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Is Vaginismus a Cause of Infertility?: Case Reports Observed in Clinical Practice

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ABSTRACT

Vaginismus is a common female sexual dysfunction in society. It is observed that society's expectations about women's sexuality and fertility may particularly affect women with vaginismus. The psychological meaning of childlessness for women is the inability to give birth, loss of control, psychological deficiency, feeling outside the female society, feeling worthless, being alone, lack of social security, lack of social role, and a decrease in self-esteem. In this case series, three couples who could not have children due to vaginismus consulted an obstetrician and underwent invasive procedures, such as in vitro fertilization (IVF) and cesarean section (CS). However, the primary problem, vaginismus, remains untreated and may have even worsened. If pregnancy does not occur because of vaginismus, couples should first be referred to a sexual therapist for appropriate treatment for vaginismus. It is both unethical and malpractice to view these couples as a source of income and subject them to unnecessary procedures like IVF and CS.

Keywords: Vaginismus, infertility, sexual dysfunctions, IVF.

ÖZ

Vajinismus Kısırlık Nedeni midir? Klinik Pratikte Gözlemlenen Olgu Raporları

Vajinismus, toplumda yaygın olarak görülen bir kadın cinsel işlev bozukluğudur. Toplumun kadın cinselliği ve doğurganlığı hakkındaki beklentilerinin özellikle vajinismus yaşayan kadınları etkileyebileceği görülmektedir. Çocuksuzluğun kadınlar için psikolojik anlamı; doğum yapamama, kontrol kaybı, psikolojik yetersizlik, kadın toplumunun dışında hissetme, değersizlik, yalnızlık, sosyal güvenlik eksikliği, sosyal rol eksikliği ve öz güven azalması olarak ifade edilmektedir. Bu olgu serisinde, vajinismus nedeniyle çocuk sahibi olamayan ve bir kadın doğum uzmanına başvurarak tüp bebek ve sezaryen gibi invaziv işlemlere maruz kalan üç çiftten bahsedilmektedir. Bu olgularda, birincil sorun olan vajinismus tedavi edilmemekte ve hatta kötüleşebilmektedir. Eğer vajinismus nedeniyle gebelik gerçekleşmiyorsa, çiftler öncelikle vajinismus için uygun tedaviyi almak üzere bir cinsel terapiste yönlendirilmelidir. Bu çiftlerin gelir kaynağı olarak görülmesi ve gereksiz yere tüp bebek ve sezaryen gibi yöntemlere maruz bırakılması hem etik dışı hem de tıbbi bir hatadır.

Anahtar Kelimeler: Tüp bebek; kısırlık; cinsel işlev bozuklukları; vajinismus.

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INTRODUCTION

Sexuality is an essential element that affects human life in many ways. It is a complex process highly influenced by physiological, psychological, economic, social, cultural, and religious factors. Nowadays, although it is easier to express in developed societies, it is more challenging to speak in patriarchal societies. Although sexual dysfunction is prevalent in society for both genders, it

causes more psychological burdens in women than in men (McEvoy et al, 2021). Vaginismus is a common female sexual dysfunction in society.

The American gynecologist Sims first described vaginismus in 1861 and used the definition of "spasmodic contraction of the vaginal sphincter." Although it was initially thought that the size of the vagina caused vaginismus, it was noticed in the following years that the size of the vagina increased with stimulation because of the flexible structure of the vagina and that vaginismus was not related to vagina and penis size. Sims considered sensitivity to be genital-specific, whereas Waltard argued that spasm was a phobic response to pain (Walthard, 1909; American Psychiatric Association, 1994).

Vaginismus is among female sexual dysfunctions in the Diagnostic and Statistical Manual of Mental Disorders (DSM), fourth edition, and it is under the title of "genito–pelvic pain and penetration disorders" in the DSM, fifth edition (DSM-5). In previous classifications, it was defined as the absence of sexual intercourse due to muscle contraction, making it challenging to define cases of lack of intercourse due to pain, fear, and anxiety. With DSM-5, its scope has increased, and fear and anxiety have been evaluated as criteria (Lewis et al, 2004; American Psychiatric Association, 2013).

According to DSM-5, "genito–pelvic pain and penetration disorder" is defined as the presence of persistent or recurrent difficulties with one (or more) of the following situations for at least 6 months and causing clinically significant distress: (1) vaginal penetration during intercourse; (2) marked vulvovaginal or pelvic pain during vaginal intercourse or penetration attempts; (3) marked fear or anxiety about vulvovaginal or pelvic pain in anticipation of, during, or as a result of vaginal penetration; and (4) marked tensing or tightening of the pelvic floor muscles during attempted vaginal penetration (Lewis et al, 2004).

Vaginismus is a condition that can make conception difficult but is not a cause of infertility. Infertility, as defined by the World Health Organization, is the absence of pregnancy despite having regular and unprotected sexual intercourse for 1 year. There is no problem in terms of pregnancy potential in women with vaginismus. However, due to lack of sexual intercourse, the possibility of sperm cells reaching the fallopian tubes decreases, thereby reducing the probability of fertilization and pregnancy (Amidu et al, 2010).

Establishing prevalence rates for vaginismus is not exceedingly difficult for several reasons. In population-based surveys, relatively high prevalence rates are reported in Eastern cultures compared to Western cultures. For instance, in Iran (Oksuz & Malhan, 2006), Türkiye (Safarinejad, 2006), and Ghana (Laumann et al, 1999), the prevalence of women reporting sexual pain was 27%, 43%, and 68%, respectively, compared to 7% in America (Ventegodt, 1998) and 3% in Denmark.

It is seen that society's expectations about women's sexuality and fertility may particularly affect women with vaginismus. The psychological meaning of childlessness for women include the inability to give birth (functional disorder), loss of control (my body does not fit my wishes), psychological deficiency (inability to satisfy maternal instincts), feeling outside the female society, feeling worthless, being alone (emotional lack of support for children), lack of social security (no one to take care of in old age), lack of social roles (mother, pregnant woman, maternity, and mother-in-law), and a decrease in self-esteem (Oksuz & Malhan, 2006). A woman whose sexual life is disrupted; who experiences conflicts with partner, feelings of inadequacy, and psychological problems; and who cannot think clearly may pursue the possibility of becoming a mother, fearing that she will not be able to experience the feeling of motherhood that will fulfill her emotionally. In this process, vaginismus treatment may be overlooked, and the possibility of becoming a mother may be prioritized for several reasons (Rosenbaum & Padoa, 2012).

In such cases, couples seeking pregnancy typically consult gynecologists and obstetricians. However, these couples should be directed first to the appropriate treatment for vaginismus. Unfortunately, some unethical physicians resort to methods such as insemination and in vitro fertilization (IVF), which are commonly used in infertility treatment. Yet again, the primary problem, vaginismus, remains untreated and may even worsen, while unnecessary cesarean sections (CSs) further increase the birth rate (Goldsmith et al, 2009).

This report aims to emphasize the incorrect and unnecessary pregnancy treatment methods to which women with vaginismus are subjected. Three cases of vaginismus are highlighted, with the patient's consent obtained for the use of their personal data.

CASE REPORTS

Case 1

Mrs. B, a 26-year-old accountant, had been married for 2 years and had 1 child.

Despite attempting sexual intercourse with her husband for two years, they had not been successful due to pain and fear. Ashamed, kept their struggle hidden, and their relatives assumed that they were infertile. They did not seek professional support for this problem. The couple, who wanted to have a baby, consulted an obstetrician instead of being referred to a

psychotherapist for treating vaginismus. Consequently, an IVF trial was performed and she became pregnant on the second attempt. CS was preferred as the delivery method for patients who found routine pregnancy controls uncomfortable.

Mrs. B had not previously consulted a psychiatrist. During her first psychiatric examination, it was understood that her primary problem, unnecessarily brought to an obstetrician and gynecologist, was vaginismus. Mrs. B and her husband subsequently underwent cognitive behavioral sexual therapy with a psychotherapist. At the end of the seventh session, they were able to engage in sexual intercourse.

Case 2

Our 31 year-old-patient, Mrs. E, had been married for 4 years. She worked in a private educational institution as a teacher.

She had not engaged in sexual intercourse before marriage. After marriage, she exhibited a normal libido but she persistently refused sexual intercourse due to an intense fear of pain, often accompanied with screaming and crying before genital contact. As a result, they could not have sexual intercourse. Desiring to conceive, they consulted an obstetrician. The doctor suggested an IVF trial for pregnancy, which they accepted. She felt shy in front of nurses and doctors during her routine checkups during pregnancy with IVF. Ultimately, they successfully via IVF and now have a 13-month-old baby.

Despite having a baby, their sexual problems continued. Because of internet research, Mrs. E realized the need to consult a sexual therapist for her problem. She was diagnosed with vaginismus after therapist evaluation and subsequently began to have sexual intercourse after eight sessions of cognitive behavioral sexual therapy. After therapy, both she and her husband reported a satisfying sex life.

Case 3

Mrs. H, a 28-year-old young teacher, had been married for 3.5 years. She and her husband had challenging times throughout their marriage, because of her fear of sexual intercourse, preventing them from engaging in sexual activity. They also wanted to have a baby. The patient was stressed by her inability to conceive and faced mounting pressure from her in-laws to have a child. She had consulted a gynecology and obstetrics specialist, who diagnosed them as having primary infertility and proposed IVF to have a baby—her recent decision to stop working in attempts to conceive.

Pregnancy after the second attempt resulted in a cesarean delivery; however, the lack of sexual intercourse, even after giving birth, disappointed the couple.

This time, Mrs. H wanted to try sexual therapy but hardly convinced her husband to accept therapy. The treatment of the couple, who found healing in the seventh session of the cognitive behavioral sexual therapy, was terminated. After seven sessions of CBT, the couple could have sexual intercourse. The couple continued therapy to address marital problems, later conceived their second child naturally.

DISCUSSION

All three of our couples were fences who married willingly and loved each other, yet they struggles with vaginismus. They felt inadequate because they could not have sexual intercourse for a long time. Additionally, that feeling increased because they could not have children. They were incorrectly labeled with have primary infertility, due to ignorance and lack of proper guidance. They were unnecessarily subjected to IVF and CS. These procedures were both physically and mentally exhausting and were riskier than normal conception and childbirth. They were quite expensive too. Our patients described the procedures for IVF as "terrible," with hospital visits being embarrassing and experiencing intense pain and anxiety during the examination. They shared the regret of not consulting a psychiatrist earlier. The most important common point was that they had the happiness of having sexual intercourse using the cognitive behavioral sexual therapy method.

Despite the difficulties they faced due to their condition, women with vaginismus showed an increased desire to have children and aimed to become pregnant (assisted or spontaneously).

Prenatal care visits often represent the first gynecological examinations for these women (Achour et al, 2019). It is essential to create an environment where they can feel safe and provide adequate medical care for women with vaginismus. However, most affected women avoided pregnancy follow-up visits because they thought that the obstetrician would not understand their fear and pain (Möller et al, 2015).

Gynecologists should evaluate couples seeking for infertility treatment in detail. If pregnancy does not occur because of vaginismus, couples should first be directed to a sexual therapist. It is both unethical and malpractice for these couples to be seen as a source of income and to be unnecessarily exposed to modalities such as IVF and CS. In developed countries, it is considered appropriate to take a detailed psychological history before initiating infertility treatment (Möller et al, 2015). Of course, some couples will benefit from assisted reproductive techniques and CSs. Considering the high rate of CS in patients with vaginismus, obstetricians should pay special attention to the needs of these women. Care should

be taken to create a gentle pelvic examination, appropriate analgesia, and a reassuring atmosphere. While employing assisted reproductive techniques, it is crucial to consider several ethical principles, including individual autonomy, respect for human life and dignity, nonharming and beneficence, equality and justice, protection of the weak, noncommercialization of reproduction, appropriate use of resources, and balancing individual and collective interests (Möller et al, 2015).

CONCLUSIONS

There is a trend for couples who exhibit vaginismus in Türkiye to present late to a sexual therapist, preferring to consult an obstetrician first before seeking psychiatric attention. Of course, there may be couples who would benefit from assisted pregnancy. Close cooperation between obstetricians and psychiatrists would ensure the best outcome in the management of vaginismus. Thus, the problem will be resolved sooner, and fewer interventional procedures will be needed. Of course, infertility is not the only problem. A satisfactory sexual life is one of the most crucial factors affecting couples. It will be ensured that couples have more satisfying sexual lives through timely interventions.

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