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DOING VAGINISMUS:

ACTIVITY AND SELF-INTERPRETATION OF CLENCHING BODIES

-MASTER'S THESIS-

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VAGINISMUS: ''A WORD THAT NEITHER WORD RECOGNIZES''

In the last months, I have had conversations about my thesis with many friends, acquaintances and fellow students. Taking in account the number of people that knew what my research topic was (that I could count on the fingers of one hand), I believe I should start by providing the reader a definition of the issue. Vaginismus is a female sexual pain disorder[1]. The pain is due to vaginal tightness, caused by contractions of the pelvic floor muscles, especially the pubococcygeus (PC) muscle, that surrounds the outer third of the vagina. Depending on the degree of contraction, the muscles can make penetration of a penis, insertion of fingers, tampons or gynecological tools hard, painful or impossible. Despite claiming the etiology of vaginismus to be uncertain, in a review article Jeng (2004) groups potential causes into the following categories: misinformation, ignorance and guilt about sexuality, religious orthodoxy, organic pathology, sexual violation, fear of pain, personality[2], parents' relationship[3], the father–daughter relationship[4] and the couple's relationship[5]. The event that triggers vaginismus can occur early in a woman's life, making her unable to engage in penetration since her first attempts or later, after she has been able to have intercourse and perform other practices of insertion. In the first case, vaginismus is classified as primary, while in the second as secondary. Doctors consider both cases to be highly treatable, with progressive dilation (insertion of progressively bigger dilators), pelvic physical therapy and Botox injections (aimed to disable the muscles to contract) being the most common treatment methods.

The embodied, psychological and social implications that come along with vaginismus make it a very fruitful, yet poorly addressed, topic for social science research.

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[1] According to medical classifications, there are more female sexual pain disorders, some of which can cause, be cased by, or co-exist with vaginismus, but not necessarily (for example dyspareunia and vulvodynia). The symptom that differentiates vaginismus from other conditions is the muscle spasm, described in the next sentence.

[2] Here, drawing on feminist theories, Jeng lists fear of intimacy, a symptom of a defensive need to be closed, the woman's way of fighting back to gain the right to be coauthor of the sexual agenda, a covert signal protesting against the cast of sexual roles, or a symptom of a lack of self-defined boundaries. As he explains, "this theoretical approach views vaginismus as a defensive bodily response to emotional pain, but without the negative connotation of a sexual dysfunction. The physical defense may not be due to the experience and/or expectation of physical pain, but can represent a defense from emotional pain and unwanted 'intrusion' " (Jeng, 2004:13).

[3] They would have a "poor" relationship, in some cases daughters could hear their mothers being forced to have sex (Jeng, 2004:13).

[4] On one hand, "fathers of vaginismic women tended to be extremely critical, domineering, moralistic and threatening" and on the other, they could have been overportective (Jeng, 2004:13).

[5] Difficulties in the relationship with her partner, such as conflict, infedelity or untrust can cause vaginismus (Jeng, 2004:14)

THEORETICAL FRAMEWORK AND RESEARCH QUESTIONS

When the idea of this research was born, my interests were very broad. Since, from a social science perspective, vaginismus is a largely unexplored topic, I wanted to address both women's individual experiences and their navigation through the social world, including certain premises of the social world that are of importance in the context of vaginismus. In the initial elaboration of my research questions, I was inspired by Margaret Lock and Nancy Scheper-Hughes' "three bodies" model (1987). According to the authors, issues related to bodies have to be analyzed on three levels. On the first level, the *individual body* is "understood in the phenomenological sense of the lived experience of the body-self" (Lock & Scheper-Hughes, 1987:7). They emphasize two aspects that could be taken in account in this context, the first being Cartesian dualism, or the separation of body and mind (ibid:8). This dualism, despite being a social construct that emerged in a specific cultural and historical context, is usually perceived as "real" and "objective", and lays underneath most biomedical explanations of certain issues and individual embodied experiences. In both cases, "self" is constructed in relation to "mind" and "body". The second aspect is closely related to the construction of the "self" – body imagery. Distortions of bodily and mindful integrity may cause deviant body imagery, such as "neurotic anxieties about the body, its orifices, boundaries and fluids" (ibid:17)[6], which, according to the authors, are quite common and might be an interesting topic for medical anthropologists.

On the next level, the *social body* represents the body as a symbol which communicates something to other people, and can be interpreted in the context of a specific culture or society. In the case of vaginismus, it would primarily be related to how women symbolize their gendered and sexual aspects through their bodily practices. Finally,

> at the third level of analysis is the *body politic*, referring to the regulation, surveillance, and control of bodies (...) in reproduction and sexuality, in work and in leisure, in sickness and other forms of deviance and human difference (ibid:7-8, my emphasis).

This control does not occur only during times of crisis, it is a regulary practice in which societies "reproduce and socialize the kind of bodies that they need" (Lock and Scheper-Hughes, 1987:25), or in other words, cultures provide "codes and social scripts for the domestification of the individual body in conformity to the needs of the social and political

[6] Vaginismus would be an obvious example of an anxiety about one's orifice and its experience seemed to be interesting to explore in the context of the body-mind dualism (and others, as it will be discussed later).

order" (ibid:26). Many authors have argued how sexuality is used as a mean to control populations, especially through the equation of "real sex" with intercourse. This issue, of great importance for vaginismus, will be addressed later in more depth.

When this model is viewed as an analytical tool, the authors explain that

> the "three bodies" represent (...) not only three separate and overlapping units of analysis, but also three different theoretical approaches and epistemologies: phenomenology (individual body, the lived self), structuralism and symbolism (the social body), and poststructuralism (the body politic) (ibid:8).

Although I use the three bodies model as a framework, this paper will not be structured in line with the three bodies, neither will I analyze every level separately. In fact, during my fieldwork, the three units seemed to me to be more interwoven and overlapping then separate. I see their relationship in the way Giddens (1984) sees the connection between structure and agency. Structure is built by agency and in return, agency is limited by the very structure. Thus, through individual agency, people can either reproduce and maintain or change the structure. In the same way, personal bodily experiences and acts are greatly influenced by body politics, but through their bodily practices people can also challenge, question or even strive to change norms imposed by these politics. Meanwhile, the same practices are also symbols that send a specific message to other people.

In this line, my final research question became how women with primary vaginismus, maintain and challenge body politics through their bodily and narrative practices? I focus on narrative practices for two reasons. First, the way people talk both influences and is influenced by experience and second, talking in terms of "narrative practices" gives me the possibility to frame my question as "what women do" instead of "how do women experience", as experience of other people is usually hard or even impossible to grasp (see for example Wilkinson, 2006; Ellis, 1999). As a mean to answer this question, I pose two sub-questions. In one of the analytical chapters, I wonder what metaphors women use when talking about their experiences of vaginismus, while in the other I explore what women *do* because of and about vaginismus. Performativity and agency are taken as movers of both approaches, in one chapter by exploring women's "activity of self-interpretation" and reflections on agency regarding their mindful-bodily processes, and in the other by describing practices that vaginistic women actively and consciously engage in. These approaches are used to show vaginistic women's own engagement with their bodies and with the social world around

them[7], focusing on their *practices* rather then only *experiences*, that have been addressed by other authors. Finally, I saw it as a nice way to "tell women's stories" and "give voice" to persons that are rarely given the opportunity to speak about their problem.

METHODOLOGY: DATA GATHERING

The first big issue that emerged right after the idea of this research was born was – who would participate? Where could I find women willing to share their stories with me? Not surprisingly, taking in account the silence that surrounds vaginismus and its sufferers' quest for anonymity, there were no patient organizations or support groups that I could contact. Another way was to contact therapists specialized for the issue and try to get to their patients – an idea that did not sound that appealing to me since, I thought, these women might be very influenced by their therapist and they would all go through the same kind of treatment with the same person, and would all receive treatment in any case. I was hoping for a bigger variety of experiences then the one I could access through therapists.

It was an "eureka" moment when I recalled that, as people like to say, "if Google doesn't find it, it doesn't exist" and managed to find a support group through an online social network (OSG). Not only was it there, but quite a few members of the group seemed enthusiastic about the fact that someone wanted to write about their struggles.

The OSG is not run by a medical professional, but by women who are suffering or have suffered of vaginismus themselves and it counted around 400 members (MSG) during my fieldwork period. The administrators are very careful about who they let in – they always request a short introduction before allowing someone to become a member. Partners of vaginistic women are also allowed to join, although during my fieldwork I did not notice any of them (at least they were not participating in the discussions). Medical professionals are welcome to join as well, but only with the scope to advise and inform women – advertising their own practices is not allowed (as with partners, during my fieldwork there were no active medical professionals). As for vaginistic women themselves, there was a wide range of profiles. The youngest member, to my knowledge, is 16 years old, while the elder ones are in their fifties; there are cases of both primary and secondary vaginismus and different kinds of (perceived) causes[8], women from all around the world with different socio-cultural

[7] For the same reason, I chose to frame my question in line with Giddens and ask "how do women maintain the body politics" instead of asking "how are women influenced by body politics".

[8] Just to give some examples: religious upbringing, childhood abuse, abusive relationship, shocking break-up, childbirth, other health problems, and a lot of them with unknown reason.

backgrounds[9], more or less able to access information and therapy, women who chose different treatment types or self-treated, who were mothers or wanted to become ones really bad, and ones that did not wish to have children at all... A lot of them stayed in the group even after *overcoming*[10] vaginismus and were sharing their "success stories".

I chose to focus on women with primary vaginismus. The fact that they were never able to engage in penetrative sex (and, some of them, to use tampons and go through a gynecological exam) differentiates them in the experiential and biopolitical sense from women whose vaginismus is secondary. In other words, I assumed that the possibility or impossibility to refer to a personal experience of intercourse could make women with primary and secondary vaginismus use different kinds of narratives – about frustrations, motivations, perceptions of and expectations about relationships and their gendered experiences. For this reason, I felt that I should focus on one of these groups. The choice of primary vaginismus is only due to my personal interests and theoretical preferences[11].

Even though initially more women replied to my post in the OSG, at the end I managed to interview ten members and in the meantime I found two more participants through personal networks, which makes a total of twelve in-depth, semi-structured interviews, long 45 minutes to 3 hours. Three interviews were made in the "space of places" (Castells, 2005), six of them in the "virtual space" (i.e. via Skype) and to my last three informants I have sent a list of questions which they answered in a written form, followed by some additional questions after I read their answers (which was more suitable for several reasons).

Apart from interviewing these twelve women, I did (virtual) participant observation in the OSG for almost six months, following women's posts and discussions as well as occasionally participating in the discussions myself. I also followed blogs led by women experiencing primary vaginismus, watched documentaries and read articles about them (or written by them). Finally, part of my analysis is focused on medical conceptualizations of

[9] I do not think that this represents a problem or challenge for my approach. On one hand, this variety enabled me to notice the impact of background on on the choice of practices, as will be further discussed later. On the other hand, Ng (2007) argues that vaginismus is a culture-bound syndrome, but present all over the world because most cultures "have a long history of suppressing female sexuality and placing high values on female virginity" (Ng, 2007:12). This, along with the "omnipresence" of the coital imperative, creates similar challenges for women all over the world and makes their stories comparable.

[10] This is the term MSG use to refer to "healing" or "treating" vaginismus, i.e. becoming able to engage in penetration.

[11] My assumption was that, lacking the component of personal experience of intercourse, women experiencing primary vaginismus would refer to biopolitical and social discourses to a bigger extent then women who were previously able to engage in intercourse, and who would draw more on their very experiences. Yet, by the time I am writing this paper I think this is not be the case; still, the presence or absence of the intercourse experience does indeed change the context of the vaginismus experience.

vaginismus, which I researched by reading medical articles about primary vaginismus and the information available at the biggest medical web-site dedicated to the issue, Vaginismus.com.

Most names of my informants have been changed in order to secure their anonymity, except if women themselves wished their real names to be used (which happened in two cases). I refer to all members of the OSG whose posts I quote, but were not interviewed, as "member of the support group" (MSG). All of them gave me their permission to quote them and were informed which quote specifically I was going to use. Further, in consultation with the four administrators of the OSG, we agreed that I should refer to it as to a "support group within an online social network". Three administrators said I could use the group's real name[12], but one of them expressed her discomfort with the fact that knowing the full name would enable any reader to track names of all members. Thus, in order to secure the anonymity of my informants as well as other members, I will refer to it as mentioned above.

Everything mentioned in this section regards data gathering. Data analysis is specific for each analytical chapter and thus will be discussed separately in each of them.

Finally, I am aware that my own position of a feminist constructionist researcher, and myself a young woman concerned with the sexualized world, influenced the shape of this study from the formulation of the research question to the choice of theories I refer to, data analysis and the very conclusions.

CONTEXTUALIZING VAGINISMUS WITHIN THE SOCIAL WORLD

Body norms exist as oppositions to deviancy; undesirable conditions are thus pathologized. In his pioneer work about the normal and the pathological, Georges Canguilhem describes

> human sciences as secularized versions of the theology that grounded the work of the Catholic inquisition in the late Middle Ages and Early Modern times. The difference between the two lays in the way that each treated 'error'" (Talcott, 2008:4).

Canguilhem's theorizations on deviancy start from how societies "treat error". According to him, error has a "tragic character" – society always wants to eliminate it, or correct it. During the times of inquisition, correction meant *conversion*; later, it meant *remedy* (ibid:5). "So

[12] For them it is very important to "reach out" and make as many people as possible know about the existence of vaginismus. Thus, in case a women that is herself struggling with vaginismus would ever read this paper, she would be able to find and join the OSG.

error comes to be associated less with choosing to obey or not, choosing to accept the system of truth or not, than with existing as an abnormality“ (ibid:6) or pathology, that can be fixed by science. Thus, norms are not natural laws, but social constructs, or in Canguilhem's words, “the norm lays claim to power” (ibid:9). These ideas where further developed by Canguilhem's student Michel Foucault. In *Truth and power* (1977), Foucault argues that truth itself, or rather what people believe to be the truth, comes out of power. What is believed to be true is the most convenient for the "sake" of the society, which means that truth is constructed in order to control populations. The ways in which modern societies exercise control over populations through body norms – according to which bodies are viewed as normal, deviant or pathological – that emerge from the authority of modern science, Foucault calls *biopower* (Foucault, 1990). He opposes biopower to sovereign power: sovereign power as the “power to kill“, a characteristic of the sovereign state, was replaced by biopower, “the administration of bodies and calculated management of life“, in the modern state (ibid:139-140). The force of biopower “derives from its ability to function through 'knowledge and desire'“ (Pylypa, 1998:21), meaning that people perceive norms that emerge from biopower as objective facts and embody them as desirable traits. This results in various "self-disciplinary practices, especially those of the body such as the self-regulation of hygiene, health, and sexuality“ (ibid:22). In this way, people subjugate themselves, without feeling an explicit pressure from higher instances to do so, which enables biopower to exercise social control on a quite subtle level. In contrast to the threatening power exercised by the sovereign state, biopower is “dispersed throughout society, inherent in social relationships, embedded in a network of practices, institutions, and technologies - operating on all of the 'microlevels' of everyday life“ (ibid:21).

When it comes to female bodies, Deborah Findlay (1993) describes how obstetricians and gynecologists, playing "upon the specific social concepts of 'femininity', reproduction, and mothering" (ibid:121), introduced notions of the normal woman, drawing "upon the pronatalist climate of the 1950s" (ibid:117). In the Foucauldian spirit, she argues that those norms were servants of social control and cites Mitchinson, who comments that

> physicians were attempting to define what the normal healthy woman should be and it is not surprising that she was what they wanted her to be and what society wanted her to be (Findlay, 1993:121).

Further, Findlay focuses on "how obstetricians and gynecologists made and manipulated the social dichotomy of normal/abnormal womanhood and femaleness as a medical, technical distinction" in order to "construct an apparently value-free version of pathological and normal

gendered behavior" which "strengthened pronatalist concepts and extended the surveillance of normality for women" (ibid:118). Similarly, arguing that sex research emerged from and supports a male-oriented view on human sexuality, Jackson (1984:44) claims that biological sciences depict coitus

> as a biological imperative which has evolved to ensure the reproduction of the species. It is argued, with dubious logic, that because coitus is 'natural' it must be pleasurable; if it were not so, reproduction would not occur and the species would die out.

In such a pronatalist and male-dominated context, the "sociocultural pressures and symbolic logic (...) [defined] penis-in-vagina intercourse as the most natural, normal and healthy form of sexual behavior" (Kaler, 2006:58). Despite the fact that women achieve orgasm more easily during clitoral stimulation that during intercourse, sex is usually equated with coitus, the activity most pleasurable to men – what Jackson (1984) calls the 'coital imperative'. Thus, the normal, "real woman" became the one that was "sexually passive or receptive, as well as caring and nurturing in relation to men" (Ayling & Ussher, 2008:300) and especially, able to engage in "real sex" or coitus with men (Ayling & Ussher, 2008; Kaler, 2006). For Jackson (1983), even notions of sexual desire and pleasure, and the wish to experience them, are tools of male supremacy over women[13] and thus means of social control.

In these circumstances, despite being able to achieve sexual pleasure through outercourse[14] and be sexually intimate with their partners, vaginistic women are still pathologizied for not being able to have "real sex" and allow gynecological exams[15]. The pressure to engage in intercourse does not necessarily have to come explicitly (or at all) from their partner. Women themselves wish to fit the norms they embodied – they want to be "real women" and "real wives" (Ayling & Ussher, 2008; Kaler, 2006), mothers or simply be able to express themselves sexually in the way they wish to. Thus, they want to overcome vaginismus and become "normal". Living with vaginismus and trying to overcome it is a social,

[13] Even though there are studies arguing that the coital imperative still is an imperative in the 21st century (for example McPhillips et al., 2001), I was not able to find any literature that tries to explain *why* is it still so, despite the perception of female pleasure has changed (it is acknowledged that intercourse is not necessarily the most pleasuring sexual activity for women), reproduction has been separated from sexuality and attempts have been made mostly by feminists to promote non-penetrative sex as the safest form of sex.

[14] Sexual activities that involve stimulation of erogenous zones, especially clitoris and other parts of the vulva, but that do not involve penetration.

[15] Some argue that the "obligation" to regularily go through gynecological exams is also a mean of social control (for example Findlay, 1993), but on a personal level this "obligation" is perceived to be fostered by the wish to be helathy and prevent illness rather then by outer oppressive forces.

psychological and embodied journey. This journey, and the social, bodily and narrative practices that constitute it, will be addressed in this analysis.

''I'M A CLENCHER'': ALTERNATIVE CONCEPTUALIZATIONS OF VAGINISMUS

Rethinking the 'condition'

Around the very beginning of my fieldwork, quite randomly checking the "medical anthropology shelf" at the university library, I came across a book entitled *Deviant Bodies*. The book immediately caught my attention, since, I thought, the "vaginistic body" is definitely perceived as "not normal", and thus deviant, by society. But, the book's editors (Terry & Urla, 1995) actually questioned the dominant perception of deviance being about bodies:

> (...) the book represents an inquiry into modern Western epistemology by examining the very idea of *embodied deviance*, which we define as the historically and culturally specific belief that deviant social behavior (however that is defined) manifests in the materiality of the body, as a cause or an effect, or perhaps as merely a specific trace (ibid:2).

They reconceptualize 'homosexual bodies' as bodies engaging in sexual behavior with other same-sex bodies, bodies with 'conditions' such as 'nymphomania' and 'hypoactive sexual desire disorder' as bodies that have more or less sex than it is socially prescribed, people 'suffering from alcoholism' as people who consume a lot of alcohol and 'aggressive people' as people who engage into aggressive behavior. Modern biomedicine devoted itself to the search for embodied causes of such behaviors, for example, looking for genes that would cause these "conditions". According to Terry and Urla, there is nothing physically deviant about these bodies; what is deviant is the behavior they engage in.

When it comes to vaginismus, it is true that in the majority of cases, no physical cause can be found that could trigger pain or muscle contractions. As for "the activity of vaginismus", firstly, what actually ensures the "vaginistic body" its label are the muscle *contractions* – an activity. Secondly, these contractions disable women to engage into a specific type of sexual *behavior* – penetrative sex[16]. In this sense, vaginismus could also be perceived as a behavior, instead of as a 'condition'.

[16] Even though "penetrative sex", "penetration" and "intercourse" are male-centered names for the activity at stake and might be replaced with terms that emphasize the activity of women and vaginas, I still use these terms because some women have reported to find these expressions and the act framed in this way problematic. In

The conceptualization of diseases as "entities in their own right" that were "*inhabiting* the patient's body" was replaced in the early nineteenth century by the concept of "*conditions* of the human body" (Foucault according to Mol & Law, 2004:2), or later, of the human "mind". In their "Prolegomenon to future work in medical anthropology", Lock and Scheper-Hughes argue for an analysis of "mindful bodies", an approach that would overcome the troubling Cartesian dualism. The idea of separateness of body and mind enhanced a "radically materialist thinking" in natural sciences, and "caused the mind (or soul) to recede to the background of clinical theory and practice for (...) three hundred years" (Lock & Scheper-Hughes, 1989:9). With the raise of psychiatry in the 20th century, mind started to be brought back into medical theories (ibid:9), but still as an entity per se. Even today, human afflictions seem to be "either physical or mental, biological or psycho-social – never both nor something not-quite-either" (ibid:10). Their causes are always perceived either as "wholly organic or wholly psychological": "'it' is in the body, or 'it' is in the mind". Apart from 'body' and 'mind', the 'it' they emphasize is crucial for further discussions. Mark Sullivan has argued that the "crucial dualism that troubles modern medicine", rather then being "the dualism attributed to Descartes, between two kinds of substance, body and mind", is "the distinction of substance and activity" (according to Mol & Law, 2004:3). Even when modern medicine acknowledges and addresses the "psychological factor" of a disease, it is still referred to as to a "substance of mind", along with the "substance of the body". As Sullivan phrased it, "the *activity* of self-interpretation or self-knowledge is eliminated from the body, rather then the entity of mental substance. The body known and healed by modern medicine is not self-aware" (cited in ibid:3). Hence, diseases are never perceived as patients' *activities*.

Indeed, having read a lot of medical articles and resources about vaginismus, I noticed that all of them, without exception, emphasized that vaginismus was caused by *involuntary* muscle contractions. According to Vaginismus.com, the biggest web-site dedicated to this problem,

> Vaginismus is a condition where there is *involuntary tightness of the vagina* during attempted intercourse. The tightness is actually caused by *involuntary contractions of the pelvic floor muscles* surrounding the vagina. *The woman does not directly control or 'will' the tightness to occur; it is an involuntary pelvic response* (my emphasis).

other words, what they "prevent" with their muscles is not "taking something into their vagina" but indeed "being penetrated".

As already mentioned, the same was emphasized in the introduction to every medical article about vaginismus that I read, as well as in the official DSM-IV definition of vaginismus. Just to give an example:

> Vaginismus is defined as the involuntary spasm of the pelvic muscles surrounding the outer third of the vagina, particularly the perineal muscles and the levator ani muscles (...). In severe cases of vaginismus, the adductors of the thighs, the rectus abdominis, and the gluteus muscles may be involved. This reflex contraction is triggered by imagined or anticipated attempts at penetration of the vagina or during the act of intromission or coitus (...) (Jeng et al, 2006:380).

This description of vaginismus seems very "embodied", in the sense that what happens to a "vaginistic person" is explained only by describing what happens to her *body*. Still, the last sentence might indicate the existence of a "psychological" trigger, which is usually emphasized more, as in this case:

> This [muscle contraction] is a conditioned response that results from associating sexual activity with pain and fear. It is a severe problem for many women, who may experience not only extreme physical pain on attempted penetration but also severe psychological pain. It consists of a phobia of penetration of the vagina and involuntary spasm of the pubococcygeal and associated muscles surrounding the lower third of the vagina (Butcher, 1999:111).

It might be argued that the medical explanation of what happens to the "vaginistic body" exemplifies Sullivan's argument very well. Although the "entity of mental substance", or the *psychological* factor, cause or origin of vaginismus, as it is being called, is acknowledged or even emphasized[17], *it* (the psychological factor, phobia) is seen as something that vaginismus is "consisted of", as a substance, while the contractions are always perceived as something that "just happens" to women, involuntarily, against their will. Women's bodies are not "self-aware".

Metaphors of dualisms in women's narratives

But what about women themselves? How do *they* perceive vaginismus? In order to answer this question I took inspiration from Emily Martin (1989:76-79), who identified several metaphors about menstruation, childbirth and menopause that women in the body live

[17] And, interestingly, in some cases even the socio-cultural factor, see for example Ng (1999) and Meana (2009)

by[18]. These are: *your body is something your self has to adjust to or cope with*; *your body sends you signals*; *your body needs to be controlled by your self*; *menstruation, menopause, labor, birthing and their components are something you go through or things that happen to you (not actions you do)* and *menstruation, menopause and birth contractions are separate from the self – they "come on", women "get them"*. What Martin argues is that menstruation, childbirth and menopause are usually perceived as substances, but that might as well be seen as *activities* women engage in, as *practices* women *do*. Further, the separation of body and mind or self lays underneath these metaphors. In this context, I see her analysis as relevant for mine, as my aim here is to discuss women's perceptions of vaginismus within the mentioned dualisms.

Even though I separate narratives in line with the 'substance – activity' and 'self – body' metaphors, I have to emphasize that the *your body needs to be controlled by your self* narrative was omnipresent in all types of women's narratives. On one hand, it shows the separation of the self (or the mind) from the body, and on the other it depicts women as "out of control", deprived of activity and controlled by the substance of vaginismus or as "taking control" and actively engaging with their bodies. I will not emphasize this narrative every time it occurs, but the reader will note it in certain quotes bellow.

Here, I analyze the language women use and the way they choose to express themselves while talking about them "having" and "overcoming" vaginismus. During the interviews, some constructions were used by women spontaneously while telling their "vaginismus story" or answering other questions, but I have also prepared questions that were aimed to encourage them to talk about their perceptions of vaginismus in terms of these dualisms. I would ask them to talk about "the spasms" and when and how would they feel them, but this question did not always foster fruitful discussion. On the other hand, unexpectedly, while talking about "what frustrates you the most about having vaginismus?", they would quite often bring up metaphors of dualisms. Another way to successfully foster interesting discussions was to introduce an argument stated on the Vaginismus.com web-site: the muscle contractions are completely involuntary and contract despite women's will. I would ask my informants to comment this argument and if they could themselves relate to it. Most of them wholeheartedly agreed, some questioned it and most of them, while explaining

[18] A play of words referring to the names of two books. In *Metaphors we live by*, George Lakoff and Mark Johnson analyse the everyday lanhuahe that people use and identify metaphors that structure the way people think. In her book, *Women in the body*, Emily Martin applies to her interviews the technique developed by Lakoff and Johnson, in order to identify metaphors about three practices that women go through during their lives: menstruation, childbirth and menopause.

their opinion, brought up metaphors of dualism. Since they used different metaphors, the answers to this question will be spread through different parts of the chapter. Except for the language women used during our interviews (including the "written" ones), I looked at the linguistic constructs they used while posting, discussing and commenting in the OSG. Additionally, a few other resources available online are used in order to exemplify certain metaphors.

• Substance: Body – mind dualism

The most usual metaphor indicating that women perceive their selves/minds as separated from their bodies is the metaphor of the *body as a lousy friend*, that does not want to cooperate with us. As Kristen wrote, "I think some of these women were just so frustrated that *their bodies weren't cooperating*" (Kristen, written interview). Indeed, many women expressed their frustration about the fact that their bodies were not "cooperating with them", not "listening to them" or generally not functioning in line with "their" wishes. After joining the OSG, a new member decided to share her "vaginismus story" and doing so she expressed her frustration:

> *I* could feel as relaxed as possible, totally in the mood and ready for things, but when it comes to that ultimate moment, *my body freezes*. As you all know, it's so frustrating that *you can't control it*! (posted by a MSG, my emphasis)

Ines did the same during our Skype conversation:

> ...when I was with my boyfriend and we wanted to do things and it was very frustrating because if I want it so much, why can't I do this, *why can't I just tell my body to open up*? (...) I felt the instinct to do things, I just wanted it, as simple as that. And yet *my body wouldn't respond the way it should*, I mean...it would get aroused, but it wouldn't...open up enough down there (Ines, Skype interview).

Susanne's words might be characterized as even more intense, although they are part of the same metaphor. After confiding to a friend about not being able to have penetrative sex with her then-partner, her friend told her:

> "maybe he's just not pleasing you right, maybe um...maybe you don't love him enough". No it's not that! *It's just my body going against me*! (...) actually, in many ways (...) it just feels like *my body hates me* [laugh] (Susanne, Skype interview).

While talking about her attitudes towards sex in the premarital and marital context, Cecilia also indicated that her body is not behaving in line with her thoughts:

> I used to think it's [sex] horrible, it's bad, you can't do it. Umm I don't think so much now that I'm married, it's like it's ok now, it's just hard...maybe it's just a little hard to figure out like ok I can do this, it's cool, you know it's not bad at all, and I don't think it's bad anymore, but I don't know, maybe *my body is still in that mood*, like noo, you can't do it! Like: you haven't done it for this long, you're not supposed to do it! [laugh] (Cecilia, Skype interview)

Since their body was not "cooperating" and "doing it to them", some women decided to "fight back". Commenting in the OSG, Mae wrote:

> I had been told a lot of things that I couldn't do. Proved them wrong and then this [vaginismus]. I don't want *my own body telling me I can't do something* so *I want to fight my own body* and be semi-normal (posted by Mae in the OSG, my emphasis).

Here, Mae depicts her *body as a stepmother* – somebody whom you do not want to receive orders from, and as *an adversary*, that she wants to fight.

In other narratives, what is separated from the self is not the body as a whole, but the vagina specifically. Even though most of them did not feel as if their vagina was less a part of them then any other part of their body, in line with the body-mind dualism, in certain occasions women would depict their vagina as problematic, instead of their whole body. When asked about how she would explain what happens to her because of vaginismus, Ines said:

> I would describe it as umm...*me wanting to do something that my vagina didn't want to*. Other times I would joke with my boyfriend and my friends, saying that *my vagina was bipolar* [laugh], because she...it would get aroused down there, you know...I...but then... it would just clench and be tight, like it was saying: I want to [have penetrative sex], but not now! (Ines, Skype interview)

Except for the metaphor of a *lousy fried*, Ines also introduces the metaphor of the *vagina as an autonomous woman*, separate from her self (even though she uses this metaphor as a joke, as she says). In this case, the "conflict" was not between her self and her body or vagina, but the vagina had an inner conflict by *her*self.

While trying to "reconcile" with their "problematic" bodies and "connect more" with them, some women would try to "become friends" with their vaginas. In these cases, the vagina is seen as a *stranger* that women decided to establish a positive relationship with. As Lavender explained, "what helped me [to start making some progress in overcoming vaginismus] is that *I actually talk to my vagina*" (Lavender, interview). Later on during our conversation, she went back to the same topic, saying:

> I used to see it like: oh, is this really mine? It looks like an alien! And sometimes I still feel like that, but wait a minute, alien, I love science fiction! [laugh] (...) And then I tried to look at *myself* everyday in the mirror and say: *I would like to introduce myself*! (Lavender)

Here, in the same sentence she depicts her vagina as herself and views her as a second person. Although not in the same sentence, the use of this kind of "mixed narratives" was quite often, as it will be shown later.

In all these examples, the mind is equalized with the self, while the body is seen as the "problematic" part. The self wanted to have penetrative sex and felt excited about doing it, but the body would not allow it. Only once I noted a construct that would indicate the contrary, that the body was the one wanting, or rather *needing* sex, while the mind was not: "*Your body needs it then your mind wont allow"* (posted by a MSG). Here, a metaphor of the *mind as a master* is employed.

Another metaphor that showed mind as problematic rather then the body, was the one of *fear as an aggressor*. What was problematic for some women was not the inability to control their bodies, but their emotions. Commenting the argument that vaginismus is characterized by *involuntary* muscle contractions, Audrey wrote:

> I am not sure I have fully understood my specific condition, since for me *fear* is the biggest factor or obstacle, and not the contractions per se. *What involuntary to me is the fear or the panic that suddenly hits me, even though I loved my then boyfriend whom I really wanted to sleep with*. (Audrey, written interview, my emphasis)

Even though a few women did think that their problem was (almost) completely located in their bodies, most of them emphasized the importance of addressing the "psychological cause" that lays behind vaginismus and how important it was not only to re-train your body, but also to engage in (self)psychotherapy. In other words, they see a successful treatment as one treating "the whole person", as Kristen expressed it:

> I think it's important to understand that there are both *physical, mental, and emotional* barriers to overcome with vaginismus (...) and that needs to be dealt with or your body probably won't cooperate. For me, I think a huge part of it is fear and anxiety. *It's important to treat the whole person, not just the body*. (...) (Kristen, written interview, my emphasis)

In Kristen's narrative, a metaphor of *body and mind as co-travelers* is implied. They have to be in balance and progress along.

The metaphor of *body and mind as co-travelers* would quite often emerge when Botox treatment was addressed in the discussions in the OSG. To give a short context, Botox treatment is considered a very fast and easy way of overcoming vaginismus. Botox is injected into the "problematic" muscles, which stops them from contracting. Some members[19] had objections to the purpose of Botox treatment, such as Sarah:

> Yet vaginismus is a *body-mind-condition*, and needs to be addressed equally in a *body-mind approach* with the goal that the woman will be eventually empowered. While botox might seem like a quick solution and last ressort for some, the anxieties that lie beneath vaginismus and may cause other anxieties in every day life as well, need to be addressed as well (posted by Sarah in the OSG, my emphasis).

Even the person that is considered the leading professional in Botox treatment of vaginismus, dr. Peter T. Pacik, emphasizes in his paper that the "emotional part" of the issue has to be addressed for a completely successful overcoming, although according to him it should be addressed after treating the "physical part", i.e. after injecting Botox. What of interest here, are his patients' reports of *feeling emotionally behind* what they can do with their bodies:

> Patients will often report that though they are doing well with dilation they "*need to catch up emotionally to where they are physically*."

[19] And feminist authors, such as Tiefer (2006) and Farell and Cacchioni (2012)

The discourse of *disbalance of body and mind* is employed in his patients' narratives as well. They felt that their bodies passed more kilometers then their minds and that their minds had to speed up to catch their bodies and continue traveling along. Before concluding this discussion about Botox treatment, I need to emphasize that not all, or even most women did criticize it in this line. The few women who did think that way were either familiar with feminist theories or were close to a "New Age" spirituality. Most of my informants would not consider Botox treatment themselves, but the reason was not feeling comfortable with injecting "strange substances" into their body. Yet, they would not oppugn Botox treatment "in general"; as Megan said, whatever she personally feels about a treatment method, she is not going to judge other women for considering it. "If it works for you, go for it! (...) Any way you can overcome it, who cares!" (Megan, Skype interview).

• The 'substance of vaginismus' and the 'activity of vaginismus'

As it can be seen from the previous examples, women separated body and mind, but also body or mind from their 'selves' – they saw their bodies or minds "doing" something to them, "preventing them" or "hitting them". Somewhat less often, vaginismus was depicted as a substance by itself. To connect back to Martin's *your body has to be controlled by your self* narrative, women often talked about vaginismus as something that was *controlling them*, something that *took away their own control* over their lives and their bodies (again implying Cartesian dualism). As Kristen wrote, "I feel like *it* [vaginismus] controls me, instead of the other way around. I think *it* leads me to think like a victim and feel powerless" (Kristen, written interview, my emphasis). Here, it is not Kristen's body causing her problems, it is the *substance of vaginismus* doing her harm. The metaphor employed for it was thus one of *a slaveholder*, and "having it" meant being a slave:

> That kind of slavery that *controls your thoughts, your life, your sexuality*, I would even argue that *controls your vagina*, because *it* has such a grip on you...Freeing yourself from *it* is absolutely empowering, because *YOU are the one in charge, YOU are the one in control, not something else, as vaginismus*, and also not something else as your background or some other people's beliefs (Sarah, Skype interview).

Still, vaginismus is not always perceived as a negative character, at least not for Thanksgiving Day, that inspired this women to depict vaginismus (and her body) as a *guardian angel*:

> *My body* also prevented me from possibly getting in the wrong relationship and having sex with a lot of guys. *My Vaginismus* pushed me to find a man whom wanted more out of the relationship (written by an internet blogger[20]).

Even though, unlike in most other narratives, expressed in a (socially valued as) positive context, the body is still perceived as separated from the self, and 'vaginismus' is depicted as an outer force (or substance) taking control over a women's life.

In other occasions, vaginismus is not referred to as a separate person, but women's activity is explicitly rejected. When asked whether she agrees with the claim that muscle contractions are completely involuntary, Matea said:

> I think it is definitely *in ourselves* and comes *from ourselves*. (...) Of course, I think *it's not conscious*, no one would have that problem, you would just say no, full stop. (...) Of course it's *against one's will*, 'cause who would want this, *who would want to do this to herself?* (Matea, interview)

In this narrative, as argued by Sullivan and thus Mol and Law (2004), the impact of one's mind is acknowledged, but activity is denied. The same can be said for Mae's answer to the same question: "I completely agree [that the muscle contractions are involuntary]. I think *stress and fear can incite it* but *I don't think its controlled by the female*" (Mae, written interview, my emphasis). Kristen was my only informant that brought in the category of 'activity' while answering the same question as Matea and Mae above:

> I think that vaginismus is somewhat physical and somewhat emotional. I believe that alot of it has to do with fears and inability to relax. *By saying that contractions are out of women's control, that seems to imply that it's impossible to cure.* Women can beat this... but I think dealing with the emotional side is just as important as the physical side (Kristen, written interview, my emphasis).

Except for expressing herself in terms of *activity*, Kristen brought *activity* in connection with *emotions* (thus the 'mind' part of the Cartesian dualism) and she was not the only one doing so. Referring to why she thinks she did not succeed to overcome vaginismus while she was married, Lavender explained: "...I believe that for me it is really here [points at her head], because I do this [presses her fists against each other, meaning: I contract/clench] constantly, basically in my marriage I was constantly like this [same gesture as before, meaning:

[20] Available at: https://vaginismusawareness.wordpress.com/2009/11/16/a-thank-you-card-to-vaginismus/#comments

clenched]" (Lavender, interview). Lavender locates her vaginismus in her head, and thus in her mind and attributes it to the fact that *she was clenching*, implying her own activity[21]. Actually, the perception of the *woman as a clencher*, indicating that women connect the contractions of their muscle with their own activity, was quite rare. Except for Lavender, I noted only two other women using this way of expression. Ines used to say that *she clenches*, but still this was something out of her control, as it can be seen in this example: "sometimes, out of nowhere, *I clench*" (Ines, Skype interview). By saying that the clenching happened "out of nowhere", she indicated the lack of her own control over it. The second woman that used this linguistic construction, and that eventually inspired me to name this chapter, was a MSG that once posted the following question:

> Does anyone else find that they *are clenchers*? Since my physio pointed this out to me I have noticed that 100% of the day *I am clenching* my vagina and bottom (posted by a MSG).

This was a unique case during my fieldwork in which a women called herself *a clencher*, thus avoiding the separation of body and self and attributing the clenching to her own activity rather then to a substance that is, be it inner or outer, separated from her self.

• Discoursive transitions: *Overcoming* dualisms, introducing synecdoches

In general, it was more common to refer to vaginismus as to a substance then as to an activity, and the narratives used by women while explaining one's experience of vaginismus were much more often based on Cartesian dualism then lacking it. What I noted only after having re-read my data more times, was that women used to express themselves in terms of the substance of vaginismus and the Cartesian dualism while talking about "*having*" vaginismus (i.e. not being "cured" yet), while the "activity narrative" and expressions lacking Cartesian dualism were more often employed in terms of *overcoming* vaginismus (i.e. being in the process of "curing" it). Interestingly, the phrases '*having*' and '*overcoming*' vaginismus contain themselves the aspect of substance in the first case, and of activity in the second one.

To give some examples, when explaining how they felt before starting the process of overcoming, Megan and Audrey explained it this way:

[21] Although the fact that she *locates* it in the head, as a specific part of her body, might indicate that she perceives it as a substance

> 'Cause I definitely wanted [to have intercourse], I waited...23 years for this, you know...but every time I would be like ok, *I'm ready, my body wasn't*. So...it's definitely not something I could control, is not that I didn't want to [have intercourse], it's not that I'm not a sexual being, I have a sex drive, I wanted to [have intercourse], but I just...*my body wouldn't let me* (Megan, Skype interview).

> I could not even try to insert something, since *my body would shut me down* in forms of severe panic attacks (Audrey, written interview, my emphasis).

Yet, when describing their overcoming process, they chose to use different expressions:

> As I was trying to overcome, I was like: ok, *touch yourself* [meaning: her vagina]! [and thinking] This is not gross, it's a part of your body (Megan, Skype interview).

> The most important thing to me was that finally I was able to *touch myself* [meaning: her vagina] and "accept" my whole body (Audrey, written interview, my emphasis)

By referring to their vaginas as "themselves", they avoided the body-mind dualism. Still, it is not as simple as that, since they both used again phrases like "part of your body" (instead of "part of yourself", for example) and "accept my whole body" (implying that her body was separated from her self). The same "discoursive transition" can be seen in Cecilia's narrative in which she looks back to the perception she had of her vagina before starting treatment. When she looked at her vagina for the first time, she thought it was "wierd" and she "freaked out a little bit", but after she tried to look at it for a few days in a row, saying to herself: "it's ok, this is beautiful, this is *part of you*", she became much more comfortable about her vagina.

> I felt like *it*'s [her vagina] invisible, like I didn't think about *it*...I mean I know *it*'s there, but I never really... looked at *it* or seen *it* or felt like...it was kind of like out of sight, out of mind kind of thing...just never occured to me that I should actually look at *it*, that I should...*look at myself* [laugh] (Cecilia, Skype interview).

Through her narrative, while referring to her vagina, Cecilia replaces the third person ("it") with the first person, overcoming the Cartesian dualism. Through their discursive transitions, Megan, Audrey and Cecilia replace metaphors of the *body as a lousy friend* and *the vagina as*

an autonomous women with a *synecdoche*[22] that equates their vaginas with their (whole) selves.

In another instance, a women replaced the metaphor of her PC muscle as a *lousy friend* with a synecdoche that equates her muscles with herself. Here is what she wrote during a discussion in the OSG about "what to do in order to stop clenching":

> Also [what might help is doing] reverse Kegels I think, just to realize how to relax...instead of contracting for 10 sec[onds], try to be relaxed as long as you can and then at some point it [your body/muscles] will clench and then [you] relax again[23] (posted by a MSG).

When it comes to the "problematic" part, i.e. clenching, this woman writes in terms of substance and Cartesian dualism, but when advising how to stop doing it ("how to take control over your body") she says "*you* relax", avoiding to separate body and mind and implying women's own activity. Lavender did the same; while referring to her struggle, she said: "I did kind of find the way [into her vagina], but of course *it*'s [*vaginismus as a substance*] not cured", but when emphasizing her success, she formulated it as: *"I opened up* already so much" (Lavender, interview), replacing the metaphor of *vaginismus as a slaveholder* with an expression that depicts the *woman as a clencher*.

Of course, this was not a common practice and women have found different ways to conceptualize their overcoming process. Mea, for example, uses a metaphor of *overcoming as a battle*, in which "she" has to defeat her body: "I don't want my own body telling me I can't do something so *I want to fight my own body* and be semi-normal" (posted by Mae in the SG, my emphasis).

Finally, even though certain patterns can be observed in the choice of linguistic expressions and "discoursive transitions", as it can be noted from most of the examples used in this chapter, women mostly combine more metaphors within the same narrative. This is why some excerpts (could) have been used to exemplify more then one metaphor, and it also shows the complexity of women's perceptions of their bodies, body parts, "relationships with

[22] "A figure of speech in which the name of a part is used to stand for the whole (...), the whole for a part (...), the specific for the general (...), the general for the specific (...), or the material for the thing made from it" (according to http://www.thefreedictionary.com).

[23] The Kegel exercises are done in order to strenghten the pelvic floor (PC) muscles. They were developed to prevent incontinency in both women and men, but sometimes women are advised to use them for purposes of increasing sexual pleasure during intercourse. The exercises consist of contracting one's PC muscles, keepeng them contracted for a while and the releasing, and repeating this process for several times. In the case of vaginismus, the "Kegel's" are thought to be useful for women to realize which muscles are contracting, but some argue that vaginistic women should not exercise their pelvic floor since it is already too tense. Instead, they should do the "reverse Kegel's", as this member suggests, which means trying to keep their muscles relaxed as long as possible.

their bodies" and "the nature of their condition". Indeed, sometimes it seemed as if they struggle themselves, trying to find a discourse that would satisfy them. After Sarah used the metaphor of "battling vaginismus" during our interview, we started a discussion about such a perception. She ended up seeming quite confused:

> I obviously did see it as something that belonged to me, otherwise I wouldn't battle it...In a way it was an enemy, yes, but...Even though I say I have vaginismus, while treating it, while using dilators, I don't think this is vaginismus, I think this is my vagina being confused in a way [laugh], you know, it needs some kind of care... Yeah, I think vaginismus is something that doesn't belong to me, but despite of it or because of it, I had a closer look [for example collecting facts and educating herself about female anatomy, looking at her vagina in the mirror] at my...my female parts and my femininity (...) I would say I have vaginismus as if it were a person that would do me harm, but when I actually treated it and when I was using dilators, I kind of thought tenderly of my OWN body parts, you know [laugh], I was actually talking to my vagina, telling her: it's ok, it's alright, you're doing fine...also again in a second person, but still being my part and being...something positive (Sarah, Skype interview).

Discussion

In this chapter, I analyzed medical descriptions and women's narratives about their experiences of 'having' and 'overcoming' vaginismus, in search for references to two dualisms so characteristic for the "modern" medical and lay conceptualization of bodies and disease – the Cartesian dualism of 'body' and 'mind', and the dualism of 'substance' and 'activity' (or 'condition' and 'behavior'). What I have found is that the way vaginismus is described in medical literature supports Sullivan's claim that modern medicine acknowledges the "mind" component of persons and disease, but denies sufferers' *activity* of self-awareness and self-interpretation. Even though most medical professionals believe vaginismus to be a 'psychosomatic' disorder and that successful treatment requires addressing the "psychological rootcause" and should include some kind of psychotherapy (along with progressive dilation, physical therapy, Botox treatment or other ways of "re-training" *the body*), the contractions of the PC muscles are always perceived as "*completely involuntary*" and "against women's will".

Women's narratives also support Sullivan's argument a great deal. They mostly described their experiences of vaginismus through metaphors of the *body/vagina as a lousy friend* and *vagina as a stranger* or *autonomous women*, usually separating their selves from their bodies or body parts, and rarely expressing it as their own activity. Yet, even though most common, these metaphors are far from being the only ones used. In fact, through their narratives, women navigate through different metaphors, searching the "best fit" for

themselves, reaching thus for linguistic constructs that imply their own activity and that equalize their selves with their bodies and their vaginas.

While all the metaphors based on the body-mind dualism, as well as the one of *vaginismus as a slaveholder* are in line with the official definition of vaginismus, the depiction of the *woman as a clencher* and synecdoches that equalize body parts with women's selves seem to emerge from a different conceptualization of vaginismus, usually not recognized by medical professionals. This alternative way of conceptualizing vaginismus would thus be to see it as *a behavior during which women clench, and doing so prevent penetration*. Of course, this way of conceptualizing would have different repercussions. On one hand, it might contribute to women feeling "in charge" of their bodies, in the sense that if they are the ones clenching, they are the ones who can also stop doing it (as argued by Kristen earlier). Since *having control over your own body* has been emphasized as important and perceived as empowering by women, this way of framing the problem might give them the sense of power that they are longing for, and transform them from "powerless victims" to empowered agents. On the other hand, a lot of women claimed that their situation was legitimized once they got a diagnosis. Being able to say that they were suffering from a 'condition' that has a name, made it much easier for them to explain to their partners and other people what was happening to them, and also made partners and other people behave more compassionately and understandingly towards them. In any case, it might be interesting to be aware of both possibilities of framing the issue, because it would at least give women the possibility choose according to their own preferences and to find a metaphor that they themselves feel comfortable with.

DOING VAGINISMUS

In the previous chapter, an alternative view on vaginismus is given, in which it is seen as an activity. In this chapter, the notion of the "activity of vaginismus" is taken a step further, by taking in consideration other activities, or rather *practices*, that vaginistic women engage in. Through the description of these practices, I aim to tell women's "vaginismus stories".

This way of telling stories and describing a phenomenon of interest for medical anthropology was inspired by Mol and Law's (2004) approach that focuses on how people *embody action* and *enact their bodies* in the context of a specific disease, condition, health problem or bodily issue. To give a theoretical background, the authors differentiate two *modes*

of knowing the body: the objective, scientific way of knowing the body from the outside, producing knowledge about bodies as *objects*, or bodies we *have*; and the subjective, private way of knowing the body from the inside, that reflects the body as a *subject*, or the body we *are* (ibid:3). In a way, both modes of knowing were addressed in the previous chapter. Yet, Mol and Law advise ethnographers to approach their topics through another "activity lense", somewhat different from the one proposed by Sullivan. They suggest not only to view a 'condition' as an 'activity', but to leave knowledge gathering apart, thus overcoming the "dichotomous twosome" of *having* and *being* a body, and focus on how people *do* their bodies through their *daily practices* (ibid:4), or in other words how do people counteract, avoid and produce (ibid:7) their "condition".

Until now, a lot has been written about treatment methods and etiologies which treat vaginistic bodies as objects, and there is some research that focuses on subjective experiences of vaginismus[24], but to my knowledge there is not much contribution to what women *do* about or because of vaginismus. Moreover, the etiology of vaginismus is not understood well by scientists (Jeng, 2004) and every women has a different "vaginismus story", consisted of upbringing, family relationships, other health issues, experiences with medical professionals, relationships with partners, sometimes traumas, and many other components. What all (except one) of my informants, as well as other women active online, have in common is that they *actively engage* with their problem. Thus, I see the "enacting bodies" approach as very appropriate for this analysis. Also, as many of my informants emphasized, "dealing with" vaginismus is a time- and energy-consuming activity, almost a full-time job. Ines, for example, postponed her treatment, since she could not give vaginismus the needed attention because of her sister's illness, that she was very focused on. She emphasized how sometimes "it is just not the right time" to deal with vaginismus. Other women also reported not being able to focus on it because they had "other things going on in their lives". Matea had to take a break from "working on vaginismus" because it was "wasting" her time and emotions to that extent that she thought she would fail all of her university exams if she would not take that break. As she said, "your whole life starts to turn around that". All in all, vaginismus requires women to engage in a lot of practices and to be very focused on them. This is why women encounter problems in finding time to dedicate themselves to the overcoming process. But

[24] For example, about vaginistic women's gendered experiences (Kaler, 2006; Ayling&Ussher, 2008). Ward and Ogden (1994) addressed women's perceived causes of their vaginismus, as well as the effects of vaginismus on women's social relationships. Yet, this is a quantitative study based on questionnaires that *lists* certain practices related to women's relationships with partners and friends, but does not describe them.

once they do, being engaged in all these practices becomes these women's reality, and maybe even a more important part of their "vaginismus story" then (perceived) etiologies.

Thus, here I explore the self-reflexive activities women engage in because of vaginismus and in order to overcome it, how do they *enact* themselves within their social and physical surrounding. Before addressing specific practices, I have to emphasize that not all women engage in all of the mentioned practices. The following is an attempt to give an overview of different activities that were often discussed by women both during interviews and discussions in the OSG. Also, except if a specific reference is given, all arguments are based on my own observations during fieldwork.

The practice of knowing

For Mol and Law, the first important mode in which hypoglycaemia, the example they discuss, is *done*, is by *knowing it*; thus, they see knowledge as a practice (2004:5). Knowing does not only encompass acquiring facts, but also "training one's inner-sensibility"[25]. Indeed, most women start their overcoming process by acquiring knowledge, on female anatomy in general and on vaginismus in specific.

While some women reported initially thinking that they "have no hole", that their vaginal orifice does not "stretch enough" or that their vaginas were "just too tight", others said that, when realizing that something was "wrong with them", they did not know how to explain to themselves why they were not able to engage in penetration. As Megan said, "I didn't even think of the word vaginismus, I just thought I'm a freak of nature!" Whatever their initial thoughts, getting to know that there was a "condition called vaginismus" helped them a lot. Not only they became aware of the fact that they were not "freaks of nature" and "alone in this problem", but it also provided information about what was actually happening during attempts of penetration and about available treatment options. The first important information for them is that what causes the tightness are contracted PC muscles. What follows is to learn where these muscles are located and how to relax them. From my data it seems women keep gathering information about the female reproductive system throughout their whole 'overcoming process' and later. In fact, in the OSG, women very often posted links to educative web-sites or videos that would enable them to understand what is the "vagina" consisted of (the term 'vagina' is usually misused, meaning: vulva – outer and inner labia and

[25] In the case of hypoglicaemia, people learn how to measure their blood sugar level and how to regulate it, but also how to "sense" its changes without actual measurment (Mol&Law, 2004:9).

clitoris, vaginal orifice and the vagina itself) and how its texture feels like. Very often women would post articles dispelling myths about vulvas (for example, that there is no "normal" or "standard" vulva), vaginas (that intercourse does not make vaginas loose up), hymens (that it is not a very thick membrane that "breakes" and causes immense pain during the first intercourse) and intercourse (that it is not supposed to hurt, not even the "first time"). A lot of women saw this process of gathering anatomical knowledge in a positive light; some of them even stated that, because of vaginismus, they got to know their bodies much better then many other women get to know their, and saw that as an advantage. "I think knowledge empowers you. Empowers us (...) as a group of woman", Megan told me. This is why she started "Facts Fridays" – every Friday she posts in the OSG some resources with facts about vaginismus, similar conditions or the female body in general.

Indeed, it seems that many women become interested in the female body in general, sharing non-vaginismus related resources about it. Megan, for example, is using a natural contraception method that made her engage with her "female body" a lot. Articles were posted in the OSG about "lunaception"[26], "the benefits of sleeping naked", "fertility foods" etc. Also, women used to post pictures of fruits that looked like a vulva in order to show vulvas/vaginas as natural and beautiful parts of the body.

Interestingly, these pictures, as well as explicit depictions of "real" vulvas caused some controversies in the group, since not all members seemed to like them. Some members got upset for having "vaginas randomly appearing on their screen" and even reported fellow members who posted these pictures for sharing inappropriate materials. After one such case, the administrators decided to post a monition about it:

> We understand that not everyone is comfortable with seeing pictures of the female genitalia. But we also know that knowledge is power. Educating yourself to the anatomy and function of the vulva and vagina helps to demystify and take the scary out of it (...) We're all here for the same reason, our vagina's are not functioning the way we would like them too. I'd even go on to say that 98% of us are here so that we can engage in sexual activities. With that said, there will be posts/pictures about vaginas and things of sexual matters. That is the function of this group (...)When you report pictures or people, you are taking away the rights of other women to learn and potentially succeed. It's not right. It's not fair. Please don't do it (...)

[26] A method that makes women's menstrual cycles align with the moon phases and thus enables them to know when are they going to ovulate, menstruate etc.

This point is interesting because it shows how women's practices of acquiring and wishing for knowledge are impacted by their backgrounds and beliefs. Of course, it is not easy to keep a balance in such a culturally, religiously, "way of life" and "worldview" heterogeneous group. As Megan, who really emphasizes the importance of knowledge, expressed her concerns:

> I think education is huge, because so many women think: oh, if I touch myself there, I will be dirty, or if I look down there – I'm not supposed to do that, or if I use a tampon, I won't be a virgin anymore... You know, I try not to step on people's toes and their cultural beliefs, but it's like, you know, why can't we think of a vagina like we do with an ear? It's just another body part, we can talk about it(...)

As it can be seen, Megan's position of a "western woman believing in science" is contrasted with positions of "religious women who think of sex and sexuality as something dirty".

As emphasized earlier, the practice of knowing encompasses more then mere acquirement of facts. In the case of vaginismus, the assembled information are not limited to "general knowledge", but become a personal "knowledge about my own body". This knowledge includes "inner-sensitivity training" – women not only need to know where certain parts of their genitalia are, but also how to *relax* their clenched muscles. These two practices – exploration of one's own genitalia and acquirement of relaxation techniques will be addressed in the next two sections.

Exploring genitalia

Even though it is not the case for all vaginistic women, most of them do not feel comfortable about their own genitalia (or female genitalia in general). Led by the though that becoming comfortable with their "private parts" is an important part of the overcoming process, many women take a mirror to look at their vulvas, realizing where are *their* outer and inner lips, clitoris and, as a final aim, vaginal orifice. Rather then looking, they *explore* their vulvas and try to develop positive feelings about them. They also touch their vulvas and try to get comfortable doing that. The engagement in this practice, as well as in gathering facts, is very influenced by women's backgrounds and not all women take this step. Many women have reported being able to insert dilators, but not their own finger, which still "freaked them out". Despite managing to get pregnant twice, Mae reported never to have looked at her vulva in the mirror.

"Active relaxation"

According to medical views, the key to overcoming vaginismus is muscle relaxation. Except for Botox treatment, every other treatment method requires women to learn how to relax their muscles themselves. This process is a great example of inner-sensibility training. They need to learn how to *feel* their muscles contracting or being tense, and also how to relax them. The most commonly suggested technique that is supposed to help women realize which muscles are at stake and how to relax them are Kegel's exercises. Originally developed for incontinence prevention, women are sometimes advised to do these exercises in order to "keep their vagina tight"[27], and vaginistic women in order to learn how to control their PC muscles. Some have argued that rather then doing "standard" Kegel's exercises (aimed to strengthen the PC muscles, which is not what vaginistic women want), they should do "reverse Kegel's" – instead of keeping their muscles contracted for as long as they can, they are supposed to keep them *relaxed* as long as they can.

Yet, for many women it is not only about relaxing their PC muscles but "their whole selves", or as Sarah expressed it, about learning how to "let go" in general and make relaxation a habit, rather then an ability. In order to achieve this, women use different techniques. Some of them start practicing yoga or meditation, others reach for different kinds of anti-depressants, not only medications, but also certain types of teas and other spiced drinks (such as warm milk with nutmeg) that are supposed to have anti-anxious effects, as well as alcohol or drugs. All methods can be embraced by some women and at the same time criticized by others.

Finally, both practices – learning to *feel your muscles* and *be relaxed* – seem to be very personal; all women find or develop their own ways that fit them best and even though there are techniques that are widely used, still it seems that every women interprets and experiences them slightly differently from others, and adapts them to their own personality. Whatever the method or its adaptation, however contradictory it may sound, relaxation is something that these women actively engage in. As Sarah explained, tenseness is her "natural" state, so she has to "actively relax" all the time.

[27] Mostly in "mondane" women's magazines, although some scientists have argued that vaginas do not become "loose" due to intercourse or even childbirth, only when women come to a certain age when all of their muscles become less strong – and then there is also risk of incontinence.

"Taking care of yourself"

Some practices that women start to do because of vaginismus actually address other parts of them, or their "whole selves". As holistic approaches, yoga and meditation are thought to have wide benefits on people's health and might impact many areas of one's life. Many women start psychotherapy during which they address other issues in their lives, since vaginismus and its causes are very embedded into other aspects of a woman's being. Also, according to some, the cause of vaginismus might impact their health in other ways too (as Sarah argued), so addressing vaginismus means rethinking one's whole life in a way. Additionally, some women focus on taking care of their "physical wellbeing" as well. Lavender, for instance, considers very important to eat healthy in general and tries to include into her diet foods such as avocado and curcuma that are "good for your skin" (also for tissue inside your vagina). *Knowing oneself, accepting oneself* and *caring about oneself* thus become the strongest weapons that women use in order to achieve their aim. Through the OSG, women encourage each other to engage into these practices. In addition to "Facts Friday", Megan also started "Mantra Monday", providing "mantras" about hope and trust into progress, "Positivity Tuesday" to enhance positive thoughts, "Workout Wednesday" with suggestions for exercises that help to relax the pelvic floor, but also other exercises to "keep in form" and "Healthy Thursday", discussing a wide range of health-related topics.

Dilation

"Every day I have an emotional standoff with a piece of plastic…five pieces of plastic, if we're being technical", says a blogger in her *Dilator Diaries*. This is a reality for many women. Progressive dilation seems to be the most common treatment method for vaginismus. It is consisted of gradual insertion of dilators of different sizes, starting with smaller ones. Women are usually advised, by their therapists or more experienced MSG, not to move on to a bigger size before they are completely comfortable with the smaller ones. The sets of dilators usually contain five to eight, plastic or silicone dilators, the smallest one being of the size of a pinky finger, while the biggest one is thought to be "bigger then an average human penis". Once women, with a little help of "lube"[28], manage to insert a dilator, some of them "keep it in" for at least 10 minutes, others do it for a few hours or even sleep with them, while

[28] As lubricants are usually refered to by MSG. Types of lubricants were discussed in more occasions in the SG – medical lubricanting jellies can be oil- or water-based, while some women prefer to use olive or coconut oil.

some women "thurst them" and "take out". However it is done, dilation is something that they should do *every day*.

The first time a woman manages to insert a dilator can feel quite empowering. After not managing to make any progress in 13 years of relationship because of the pressure she felt[29], the again-single Lavender decided to make a trip on her own, traveled to another country and brought her dilators with her. Coming back into the apartment in which she was staying alone[30], and having seen a lot of beautiful things, Lavender felt it was the right time:

> so I was like ok, if it doesn't work, there's no guy...you know, timing, just hurry, hurry [laughs] you know, and I kind of felt like this in a relationship, I felt like this [puts hands around her neck to symbolize strangling]. So I was like, ok I'm just going to try, and I put on some music, what I like, relax myself, I put some music and did some yoga, I tried to relax myself, candles and everything...and I was like ok, ok. And I was, literally I was like no, you have to try to relax, but at the same time I was...in a pillow like this [shows how tightly she was holding the pillow with her hand] you know (...) and I was like: is this going to hurt? I don't know but, I used a lot of lubricant, and I was like, ok just, just a small...just a first try [shows a little part of her finger, size of the nail] and I was like, I have to give myself this chance, you know but I don't know if I can and I was like...[laughing] very mixed up, having a conversation with myself [laughs]. And it was like...ok...and then it was in, it was this size [shoes her pinky]. Huh? Ok. Oh, oh, that wasn't so bad, you know. Ok... and then I just let it in for about I think 10 minutes, and then slowly [took it out]...I was like oh, ok, oh, oh, God it was nice [laughs]. You know I was very surprised, because I was like I don't have it! I don't have a...[lowers her voice] a hole. And so hmm...then then I was like, I already have this, so I can do this a second time, and a third time and a fourth time and...

But when dilation actually becomes a routine, it does not always feel that nice. It is quite often stressful, frustrating and women might have problems with "creating the right mood" or fitting it into their busy daily schedules. As Cecilia explained,

> "It's actually kind of hard, I need to do a better schedule, but it's hard...me and my husband both work full time (...) so in the morning, I'm not up to do it in the morning, I like doing it in the night, when I'm done [with everything she has to do during the day], but...after I worked, I'm tired, you know and so it's about like once or twice a week that I do [dilate]" (Cecilia, Skype interview).

[29] Pressure to have intercourse with her husband – this is a very important point that will be further discussed below.
[30] After divorcing her husband, she moved back in with her parents and saw that as an obstacle to successful overcoming, because she felt she needed to be on her own.

For Ines, on the other hand, what represents an obstacle to regular dilation is the fact that she and her boyfriend do not live in the same city:

> [I don't like to do it alone] not because it is gross, but just because it's different, I think when I am with him, in our intimacy, there is a different environment, it's a romantic thing...when I'm alone with myself, it's...it's like it looses it' meaning, you know, like sexual experience looses it's meaning when I am alone (...) so when we are together, that facilitates, yes... (Ines, Skype interview).

Perceiving it as a quite hard and long process, women in the OSG often remind each other to "celebrate every little step" and to feel proud of themselves after every accomplishment, even if it means that they managed to get the dilator one millimeter more "in" then ever before. On the other hand, not that rarely, women reported "regressions", which means that they stopped being able to do something they previously became able to. After learning to insert the biggest dilator, Sarah had intercourse with a man she had feelings for, but then found out that he did not have the intention of building a serious relationship with her. As she says, at that point her "real journey" of overcoming vaginismus begun. Shortly after I joined the support group, Susanne announced that she managed to have sex with her partner. Still, by the time I interviewed her a few months later, she ended the relationship with that man and claimed to have regressed. She also left her dilators at her ex-boyfriend's apartment, and told me she should "get them back" and exercise again. Finally, Mae also claimed having regressed after giving birth to her son.

Even though most women do use dilators, some think they are "too clinical" or "too cold", and prefer to use their own or their partner's fingers instead. Ines, for example, told me she was inspired by a women who's video she saw on YouTube and who overcome vaginismus only by using fingers. She wanted to follow the same path, along with doing yoga to relax and creating a romantic environment with her partner. Finally, some women were not able to purchase clinical dilators (mostly in countries where they were not allowed for religious reasons). What they had to do was to make some by their own, employing very creative techniques such as using candles of different size, melting plastic objects and making dilators out of that plastic, or pealing cucumbers to the wished size (the later is sometimes used also by women who do own dilators but feel that the difference between two dilators that should follow each other is too big, so they create "inter-sizes").

To summarize, women find many different ways to practice dilation, including the "mood" they create and the types of lubricants and dilators they use.

In the practices described above, the presence or use of many "excorporations" (Mol & Law, 2004:9) can be noted. In fact, other then women's vaginas, these practices involve their hands and eyes, mirrors, lubricants and oils, food and relaxants. As Mol and Law (2004:11) argue, "the self aware body has semi-permeable boundaries", which means that acting bodies are not isolated, but on the contrary, "they interact and sometimes partially merge with their surroundings". The insertion of dilators is an obvious example, when outer objects – dilators, as well as lubricants on them – cross "boundaries" of women's bodies. Realizing how "permeable" these boundaries are and not feeling anxious about it is in fact of huge importance for vaginistic women.

Yet, excorporations are not only objects that merge and interact with the body, and doing vaginismus involves much more then learning how to insert an object into one's vagina – it includes other persons. Thus, the next sections will address practices women engage in because of their vaginismus, which include other people.

Doing relationships with partners.

Half of my informants found out about their inability to engage in intercourse after getting married, while the other half was in quite stable relationships[31]. Their partners were mostly supportive at the beginning, while thinking that they were just afraid of the "first time" and that it will "get better". But, once realizing things were not going to "get better" that quickly and that their partner suffered from something called vaginismus, their reactions could change. Women are usually very concerned about how their partners would position themselves, and this issue is often discussed in the OSG.

• Will he[32] cheat?

It happened a few times that women would post about being afraid their partner would engage in sexual relationships with other women, since "men need sex". In these occasions, other MSG, especially administrators, would try to convince them in the opposite, telling

[31] Only Veronica does not want to have sexual activities yet, but because of her inability to use tampons , fear of GEs and attitudes towards sex, she believes she has vaginismus

[32] Even though vaginistic women might as well have female partners, I did not come across this situation during my fieldwork and, since women I was in contact with always talked about "him", for practical reasons I decided to use the same gender, instead of writing he/she every time. Only one of my informants saw herself as bisexual and had sexual experiences with both women and men, but when discussing her experiences with women she never emphasized her inability to to perform penetration to be problematic, but rather her inability to express her preferences or as she put it, "to say what I like".

them that "men need sex" is just a myth and that there are supportive and kind men who stay faithful.

• Will he have patience?

Worries about this put a lot of pressure on most women to overcome vaginismus as soon as possible. Usually their partners would not explicitly tell women to "hurry up", but just the fact of having someone "waiting for you" creates a feeling of pressure in many women. Lavender felt like being strangled throughout her years of marriage. She tried to overcome vaginismus, but "it didn't work, because there was too much pressure I guess". Matea and her boyfriend have been dating, breaking up and getting back several times in the past three years. She says they get along very well, but when it comes to sex, problems emerge that threaten the basis of their relationship "(...)because he hopes and encourages me to deal with this, hopes that it will get better [their sexual life]. If it's going to stay like this [her avoiding sexual intimacy], that's definitely not acceptable for him" (Matea). When asked whether she feels pressured, she claimed:

> Well...not really because I'm not allowing it, because this used to be such a problem for me and I used to suffer so much because of it at some points, that now in my head it is really like, when it comes to this [her sexual life], I am my own priority. And that's why I don't feel pressured.

Still, when comparing how it felt to "deal with vaginismus" while being in a relationship and being single, she said that

> it's much easier when I'm alone. Because then it [the overcoming process] goes at its own pace, as it should go, as it wants to go. And this way [being in a relationship] something is interrupting you all the time...or pushing you.

.

Megan also reported feeling pressured by the feeling that her husband was "waiting for her". She gave herself a deadline and wanted to have intercourse on their first anniversary. Her husband made her promise that if she would not be ready by then, she would not be disappointed, because he wanted them to have a good time even if they could not have intercourse. Despite she made a lot of progress, about a week before their anniversary Megan realized that she would not be completely ready, which disappointed her very much. When she started crying, her husband reminded her about her promise. But although she wanted to

keep it, she needed to cry about it "right now". Eventually, they had intercourse about three weeks after their first anniversary.

Cecilia's husband has erectile dysfunction. Yet, even though one might think the opposite, this fact does not take the pressure away from her, neither does it make them "share the guilt". As Cecilia explained, "he can just take the pill and he's ready to go", while it takes months for her to "fix *her* problem".

Lotte found out about vaginismus after getting married to her ex-husband. He acted "as if he couldn't breathe" (Lotte) and she felt very pressured because of his behavior. Now, she is in a relationship with another man who is "fine with her" as she is. As she explained, instead of having sex, they can always sit on the couch together and watch television. When Sarah told her partner about her condition, he gave an answer that thrilled her: "I'd much rather go ballroom dancing with you!" Even though they never went ballroom dancing, they stayed committed to each other and, as she explained, had a great time together outside of bed – that is in fact, as she concluded, most of the time people actually do spend together (she did overcome vaginismus eventually).

• Should he take part in the treatment process?

The answer to this question depends on both parties involved – the partner, but also the woman herself. As shown while discussing the previous question, some women preferred to treat on their own, in order to avoid pressure and doing it for their partner, instead of "for themselves". Other women wanted their partners to be involved more. Some of them were hurt by the fact that their partner considered it as "your thing", something that "you" have to deal with. As Kristen explained,

> My husband was disappointed, but was very hopeful at first. After several months, he got quite discouraged. He referred to it as my problem, which was hurtful. I viewed it as our problem, since we were married.

Ines also wants her boyfriend to be involved; in fact, she does not like to dilate alone because, without her boyfriend, sexuality would loose its meaning for her and thus "when we are together, that facilitates [dilation]" (Ines).

These two stories represent two opposite situations, but there are lots of stories "in between". Whether the partner is going to take part in the healing process or not, and how much he will be involved depends on the vaginistic women's motivation to overcome, her

reason why she wants to have intercourse, the issue she perceives as having caused her vaginismus, the nature of their relationship in general, the partner's attitudes towards sex and vaginismus and his willingness to get involved and many other factors.

• How to let him know?

Sometimes, men indeed do not have patience and do cheat, or women's relationships with their partner with whom they found out about having vaginismus just end for other reasons. In any case, these women find themselves on the "dating market" again, knowing that intercourse is not something they can offer. Thus, in addition to the first three questions, these women have to think about how to let their new or potential partner know that they have vaginismus?

I came across discussions about this issue several times during my fieldwork. What women would advise to each other was to let the partner know as soon as possible. The first time Sarah found herself in such a situation, she made her partner "sit down" and explained him what the issue was. He told her not to do it that way ever again, but to just "slip it into the conversation". So the next time she had to have this conversation, she "just slipped it into the conversation" – but it seemed that, in whatever way she would do it, the situation would always be unpleasant.

Susanne has been involved with several partners. As she explains,

> I try to get these things across as early as possible (...)because I don't want to, you know, get attached and then find out that they're assholes...so...I mean as soon as sex comes up, even in just a casual conversation...I bring that up (...)some of them asked me what I do...like, do in bed and what am I doing about it, and all sorts of stuff like that. I never had anyone turn me down because of that. I have had more then one person umm asking me again and again to try and I had to explain to them: no, I can't, especially right now, because I'm feeling anxious, or right now because I'm feeling more depressed, and...After a few times like that, I usually stop talking to them, because it's too much.

• What kind of man do I want?

As it can be seen from Susanne's narrative, letting a potential partner know about vaginismus was perceived as a good thing to do in order to avoid getting attached to a person that was not ready for a "sexless" relationship. Although it would hurt women, being rejected because of vaginismus was not always interpreted as a misfortune. After having got divorced, Lotte would tell her new partners about vaginismus

> quite quickly, in the early stages [of their relationship]. And if he would have a problem with it, then it wouldn't be so bad, because then it would be just the wrong guy [laugh]. And, yeah, that would be sad, but then you wouldn't have the problem of being very very hurt, because I think if he just ends the relationship because of the condition then yeah...I think you're not a very nice person.

Lotte's opinion was shared by more women, as it can also be seen in the example posted on Thanksgiving day, used in the previous chapter. Not being able to have intercourse enabled them to find a partner who loved them for more then just sex – which was evaluated as a desirable trait by women.

"Even though I have vaginismus, I still date", says Lavender, "because, what if I find a man who can open me up?". She was given this advice by her therapist, a woman who overcame vaginismus herself. As Lavender explained, getting to know more men enables her to realize what she likes and dislikes about them, what she wishes and what she does not. By now, the most important trait that her partner should have is to make her feel safe. She has ended several relationships despite being in love, because she would not feel completely safe and would feel that her boundaries might be crossed. Only once she felt safe – with a man who had to flee from his own country and understood how it was not to feel safe.

Before going to her third date with the man she is still in a relationship with, Sarah made a list of 17 questions that he had to answer, because she was "fed up of meeting men who don't have the intention of following through". The list included questions such as

> Do you want to marry, how many children do you want to have, where do you want to live, how do you like holidays...? You know, all those questions that...online date sites would ask. And then also, how often do you want to have sex in a week? [laugh] He was so shocked! And until this day he's shocked about it. But it was important for me, you know, not to be pressured into something I couldn't give or I thought I couldn't give.

When he told her that sex was not the most important part of a relationship and that he would rather go ballroom dancing with her, she knew that this was a kind of man that she wanted to become close with.

Doing gender

Vaginismus might also have an impact on women's gendered performance and the ways in which they symbolize their femininity to other people. Here, I have to start from Judith Butler, according to which

> to be a women is to have become a women, to compel the body to conform to a historical idea of 'woman', to induce the body to become a cultural sign, to materialize oneself in obedience to a historically delimited possibility, and to do this as a sustained and repeated corporeal project (Butler, 1988:522).

In other words, for Butler, people *are* not of certain gender, they *do* their gender, symbolize it through certain corporeal acts according to the norms valid in their culture and historical period. Other authors have dealt with gendered performance of women who are not able to engage in intercourse. Drawing on Connel (1995), in her study about women who live with vulvodynia[33], Kaler starts from the position that gender constantly refers to what bodies *do* or *not do* (2006:54). In this sense, "gender identity proceeds from and is produced by sexuality and bodily practices" (ibid:51). Since "to be a 'woman' in heterosexist society means to have sex with men" (ibid:54), one's feminine identity emerges from the act of intercourse, which is both gendered and gendering:

> Excluded from sexual intercourse, they describe themselves as effectively 'genderless' or 'degendered'. In their descriptions, they invoke images of gender failures, of women who are not really women, because of their inability to perform this one hallowed heterosexual activity. These images enable us to trace out the conceptual links between heterosexuality and gender, and to reinstate the central importance of sexual activity to doing, and living, gender (ibid:51).

Kaler concludes that women with vulvodynia do not feel like 'real women' because of their inability to engage in what is perceived as 'real sex' – as mentioned, she depicts her participants as 'genderless' or 'degendered'. In another study on women with vulvodynia, Ayling and Ussher (2008) found similar narratives – those of 'inadequate sexual partners' and 'inadequate women'. Although similar, the phrases 'not being a real women' and 'being an

[33] Chronic vulvar pain with no known cause (according to www.webmd.com). Even though the physical characteristics of vulvodynia are different from the characteristics of vaginismus, the consequences are very similar – inability to engage in specific sexual acts. In addition, a lot of women suffer from both vaginismus and vulvodynia and the tow conditions might be interconnected and are sometimes thought to even cause each other.

inadequate women' have a crucial difference: 'inadequate' women are still women, they are not deprived of their gender and gendered identities.

During my fieldwork, many women have indeed reported feeling "less of a woman". Megan, for example, struggled with a strong feeling of being a "freak of nature" and "not fully a woman"; even after having overcome vaginismus and despite the fact that she is the one who financially supports her and her husband, she still carries a burden of being a "bad wife" (and even though her husband is trying to convince her in the opposite). Lavender, on the other hand, claimed never to have experienced feelings of gendered inadequacy, although she was told by a former partner that she was not a "real woman" because of vaginismus. According to her, this happened because she ended their relationship – something that his ego could not support – and thus he reacted out of affect. While they were still seeing each other, on the other hand, he told her that she was very sensual and that sexual experiences were "much more fun" with her despite vaginismus, then with women who could have intercourse, but would "just lay down". She did feel very sad about his insult, but still opposed: "You're not a woman because you have a vagina!" Most of my informants were somewhere between Megan and Lavender; as Lotte put it, "sometimes you do feel a bit broken", but in general vaginismus did not cause feelings of de-genderness. Only Matea claimed that when, for example, gender inequality is discussed, she does not feel addressed – as if something of concern for 'women' is not of her own concern.

The mentioned studies as well as my own findings mentioned above are focused on gendered experience, while performativity is regarded only to the act of sexual intercourse. Yet, gendered performance includes more then just sexual behavior – there are many other practices that are considered as "feminine" or "masculine". Thus, I will try to depict two opposite situations of gendered behavior. Megan and Matea both claimed that vaginismus influenced the way they dressed. Megan used to wear shoes with high heels – "the higher the better" – but stopped after her struggle with vaginismus started. She had a lot of clothes that she used to wear before getting married that were just hanging in the wardrobe. "Why should I start something I couldn't finish?", she asked, perceiving that 'something' as "provocative" dressing or even kissing, practices that she felt might lead to sex. Matea's experience was similar: she had phases in her life when she would wear only baggy clothes, and became hesitant about any kind of sexual intimacy, eventually loosing her sexual desire almost completely. On the other hand, Lavender described herself as very passionate during sexual encounters and enjoys outercourse very much. She also likes wearing dresses and dressing in a typical feminine way – "I'm a girly girl", she concluded. Similarly, Cecilia claimed not to

have feelings of gendered inadequacy and that she would feel feminine "when I dress up I guess [laugh], go to the spa or get my nails done or whatever...that's when I feel like a lady [laugh]". Ines never felt "less of a woman" and claimed that vaginismus did not impact her gendered expression, except in one instance: "I just felt that I had so much energy that I needed to put out, you know...to...to express, and I couldn't find the means to express it, sexually at least".

Managing gynecological exams

Gynecological exams (GE) are considered by many women as something not very pleasant and, obviously, for vaginistic women it is even more so. Thus, a *practice of avoidance* is used commonly. Certain MSG reported having read articles that claim that GE do not need to be performed yearly – for a healthy woman, every second or third year should be enough. Some have even marked GE as "legitimized rape" and advocated for self-examinations.

Still, most women conform to the reproductive biopolitics and do (try to) perform GEs. Many of them indeed visited a gynecologist after realizing that they were unable to perform penetration. Even though some of them got a diagnosis of vaginismus and advice for further steps from their gynecologists, many of my informants reported having negative experiences with gynecologists – they thought them to be uninformed, ungentle and even rude. For example, even after giving a diagnosis of vaginismus to Ines, her gynecologist

> forced me to be examined, in a way. So it was a disaster, because it hurts, really, really... I even had sort of a panic attack because I couldn't breathe, I was really, extremely, uncomfortable. And I think it only made thing worse (Ines, Skype interview).

Other women had similar experiences. Matea was able to perform a GE with some difficulties, but after her gynecologist extremely rudely yelled at her for "making things complicated", she never went back again. Lavender tried to have her first exam when she was 32 – this fact freaked her gynecologist out and she tried to force Lavender to insert her own finger. Lavender almost fainted and after recovering from the shock, she left never to come back again.

Sarah suggests that what women should *do* when going to an appointment with a gynecologist, even after having overcome vaginismus, is to take a leaflet with information

about vaginismus and pelvic pain with them and ask their gynecologist to read it and inform themselves about the issue. They should approach the gynecologist and "take charge" over the situation, not letting themselves to be victimized.

Living with a sexual(ized) body in a (dangerous) sexualized world

Women are not only "actively engaged in enacting" a "condition", the "condition" itself "in its turn, helps to enact the body – in a quite specific way" (Mol & Law, 2004:12). In order to exemplify this claim, Mol and Law argue that "living with asthma makes people acutely aware of the air they breath", while "trans-sexuality comes with an overwhelming sense of living in a sexed body". Rather then making women acutely aware of their *sexed* bodies, vaginismus makes them aware of their *sexual* and *sexualized* bodies. And not only their own, but every body they encounter in their physical and virtual surroundings. Susanne, for example, explained that "because of my vaginismus, I am so fixated on sex that...when I hear that a friend is pregnant or had children, I think: oh my God, she had sex! [laugh]".

Further, many women reported feeling jealous of pregnant friends or relatives. They would feel bad for not being able to be sincerely happy for the future mother, but could not help themselves – it was making them acutely aware of their inability to have intercourse and bare a child. Megan told me that she and her husband used to watch a television show about pregnant teenagers, which would make her angry because "they're kids and they shouldn't be having sex and I'm a grown up and I can't do it". Television and other media were rubbing salt on her wound and making her think: "What person can't have sex, sex is everywhere, on the TV, there are pregnant teenagers walking around, everyone can have sex, but I can't, something is definitely wrong with me!" (Megan, Skype interview). Sexualizing media were a source of frustration for other women too. Sarah, for example, criticized the way sex, sexual and romantic relationships were depicted in most television series and movies. During her second curing cycle, she was following a very popular series[34] and at a certain point realized that it had a really bad impact on how she perceived herself, sexuality and men. She said she would literally clench up while watching it and that there was "no one single normal, loving and caring relationship in the whole series", so she stopped following it. In her opinion, "for someone who is sensitive, especially in that aspect", this kind of series can be traumatic.

[34] The series ineed caught public attention for scenes of violence, a great part of which was specifically sexual violence and abuse.

Finally, some of my informants reported not only being angry and disappointed about sexualizing media, but also about the way sex is talked about in society in general, especially when it comes to sexual education, which is, in their opinion, inappropriate or lacking important parts. As Megan explained, "they just say this is a penis and this is a vagina, they never talk about sexual dysfunctions, neither in nursing school". Other informants expressed similar concerns. In Cecilia's words:

> it's like: here's all the diseases you can get, you know and...it really doesn't highlight the greatness, I mean I understand that they don't want teenagers going around having sex, but there is no benefits to it, it's just...this is what happens ok, this is what's gonna happen, you're gonna get pregnant, you're gonna get STDs, you're gonna, you know...there's nothing beneficial, there's nothing healthy about it, sex is a healthy part of life. I think if education involved that, I think the benefits would probably help a lot of women (Cecilia, Skype interview).

To summarize their thoughts, they all felt that sexual education was based on a "danger discourse", while lacking useful information about sexual performance, such as whether sex should hurt, when does it hurt and what to do if pain is unbearable. To link this back to practices that consist "doing vaginismus", Lotte claimed she became aware of this issue after she started dealing with vaginismus. Matea and Susanne had a similar experience, both of them becoming focused on the issue of sexual consent. As Susanne explained:

> Since I learned of my vaginismus, I wanted to have good sexual education. People should know about their bodies, they should know about consent, they should know about sex (...) Consent, consent is so important. They talk about contraception and they talk about STIs...but they don't talk about consent! Both of you need to want it. Both of you need to enjoy it. I mean, it's supposed to be so basic! (Susanne, Skype interview).

Her struggle with vaginismus stimulated Matea to look into feminist literature, and the question of consent caught her attention too. When she first came across the radical feminist claim according to which even "yes" sometimes means "no"[35], she rejected it as nonsense, but after thinking about it for a while, she came to the conclusion that she agrees and started to question her own will and pressure that is put on her to have sexual relationships.

[35] In their campaigns against sexual violence, feminists used "yes means yes and no means no" as a slogan. Some authors pushed it further, claiming that women sometimes say "yes" even though they do not want the sexual encounter to happen, because they feel obliged to do it (and the feeling of obligation or even fear emerges from the patriarchal social arrangement).

Along with a critique of over-sexualizing media and negative discourses surrounding sexuality, the question of the appropriateness of sexual education emerged as a big issue during my fieldwork, that could be discussed in more details if it was not for space limitations. Part of it will be further addressed in the next section about "spreading the word" about vaginismus.

Doing silence and talking vaginismus

Most women have never heard the word 'vaginismus' when they attempted to have intercourse for the first time, and to some of them it took years to find out why were they unable to do it (Pacik, 2014:1615-1616). During my fieldwork, most people who would ask me about my research would hear about vaginismus for the first time from me and, as noted in the *Dilator Diaries*, neither does Microsoft Word recognize the word. Some women reported wishing to have known about it earlier in order to start doing something about it earlier. Mae, for example, recalled how no one took her to a doctor when she fainted at age 13 while trying to insert a tampon. As she explains,

> No one told me that I had a condition that with the proper treatment could have been worked on. The reason wasn't because they didn't care. It was because no one knew.

She did not get a diagnosis neither after a failed GE. And then she got married. Many women share Mae's story and wonder why is vaginismus, as well as other pelvic floor and sexual pain issues, surrounded by such a veil of silence. Here, I do not see the fact that vaginismus is rarely talked about in public as a lack of agency or absence of meaning. On the contrary, I see this silence as a cultural practice (Woolley, 2012; Ling, 2003). In other words, the rare presence of discourses about vaginismus is indicative of society's attitudes towards (problematic) female sexuality and sexual pain is still often perceived as taboo for a reason[36].

Vaginismus is not only surrounded by silence in public spaces, but also in private spaces of personal networks. Indeed, many women reported how hard it was for them to open up about their vaginismus, not only to their partners, as discussed earlier, but also to other people that are parts of their lives. According to Sarah, "you make yourself very very vulnerable if you do tell a person". The inability to engage in intercourse makes vaginistic women feel disadvantaged compared to other women, which makes them employ different

[36] A detailed analysis of the reasons of this silence excedes the scopes of this paper.

techniques of "managing their spoiled identity" in order to avoid disclosure and feelings of humiliation (Goffman, 1986). Some women confied in their mothers, while others keep it a secret to them. Audrey claimed her mother has been a great support for her. Matea has also a supportive mother, but she experiences her mother's wish to help as slightly pressuring. Cecilia, on the other hand, is "working on telling her parents", but she finds it problematic because she knows that her mother is very enthusiastic about becoming a grandmother, and Cecilia does not want to disappoint her telling her that this is not going to happen that soon. For others, such as Sarah, the reason not to open up to her mother is simply that sex is not something that she feels free to discuss with her parents. Even though quite some women find a support in their mothers, much less of them opens up to their fathers. Of my informants, only Ines reported having talked openly about it to both of her parents.

Cecilia was my only informant about whose condition no one except her husband knows. Most other women have opened up to someone at a certain point, usually to a few close friends. Matea and Ines were my only informants who claimed not to have problems talking about it to anyone, especially not to their closer friends, who had known about their struggles from the very beginnings. Others usually choose a few persons that they felt they could trust, but would not discuss it with other people. Thus, in certain situations they had to employ specific "techniques of avoidance". One of them is "changing subject", as Megan explained:

> When I came back from my honeymoon, my friends were like: so, what was it like? And I had to make up some lie and change subject, and when I changed subject, they stopped asking. So...what I would mostly do is just change the subject. Like: Oh, yeah, sex is cool, oooh, did you see that movie the other day? It's pretty much all I did.

Cecilia's technique was "pretend everything is fine". After she and her husband got married, "everyone's like oh you guys probably have sex all the time, blablabla...and it's like...[facial expression showing an embarrassed 'not really'] yeaaah, we dooo, it's lovely! [laugh]". Lavender, on the other hand, employs a technique of "partial disclosure". She would tell people that she had a phobia that created problems in her relationships, but would never go into details about what kind of phobia it was.

In general, most women talked about the inability of other people to understand what was going on in their lives. Some were irritated by their mother's or friend's benevolent comments such as "you just have to relax, it's all in your head". Vaginistic women felt that

other people just could not grasp the full complexity of their situation. For some, this became the very reason not to talk about it. Cecilia felt

> it's hard 'cause I try not to say too much and it's like[everyone is asking you]: how is yours[sex life]? (...) you try, you know, you don't wanna...say too much about it 'cause...they don't understand and they don't really know, the struggle that we're going through(...)

Taking this in account, it is not surprising that a post such as "I have no one else to talk to" emerged quite often in the OSG. Indeed, some MSG have called the OSG "a blessing", because that was the only "place" where they could talk about it completely openly and share their experiences with other women who were going through the same struggle and understood how hard it was. The OSG and other virtual spaces provided women a possibility to "reach out", keeping their anonymity at the same time. Many women wanted to "scream on the top of my lungs: hey, this is out there and it's hard for me!" (Cecilia), but were held back by this practice of silence. In the virtual spaces, they could scream under a pseudonym and an avatar. Sarah is, for example, said that active participation in the OSG and other internet forums and information web-sites helped her to become able to phrase her feelings better, but she is using a pseudonym and still has problems doing it "as my own person".

Finally, and to go back to the question of sexual education, the aim of many vaginistic women was not only to share their own stories, but also to "spread the word" about vaginismus in general. All of them agreed that more information should be available, because then women could recognize what their problem was sooner, avoid feeling as "freaks of nature" and "alone in the world in this condition", and would know what steps to make in order to solve the problem, without spending months or years looking for a solution. Still, not all women agreed on the means of "spreading the word". Mae wrote a letter to the the political authorities competent in the place where she comes from, claiming that

> While I don’t want to bore you with my lack of sex life or health problems. I keep thinking about the fact that had I known about the condition. Had it been taught in sex education or a health class. I could have gotten support and started treatment. I would like to change the fate that so many women with primary vaginismus (...) have to endure. I would like to have vaginismus and the pelvic floor issues being taught in every public school.

Others yet did not support the idea of making vaginismus a school subject, but agreed that there should be word about it in families, female magazines or play groups in churches

(Kristen), for instance. Finally, some women did not think that vaginismus specifically should be given more attention in public spaces, because

> Men with erectile dysfunction or premature ejaculation are being ridiculed, and that's so wrong. And umm...I don't know if...like...umm...[if vaginismus would be more present in the media] I don't think that women would be umm...a-a...pittied or ridiculed, but both is wrong and I know it would be one of them (Susanne).

Instead, sexual consent should be given more importance (Susanne) as well as "important practicalities" about sex that would address the existence of sexual pain in certain situations (Lotte).

Having a long and intense experience of participating in online spaces dedicated to vaginismus, Sarah claimed to have noticed a pattern: women who were still struggling with vaginismus usually had problems opening up about it and felt very ashamed; once they would overcome, their wish to "reach out" and "spread the word" would rapidly increase. In this way, even after having overcome it, women would still keep engaged with vaginismus.

Doing post-vaginismus

After a MSG posted asking whether it means that she has overcome vaginismus if she is able to insert the biggest dilator, the answer she got was never to think about vaginismus as "being overcome". There is always a threat of "regression" if a women stops "practicing" and there is, of course, secondary vaginismus – after childbirth or an infection, as most common examples. Vaginismus can always "come back"[37].

For many women, keeping on with active participation in the OSG after having "overcome" is a way to "keep doing it", to "stay engaged". Sarah compared her situation with a story of an anorexic girl who decided to become a baker in order to engage with food throughout her whole life. This was her way to deal with her anorexia. In the same way, engagement with the OSG was Sarah's way to deal with her vaginismus. Some MSG even started another support group only for post-vaginismus. Even though it counts only about 60 members, it still indicates that there are women who feel the need to stay engaged, and that online support groups provide them too a way to do it.

[37] This can be seen as a metaphor of *vaginismus as a stalker* (and thus a substance outer to women).

FINAL DISCUSSION

The previous two chapters could be read as two comprehensive analyzes. Yet, as announced in the introduction, I want to use the two research questions – how do women talk about 'having' and 'overcoming' vaginismus and what do they *do* about and because of vaginismus – in order to discuss how do they maintain and challenge body politics and other structured ways of thinking about one's body. In other words, I will discuss instances of conformism to social norms about bodies and sexuality and instances of resistance to these norms.

Even though Lock and Scheper-Hughes discuss Cartesian dualism on the level of the individual body, I see it as a "structure" – a way we are taught to think about our selves. And the same is valid for thinking about bodily issues as substances. The narrative analysis has shown that most of the time women do conform to this ways of thinking, verbalizing their experiences of vaginismus through Cartesian dualism and in terms of substance. Yet, they do find different ways to express themselves – equating their selves with their bodies and depicting vaginismus as their own activity. This alternative way of conceptualizing vaginismus challenges the normativity of dominant ways of self-experiencing, while at the same time constituting new "experiential plots". The "narrative turn" medical anthropologists describe illness experiences as being *emplotted* into certain *plots*. While a plot is defined as "the underlying structure of a story" (Good, 1994:144), emplotment is "the activity of a reader or hearer of a story who engages imaginatively in making sense of the story" (ibid:144). While suffering, people follow prescribed codes (Dumit, 2006) or plots, that include a specific "nature of relationships among events and characters" (Good, 1994:145). In the case of vaginismus, the dominant plot's main characters are bodies, minds, selves and the personification of vaginismus. Expressing themselves in "alternative" ways, women emplot their experiences of vaginismus into new plots rather then the dominant one, changing the main characters, their relationships and the nature of events.

It has to be noticed that a "politic of control" lays underneath most narratives and metaphors of vaginismus. Using imagery rooted in Cartesian dualism, women talk about controlling their bodies, their vaginas, their thoughts and fears. They want to control their lives, instead of the 'substance' of vaginismus. Or they want to "take charge" and *do* their bodies themselves. However it is expressed, the idea of *control* is omnipresent in women's narratives and consequently in their practices.

Another important thing to be emphasized is that, while writing about women's ways to express themselves, sometimes I found it difficult to find the right words and express myself in the way I wanted to. As Lock and Scheper-Hughes wrote, "we lack the precise vocabulary with which to deal with mind-body-society interactions" and thus we are ourselves often "trapped by the Cartesian legacy" (1987:10). I experienced the same with the dualism of substance and activity and expressions based on control. My point here is to emphasize how limited I was, as well as my informants, by the "given ways" to express yourself. Language represented the first barrier to constructing alternative ways to conceptualize, and thus experience vaginismus – a good example of how bio-power restricts "freedom of speech" when it comes to "body talk", as Bruno Latour (2004) argued.

Further, practices women choose to engage in and ways in which they do these practices are influenced by their "backgrounds". Strictly religious women who believe masturbation to be a sin, and equate self-exploration with masturbation, would never engage in this practice. Other women, who believe knowledge to be empowering, see self-exploration as one of the most important steps towards 'overcoming'. The same is true for pictures of vulvas, which can be perceived either as empowering information or as unwanted pornography. Further, women prone to "medicalized attitudes" towards bodily issues usually choose to visit a therapist and/or to use clinical dilators and will more probably use medical relaxants, while, for example, women close to "New Age" ideas prefer self-therapy, using fingers in a romantic atmosphere and doing yoga or meditation in order to relax. These are two "extreme" examples, but all women, depending on their various "backgrounds", create their own "healing program", consisting of practices that fit their own personality and identity. Although it has to be taken in account that their identities are shaped within and trough the given structures, it can still be concluded that women do enjoy a big amount of "free choice" while looking for their "best fit" treatment method – they can choose among the many existing methods or create their owns. Despite the existence of various methods, financial and/or geographical matters greatly restrict access to treatment. Many MSG reported not having (what they perceived as) adequate treatment available in their own town and not being able to afford to travel to another town on a regular basis, or not being able to afford any kind of treatment that would include a medical professional, despite his or her geographical closeness. One of the most extreme examples are the restrictions faced by women living in countries where dilators cannot be purchased for religious reasons (mostly Arabic countries), although, as explained earlier, they find ways to manufacture dilators by themselves. Another example is a worldwide famous therapeutic center located in the United States, that claims being able

to help women overcome vaginismus in about two weeks and having a success rate of almost 100%. This privilege costs about 10 000 dollars plus travel and accommodation costs – something that most women simply could not afford. Additionally, the center invests a lot of effort into keeping their procedures secret, which made a lot of MSG resentfully wonder: "Am I not worthy of healing, if I cannot afford to pay for it?" This issue might be discussed further in the context of comodification of treatment and information access.

Women's "free choice" also has to be questioned when it comes to the fact that all except for one woman[38] in the OSG did want to overcome vaginismus. Continuing to live with it was not a desirable option for them. Some women wanted to overcome in order to be "real women" or because they thought intercourse was something a married couple should do, others because they saw intercourse as a final instance of intimacy and closeness to their partners, and others again to "do it for themselves" and reconcile with their bodies,. Although detailed explanation exceeds this paper, it is interesting to notice how women's motivations are also emplotted into certain social discourses. Whatever their reason, they all wanted to fit the norm of coital imperative. Even though the wish to meet the norm of a "real woman", "good wife" or "true lover" might seem more explicitly pressuring, "doing it for yourself" is no less normative then other motivations. As many feminist authors have argued for the case of cosmetic surgery, "doing it for yourself" is not a "free choice" of an "independent individual" – it is rather a "choice towards norms" of a "cultural being" (Braun, 2009; Chen, 2013). To be clear, this is not something that I want to criticize. Being a cultural and social being is not something negative, some would argue that this is what makes us "human". But it is to be acknowledged that through their wish and effort to overcome vaginismus, whatever reason lays behind it, women do maintain the normativity of the coital imperative. As Davis (1991) argued, women do what is best for them *in the given circumstances*. For vaginistic women, it means becoming able to have intercourse.

Finally, by not opening up about their condition, women maintain the practice of silence that emerges from the biopolitics of female sexuality. On the other hand, a strong wish to "spread the word" and "reach out" expressed by many women in the OSG represents a way to challenge these biopolitics. By running blogs, writing articles and filming short documentaries, women are striving to "break a taboo". Further, Mae's letter, asking for the incorporation of information about sexual pain into formal education, represents an attempt to influence existing biopolitical norms through the modification of actual politics.

[38] Still, she claimed that she does not want to do anything about her vaginsmus before getting married, but once she gets married she would consider doing it "for her husband".

CONCLUSION

The aim of this study was to show how do women with primary vaginismus navigate the social world within the given circumstances. I chose to do this by focusing on the narrative, bodily and social practices they are involved in and have shown the complexity of their experiences, surroundings and ways of doing their vaginismus. Despite its various limitations in time, space, accessibility to women with primary vaginismus, my own positioning and other factors, this study has fulfilled two functions. From an "engaged science" perspective, to give voice to at least some women with primary vaginismus who felt the need to "scream on the top of their lungs" about their situation and "spread the word" about vaginismus. From a theoretical perspective, to give some insight into the variety of human experiences, showing the complexity of mindful bodies and their social environments and making at least a little contribution to anthropological and sociological theorizations about the complex relationships of bodies, persons, practices, norms and politics. Finally, this project raised more questions that might inspire further research. Again, for "engaged scientists", the question of how to make young women aware of sexual pain and pelvic floor issues in a culturally appropriate and sensitive way might be important. Theoretically, it could be interesting to explore women's motivations to overcome vaginismus and how these motivations are "emplotted" into certain social discourses. Finally, this could give some insight into a very interesting, yet to my knowledge unanswered question – why is the coital imperative still such a persistent norm?

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