, goals, as well as one's place in the world.

According to Hinchliff & Gott (2004), rewarding sexual relationships have a positive influence on an individual's sense of self and overall well-being. Conversely, sexual problems impact negatively on how young women see themselves (Robinson, 2003). 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 and begin to doubt themselves and their capabilities.

In this regard, Jeng (2003) discussed vaginismus specifically, suggesting that self-esteem may be affected by unsuccessful attempts at having intercourse, which may induce a sense of failure. Carosella & Lackner (1999) relate self-esteem to the notion of control. They suggest that weak convictions of control regarding the condition may contribute to a poorer self-esteem. 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, despite the fact that they often present as competent and confident.

Other research has focused on the issue of the pain in relation to self-esteem, rather than focusing on the condition itself. 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; Carosella, & Lackner, 1999; Christie, 1981; Estlander, Moneta, Kaivanto, & Vanharanta, 1994; 2003).

Bayer-Rots, Bekker & Peters (1989) proposed a different relationship. They suggested that low self-esteem may be somatised as pain, particularly in the pelvic region. Psychoanalytic theorists, however, conceptualise the relationship as cyclical. It has been suggested that the early experience of pain may play a role in the formation of the ego and by extension, the development of self-esteem. Extensive use of pain inflicted by parents, as with physical cruelty and abuse, may contribute to the formation of a cruel, unyielding superego. In such cases, a chronic sense of guilt and low self-esteem may develop, and later in life the experience of pain may be used as a means of expiation and tension reduction (Sternbach, 1978).

E) FEMININITY

Tyson & Tyson (1990) define femininity as the ‘psychological configuration that combines and integrates personal identity and biological sex’ (Tyson & Tyson, 1990, p.326). Thus, a comprehensive exploration of a woman’s sense of self incorporates her understanding of what it means to be a woman. Whilst this study focuses on the individual woman’s notion of femininity, different levels of understanding have been elucidated in the literature.

Auster & Ohm (2000) suggested that the construct of femininity may include overt characteristics, i.e. external, visible manifestations of femininity, such as one’s appearance, as well as observable interests and behaviours. Tyson & Tyson (1990) concur, suggesting that the female’s sense of gender identity is associated with her narcissistic investment, namely her pride about her body as well as herself as a feminine being. Various trends have been highlighted in the literature in this regard.

Fredrickson & Roberts (1998) proposed that negative perceptions of physical appearance, which include assessments of physical attractiveness, sex appeal and weight, may lead to high prevalence of sexual dysfunction amongst women. Kabakci & Tugrul (1997) also identified body image as being relevant to sexual dysfunction. Conversely, Robinson (2003) found that many women suffering from sexual dysfunction do not view themselves as feminine. Robinson suggested that such conditions may lead to negative perceptions of one’s body and overall appearance. Such women have also been found to develop an obsession with weight and hygiene. These trends, however, have not been identified specifically in women with vaginismus.

In addition, Auster & Ohm (2000) suggest that there are many aspects related to femininity that are not observable. These include attitudes and meanings attached to femininity that may be specific to each woman. Tyson & Tyson (1990) proposed different levels of conceptualisation, describing both conscious and unconscious manifestations of femininity.

According to psychoanalytic thought, femininity is inextricably tied to sexuality (Tyson & Tyson, 1990). Consequently, the development of vaginismus, a sexual dysfunction, is also viewed in this light. The condition is therefore explained as the physical expression of a woman's unconscious wish to frustrate a man's sexual desires or more specifically her wish to castrate him (Jeng, 2003).

This viewpoint is connected to the belief that feminine development, based on anatomical difference, involves penis envy. In some cases envy may manifest as hostility toward men and an unconscious wish to castrate them. Allowing themselves to be penetrated is thus a reminder that men have what they do not, an experience that confronts them with painful feelings of envy. By unconsciously preventing penetration the male partner is frustrated (symbolically castrated), while the woman is spared suffering the experience of having what she envies enter her. According to this theory, if women do not resolve their penis envy, they may develop vaginismus in later life. While vaginismus may serve the unconscious purpose of keeping out the penis, it should be noted that true vaginal spasm cannot be produced voluntarily and so cannot consciously be used by women to avoid intercourse (Jeng, 2003).

Another conceptualisation of femininity examines vaginismus within a socio-cultural context. Courtenay (2000) suggested that health-related beliefs and behaviours, like other social practices that women engage in, are a means of demonstrating femininities. This theory proposes that health behaviours are used in daily interactions in the social structuring of gender and power. This viewpoint has also been endorsed with regard to vaginismus. The condition is believed to represent a feminine protest of sexual agenda (Reissing, 1999), or perhaps reaction to traditional female roles that require self-sacrifice and compromise (Barnes, Doherty & Kennedy, 1995; Dear and Roberts, 2002).

As has been elucidated, the literature incorporates different understandings of the relationship between femininity and vaginismus. However, this study focuses on subjective experience, and how women suffering from vaginismus perceive their own femininity.

1.3 SIGNIFICANT RELATIONSHIPS

According to Popovic (1995) close, satisfying relationships are crucial to happiness, emotional functioning and health. In fact, certain research has suggested that both psychological and physical health are intimately connected with the interactions with significant people in one's life (Graham in Hunt, 2002; Hunt, 2002). By implication, this social context forms an integral part of illness as well (Frandsen et al, 2002). It is therefore believed necessary to explore women's perceptions about their significant relationships as experienced throughout their lives. However, this study limits this exploration to relationships with intimate partners, as well parental figures.

1.3.1 INTIMATE RELATIONSHIPS WITH PARTNERS

Given the fact that vaginismus is a sexual dysfunction, perhaps the most obvious social factor to consider is the vaginismic woman's relationship with her partner (Barnes, Doherty & Kennedy, 1995). This study aims to explore both the qualities of chosen partners as well as relationship dynamics.

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). This is an important point to consider. If there is a discernable pattern in choice of partner this may have an effect on the type of relationship experienced by such women.

Dawkins and Taylor (1961), Gindin & Resnicoff (2002), and Silverstein (1989) suggested that husbands of women with vaginismus tend to be passive, overprotective and afraid of their own aggressive sexuality. These findings are consistent with Kennedy (1995) who emphasised the 'gentleness' of these partners (Kennedy in Kabakci & Tugrul, 1997). A psychometric study by Barnes, Doherty & Kennedy (1995) found that vaginismic women tend to chose male partners who are 'reserved rather than outgoing,

sober rather than happy-go-lucky, shy rather than venturesome, trusting rather than suspicious, and tense rather than relaxed' (Barnes, Doherty & Kennedy, 1995, p.11).

Kabakci & Tugrul (1997) evaluated the reaction of men to their partner's having vaginismus. The researchers suggested that these husbands tended to be considerate and helpful towards the dysfunction, with almost one third of them showing no overt negative reaction to non-penetrative sex. However, such partners tended to have a relatively high frequency of sexual dysfunction themselves.

B) RELATIONSHIP DYNAMICS

There is considerable literature on the connection between interpersonal relationships and sexual activity in couples. Some researchers (Hartman, 1980; Hartman & Daly, 1983; Metz & Dwyer, 1993; Rust, 1988) argue for independence between these two factors, whilst others (Ables & Brandsma in Kabakci & Tugrul, 1997; Dawes & Howard, 1976; Daya et al, 2001; Epstein & Metz, 2002; Frandsen et al, 2002) argue for an association.

Of the latter, some advocate that problems related to attitudes, needs and responses within a relationship may lead to sexual dysfunction (Daya et al, 2001; Frandsen et al, 2002). Christie (1981) also suggested this connection between marital and gynecological problems. She proposed that problems in a marriage may result in the wife feeling hurt and losing her erotic sensitivity. This emotional pain may then take an organic form in the relevant body area. One may relate this to vaginismus specifically. The condition has been described as a protective mechanism or response to emotional pain (Silverstein, 1989). It is therefore possible that vaginismus may develop as a defense against an unhappy relationship. However, no literature pertaining specifically to vaginismus could be found and this is merely conjecture.

Conversely, Jeng (2003) suggested that vaginismus may affect the relationship because women and their partners are unable to enjoy intercourse. For this reason, Jeng suggests that couples who cannot consummate a sexual relationship are amongst the most stressed seen in clinical practice, and the ones most grateful when successfully helped.

However, it is also believed that sexual dysfunction may exist in the absence of significant relationship problems (Metz & Dwyer, 1993). Rust (1988) found that female sexual dysfunctions were not particularly intrusive with regard to the couple's relationship (Rust in Kabakci & Tugrul, 1997). Moreover, several studies have found that couples with sexual dysfunctions may experience greater general satisfaction with their relationship (Hartmen, 1980, Metz & Dwyer, 1993, Reissing, 1999).

Several reasons have been suggested for this. Sexual dysfunction may provide a distressed couple with an attributional strategy, allowing them to perceive and explain their problems in a functional way (Hartmen, 1980). Sexual dysfunction may also serve to insulate a relationship from more generalised distress (Metz & Dwyer, 1993). However, a study by Hawton & Catalan (1990) found that greater relationship satisfaction was only achieved in couples seeking treatment. Focusing specifically on vaginismus, they proposed that a lack of appropriate treatment often resulted in couple difficulty and, in many cases, lead to separation or divorce.

The literature is thus divided. However, this study aims to explore how vaginismic women perceive their intimate relationships, as well as their beliefs regarding association. As directed by literature, an exploration of their narratives will include the following aspects.

B1) INTIMACY

Intimacy is an essential factor in relationship quality, stability and satisfaction (Popovic, 2005). Therefore, it is believed to be an important factor to explore in this study. According to Popovic (2005), the construct of intimacy incorporates two elements. Physical intimacy refers to the sharing of physical affection as well as sexual activity. This aspect is relevant given the fact that vaginismus is a sexual dysfunction, thus inhibiting certain sexual acts. Emotional intimacy refers to experiencing 'feelings of closeness, of being listened to, understood and free in expressing oneself.' The term is further associated with 'deep privileged knowledge' of one's partner (Popovic, 2005, p.35). Both aspects of intimacy are explored in this study.

With regard to physical intimacy, Kabakci & Tugrul (1997) found that women with vaginismus do not have frequent sexual contact in their relationships. According to Jeng (2003), this may result from their inability to enjoy intercourse, which may lead to an avoidance of intimacy altogether. Snyder and Berg (1983) suggest that this may extend to an avoidance of physical affection as well (Snyder and Berg in Cobain & McCabe, 1998). Conversely, low levels of affection within a relationship have been found to contribute to sexual dysfunction (Cobain & McCabe, 1998). Regardless of the nature of this relationship, women suffering from vaginismus have been described as showing little sexual curiosity as well as not being very sensual during sexual interaction (Kabakci & Tugrul, 1997).

However, Gindin & Resnicoff (2002) did not concur. They found that sexuality was rarely completely absent in women with vaginismus, suggesting that many had a rich sexual life without coital penetration. Once again, there are contrasting ideas in the literature with regard to the relationship between physical intimacy and sexual dysfunction.

This is also the case with emotional intimacy. Certain research has suggested that sexual dysfunction intensifies emotional intimacy. According to Gindin & Resnicoff (2002), vaginismic couples often reach a deeper intimacy when knowledge of the dysfunction is only shared amongst the couple. This secret which bonds them, often hidden from family and close friends, paradoxically strengthens the relationship. However, there is also 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 (Lorber and Moore, 2002; Flor, Turk & Rudy, 1989). It is recognised, however, that sexual dysfunction may be more sensitive to talk about than other medical conditions.

B2) COMMUNICATION

Communication between partners plays an important role in the general quality of the relationship as well as sexual functioning (Kelly, Strassberg & Turner, 2004). According to Ahvenainen, Koskenenvuo, Helenius, Ojanlatva, & Rautava, (2003), sexuality involves communication, perhaps more than other areas of life. This aspect of relationships will therefore be explored in the study.

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). In fact, problems in communication are among the most common complaints presented by couples seeking marital therapy (Fowers, 2001; Halford, Hahlweg & Dunne, 1990; Kelly, Strassberg & Turner, 2004; Schmaling & Jacobsen, 1990). This view was not consistent in all the literature. A study by Hawton & Catalan (1990) 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 to note that both couple and sex therapy incorporate the issue of communication, regarding it as an important aspect of the relationship to address. Epstein & Metz (2002) advocated that a communication process which allows the couple to solve problems constructively is essential when treating sexual dysfunction.

B3) CONFLICT

Conflict is inevitable amongst couples. Nevertheless, the way in which conflicts are handled plays a major role in relationship satisfaction (Epstein & Metz, 2002; Hartman, 1980). Conflict can allow couples to deepen their emotional and sexual intimacy. A respectful, affirming process of conflict resolution gives couples confidence that future arguments can be positively resolved. The presence of unresolved conflict, however, can

be detrimental to the stability of a relationship (Epstein & Metz, 2002). This aspect of relationships is therefore important to explore in the study.

The issue of conflict is believed to be particularly significant, given the strong association between relationship conflict and sexual dysfunction that has been identified in the literature (Epstein & Metz, 2002; Hartman, 1980; Hof, 1987; McCarthy, 1999; Metz & Dwyer, 1993). According to Hartman (1980), conflict may cause or maintain sexual dysfunction as well as influence the outcome of therapeutic interventions for sexual problems. Certain investigations have suggested that couple difficulties such as infidelity and conflict may result in or contribute to vaginismus specifically (Chisholm, Lamont, Shortle & Jewelewicz & Weiner in Reissing, 1999.)

This issue is believed to be so significant that many therapists, such as Slowinski (2001), have incorporated couple therapy into the treatment of female sexual dysfunction. This includes discussing the couple's coping strategies with sexual frustration as well as their decision-making and negotiating skills. However, one needs to explore the nature of the relationship between conflict and sexual dysfunction. Several possibilities have been proposed in the literature.

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. Conversely, sexual dysfunction, which may at times have a physical cause, can undermine a couple's overall sense of intimacy. This may create a negative atmosphere for resolving conflicts in the relationship. Sexual dysfunction may also be symptomatic of a larger relationship problem. 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).

However, it is also acknowledged that sexual dysfunction is not synonymous with conflict. Some couples can successfully manage the distress concerning sexual

dysfunction, allowing themselves to sustain overall relationship satisfaction (Epstein & Metz, 2002). Kabakci & Tugrul (1997) found that conflict, related to vaginismus specifically, was not generally prevalent. They suggested that husbands with wives suffering from vaginismus were not particularly dissatisfied with the dysfunction. These husbands appeared to accept the problem and find ways to cope with it. This is consistent with the personality profile of men chosen as partners by vaginismic women.

1.3.2 EARLY PARENTAL RELATIONSHIPS

There is a growing opinion that patterns of interpersonal relatedness throughout one's lifespan are intimately connected to the quality of childhood experiences (Bowlby, 1980; Crandell & Fisher, 1997). This study therefore demands an examination of early relationships. The parental relationships experienced by women suffering from vaginismus will therefore be explored. Several theoretical frameworks will also be examined.

A) QUALITIES AND RELATIONSHIP DYNAMICS WITH PARENTAL FIGURES

The mother is usually considered the primary caregiver, as she predominantly attends to the children, particularly during infancy. Healthy sexual processes are first introduced by mothers through the potentially erotic encounters of the nursing process (Ahvenainen et al, 2003). Further, early identifications with the mother are suggested as being essential to a woman's sense of being female (Tyson & Tyson, 1990). An exploration of the maternal relationship is therefore essential.

Various themes have been identified in the literature. 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 among women. Hiller (1996) described the possible impairment of sexual functioning that may result from a mothering approach that is over-intrusive and lacking clear boundaries. Addressing vaginismus specifically, Gindin & Resnicoff (2002) suggested

that women with vaginismus may have had authoritarian mothers who imposed on them the belief that sex was sinful.

Conversely, 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 is not easily accepted. The notion of identification is also suggested by the finding that, in some cases, the mother may have suffered from vaginismus herself.

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. 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.

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. In addition, Barnes, Doherty & Kennedy (1995) pointed out that sisters of vaginismic women do not necessarily suffer the same fate, despite having had the same parental figures.

1.4 CHAPTER SUMMARY

It is important to recognise that little progress has been achieved in understanding vaginismus. The condition has not been well researched. However, there may be another reason for the lack of clarity around the condition. Despite attempts at establishing aetiological factors, as well as profiles of women suffering from vaginismus and their significant relationships, no consensus could be found in the literature on almost any issue.

Several aetiological factors have been elucidated. However, for each one there is support and criticism. It is interesting that many of the proposed causal factors involve childhood experiences or influences. These include misinformation about sex, and sexual guilt resulting from conservative or strict upbringings. These factors highlight the importance of exploring early relationships, as they appear to impact on sexual functioning and, some may argue, the development of vaginismus. Other factors involve the element of fear, and consequently the need to protect oneself from the feared stimulus by avoiding sexual intercourse. This is seen with the fear of pain and pregnancy. Similarly, proponents of sexual violation as a causal factor, conceptualise vaginismus as a protective mechanism against expected sexual intrusion.

The literature has also attempted to investigate if there are characteristic features of women suffering from vaginismus. Trends have been highlighted, but never without contention. The literature is also divided as to whether certain features predispose women to developing vaginismus, or whether they are resultant from having the condition.

An exploration of possible profiles of intimate partners as well as parental figures has been attempted. Certain qualities have been found to be pervasive. For example, research suggests that vaginismic women tend to choose men who are passive and gentle. Certain parental qualities have also been suggested. Despite this, there is little agreement with regard to the relationship dynamics experienced by vaginismic women.

The lack of consensus and clarity does indeed suggest the need for more research to enable a better understanding of the condition. However, this may also be indicative of the fact that vaginismus does not have a universal profile. There may not be one clear aetiological mechanism. Women suffering from the condition may not have set characteristics, relationships or even experiences. Nevertheless, this does not exempt the research community from their responsibility to explore what appears to be a complex phenomenon.