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Case Report

Vaginismus: An Approach from Biology to Psychological Aspect

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Abstracts

Introductions: The prevalence of vaginismus ranges from 1%–6%, and the ratio becomes 5%–17% in the clinical setting, although it varies widely worldwide. The main cause of vaginismus is unknown but is often considered multifactorial. This paper aims to describe the psychological aspects that contribute to vaginismus. **Case:** A 26-year-old married woman complained about not being able to have sexual intercourse. About 1 month ago, since marriage, the patient was unable to have sexual intercourse with her husband. The patient feels guilty and anxious because of her inability to please her husband. The patient's father was very dominant and was a "religious" type of parent who always advised with religious aspects regarding all matters. The patient's mother was a nervous person and always said that what the father said was a law that had to be followed. Likewise, talking about sex is a taboo topic of discussion and is considered embarrassing. **Discussions:** Many factors need to be explored related to vaginismus. In this case, the biological aspect can be ruled out because the patient has consulted with an ob-gynecologist. From the psychological aspect, perceptions, attitudes, and attitudes towards sex, as well as the values held by parents, contribute to vaginismus in this patient. **Conclusions:** A therapeutic approach that focuses on all aspects promises quite good therapeutic outcomes.

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Introductions

The sexual function of a human being is an important component of life. The presence of sexual disorders, or what is commonly referred to as sexual dysfunction, can affect all aspects of a person's life, including quality of life, the potential for procreation, and interpersonal relationships [1,2]. Vaginismus, one of the common sexual dysfunctions in women, is defined as the inability of the vagina to be penetrated or painful penetration due to the continuous, involuntary contraction of the pelvis [3,4].

Currently, in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), the terminology vaginismus is included in the category of Genito-Pelvic Pain Disorder/Penetration Disorders (GPPD) along with dyspareunia. The prevalence of vaginismus ranges from 1%-6%, and the ratio becomes 5%–17% in specialized sexual dysfunction clinics, although it varies widely worldwide [5,6]. In Turkey, the prevalence of vaginismus is reported to be higher, at around 41%–58% [7,8]. While in Italy, Portugal, and Iran, it ranges from 7.8%, 6.4%, and 33% [9–11].
Vaginismus is often underdiagnosed and undertreated [3,4,5]. This is due to many factors, including the fact that the primary cause of vaginismus is unknown, many patients do not seek treatment out of fear of a gynecological examination or feeling embarrassed, and variations in diagnosis methods. Some studies have found that examining patients from a broader perspective improves therapeutic outcomes [12]. The interaction of all aspects that may contribute needs to be explored to obtain a better prognosis [12]. This case report aims to describe the psychological aspects that contribute to the occurrence of vaginismus, especially in a young patient.

Case

A 26-year-old female health practitioner who had been married for a month complained about not being able to have sexual intercourse since getting married. Despite adequate foreplay and preparation to create a conducive environment for sexual intercourse, the patient experienced intense anxiety during penetration attempts, and thus penetration was unsuccessful. According to her husband, when they attempted to have sexual intercourse, the patient appeared tense and fearful. The patient believed her husband understood her condition and never forced her to have sexual relations, but this made her feel guilty and worsened her anxiety due to her perceived inability to please her husband. When she tried to have sexual intercourse, she was afflicted by the fear that she would fail and would not be able to satisfy her husband. The patient was also worried about her inability to have children in the near future. An assessment by an obstetrician-gynecologist revealed no structural abnormalities. There was no previous psychiatric history, and this was the patient's first visit.

The patient married her husband about a month ago consensually after knowing each other for 6 years. Her husband was described as patient, loving, and understanding by the patient. The patient's husband always supported her and gave her control over the pregnancy. Because of her upbringing in a religious family, the patient rarely discussed the subject of sex with her husband as it made her feel awkward. The patient's father was an authoritarian figure who imposed his religious values on all aspects of their family life. Significant emphasis had been placed on a woman's "awrah," or the parts of a person considered private and covered by the Islamic religion, as well as the associated penalties for any form of violation. The patient's mother was a nervous person who always said that the father's word was law and that it had to be followed. The same was true for discussing sex, which was a taboo subject and was considered disgraceful. Behavior thera-

py, education, and situational anti-anxiety medications were used to treat the patient.

Discussions

The preceding case illustration demonstrates that vaginismus is a complex condition that must be assessed from multiple perspectives [12,13]. Currently, research on the pathophysiology of vaginismus focuses on the interaction of biological and psychological aspects, involving genito-pelvic and central areas, including the autonomous pathways, chronic pain pathways, and the limbic system. The pathology of pelvic floor dysfunction, pelvic genitourinary reflexes, pain experiences, and cognitive-affective factors are hypothesized to contribute to vaginismus [14]. The organic abnormalities that can cause vaginismus include hymen abnormalities, vaginal anomalies, vaginal atrophy, and adhesion, either primary or secondary due to surgical action, uterine prolapse, infection, tumor, or pelvic congestion [12,13,14].

Based on the hypothesis of the genito-pelvic reflex theory, vaginismus occurs due to the presence of stimuli on the pain receptors that activate the contraction of autonomous reflexes [14]. Inadequate contraction and relaxation of the pelvic floor muscles occur as a way to protect from pain caused by infectious processes, trauma, stress, or anxiety. This contraction occurs continuously so that it causes damage to the submucosa layer and stimulates pain receptors located in the area. Stimulation on such receptors will subsequently induce the autonomic reflex contraction, which ultimately makes it impossible to penetrate [14].

From a psychological perspective, vaginismus is also frequently associated with anxiety or fear that arises due to past negative experiences that were traumatic, either directly experienced or heard about from other people's experiences [15]. This experience can be in the form of sexual or emotional experiences, such as physical violence, sexual violence, the experience of feeling pain during sexual intercourse or gynecological examinations, or interventional procedures of the genital area and its surroundings, for example inserting a catheter or administering enemas and suppositories [12,13,15].

Negative experiences (including pain) will be remembered as catastrophizing, causing an anticipatory fear of penetration. This fear will stimulate the autonomic nervous system to cause vaginal muscle spasms and avoidance behavior during sexual intercourse [16,17]. Negative experiences, on the other hand, that are recurring or significant, will activate the limbic system, which indirectly innervates the pelvic floor muscles. The limbic system will become more sensitive to pain or external genital manipulation, making it easier to induce pelvic muscle contractions [18,19]. Perceptions, attitudes, and beliefs about sex and sexuality all play a role in vaginismus. One of the factors that influences patient perceptions and beliefs is sex and sexuality education. The majority of the patients with vaginismus do not possess sufficient sex-related information. While some are receiving misinformed sex-related information [12,13]. The emergence of negative perceptions and beliefs about sex will trigger feelings of fear and guilt when doing or thinking about sex, so they choose to avoid everything related to sex, including sexual intercourse. Parental values (such as moral, cultural, and religious values) also play a role in sex-related information and education transfer to children [20].

The identification process of a child with their parents will make children have similar thoughts and values to their parents [12,21]. This certainly needs serious attention because it might affect efforts to seek treatment if one experiences sexual problems [22]. When viewed from the dynamics of family relationships, patients with vaginismus have a pattern of emotionally distant, confused, and misaligned family

relationships [12]. Mothers have negative perceptions and beliefs about sex and do not provide clear information regarding sex and sexuality. The mother is viewed as a weak figure by the children, who regard men as dominant figures [12]. Meanwhile, the father is a dominant figure, overly controlling, overly protective, and moralistic, and he has an unfavorable relationship with the mother [12,13,21]. Patients with vaginismus typically have submissive personalities, are unable to express their emotions, and subconsciously believe that their emotions cannot be tolerated, making them feel insecure if they are more open, either physically or emotionally. They also have a bad self-image and require constant approval [12].

Concerning the dynamic aspects of the case, one must consider three things that may come into play. Those three are drive, wish, and motive. Looking into her drive, what's already known about the patient was that the biomedical cause of vaginismus may have been dismissed. What should be explored further was the psychic sexual drive. The patient seemed verbal about how she viewed sexuality in light of norms and ideals. That was, she viewed sexual intercourse as something to be done in serving her idealistic view of a faithful wife. In contrast, the patient never explored her fantasies and wishes, and how she expected her sexual life privately. This might be hypothesized as a denial of her own sexual needs, and therefore provide a blockade to her satisfaction, thus preventing the individualistic goals of therapy.

As a medically trained individual, cognitively, the patient had known what role sexuality played in one's health. This might promote the conscious effort to brighten her sexual marital life. This might provoke her behavior to seek professional help. And as an individual with a strict religious upbringing, idealistically the patient had known what role a wife played in sexual marital life. It might be hypothesized that these two factors to her wish (cognitive and idealistic) were negating her aspects of sexuality. Considering how she perceived sex as shameful, and that shame was an effect brought forward by the superego, there might come consequences, such as how the patient might only view sex as a means to get her marital life accomplishment, furthering the distance she made with personal satisfaction. Thus, after achieving her marital goal (to become pregnant), she might cease therapy altogether.

The relationship with the partner should also be explored. The partner's personality and the pattern of their relationship were factors that can both cause and be affected by them. A partner who is incompetent, anxious, overly patient, or has a history of sexual problems usually exacerbates vaginismus, whereas many vaginismus patients prefer partners who are passive and not assertive [12,13]. In marital relationships, vaginismus can occur as a result of marital conflict (e.g., an affair), or it can trigger marital conflict, potentially leading to separation [22–24].

In terms of the case, the relationship pattern between the patient and her husband might be related to unconscious object relations. Her early experience of viewing a husband figure, as with many persons, was her father. She had a father whose religious zeal excels in their daily life and taught her the ideals of life, thus risking an emotional distance from his daughter. This religious zeal accompanied by a lack of emotional connectedness paved the further way for how she relates to her husband: a view of an idealistic and faithful wife with less to no individualistic fervor. And this might yet again strengthen a view of sexual intercourse that excluded her own sexual needs. All three dynamic aspects (drive, wish, and motive) above led the patient to experience ambivalence. She did not feel the need to seek pleasure from sexual intercourse. The only feeling verbalized was a sense of embarrassment. But as a wife (who strives to

achieve ideal quality), she felt compelled to engage in sexual intercourse as a means of devotion to her husband and to provide children to their familial life. These conflicting views provided an anxious attitude towards sexual intercourse: shameful activity, but obligatory nonetheless.

Conclusions

Vaginismus is a complex sexual disorder that can affect all aspects of life, both for the patient and their partner. Many aspects need to be explored further to plan effective therapeutic modalities for patients. Even though the exact cause of vaginismus is unclear, a therapeutic approach that focuses on all of the above aspects promises a fairly good therapeutic outcome.

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Not Declaration

Conflict of interest

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