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A Portfolio Submitted for the Award of Doctorate in Counselling Psychology
(DPsych)

Alice Bingham

An IPA Study on the Experience of Receiving Psychosexual Therapy for Vaginismus and a Case of Therapeutic Practice using Assimilative Integration

City University London

Department of Psychology

March 2024

I, Alice Bingham, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis. [redacted]

THE FOLLOWING PARTS OF THIS THESIS HAVE BEEN REDACTED FOR DATA PROTECTION REASONS:

Part C: Clinical Case Study

Appendix i: Formulation diagram.

TABLE OF CONTENTS

PART A: Research Study

LITERATURE REVIEW

METHODOLOGY

ANALYSIS

DISCUSSION

DECLARATION

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Acknowledgements

Firstly, I would like to thank all of the women who took part in this study. I felt privileged that they chose to share their experiences of vaginismus with me, and be so open about a difficulty that is so rarely discussed.

Thank you to all the clients I have worked with. I have been inspired by and learnt so much from them all.

Thank you to my supervisor, Dr Angie Cucchi, for her invaluable guidance and feedback throughout the project. And thank you to all of the staff at City University who have always shown me such kindness during many difficult points of the research.

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List of Tables:

PREFACE

This portfolio comprises three pieces of works submitted to meet the criteria of the Counselling Psychology Doctorate program at City University London. Whilst focussing on the theory and practice of counselling psychology, it pays particular attention to the social and cultural context in which psychological difficulties occur. The portfolio reflects my progression towards becoming a counselling psychologist and my developing identity as a reflective practitioner. I will describe each section of the portfolio, whilst exploring some of the shared themes connecting each part, and reflecting on how they have influenced and been influenced by personal and professional experiences.

The first section consists of my doctoral research project, which explores how woman with vaginismus experience psychosexual therapy. My decision to carry out this project was influenced by my experiences working in a psychosexual service where many of the clients I worked with presented to therapy for difficulties with penetration. Before working at the service, I had never considered that such difficulties existed, and I felt acutely aware of my limited knowledge in the area. Whilst I developed this over time through conversations with my supervisor and reading the literature, I could not find much research exploring how women experienced these difficulties and what was important for them. My supervisor similarly reflected that she struggled to know where to direct trainees who were keen to understand their client's perspective.

One of the key assumptions that underpin counselling psychology involves its acknowledgement of the social processes that influence people (Joseph, 2017). Counselling psychology promotes an attitude of curiosity and reflexivity regarding the assumptions we make as practitioners and human beings (Milton, 2010). Whilst designing this research, I was encouraged to think more generally about what sexual wellbeing means for women with and without sexual difficulties. Reflecting on influences, such as the media, on how woman expect their sexual experiences to be like, I became more aware of what it might mean for woman to experience difficulties in this area. I also paid more attention to how sexual wellbeing was rarely discussed in other settings, such as during university supervision groups, or in my other placements. It seemed like sexual difficulties were differentiated from other areas of mental health. This was certainly my own experience before working in the psychosexual service, which I think was linked to a personal discomfort talking about sex, as well as my expectation that others may feel the same.

The study therefore aims to give women with vaginismus a voice and to improve the understanding of counselling psychologists and other health professionals supporting woman experiencing difficulties with penetration. Interpretative Phenomenological Analysis (IPA) was used to capture the experiences of participants. Data was collected through online semi-structured interviews. Findings from the analysis of the data revealed three Group Experiential Themes (GET) and 11 experiential subthemes, which reflected my understanding and interpretation of the participants experiences of receiving psychosexual therapy for vaginismus. These findings are considered in light of the existing research and clinical implications are considered.

One of the findings from this study supports those from previous studies reporting on how heteronormative discourses around sex and womanhood, e.g., the equating of penetrative sex with ‘real sex’, may contribute to the way women experiencing vaginismus feel about themselves. Svedhem, Eckhert and Wijma (2013) suggest that if norms around sexual expression changed, then woman may not need to feel like a failure. Findings from the present study reflect participants developing awareness of how such norms influenced the way they felt about themselves because of their difficulties with penetration. This theme regarding the way that people make sense of their difficulties in the context of dominant social discourses was also present in the second section of the portfolio.

The second section is a case study reflecting my clinical work in professional practice. The study describes my work with a client experiencing complex mental health difficulties and represents my process of assimilating narrative therapy into my host model of Cognitive Behavioural Therapy (CBT). A key element of narrative therapy is its recognition of and attention to how we understand our lives and how this is influenced the broader stories of the culture we live in (Morgan, 2000). More specifically, the beliefs, ideas and practices of our culture play a significant part in the meanings we make of our experiences (Morgan, 2000).

Taking a different view on psychological difficulties, narrative approaches understand there to be problem-saturated stories, which have developed over time, and do not align with lived experience (Harper and Spellman, 2014). Before working with the client in this case study, they had previously received a range of different diagnoses form different professionals, and they had developed a way of understanding themselves which was influenced by this, as well as the dominant social scripts around mental health. Through the lens of narrative therapy, I became more aware of my own beliefs and assumptions around what it meant to experience complex mental health difficulties, and the potential impact this may have on the therapeutic work. This was my first experience of using techniques from narrative therapy. I chose to present this client study because of how it represents my developing skills in applying psychological theory to practice, as well as a moment in my training when I became more acutely aware of the powerful role social and cultural factors can play in the way people perceive themselves and their experiences.

The final section includes a publishable paper that summarises the main findings from the research project, focusing specifically on two of the Group Experiential Themes: The Embodied Experience and Living with Vaginismus. I decided to only include two of the themes, rather than attempting a more comprehensive summary of the findings, as I felt that this would allow them to be presented in more depth, with a more detailed discussion of their implications for practice. Findings from the research demonstrated participant's experience of feeling more empowered to manage their vaginismus, and this was partly associated with their experience of recognising and challenging unhelpful narratives developed within a cultural context.

This article has been written with the intention to submit it into the *Health and Psychology* Journal. I initially considered writing it for the Journal of Sex and Relationship Therapy, however, based on potential implications around the marginalisation of psychosexual therapy as a specialisation (Tiefer, 2006), I felt that it would benefit from being included in a journal which may reach a have the potential to reach a wider audience of psychologists and mental health professionals. I felt that this was particularly important in light of low social awareness around vaginismus and potential social discomfort people feel talking about sexual issues.

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Abstract

Vaginismus is characterised by involuntary muscle spasms in the vaginal walls, making penetration painful, difficult, or even impossible. It is an under-researched area of female sexual health, and can have significant implications for a women's psychological and sexual wellbeing. Female sexual difficulties are also uniquely shaped by social and cultural factors, however, outcome studies examining psychological interventions for vaginismus primarily focus on the ability to engage in penetrative sex. This potentially ignores factors which may contribute to the complexity of the experience of vaginismus and its management. For example, a woman's self-worth, which is likely to be shaped by societal constructions around sex and womanhood, is not explored. This study therefore aims to give voice to women with vaginismus, to provide an in-depth exploration of their experiences of psychosexual therapy. The findings suggest that women with vaginismus initially struggle to communicate their difficulties around penetration, and whilst they feel a relief to learn about vaginismus, they also feel ambivalent about beginning psychosexual therapy. They also emphasise the importance of embodied experiences for women receiving psychosexual therapy for vaginismus, highlighting the challenges they experience around psychosexual exercises supporting them to develop a connection with their bodies, and their changing relationship to these. Finally, the findings indicate the potential of psychosexual therapy to help women make sense of and manage the impact of vaginismus on their lives, improve their sense of self-worth, feel more empowered to manage vaginismus, and hopeful about the future. Implications for counselling psychologists and other health care professionals are discussed in regards to both research and practice.

1.1 Introduction

Female sexual health is an important, but under-researched areas of psychological wellbeing. Vaginismus, a female sexual difficulty characterised by involuntary muscle tension in the vaginal walls making penetration difficult or impossible, can cause significant psychological distress, impacting on a woman's relationship with others, and how they feel about their sexual self (Svedhem, Eckert and Wijma, 2013: Ward & Odgen, 1994). There is also a considerable amount of shame and stigma attached to talking about sexual difficulties, which makes it harder for women to seek help (Shallcross, Dickson, Nunns, Mackenzie & Kiemle 2019).

One form of treatment for vaginismus includes psychosexual therapy (also referred to as sex therapy or sex and relationship therapy), a form of talking therapy incorporating a range of interventions that have been adapted to treat sexual difficulties (Tabatabaie, 2014). Outcomes for women receiving psychological therapy for vaginismus have predominantly been examined using quantitative measures, focussing on factors such as changes in sexual function or performance (Maseroli et al., 2018). However, it has been suggested that this adherence to a biomedical model is unable to capture the multi-dimensional nature of sexual wellbeing (Tiefer, 2012). Leiblum (2007) (cited in Tabatabaie, 2014) explains that the subjective experience is important in sex research as numerical questionnaires may be unable to capture a client's "deeply held but subjective difficult to articulate hopes and experiences" (p.270).

Furthermore, sexual experiences are particularly influenced by social and cultural contexts. A number of studies exploring the lived experience for a range of female sexual issues, have reported that a women's distress is often related to the impact it has on their ability to live up to socially constructed sexual norms, such as the prioritisation of penetrative sex as 'real sex' (Lavie & Willig, 2005; Svedhem et al., 2013). This indicates the importance of a qualitative approach to provide more insight into the role social, cultural and relational factors play in women's experiences of psychosexual therapy for vaginismus.

By exploring the subjective experiences of a small group of seven women who have all received psychosexual therapy for their difficulties with penetration, this study aims provide a greater insight into what this experience was like for them. It is interested in their thoughts, feelings and embodied experiences in relation to seeking help and receiving psychosexual therapy for vaginismus, as well as the meaning they attach to these.

This study consists of four chapters. The initial chapter includes a critical review of the literature to provide an understanding of vaginismus and the related role of psychosexual therapy, as well as highlighting the potential gaps in knowledge. The second chapter offers an account of the methodology, including the philosophical assumptions underpinning the research, and a detailed description of research procedures. The third chapter presents the findings which emerged from the analysis of the data, and the final chapter discusses these within the existing theory and research.

1.2 Defining vaginismus

Descriptions of vaginismus have been around since the 19th century, yet it first became a feature of the Diagnostic and Statistical Manual of Mental Disorders (DSM) for its third edition (American Psychiatric Association, 1980) (Pacik, 2014). Defining characteristics for diagnosing vaginismus have changed over the recent years. The original model of vaginismus centred around the "recurrent or persistent involuntary spasm of the musculature of the outer third of the vagina" and this alongside its "interference with sexual intercourse" was the first definition of vaginismus included in the DSM (American Psychiatric Association, 1980). Later, a revision to this definition was made based on the lack of empirical support for the presence of the pelvic muscle spasm. An alternative behaviour description was proposed and in the fourth edition of the DSM vaginismus was defined by the "inability to allow vaginal entry of any object despite the woman's expressed wish to do so" (Basson et al., 2004). Vaginismus can be lifelong (primary) or it can occur after penetration has been possible (secondary) (Crowley, Goldmeier & Hiller, 2009). Women can experience total vaginismus whereby they are unable to tolerate penetration with any object or partial vaginismus meaning they can tolerate some penetration with difficulty and pain (Crowely et al., 2009). It can occur only with certain partners or in specific situations (situational) or occur independently of partner or circumstances (global) (Crowley et al., 2009). More recently, a growing body of empirical research has demonstrated the significant overlap in clinical presentation for dyspareunia (recurrent or persistent pain associated with sexual intercourse) and vaginismus (Lahaie, Boyer, Amsel, Khalife & Binik, 2010). As a result, the two have been subsumed under one diagnostic category called Genito-Pelvic Pain Penetration Disorder (GPPPD) (American Psychiatric Association, 2013).

This new category has responded to empirical research highlighting the cognitive, emotional and behavioural factors associated with the physical symptoms of "marked muscle tension" or pain (Basson et al., 2003). A diagnosis of GPPPD requires the presence of at least one of the following symptoms: difficulty with vaginal penetration during sexual intercourse; marked genital or pelvic pain during intercourse attempts; significant fear of pain as a result of vaginal penetration; and tensing or tightening of the pelvic floor muscles during attempted vaginal penetration (American Psychiatric Association, 2013). Importantly, anxiety, fear of penetration or pain during penetration are considered sufficient for a diagnosis of GPPPD, whether tightening of the pelvic muscles are present or not. Whilst this is positive as it recognises the multifaceted nature of and unique reasons for the vaginal spasm and experience of pain in each woman (McEvoy, McElvaney and Glover, 2021), some issues have also been raised.

Whilst GPPPD accounts for difficulties with penetration during intercourse it does not explicitly provide for the inability to experience penetrative intercourse (Reissing et al., 2014). Moreover, the "marked tightening or tensing of the pelvic floor muscles" appears to be no less vague than previous descriptions of "involuntary spasms of the musculature of the outer third of the vagina" and therefore difficult to diagnose in women with lifelong vaginismus, especially as for many the anxiety associated with examination becomes a barrier to diagnosis (Reissing et al., 2014). Finally, women with vaginismus in eastern cultures such as Turkey or Iran are more likely to report fear of penetration which is unrelated to pain and therefore a diagnosis of GPPPD fails to adequately reflect their experience (Reissing et al., 2014). For these reasons, Reissing et al., (2014) have pointed out that people with lifelong vaginismus who have never been able to have penetrative sex fall into a "diagnostic void" (p.1210). They argue that not being able to differentiate people with lifelong vaginismus has implications for research and practice. For example, they suggest it may halt the efforts of existing research to potentially identify dimensional or categorical differences between vaginismus and dyspareunia, which in turn may impact the tailoring of interventions for individual needs.

Another issue relates to the role of diagnosis as part of a wider biomedical approach to understanding and treating sexual problems. In acknowledging the conflict experienced by counselling psychologists working within a mental health profession dominated by the use of diagnostic classifications, Milton et al., (2010) highlight the detrimental impact of such systems. By drawing our attention to the underlying preconceptions of both normality and abnormality implicit to a diagnosis, they argue that an individual is treated as the "locus of pathology" (p.91), whilst contributing socio-cultural factors go largely ignored. They suggest the importance of viewing diagnostic classifications as "historically situated ways of talking which have constitutive effects" (p.91). Within the field of sexuality research and practice, Tiefer (2001) similarly asserts that the prevailing medical model promotes specific sexual norms, including those of correct genital performance. For example, they emphasise the ability to enjoy penetrative vaginal sex as necessary to a successful sexual experience. Tiefer (2001) identifies how meanings and motivations around sexual activity are derived from cultural scripts, however, within the medical model of sexual problems cultural or religious factors become less relevant. Tiefer (2001) suggests a different way of understanding sexual experience whereby women can define their own sexual problems, and avoid assumptions around a specific aspect of sexual experience being more 'normal' than another.

Whilst acknowledging these issues with diagnosing female sexual difficulties, the term vaginismus will be referred to throughout this research project. The reason for this can be linked to the overall research aim to explore women's experiences of receiving psychosexual therapy for vaginismus, whereby having a diagnosis of vaginismus may be a relevant aspect of this experience. Furthermore, much of the research discussed in the literature review has utilised this term, suggesting it continues to be theoretically and clinically meaningful (McEvoy et al., 2021), despite the aforementioned changes to DSM categories. However, when cited research refers to the term GPPPD this will be acknowledged. In addition, and depending on the context, phrases such as difficulties with penetration will also be used to describe women's experiences.

1.3 Prevalence factors

Whilst reports suggest vaginismus is a common sexual problem, there is no consensus for prevalence rates (Pithavadian, Chalmers & Dune, 2023), and a number of reasons why they may be difficult to establish. These include definitional problems and a lack of research focussing on female sexual problems (McEvoy, 2021: Reissing, 2021). In addition, a lack of awareness and understanding around vaginismus may mean that women do not recognise their symptoms and know how to express them to health professionals, which may be reinforced through societal normalisation of sexual pain (McEvoy et al., 2021: Pithavadian, Chalmers & Dune, 2023). They may also keep symptoms a secret due to social taboos associated with talking about sex and feelings of shame around their sexual problems (Odgen and Ward, 1995: Pacik, 2014). A recent study in Denmark suggests a prevalence rate of 0.8% in the female population (Andresen, Graugaard, Andersson, Bahnsen & Frisch, 2022), however, higher rates have been found in more conservative cultures. For example, prevalence rates for sexual pain of 42.9% and 26.7% have been reported in Turkey and Iran respectively (Oksuz & Malhan, 2006: Safarinejad, 2006).

1.4 Understanding vaginismus

Meana and Binik (2022) write that it is difficult to determine an aetiology of sexual pain conditions (including vaginismus) due to their complex relationship with psychological and relational well-being. The associated distress of vaginismus may manifest itself in unhelpful coping mechanisms, which maintain or worsen difficulties. They refer to this as the bio-psycho-social puzzle of painful sex, specifying that a wide range of characteristic have the potential to cause, influence or a be a consequence of vaginismus (term used GPPPD). Whilst Reissing (2021) highlights the lack of systematic research focussed on developing an understanding of vaginismus, McEvoy et al., (2021) suggest that it is helpful to consider the factors contributing to vaginismus as a spectrum from “physical to psychological, relational and cultural” (p. 2). This section will explore what is known about the different factors associated with the development and maintenance of vaginismus from these various perspectives.

1.4.1 A psychological perspective:

A recent shift in research focus has emphasised the psychological perspective, acknowledging the functional role of autonomic muscular contractions in vaginismus as a type of defensive phobic reaction (Fugl-Meyer et al., 2012). Dias-Amaral & Marques-Pinto (2018) state that it is important to acknowledge how the pelvic floor works as an emotional organ, and anxiety or other threat-based emotions can cause contractions of the pelvic muscles. For example, Van der Velde & Everaerd (2001) examined the response of pelvic floor muscle activity for women (with and women without vaginismus) being shown film clips showing threating and sexually-threating, neutral, and erotic material. The researchers found that changes in muscle activity occurred in response to the threating material for both groups of women.

Further evidence for the potential role of threat-based emotions such as fear, anxiety and disgust in the development of vaginismus comes from research highlighting that women with vaginismus are more likely to be clinically diagnosed with an anxiety disorder (Lankveld, 2000) and have higher levels of general anxiety (Watts and Nettle, 2010). A number of studies have also identified the possible role of disgust in vaginismus (de Jong, van Overveld, Schultz, Peters & Buwalda, 2009). Disgust is defined as a defensive mechanism protecting the body from contamination with pathogens, and sexual disgust may be associated with a defensive response to the anticipation of penetration (de Jong et al., 2009). Levator-nasi muscle activity, which is a unique physiological expression of disgust, was found to be enhanced in response to a female friendly sex video clip for women with vaginismus compared to a control group of women without symptoms (Borg, de Jong & Schultz, 2011). In the same study, women with vaginismus also showed enhanced subjective disgust towards pictures depicting sex as well as a higher threat response (Borg, de Jong & Schultz, 2011).

The Vaginal Penetration Cognitions Questionnaire (VPCQ) has also been used to examine the relationship between penetration cognitions and threat-based emotions such fear for women with vaginismus (Klassen & ter Kuille, 2009). In a study to validate the questionnaire, women with vaginismus reported greater concerns about loosing control, negative body image, catastrophic pain, and beliefs about their genital incompatibility during vaginal penetration when compared to women without vaginismus (Klaassen and Ter Kuile, 2009). Studies have also highlighted that women with vaginismus have lower levels of knowledge and positive beliefs about penetration (Cherner & Reissing, 2013: Doğan, Saracoglu & Budak, 2018: Klaassen and Ter Kuile, 2009). Women who have more negative beliefs and thoughts about vaginal penetration are more likely to avoid or stop intercourse (Molaeinezhad et al., 2014). Findings from research exploring the sexual repetoires of women with and without vaginismus have found that they may be more limited in women with vaginismus compared to women without vaginismus, suggesting greater avoidance around sexual activity more generally (Cherner & Reissing, 2013; ter Kuile et al., 2007).

Bringing together the evidence from these studies examining the role of emotions, beliefs and behaviour for women with vaginismus, a Fear Avoidance Model of vaginismus (FAM-V) has been developed (Reissing, 2021). According to the FAM-V, negative and catastrophic beliefs about penetration result in a fear of penetration, which in turn leads to avoidance of penetration behaviour or hypervigilance to information supporting negative beliefs. For example, hypervigilance may involve increased focus on physical sensations and emotions facilitating or potentiating pain during sexual activity (Cherner and Reissing, 2013). Fear, hypervigilance and negative emotions can then result in the involuntary and defensive contraction of pelvic floor muscles, leading to difficulties and pain associated with vaginal penetration, and confirming negative and catastrophic beliefs about penetration (Reissing, 2021). Avoidance of vaginal penetration and sexual activity is proposed to be a maintaining factor in this model in as far as it works to temporarily reduce fears and negative emotions, preventing the disconfirmation of the negative penetration beliefs perpetuating the cycle (Reissing, 2021).

Further support for this model has come from qualitative research exploring women's subjective beliefs about the causes of their vaginal penetration difficulties. For example, Ward and Odgen (1994) examined women's causal attributions for their experience of vaginismus in a questionnaire study which incorporated closed and open-ended questions. They concluded that different women may hold different and multiple beliefs about why they experience difficulties with vaginal penetration, however, a majority of the women identified fear of pain as a key factor. Ward and Odgen (2010) highlight one particular description written by a participant about their fear of penetration: ‘‘Imagine trying to poke yourself in the eye – that's what it feels like." (p.431). Fear of injury, loss of control and intimacy were also identified as relevant to participants experience of vaginismus (Ward and Odgen, 1994). In another survey study exploring the perception of women with lifelong and acquired vaginismus for the cause of their vaginal penetration difficulties, fear of pain because of previous painful experience was "universally and strongly endorsed" (Reissing, 2012, p.257). Reflecting similar results to Ward and Odgen (1994), this study also found that women with lifelong vaginismus identified fears about what they had heard about pain and intercourse, of possible injury, and of losing control as additional causal factors.

One Grounded Theory interview study explored particiapant's constructions for the origin of their sexual pain and difficulties with intercourse (Koops and Birkin, 2021). The study identified women's feelings of vulnerability regarding physical, psychological and social matters to be one aspect of the origin of their difficulties. The authors reported that many participants who had not experienced sexual boundary violations or physical violence appeared to link such experiences to their difficulties. They suggested that instead these experiences acted as a metaphor for their feeling of being vulnerable to such violations, and can be linked to a fear of pain or injury in vaginismus. Finally, a study using an Interpretative Phenomenological Analysis (IPA) methodology to explore the lived experience of vaginismus (term used GPPPD) also found fear of pain to be a key theme for their participants (Svedhem et al., 2013). Some participants described this fear as unbearable and additionally expressed a fear of the anxiety that was associated with pain.

1.4.2 Social, cultural and religious contexts:

It is important to examine the different contexts in which fear and disgust in response to and negative beliefs around penetration and sex may develop. Tiefer (2001) argues that the focus on the vaginal spasm in vaginismus does not take into consideration other factors such as cultural and relationship dynamics, which may play a role. Many researchers have acknowledged how sexual values and meanings of sexuality are culturally embedded (McEvoy et al., 2021; O'Mullan, Coates & Tilley, 2019). Furthermore, the varying prevalence rates of vaginismus across different social and cultural contexts further emphasises the relevance of these factors for understanding vaginismus (McEvoy et al., 2021). A number of studies carried out in Turkey have reported vaginismus to be the most common presenting complaint for women attending a sexual health clinic (Yasan and Gurgen, 2008; Doğan, 2009; Yildirim et al., 2011). It has been suggested women with vaginismus may be more likely to seek help due to the impact it has on the relationship in comparison to other sexual problems such as low sexual desire (Doğan, 2009). McEvoy, McElvaney & Glover (2023) also point to the higher prevalence of vaginismus in Ireland compared to other Western cultures (O'Sullivan, 1979 cited in McEvoy et al., 2023). They reflect on the increased presence of taboos around sex and conservative attitudes regarding intercourse in Ireland linking sex with shame, which may contribute to vaginismus (McEvoy et al., 2023).

Some specific factors have been implicated in the relationship between cultural dynamics and vaginismus. These include: the restriction of sex before marriage; expectations of virginity in some religious structures; and the prioritisation of male sexual satisfaction (Tuğrul & Kabakci, 1997; Dogan, 2009; Fadul et al. 2019). A woman's experience of "losing" their "virginity'" may be associated with threat and pressure (Dogan 2009; Farnham, Janghorbani, Merghati-Khoei & Raisi, 2014). In societies which place importance on women maintaining their "virginity" until their wedding night, successful intercourse is measured by vaginal penetration, which may cause significant anxiety, especially when expectations around pain and bleeding are taken into consideration (Dogan, 2009). Moreover, for some women the need to demonstrate their "loss of virginity at the first night of marriage, not before" may also contribute to greater fear (Dogan, 2009).

In their study conducted in the Netherlands, Borg et al., (2010) found that woman with primary vaginismus demonstrated stronger adherence to conservative values alongside less adherence to liberal values than a control group of women without sexual complaints (Borg et al., 2010). They reflected on the possible relevance of a perceived "immorality" of sexual behaviour in the development of vaginismus. Interestingly, a Grounded Theory study carried out in Germany exploring the origins of vaginismus and dyspareunia found that whilst participants from Turkish families living in Germany described the sexual norms of their peer group as stricter than those of the German culture they lived in, constructions of the origins of their sexual difficulties remained quite similar to those of German woman (Koops and Brikin, 2021). The authors explained that narratives for woman from both cultures included "heteronormative double standards and restrictions on the expression of womanhood" (Koops and Brikin, 2021 p. 716). The authors argue that Western women's sexual freedom is still constrained by certain cultural expectations.

The development of vaginismus has also been linked to a lack of or incomplete sex education, which may be biased by conservative or religious beliefs (Van Lankveld et al., 2010; Reissing, 2021). Fadul et al., (2019) found that most women with vaginismus in their study reported a lack of sexual knowledge (97%) and more than half were exposed to misconceptions about sex due to religious reasons. Çankaya and Nur Aslantaş (2022a) identify how false sexual myths associated with religious traditions can be accepted as truth in society and can result in increased fear around penetrative activity. For example, common misbeliefs may include the vagina being too small and the penis too big as well as "unbearable pain" and "excessive bleeding" occurring during first attempts at intercourse due to the hymen being too thick and tight (Dogan, 2009). In a correlational study, Kurban, Eserdag, Yakut & Mishra (2021) reported that 74.1% of female participants with vaginismus described hearing "horrifying" stories about the first night of marriage in the pre-marital period. A case-controlled study found that women with vaginismus were more likely to develop their knowledge about sexuality from social media (Çankaya and Nur Aslantaş, 2022a).

Finally, in their qualitative study carried out in Brazil, Silva, Sei and Vieira (2021) interviewed nine women with vaginismus about their experience of family, religion and sex education, which were then analysed using content analysis. Their findings highlighted how inappropriate sex education and a lack of sexual knowledge contributes to greater insecurity and fear associated with sexual activity. For example, participants spoke about how they believed that pain was inherent to penetrative sex, as one participant expressed "my friends always warned me it'd hurt a lot and made me fear it" (Silva et al., 2021 p. 15). For the authors, this identifies the role of social discourses for the development of difficulties with penetration.

A number of authors have also identified the potential role of parental attitudes around sex for the development of vaginismus. Ward and Odgen (1994) reported that being brought up to believe sex is wrong was the second most endorsed belief by participants for the cause of their vaginismus. McEvoy (2021) carried out a Grounded Theory study to examine the experience of vaginismus in Ireland and the woman interviewed recalled the negative messages they received about sex in the home, these included messages about sex being painful, men being untrustworthy, as well as shaming messages around pregnancy. McEvoy et al., (2021) reflect on the tension between anti-sexual and pro-procreation scripts originating from family and culture and a woman's own sexual desires which may contribute to sexual difficulties such as vaginismus.

1.5 Living with Vaginismus

Ward and Odgen (2010) describe the experience of vaginismus as powerfully permeating to many aspects of daily life. It may have implications for a women's identity, relationship with others and sexual wellbeing. A range of quantitative studies have demonstrated a relationship between vaginismus and psychosocial factors such as sexual functioning, self-esteem and relationship adjustment, however, as Meana and Binik (2022) identify it is difficult to disentangle these different associations. There are, however, also a small number of qualitative studies, providing a more in depth understanding of what it is like to live with vaginismus from a personal and subjective perspective.

1.5.1 Sense of self:

Experiencing vaginismus can impact on the way a woman perceives themselves as an individual. A sense of self is a distinctly subjective phenomenon and shaped by an individual's interactions with their social environment, which makes it hard to quantitively measure (Pithavadian, Chalmers and Dune, 2023). In their mixed-methods questionnaire study exploring how living with vaginismus can affect how individuals feel about themselves, their sexuality and their relationships, Ward and Odgen (1994) suggested that women with vaginismus may experience low self-esteem and poor self-worth. From the quantitative data, the most commonly endorsed self-belief by participants was feeling angry at themselves, followed by feeling helpless and guilty. The qualitative data also supported the quantitative analysis and participants described the negative feelings and attitudes they held towards themselves, for example, participants described feeling "incomplete as a woman"; "unfeminine; and "blocked off from all possibilities" (Ward and Odgen, 1994 p.441). Some women also spoke about difficult feelings associated with their romantic relationships, such as feeling as if they cannot be a "real lover".

Svedhem, Eckert and Wijma (2013) used an IPA methodology to explore the personal and subjective experiences of vaginismus (term used genito-pelvic pain penetration disorder) for eight women living in a heterosexual relationship in Sweden. One of the themes identified in participants' stories involved experiences of *Failure*, on a sexual and personal level. For example, participants described how they felt as a result of their sexual difficulties and one woman described feeling "totally useless as a sexual being" and another woman described feeling "low and worthless as person" (Svedhem, Eckert and Wijma, 2013, p.342). These results are also supported by quantitative studies examining the relationship between vaginismus and self-esteem. For example, one Iranian study comparing women with vaginismus (n=22) to women without sexual problems (n=22), reported significantly lower levels of self-esteem for women with vaginismus (Farnham et al., 2014) and a study in Ireland found that women with vaginismus demonstrated lower self-esteem than their partner (Kennedy, Doherty & Barnes 1995). A more recent study found that women with vaginismus (n=24) demonstrated significantly more difficulties with self-worth regulation than a control group with no sexual complaints (Koops, Wiessner, Ehrenthal & Briken 2021).

Several studies have also highlighted how difficulties reconciling experiences of vaginismus with normative discourses around sex and womanhood contribute to the way that woman feel about themselves. Kaler (2006) carried out a qualitative interview study with woman experiencing sexual pain including vaginismus and described a prevailing discourse around sex whereby penetrative intercourse is viewed as ‘real sex’ and an inevitable part of sexual activity within a heterosexual relationship. Kaler (2006) concluded that this led women with genital pain related sexual problems to feel like they were not “real” women. In addition, Koops and Brikin (2021) carried out a grounded theory study examining biographical interviews with 28 woman who fulfilled the diagnostic criteria for either vaginismus (n=17) of dyspareunia (n=11). The researchers also identified a theme around living up to sexual normality and reported that participants associated not being able to engage in penetrative intercourse with a perceived loss of “womanliness”.

Furthermore, Svedhem, Eckhert and Wijma (2013) suggest that the image of sexuality for the women in their study and surrounding society plays a role in the way that vaginismus affects their mental wellbeing. The authors identified that if norms around sexual expression changed then women would not need to feel like a failure. McEvoy (2021) reflects that the means by which experiences of vaginismus impact on a women’s self-esteem may also be influenced by cultural factors. For example, in cultures where sexuality is more likely to be associated with “intimacy, pleasure and love”, vaginismus may be viewed as detrimental to relationship satisfaction, whereas in cultures linking sexuality to “marital duty and reproduction” it may be associated with a loss of social status (McEvoy, 2021, p.44).

1.5.2 Relationships:

Living with vaginismus can also affect a way an individual experiences their relationships with others. Qualitative data in the study conducted by Ward and Odgen (1994) revealed a sense from participants of feeing different and a belief that others would not understand.

Woman expressed feeling "abnormal, separate and distanced from other people" (p.444) and comments were made about feeling excluded in conversations about sex and having children. The authors highlighted the participants need for secrecy around their experience of vaginismus and suggested this may be due to taboos around talking about sexual problems and social norms placing importance of penetrative sex. Svedhem, Eckert and Wijma (2013) also described the experience of *Loneliness* as another important theme for participants in their study, highlighting participant experiences of feeling like they had *no one to talk to* and a sense of *being an outsider*. For example, many of the women felt that even though their partner knew about their difficulties, they still did not feel able to speak openly with them. One participant explained "it feels like this is only me and there is no one else who has it like this" (Svedhem et al., 2013, p.342).

Participants from the same study also expressed a *fear of abandonment* and reflected that they often questioned their relationships (Svedhem et al., 2013) and whether it could be "real" due to their difficulties with being able to experience penetrative sex. Similarly, Sutherland (2012) in a qualitative study of women experiencing pain and discomfort during intercourse reported that participants experienced a *fear of rejection* associated with their inability to engage in penetrative sex. Furthermore, Koops and Briken (2021) reported assumptions by participants that their sexual difficulties were associated with their partner simply not being the 'right' one or that a relationship without sexual intercourse would lead to partner unfaithfulness. Ward and Odgen's (1994) mix methods study revealed that 81% of participants reported their relationship to be good and "unhappiness with partner" was rated as 11th out of 17 possible causes for their experience of vaginismus. Interestingly, this did not always correspond with the qualitative data and some participants spoke about difficult feelings associated with their romantic relationships, such as feeling as if they cannot be a "real lover".

1.5.3 Sexual Wellbeing:

The experience of vaginismus may also play a role in the sexual wellbeing for an individual or couple. Svedhem et al., (2013) identified themes relating to loss of sex and loss of sexual desire. Many of the participants reflected on how vaginismus had led them to withdraw from sex and sexual closeness with their partners due to their associations of sex with fear or discomfort and concerns that they will give their partners false hope. The women in the study also spoke about how always being alert to what was happening in their bodies negatively affected their sexual desire. Some of the women also reflected on how learning that sex should not hurt in treatment had resulted in an increased sensitivity to any discomfort in the genital area and prevented them from relaxing and letting go during sexual interactions. For example, one woman in the study explained: “I’m on the alert all the time to keep track of whether there is anything that does not feel good – if it’s something that is about to hurt. I really do not want to do something that doesn’t feel good because then I think, or I’ve been thinking for the past five or six years that it will get worse, and then it’s likely to take longer before I get cured” (p.343)

These themes are also supported by the existing empirical evidence reporting that women with vaginismus experience a range of sexual difficulties (Van Lankveld et al., 2006). One comparative questionnaire study used validated measures including the Female Sexual Function Index (FSFI) to examine differences in sexual functioning for 46 women with vaginismus compared to a control group of 47 women without sexual complaints (Cherner and Reissing. 2013) The FSFI includes subscales for sexual desire, arousal, lubrication, orgasm and sexual satisfaction (Rosen et al., 2000). One benefit of using this measure is that it does not focus on penetrative sex and is therefore able to provide a more reliable measure of sexual functioning in woman experiencing penetration related difficulties. Findings from this study showed that the women in the vaginismus group reported less desire, arousal, orgasm and satisfaction than the control group. More recent case-controlled studies comparing sexual functioning and satisfaction for woman with vaginismus to woman without sexual complaints have also replicated these findings (Doğan et al., 2018 and Çankaya & Aslantaş, 2022b).

Svedhem, Eckert and Wijma (2013), however, also noted that some woman in their study described a quite different experience and identified that vaginismus did not make a great difference to their experiences of sex. More specifically, for them, the relationship worked and sex worked. Ward and Odgen (1994) reported similar themes, whilst some participants reported that they avoided sexual activity, 81% of participants assessed their relationship as good and 65% reported being able to enjoy non-penetrative sex. Svedhem, Eckert and Wijma (2013) identified that the experience of vaginismus for the women in their study depended on their relationships with the partners, how long they have experienced the problem and their personalities. For example, participants who described their relationship as secure and allowing them to feel good enough found vaginismus easier to manage whereas woman who experienced a pressure in the relationship to “cure” vaginismus found it more difficult to manage. This is supported by quantitative data which has reported higher levels of stress and anxiety in women with vaginismus who have non-supportive partners and feel a pressure to be ‘cured’ (Watts and Nettle, 2010).

Results from the literature for GPPPD have also highlighted the important role of interpersonal factors (Meana and Binik, 2022). A recent study reported that perceived partner responsiveness including expressions of understanding, validation and caring was associated with sexual wellbeing for women with GPPPD (Bergeron, Pâquet, Steben & Rosen 2021). Svedhem, Eckert and Wijma (2013) also note that woman who had experienced vaginismus for longer were able to gain a more helpful perspective and managed the impact it had on their lives more effectively. The authors reflected on how a diagnosis may not need to be an obstacle to experiencing a “functioning relationship and a satisfying sex life”. Furthermore, in another qualitative study, some woman spoke about being able to enjoy other types of sexual interactions besides intercourse and importantly were able to think of these as “real sex” (Kaler, 2006).

1.5.4 Embodied experience:

A disconnection from the body has been another key theme emerging from the qualitative studies exploring the experience of vaginismus. For example, in their systematic metaphor analysis of biographical interviews conducted with woman diagnosed with vaginismus and dyspareunia (term used GPPPD), Koops and Frith (2021) identified a range of metaphors used to create imagery of the *body as a kind of machine,* and the sexual body was described as something which “just doesn’t function the way it should do” (p.8). The authors reflect that this metaphorical concept of the body as a machine appears to assign it the status of an object, in some way ‘serving’ the self, but distinct. One woman explained “I don’t live in my body somehow, like properly” (p.9) when reflecting on her experience of going out dancing, whilst another participant spoke about feeling like a “plank” during attempts at sexual intercourse with her partner (p.11). Koops and Birkin (2021) also described the process of *Othering the body* in their grounded theory study using data from the same biographical interviews in the aforementioned study. The authors identified that the participant’s conceived of their body and mind as fundamentally distinct, and their body was viewed as having “a life of its own”. One woman explained “my body didn’t want this either and tensed through that” (p.713).

Another Grounded Theory study involved interviews with 10 couples together about their experience of vaginismus and help seeking in Ireland, and benefited from including the perspective of 18 healthcare professionals supporting woman with vaginismus (McEvoy, 2021). The woman in this study reflected on their reluctance to look, touch or explore their own bodies and this sense of disconnection from their bodies was reiterated in data from the interviews with professionals. These themes are supported by quantitative research demonstrating that woman with vaginismus experience more difficulties with perception and experience of their bodily self in comparison to a group of controls (Koops et al., 2021).

1.6 Psychosexual Therapy

Psychosexual therapy (also referred to as sex therapy or sex and relationship therapy) is a form of talking therapy involving a range of interventions developed and adapted to treat male and female sexual problems (Tabatabaie, 2014). Meana and Binik (2009) point out that it does not have a “unified underlying theory” or a “unique set of practices” (p.1016), however, the most widely known elements of psychosexual therapy were initially developed by Masters and Johnson (1970). These constitute the behavioural elements and strategies of psychosexual therapy, which aim to reduce avoidance of sex and gradually re-introduce sexual activity (for example, see Linschoten, Weiner & Avery-Clarke 2016 for a review of the literature on Masters and Johnson’s sensate focus exercises). A number of integrations have since been made to this original behavioural approach, which include cognitive therapy approaches (e.g., Bergeron et al., 2020), systemic therapies (e.g., Clement, 2002), and third wave approaches such as mindfulness (e.g., Brotto et al., 2013).

1.6.1 Psychosexual Therapy for Vaginismus

There are no therapeutic interventions that have been specifically developed and standardised for the treatment of vaginismus (Işık & Aslan, 2023). Traditionally, treatment for vaginismus consists of vaginal dilation behavioural exercises, combined with progressive desensitisation and relaxation techniques, which aim to target the muscle spasm interfering with intercourse (Reissing, 2021). Often, however, a number of additional components are added to the treatment process, which include: an exploration of psychological factors such as fear of pain or negative beliefs about sexuality; sex education to “enhance accurate knowledge and positive beliefs about sexuality and genital anatomy” (p.370 Reissing, 2021); and interventions to improve communication, sensitivity and trust within the couple, for example, sensate focus exercises which aim to “enhance non-penetrative sexual activity” (p. 370 Reissing, 2021).

A review of the literature for treatment studies identifies a range of interventions for treating vaginismus (Pacik, 2014; Maseroli et al., 2018). Some medical treatments, such as local botulinum toxin (botox) injections and pharmacological therapy, focus on the presence of the physical spasm. Botulinum toxin is a temporary muscle paralytic (Pacik, 2014). It has been used in the treatment of vaginismus with the aim to decrease the hypertonicity of the pelvic floor muscles, and has been gaining popularity in recent years (Maseroli et al., 2018). Other interventions are considered to be psychologically orientated (CBT, mindfulness training, and hypotherapy) (Maseroli et al., 2018). Maseroli et al., (2018) conducted a meta-analysis of observational studies exploring outcomes for a range of treatments for vaginismus, including CBT, behavioural sex therapy, botox injections, pharmacological therapy and pelvic floor physiotherapy. The authors reported that no approach was found to be more effective than others in regards to the outcome of being able to have penetrative intercourse. However, there are only a few good quality Randomised Controlled Trial (RCT) studies providing empirical evidence for the efficacy of interventions for vaginismus and these have predominantly focussed on evaluating CBT- based psychosexual interventions (e.g., Van Lankveld et al., 2006; Zarski, Berking & Ebert 2021), which is an approach often used in clinical practice (Maseroli et al., 2018).

1.6.2 Cognitive Behavioural Psychosexual Approaches:

Based on the assumption that an individual’s thoughts, feelings and behaviours are all interconnected, CBT aims is to help people to identify and c§§hange unhelpful thinking patterns and behaviours. It is goal orientated and focusses on supporting the development of new coping skills (Ford, 2005). Researchers and clinicians point to the aforementioned Fear Avoidance Model of vaginismus (FAM-V) and the important role of anxiety in vaginismus to explain why CBT may be a useful intervention (Van Lankveld et al., 2006 & ter Kuille et al., 2013). Accordingly, exposure to the feared stimuli is important for women to work through their anxiety, re-evaluate the negative cognitions reinforcing it, and encourage them to feel more confident with different types of penetration behaviour, including intercourse. The components of a CBT integrated psychosexual treatment for vaginismus may include psycho-education, gradual exposure using vaginal dilators combined with relaxation techniques, cognitive restructuring, pelvic floor muscle exercises, as well as standard psychosexual therapy techniques such as self-exploration and sensate focus exercises with a partner (Lankveld et al., 2006: Ter Kuille & Reising, 2020: Zarski, Berking & Ebert 2021)

1.6.3 Intervention Studies

One RCT explored the efficacy of group CBT for lifelong vaginismus (Lankveld et al., 2006). The primary outcome explored in the study was successful penetrative intercourse, which was reported by 14% of the women in the treatment groups compared to none in the waiting list group at post treatment. Whilst the study also reported some improvements in subjective aspects of sexual functioning for the treatment group, this continued to be lower than general population, and effect sizes were small (Lankveld et al., 2006). Furthermore, dissatisfaction with the relationship in general increased gradually, becoming significantly different from baseline at 12 month follow up for the treatment group. Whilst the authors note that this possibly reflects a ceiling effect pre-treatment, it also, however, points to the difficulty knowing what the outcome of improved ability to have penetrative intercourse actually means for the women in the study (Lankveld et al., 2006). This study would therefore have benefited from evaluating further outcomes, for example, levels of enjoyment or pain during intercourse.

Another RCT evaluated the efficacy of a programme for a therapist-guided face-to-face CBT exposure treatment. This consisted of a total of three 2-hour sessions with the participants and their partners in which women were exposed to their feared penetration objects such as dilators, fingers and tampons. Exposure was self-controlled and the women performed the vaginal penetration exercises themselves, however, their partner and a female therapist would be in the room for support. The authors describe the role of the therapist: “to guide the woman (and her partner) through the difficulty of approaching penetration-related fears, to manage the associated intense fear, and to encourage non-avoidance”. Additionally, the therapist helps the woman to verbalise any catastrophic cognitions about what could happen during penetration exercises, which are then continued at home (ter Kuile et al., 2013).

Compared to the Van Lankveld at al., (2006) study, this face-to-face exposure study revealed a much stronger effect of treatment and 89% of women in the IG group (n=35) compared to 11% of women in the WCG (n=35) were able to have successful intercourse post treatment (ter Kuille et al., 2013). This study also benefitted from evaluating further relevant outcomes including "coital pain" and "coital fear". Significant reductions in fear of and pain during penetrative intercourse, as well as symptoms of vaginismus were reported for the intervention group. However, the authors note that for half the participants, levels of pain during penetration were still not within the healthy range of "sexually well-functioning women" (p.1134), suggesting that these participants continued to experience discomfort despite engaging in penetrative intercourse. Furthermore, due to the lack of long term follow up data, it was not clear how this may have impacted future sexual experiences for the women in this study. For example, it is possible that continued experiences of discomfort might result in greater levels of fear and avoidance in the long term. Further analysis also revealed that frequency of penetrative intercourse, pain during intercourse, and symptoms of vaginismus were mediated by changes in positive and negative penetration beliefs (ter Kuille et al., 2015). In support of the FAM-V, the authors suggest this demonstrates that exposure treatment provides the potential for women to test their penetration beliefs, and explore the extent to which their feared consequences actually occur.

Importantly, therapist aided exposure in a gynaecological setting is not widely available in routine care (Zarski et al., 2021) and a more recent RCT evaluated the efficacy of an internet based CBT treatment for 77 women with vaginismus in a heterosexual relationship (Zarski, Berking, Fackiner, Rosenau & Ebert 2017). The ability to have penetrative intercourse was again the primary outcome evaluated and 31% of women in the IG compared to 21% of women in the WCG reported having penetrative intercourse post treatment. Further outcomes explored by Zarski et al., (2017) included non-intercourse penetration behaviours; sexual functioning; and fear of sexuality. The results demonstrated a significant increase in non-intercourse penetration ability (e.g., self-insertion with a dilator or finger) in the IG compared with the WCG. The authors highlight that "fear of losing control" was one of the most frequently cited reasons for vaginismus in the IG and suggest that this possibly reflects women in the IG successfully coming to terms with this fear. This is supported by the results demonstrating a significant decrease in 'fear of coitus' as measured by the fear of sexuality questionnaire for the IG. Despite these improvements, 90% of women continued to report pain during all types of penetration, and women continued to report clinical levels of sexual problems. Furthermore, other important outcomes such as enjoyment of intercourse were not evaluated, therefore it is not known how the changes in the ability to have penetrative intercourse and engage in non-intercourse penetration behaviour was experienced by participants, e.g., whether they were able to enjoy sex or whether improvements contributed to improved self-worth as a sexual partner.

A more recent, larger scale RCT evaluated the efficacy of an amended version of the same internet-based CBT intervention study carried out by Zarski et al., (2017) for 200 participants (term used GPPPD) (Zarski et al., 2021). This study benefited from exploring additional secondary outcomes and reported that genital pain, negative penetration related cognitions and well-being were all improved at six month follow up in the IG compared to the WCG. Whilst the results demonstrate that the intervention is effective for women with penetration difficulties, the study also had a high dropout rate for the IG (42%) compared to the WCG (9%), and not all participants benefited equally from the intervention. For example, women with higher pre-treatment levels of genital pain were less likely engage in gradual exposure exercises during treatment. The authors suggest this raises an open research question regarding whether it may be more beneficial to encourage some women with vaginismus to take an acceptance-based attitude towards difficulties with intercourse rather than continuing with gradual exposure exercises. It has been suggested that for these women, a focus on expanding sexual activity in other areas to improve sexual satisfaction may be more appropriate, and consequently future studies should record sexual distress throughout the intervention phase to examine this possibility further.

1.7 The Problem with Measuring Outcomes in Terms of Sexual Functioning

These findings from the studies discussed emphasise the difficulty in knowing what the primary outcome of ability to have penetrative sex means for women if they continue to experience pain or discomfort. Accordingly, it appears that all studies may have benefited from exploring other relevant factors such as the impact of interventions on their ability to enjoy sex or their sexual self-confidence. This is especially important considering results from a qualitative Grounded Theory study exploring why young women continue to have sexual intercourse despite pain and discomfort (Elmerstig, Wijma and Bertero, 2008). In this study, the women's experience of pain and discomfort decreased their sexual desire and arousal. The authors concluded that the reasons for their behaviour involved a "striving to be affirmed in their image of an ideal women" (p 362), which involves someone who is willing to have sexual intercourse and is able to satisfy their partner's needs. They also described their participant's experiences of resignation, guilt and sacrifice associated with sexual intercourse and suggested that this, rather than a desire, provided an explanation for why they continued to have sexual intercourse despite pain and discomfort. Furthermore, as discussed in the previous section, a number of qualitative studies have highlighted how the experience of vaginismus may impact on an individual's sexual self-esteem and wellbeing (e.g. Svedhem et al., 2013)**,** emphasising the additional value in examining outcomes related to these factors.

These results also point to be a more general issue with intervention research which prioritises the ability to have penetrative intercourse as the primary research outcome. Qualitative studies have identified how normative sexual values such as the prioritisation of penetrative sex have contributed to poor self-worth for women with vaginismus, and in their IPA study, Svedhem, Eckert and Wijma (2013) suggested that if social norms focused on sex being great whatever form it took then women with vaginismus may not need to feel like a failure. Intervention studies would also therefore benefit from paying closer attention to individual treatment goals and what outcomes mean for participants, which appears to be especially important considering the relationship between vaginismus and socio-cultural contexts.

Engman, Wijma and Wijma (2010) conducted a retrospective questionnaire study for women more than a year after they had received CBT for vaginismus in a single sexual health clinic in Sweden. They reported that the proportion of women with positive treatment outcomes varied depending on how it was evaluated: 81% were able to have intercourse and 6% were able to have intercourse which was totally pain free and they were able to enjoy. In addition, self-worth in all areas was found to be significantly improved at follow up, however, as the study is partly retrospective it is not possible to determine whether this is a result of specific treatment mechanisms or whether their ability to have penetrative sex improved their self-worth. The study also benefited from evaluating fulfilment of individual treatment goals, such as being able to enjoy intercourse, rather than the goals defined by researchers or therapists. The authors argue that this eliminates the potential bias of measuring the effect of therapy by "male performance" markers, which focus on "penetration and intravaginal ejaculation" (p199). Fulfilment of individual treatment goals was reported to be high by two thirds of the women in the study.

As already discussed, previous research using a qualitative methodology has provided a more in-depth perspective into what it is like for women living with vaginismus, identifying the interaction of bio-psycho-social factors. Themes around the impact of vaginismus on an individual's self-worth, sexual wellbeing and relationship with others have been explored, whilst acknowledging the role socio-cultural contexts play in how women make sense of their experience. Researchers have argued that the therapeutic process needs to reflect this understanding of vaginismus (McEvoy et al., 2021). For Ward and Odgen (1994), this means taking a holistic approach and focusing on sexual wellbeing rather than the existing specific focus on the muscular contractions interfering with penetration. Elmerstig, Wijma and Bertero (2008) emphasise that women should be guided to see the worth in their own sexual pleasure.

Furthermore, for some researchers, evaluating intervention outcomes in terms of ability to have penetrative sex reflects the predominance of a biomedical approach to sexual difficulties, which does not capture the unique lived experience of women and the multidimensional nature of sexual wellbeing (Tiefer, 2012; Kleinplatz, 1998). Kleinplatz (1998) argues that there are limitations and consequences of "success" being measured by the ability to have penetrative sex, which is criticised as being "mechanistic, reductionist and objectifying". For Kleinplatz (1998), if the goal is to eliminate the barriers of "normal" sexual functioning, the focus is on reducing symptoms regardless of the possible meaning behind them. Rather than helping women to become more aware of the social context to their experience of vaginismus, it encourages them to conform to a narrow understanding of sexual norms. She suggests that a sex therapist should explore alternative goals which prioritise and value the clients experience of "sexual meaning and fulfilment". This is also arguably more in line with the philosophy of the counselling psychology profession, which in its appreciation of subjective and unique experiences, aims to guide individuals towards the change they want (Rafalin, 2010). For ter Kuille et al. (2013), however, an inadvertent consequence of taking the focus away the ability to have penetrative sex is the implicit fostering of avoidance regarding penetration behaviour. The authors argue that it therefore advisable to carry out exposure therapy whilst preserving a person-centred approach.

Despite these debates and controversies regarding how to assess when treatment is successful and completed, women's voices around the experience of psychosexual therapy remain unheard. There is very limited research on the subjective and personal perspective of what it is like to receive psychosexual therapy for vaginismus. One recent meta-analysis of the three RCT studies (Lankveld et al., 2006: ter Kuille et al., 2013: Zarski et al., 2017) observed that compared to controls, psychological therapies did not significantly improve the probability of being able to have successful penetrative intercourse, although a trend towards significance was reported (Maseroli et al., 2018). A number of the studies also had high drop-rates which were not accounted for in the statistical analysis, e.g., Zarski et al., (2021). Mixed or inconclusive results highlight a need to better understand the psychosexual treatment process from a participant's perspective using a qualitative approach. The next section will describe the small number of qualitative research studies exploring participant's perspectives on different aspects of the treatment experience for vaginismus.

1.8 Women's Experiences of Treatment for Vaginismus

One UK based study used a qualitative methodology to explore what it is like to experience vaginal dilator training for vaginismus (Macey, Gregory, Nunns and das Nair, 2015). 13 women who had used vaginal trainers (dilators) for vaginismus took part in semi-structured interviews, which were then analysed using thematic analysis. The authors described the two themes of *Difficult journey* and *Making it easier*, which shed light on the "circuitous and arduous route 'into treatment'" (p.4) as well as the emotional demands of being 'in treatment' that were represented in the participants' experiences. In the participant's descriptions of treatment barriers, they described overcoming "feelings of embarrassment" and "abnormality" (p.4); developing the courage to ask for help; doubting the legitimacy of their difficulties; and questioning whether their pain was normal. They also described their difficulties navigating a complex healthcare system, which at times did not feel sympathetic to their experience. For example, some women did not feel their difficulties were taken seriously and received information about foreplay and lubricant during their initial consultations rather than information about vaginismus, which for some meant they did not attempt to seek help again for years.

The authors noted that the women often identified their hope that treatment would be an easy solution to their difficulties, whilst in reality progress was different to their expectations and the process was demanding. Treatment encouraged them to "confront the realities of their penetration difficulties and how these difficulties made them feel about themselves" (p.7), which could be emotionally demanding and for some distressing due to their experience of abusive sexual experiences. Women also described the dilators as 'clinical' or 'unnatural' and would instead try alternatives such as their own fingers or tampons. Lack of appropriate information on how to use the dilators and being encouraged to use them in ways that caused them pain was also highlighted.

The study identified the type of support most appreciated by the women. Practitioner's specialist knowledge and skills were highly valued as well as a non-judgemental, understanding approach. Participants in relationships also spoke about the importance of support which allowed them to enhance communication with their partners. Whilst this study to explore women's experiences of using vaginal trainers (dilators) provides valuable information regarding the treatment process, thematic analysis does not allow for an in-depth perspective of what it is like. Furthermore, the vaginal trainers (dilators) only constitute one aspect of psychosexual therapy and the study is unable to provide a subjective perspective into other aspects of the psychosexual therapy experience.

McEvoy (2021, cited in McEvoy et al., 2023) carried out a Grounded Theory study exploring the help-seeking process for women with vaginismus and their partners in Ireland as well as healthcare professionals supporting women with vaginismus. McEvoy (2021 cited in McEvoy et al., 2023) reported that women who attributed their difficulties to psychological rather than physical causes had more positive experiences of treatment and for some this realisation was a turning point. The experience of psychosexual therapy enabled them to make sense of the psychological components of vaginismus, developing connections between thoughts, feelings and the body. Psychosexual therapy also helped couples to understand vaginismus as a shared problem to be resolved together.

Another qualitative study, carried out by an anthropology researcher, involved the interviews of women with vaginismus about their experience of the 'overcoming process' and analysed the data through a feminist constructionist lens (Stelko, 2015). The author reported on women's experiences of a number of different elements of the process. Firstly, the author described what it was like for the women to develop knowledge about their bodies and learn about what was happening during attempts at penetration. They reflected that having vaginismus allowed them to get to know their bodies in a way they may not have otherwise, experiencing this as an advantage. For example, one woman explained: "I think knowledge empowers you. Empowers us (...) as a group of women" (Stelko, 2015 p.43). This was experienced as more than general knowledge, instead becoming a personal experience of their own bodies.

The study also described the women's experiences of pelvic floor muscle relaxation exercises, which aim to help women with vaginismus to learn how to feel their muscles being tense as well as how to relax them. Many women described this as being about more than relaxing their pelvic floor muscles, but relaxing 'their whole selves' (p.44), making relaxation a habit rather than an ability. The author highlighted how the process of learning to feel and relax these muscles was a very personal one. Whilst the women in the study interpreted the exercises differently, adapting them to their own personality, relaxation was something they needed to actively engage in. Finally, the women in the study also spoke about their experiences of dilating. They reflected that being able to use a dilator for the first times was empowering, however, the routine of it became stressful and frustrating. Reflecting similar results to the study by Macey et al., (2015), the women perceived the process as hard and long. They also recognised the importance of celebrating and feeling proud of each step and accomplishment.

One integrative review of qualitative and quantitative studies identified the experience of help seeking and its impact on sense of self for women with vaginismus in the available literature and examined the findings using thematic analysis (Pithavadian, Chalmers and Dune, 2023). The study reported that help-seeking for women with vaginismus was motivated by heterosexual and heteronormative expectations of womanhood, including the prioritisation of penetrative sex. The authors highlight how woman would often have to overcome social taboos around discussing sexual matters before feeling motivated to seek help, and it could take years for them to receive a diagnosis of vaginismus, involving consultation with a range of professionals. The authors reflect that the impact of vaginismus on a women's self-image of femininity may exacerbate their difficulties finding help or engaging in treatment. They emphasise the importance of normalising non-penetrative sex in order to "strengthen women's sense of self to believe in themselves as capable women, to persevere even when the treatment seeking journey is trying" (p.15). Aspects of therapeutic interventions which women found most helpful were also identified, which involved the presence of a mutual understanding and expectation with healthcare professionals. Importantly, the study emphasised how women's voices were mostly absent from research regarding the help seeking process (Pithavadian, Chalmers and Dune, 2023). Furthermore, none of the studies identified from their systematic review considered how the experience of help-seeking impacted on a women's sense of self.

1.9 Rationale and Relevance for Counselling Psychology

Hodgetts and Wright (2007) argue that within intervention research, little attention is given to the client's perspective. A number of authors have identified the gaps in knowledge around the psychotherapy process and how it can be filled by paying greater attention to the client's perspective (Bohart and Wade, 2013; Hodgetts and Wright, 2007; Levitt, Pomerville and Surace, 2015). For example, whilst quantitative research may highlight the importance of motivation and engagement in outcomes, it does not tell us how someone may become motivated (Fuertes et al., 2017). The same authors highlight that it is important to better understand client's experiences in therapy, including what motivates and engages them, as well as why some may benefit and others not from the same therapeutic intervention. Additionally, Levitt, Surace and Pomerville (2016) conducted a qualitative meta-analysis of client's experiences of psychotherapy. The authors reflected that a client's phenomenological experience of change should be defined as a holistic lived experience rather than by "singular forms or sequences of pattern identification". This also reflects the values of the counselling psychology profession, which recognises the need to understand each person as unique, and the importance of understanding the world from the client's perspective (Joseph, 2017).

There is also a growing recognition for the relevance of qualitative research in the field of sexuality, especially using an IPA methodology. O'Mullan Doherty, Coates & Tilley (2014) argue that what distinguishes IPA and makes it particularly relevant to exploring women's sexual problems is its ability to highlight individual as well as shared experiences. They suggest that it enables women to define their own sexual difficulties rather than ascribing to a pre-established set of definitions such as those in the DSM. In addition, sexual experiences and behaviour are particularly influenced by social and cultural contexts, especially in regards to female sexuality (Smith, Flowers and Larkin 2009; O'Mullan Doherty, Coates & Tilley, 2014). An IPA methodology is importantly able to acknowledge this complex interaction between social, cultural, relational, and individual factors (Smith, Flowers and Larkin, 2009).

Previously, there have not been any known IPA interview studies exploring the lived experience of receiving psychosexual therapy for vaginismus. There have however been a small number of IPA studies exploring what it is like to experience a range of female sexual difficulties, including vaginismus (term used GPPPD), vulvar pain, anorgasmia and the sexual side effects of anti-depressant medication. These studies have all shed light on the complex interaction between psychological, social and cultural factors and how these influence women's experiences of their sexual difficulties. Marriott and Thompson (2008), for example, carried out an IPA study to explore the meaning women make of experiencing and being treated for vulval pain. For the women in the study, the experience of vulval pain was not the central issue, and instead they emphasised the impact of pain on their relationships and feelings about themselves. They held concepts of normal sexual functioning and felt abnormal in comparison to these, making sense of their pain within "a psychosocial context of their gendered scripts of what it is like to be a heterosexual woman" (p.253). Similarly, a key finding for Lavie and Willig (2005) was the impact of experiencing 'inorgasmia' on their sense of female identity and romantic relationships.

As mentioned above, there are only a small number of qualitative studies focusing on the experience of treatment for vaginismus, and no studies specific to psychosexual therapy. Whilst no known published IPA studies have explored the experience of psychosexual therapy for vaginismus, IPA has, however, been previously used to explore the experience of a range of other therapeutic interventions, including acceptance and commitment programmes for chronic pain (see Kanstrup, Jordan & Kemani, 2019) and compassion-focused therapy for trauma (see Lawrence & Lee, 2014). This demonstrates that participants are able to report directly and validly about their experience of psychotherapeutic interventions (Fuertes & Williams 2017) and highlights the benefit of a study that is able to provide an in-depth perspective of what it is like to receive psychosexual therapy. The client's perspective has always been of great value and importance to the counselling psychology profession, which is guided by the Rogerian principle of "maintaining curiosity and respect for client phenomenology, culture and autonomy" (Fuertes & Williams 2017, p.370). As Fuertes & Williams (2017) point out, the client is in the best position to describe their experience.

Furthermore, IPA can provide a more authentic insight into how social and cultural factors may impact on how a women makes sense of the therapeutic process for vaginismus (Smith, Flowers & Larkin 2009). Rafalin (2010) suggests that it is important for counselling psychologist to improve the representation of individual's unique experiences by "locating them securely within the socio-political context that shapes and colours them" (P.50). For these reasons, this study will interview 7 women who have received psychosexual therapy for vaginismus, and IPA will be used to analyse data from the interviews. The research aims to contribute to process and outcome research. It also aims to inform practice, support professional’s sensitivity to their client’s experience, and guide them in tailoring their interventions for individuals.

Methodology Chapter

2.1 Research Design and Rationale

As highlighted in the first chapter, vaginismus is an under-researched area of female sexual health (Watts & Nettle, 2010). There are only a small number of published qualitative studies exploring what it is like to experience vaginismus, and none that have specifically focused on women's experiences of psychosexual therapy for vaginismus. This indicates that a study of this nature is important. An in-depth exploration of women's experiences of seeking help and receiving psychosexual therapy for vaginismus will provide a greater insight into what this experience is like for them, and can also highlight the difficulties and possibilities associated with the process. Knowledge gained from this can be used to support counselling psychologists, and other healthcare professionals, to be more aware of and sensitive to the needs of women with vaginismus, which may in turn help to improve the support they receive.

In this research study, I employed a qualitative research methodology, specifically IPA. I conducted semi-structured interviews with seven women who have received psychosexual therapy for vaginismus. I then analysed the data from the interviews in order to generate experiential themes. The aim of the study is to understand women's subjective experience of receiving psychosexual therapy, which also reflects a period of coping with and working towards overcoming vaginismus. By carrying out my research, I aimed to explore the question "how do women make sense of receiving psychosexual therapy for vaginismus?"

The counselling psychology profession is primarily concerned with the meanings individuals attach to their phenomenological realities (Rafalin, 2010). As has been discussed in the first chapter, it is not known how women make sense of the therapeutic process associated with vaginismus, and which aspects of the experience they consider to be meaningful. This is especially important considering the issues raised around who is prioritising what kinds of outcomes in psychosexual therapy for women with vaginismus, as well research highlighting the complexities and challenges inherent to coping with and overcoming vaginismus (Kleinplatz, 1998: Svedhem et al., 2013: Macey et al., 2015: McEvoy 2021). It is hoped that the findings from this study will support counselling psychologists working with women experiencing vaginismus to feel more able to adapt and tailor their therapeutic work to suit the specific needs of individuals. Furthermore, it hopes to raise awareness of the unique and socially embedded experience of managing vaginismus.

2.2 Rationale for Qualitative Research

Quantitative and Qualitative research methods both aim to contribute to the accumulation of knowledge, however, the type of knowledge they aim to contribute may be different (Willig, 2022). Bhati, Hoyt and Huffman (2014) explain how the two approaches represent different research cultures, values and goals. Generally speaking, quantitative research is considered to be nomothetic: its primary goal is to predict and explain phenomena, and the type of knowledge it aims to produce may be related to understanding cause and effect relationships (Ponterotto, 2005; Willig, 2022). Qualitative research on the other hand is idiographic: it is focussed on understanding the uniqueness and complexity of an individual, and is more likely to be concerned with the production of phenomenological knowledge (Ponterotto, 2005; Willig, 2022).

Quantitative research emphasises the quantification of observations to produce data, whilst carefully controlling for empirical variables (Ponterotto, 2005). Qualitative research, however, emphasises the description and interpretation of participant's experiences within a specific context (Denzin and Lincoln, 2011). Willig (2022) explains how qualitative research is concerned with meaning and how people make sense of the world. It aims to capture what an experience 'is like' from a subjective perspective and directs a researcher to focus on the "quality and texture" of experience (Willig, 2022). Consequently, its contribution to knowledge is based on "thick descriptions, critiques of existing conceptualisations and theory building" (Willig, 2019, p.801). This can be directly compared to quantitative research, which is theory driven, and aims to falsify or verify a pre-existing hypothesis (Ponterotto, 2005). Qualitative researchers, being particularly interested in the meaning participants attach to events, view preconceived variables as imposing on that meaning.

Psychology has traditionally been associated with quantitative research methods, however, there has been a recent growing interest and acknowledgement of qualitative methods, and increasingly the two approaches are considered to be complimentary (Bhati, Hoyt and Huffman, 2014). As Smith and Nizza (2022) write, psychology should be both experiential and experimental. Pluralism is a key philosophy underpinning the counselling psychology profession. Applied to the research process, this reflects a methodological pluralism, which encourages an appreciation of the value of methodological difference in research (Rafalin, 2010). Whilst acknowledging what quantitative methods can bring to psychological research, my decision to conduct qualitative research was guided by my research aim to understand how women make sense of their experience of psychosexual therapy for vaginismus.

As discussed in the first chapter, there is little knowledge about the experience of psychosexual therapy for women with vaginismus, and it therefore seems valuable to remain close to the participant's experiences and to learn from this. Haverkamp & Young (2007) describe a distinct characteristic of qualitative research as its ability to explore phenomena in depth. By aiming to develop an in-depth understanding of participant's experiences, I did not aim to answer questions regarding outcomes or mediating factors associated with psychosexual therapy for vaginismus. In this respect, my aims were idiographic rather than nomothetic, and consequently more suited for a qualitative research design.

I am also guided by the humanistic underpinnings of counselling psychology. I am interested in understanding the full range of ways participants can make sense of their subjective experience of psychosexual therapy for vaginismus. Hicks (2010) explains that it is important that counselling psychologists do not passively consume theory, but instead they actively contribute to knowledge in ways that offers more adequate understandings of clients. Qualitative research methods, in their unique ability to explore "what is most human about human experience", are able to do this (Haverkamp & Young, 2007 p.289).

2.3 Ontology and Epistemology

In their important guidelines for publishing qualitative research, Elliott, Fischer & Rennie (1999) recommend that researchers state their guiding research paradigm and Haverkamp & Young (2007) highlight that a rigorous qualitative research project will demonstrate congruence between the research aims and underlying paradigmatic assumptions. Willig (2022 p.17) suggests that it is important for a researcher to ask themselves three questions before beginning a research project: "what kind of knowledge do I aim to create?"; "what are the assumptions I make about the world I study?"; and "what is the relationship between myself and the type of knowledge I wish to create?". These questions can help a researcher to understand the epistemological and ontological positions underpinning their research paradigm. Whilst ontology considers what can be assumed about the nature of reality and being, epistemology considers how knowledge about the world can be acquired (Ponterotto, 2005).

An important question related to what kind of knowledge we aim to produce is the extent to which we consider there to be an external reality that can be known and understood. Positions regarding the nature of reality can be considered on a spectrum with extreme realism on one end and extreme relativism on the other end (Ponterotto, 2005). Whilst realism understands there to be an external objective reality to uncover, relativism considers there to be multiple realities constructed in the mind of the individual or by underlying social, cultural or language structures (Ponterotto, 2005).

I am interested in my participant's subjective experience of the world, rather than the objective nature of their reality. I assume that the meanings individuals give to events are influenced by social interactions and how people make sense of the world is linked to a social world, which exists independently of them. Accordingly, I adopt a critical realist ontological position (Willig, 2022). Whilst I assume there to be a single reality, interpreted differently by different people, I reject the extreme realist position as I don't believe that reality can be accurately described by participants who only have access to their subjective experience (Willig, 2022; Ponterotto, 2005). I also reject the extreme relativism position, as I believe that the participant's account gives us access to an actual reality, and not one that has been purely constructed by society, language and culture (Ponterotto, 2005).

Influenced by its humanistic roots, a key value of the counselling psychology profession is to seek understanding rather than to demand a universal truth (Rafalin, 2010). I want to understand how my participants experience the world and I am interested in creating knowledge which relates to what and how people think of their experiences (Willig, 2022). My epistemological position is phenomenological and I aim to produce interpretative phenomenological knowledge. Willig (2022) points out that a researcher concerned with producing phenomenological knowledge is interested in the quality and texture of a participant's experience, rather than whether their account is an accurate reflection of what happened to them.

The aim of the researcher is therefore to get as close as possible to the participant's experience and to see the world through their eyes (Willig, 2012). However, I also acknowledge that it is not possible to have direct and unmediated access to this, any knowledge produced will always be influenced by my own perspective, and is consequently always reflexive (Willig, 2022). This also means that as the researcher, any understandings of how the participant's experience the world is necessarily intertwined with the way I engage with and interpret their accounts. This recognition that meanings are negotiated within a social context is referred to as the symbolic interactionist perspective (Willig, 2022). My aim is therefore to capture something of the participant's experience in a particular context.

2.4 Interpretative Phenomenological Analysis

It can be possible to divide qualitative methods into two approaches: experiential and discursive (Willig, 2022). IPA is part of a family of phenomenological approaches which all share a commitment to the experiential (Eatough and Smith, 2017). They are primarily focussed on understanding the first-person perspective and value subjective knowledge for developing understanding in psychology (Eatough and Smith, 2017). IPA can be distinguished by its acknowledgement that the process inevitably involves interpretation on the part of the researcher and participant (Eatough and Smith, 2017). The fundamental aim of IPA research is to explore how participants make sense of their experience (Pietkiewicz and Smith, 2014). To carry out this process, IPA draws upon three theoretical ideas: phenomenology, hermeneutics, and idiography.

2.4.1 Phenomenology

Phenomenology, first developed by Edmund Husserl, is a philosophical approach to the study of human experience. Phenomenologists are interested in thinking about what the experience of being human is like and how it is possible to understand an individual's experience of what the world is like (Smith et al., 2022). Phenomenological inquiry asserts that experience should be examined and described "in the way it occurs" and "on its own terms" (p.7 Smith and Nizza, 2022). Husserl was interested in understanding the essential qualities of experience of a given phenomena, emphasising the need to go back 'To the Things Themselves', and reflecting an intention to describe how the world is experienced through consciousness (Eatough and Smith, 2017). He argued that in everyday existence, our experience of the world is taken for granted, and that modern scientific inquiry, through its adherence to a pre-determined categorical or theoretical system, concealed the nature of things (Smith et al., 2022). Phenomenology, however, examines how a person can accurately gain access to the essential qualities of experience, whilst transcending the contextual and personal (Eatough and Smith, 2017).

For Husserl, a study of the subjective experience of things or experience must necessarily be prior to any objective scientific account – the experiential world provides the grounding for the scientific or objective world. Accordingly, phenomenological inquiry requires the "bracketing" of any presuppositions or preconceptions about the world which may impose themselves on our perception of it (Pietkiewicz and Smith, 2014). It involves the stepping outside of everyday existence and holding a phenomenological attitude of 'reflexivity' (Willig, 2022; Smith et al., 2021). Being phenomenological means turning our attention away from objects as they are in the world, and towards our perception of them (Smith and Nizza, 2022).

Whilst Husserl's aim was to get to the essence of experience, IPA is more concerned with capturing particular experiences as they are for a particular person or group of people. A focus on examining lived experience through an individual's "conscious awareness and reflection" is central to IPA (p.7 Smith and Nizza, 2022), as it attempts to get as close as possible to the experience of the participant. This connects IPA with Heidegger's distinctive phenomenology, which is underpinned by an understanding of human beings as 'Being in the world' and emphasises the worldly nature of subjective experience and the temporal nature of life (Smith and Nizza, 2022). According to IPA, people and their lived worlds are understood to be "socially and historically contingent and contextually bounded" (Eatough and Smith, 2017 p.195). Heidegger asserts that it is a pre-existing world of objects, language, culture and so on in which we are 'thrown'. This idea replaces the Cartesian dualism of person/world, subject/object and mind/body with people as 'Being in the world'. The idea is developed further by Merleau-Ponty to include the embodied aspect of the experience of 'Being in the world'. For Merleau-Ponty, the body is a *body-subject,* disclosing the world to each person in a specific way and phenomenology is interested in the lived body rather than the body of "physiological mechanisms and chemical reactions" (Eatough and Smith, 2017 p195).

2.4.2 Hermeneuitcs

Heidegger, a pupil of Husserl, remained committed to the examination of experience in its own terms, however, he was influenced by hermeneutics (the theory of interpretation) and questioned the possibility of phenomenological knowledge outside of an interpretative lens. For Heidegger, to say something appears suggests that it is entering a new state. In coming forth and presenting itself to us, it is already in contrast to a previous state where it was not present. Appearance, therefore, has a dual quality – things can have both visible and hidden meanings for us – and the meaning of experience is not always directly accessible, but instead, it requires a looking beyond of the surface account (Smith et al., 2022; Smith and Nizza, 2022). Heidegger's phenomenology was concerned with understanding the thing as it reveals itself, as this is connected with its "deeper latent form" that both remains a part of it and apart from it (Smith et al., 2022). Moran (2000) notes that how things appear or are covered up must therefore be explicitly studied (cited in Smith et al., 2021). Smith and Nizza (2022) helpfully point out that being phenomenological involves detective work, staying close to what is being described, whilst looking for clues to what it may actually mean.

An interpretation will always be founded upon the prior experiences, preconceptions and assumptions (fore-structures) of the interpreter. However, for Heidegger, the task of interpreting is to work out what these are, making sense of "fore-structures in terms of the things themselves". Smith et al., (2022) explain that whilst the existence of fore-structures may precede encounters with new things, understanding may in fact work in the other direction (from the thing to the fore-structure). In IPA, a researcher may encounter data without any understanding of their relevant fore-structures, which they then get to know after beginning to engaging with the data. Gadamer identifies the cyclical nature of interpretation whereby the thing itself influences the interpretation, which in turn influences the fore-structures, and these then may influence the interpretation (Smith et al., 2022). IPA is therefore a dynamic, cyclical process which can never be fully achieved, and multiple conceptions can be "held, contrasted and modified" during the sense making process (Smith et al., 2022).

Whilst fore-structures may act as an obstacle to interpretation, they are also inevitable, and therefore there needs to be a process which acknowledges what both the interpreter and interpreted brings to the analysis. IPA refers to this process as 'bracketing' (Smith et al., 2022). Furthermore, whilst IPA is concerned with examining subjective experience, it is always the subjective experience of something, and IPA researchers acknowledge that not only is the participant interpreting their experience, but the researcher is interpreting the participant's interpretation of their experience. In IPA, this is called the double hermeneutic – the researcher making sense of the participant making sense of their experience (Smith et al., 2021).

The hermeneutic circle, another important aspect of hermeneutic theory, refers to the dynamic relationship between the parts and the whole on a number of different levels: to understand the whole you look to the parts and to understand the parts you look to the whole (Smith et al., 2022). The whole may refer to a sentence, a complete text, the research project or a complete life; and the parts may refer to a single word or extract, a particular part of the text, or a single interview (Eatough and Smith, 2017). Consequently, the interpretation process in IPA is iterative rather than chronological, moving back and forth through various ways of thinking about the data (Smith et al., 2022).

2.4.3 Idiography

IPA is idiographic because of its focus on the particular: it involves the in-depth analysis of a particular case in its unique context before any general statements are produced about a particular group of people in a particular context (Smith et al., 2022). This means its focus is on understanding the individual as a "unique, complex entity" and aims for an in-depth understanding of an individual's experience (Smith et al., 2022). This is why IPA studies use small, purposive, and homogenous samples. The underlying principles of IPA are therefore in direct contrast to nomothetic principles characteristic of quantitative methods, which produces general statements about groups of people based on probabilities. In practice, this means that an IPA researcher will explore each case in detail first, giving them equal attention, before moving on to make comparisons between cases (Smith and Nizza, 2022). Whilst an IPA study will describe patterns of convergence between cases, this will also include an analysis of the unique and different ways these are expressed by individuals (Smith and Nizza, 2022). General statements made will be grounded in the data by linking them to directly to direct quotes from the participant accounts. By connecting emerging themes to the psychological literature, IPA is able to bring depth to the existing nomothetic research. As Smith et al., (2021) point out, this is another iteration of the relationship between the parts and the whole that characterises IPA.

2.5 Rationale for IPA

As previously discussed, vaginismus is an under researched area of female psychosexual difficulties. Concerned with an individual's subjective experience, counselling psychologists value the "complexity of difference" (Rafalin, 2010 p.41). IPA allows individual and shared voices to be heard, and is therefore a useful approach for developing a more in-depth understanding of women's experiences of sexual difficulties including vaginismus (O'Mullan et al., 2019). As a phenomenological approach, it has the potential to really explore participant's accounts of personal processes associated with psychosexual therapy for vaginismus, and communicate this as much as possible on its own terms. Unlike quantitative outcome research, which focuses on measurable outcomes, IPA provides the opportunity to bring a depth of understanding to more complex experiences associated with psychosexual therapy, such as sexual wellbeing. Being influenced by the philosophy of Merleau-Ponty, IPA is also focussed on understanding participant's lived experiences of their embodied selves (Eatough & Smith, 2017), making is particularly fitting to explore the experiences of women experiencing the bodily symptoms of vaginismus.

Traditionally, the values of the counselling psychology profession encourage a focus on "human potential and social justice" (Haverkamp and Young, 2007 p.289). Aligned with these values, the interpretative lens of IPA aims to provide a critical and conceptual commentary on how participants make sense of their experience, in order to think about what is means that that they have expressed these thoughts and feelings in this particular context (Larkin, Watts & Clifton, 2006). Vital to its interpretation, is the double hermeneutic – the researcher making sense of the participant making sense of their experience. Accordingly, IPA encourages me as the researcher to take a critical position in regard to my beliefs and assumptions about the world. Furthermore, sexual experiences, and especially female sexual experiences, are particularly influenced by social and cultural contexts (O'Mullan et al., 2019). Importantly, IPA acknowledges the historical, social, cultural and theoretical context of its participants and is therefore able to develop an understanding of the contextually located experience of psychosexual therapy for vaginismus.

In IPA, understanding accessed through the data is not seen to be 'the truth', but instead, and importantly, it is understood to be 'meaningful' (Smith, Flowers & Larkin, 2022). IPA, therefore, also reflects my values as a counselling psychologist, as I am concerned with what is meaningful for clients and the role of the therapeutic relationship in facilitating this. A final, but important reason for choosing IPA, is its congruence with my own epistemological and ontological positioning. It recognises that it is not possible to separate our thoughts, feelings, meaning systems and so on from our world in order to identify how things *really are* and instead acknowledges that the only way to understand a participant's experience of the world is as a person in context (Larkin et al., 2006). Whilst IPA is able to assert the existence of an external reality, it recognises how this is mediated through the subjective interpretation of both the participant and the researcher.

Often considered as an alternative approach to IPA, I could have decided to conduct a Grounded Theory study. The primary aim of Grounded Theory is to generate a theory to explain social processes connected to participants experiences (e.g., Charmaz, 1990). However, my research aims were to understand how women make sense of the therapeutic process for vaginismus. A Grounded Theory study would therefore not be able to adequately reflect the depth and richness of participant's unique and shared experiences of this.

Foucauldian Discourse Analysis (FDA) was also considered as an alternative qualitative method to explore and understand women's experiences of psychosexual therapy. FDA is concerned with language, how it is constructed, and its influence on social and psychological life (Willig, 2022). In the context of the present research, this would involve a focus on how women with vaginismus use language to discuss their experiences of therapy, rather than on the experience itself. FDA is committed to being critical of psychology as a body of knowledge and exposing the historical conditions by which it plays a role in shaping individual's experience (Arribas-Ayllon & Valerie Walkerdine, 2017). Considering the historical predominance of a biomedical model in the treatment of vaginismus, which in its focus on cure rather than wellbeing, has the potential to shape how a woman makes sense of herself (Farrell & Cacchioni, 2012), I could see the benefits of using FDA. However, it did not fit well with my research aims to explore what it is like for women with vaginismus to experience psychosexual therapy, and instead, I felt that IPA's emphasis on the depth of a participant's experience, as well as the patterns of convergence and divergence across participants, would provide a better understanding of this (Smith et al., 2022).

Finally, a descriptive phenomenological approach was also considered. Whilst descriptive phenomenologists acknowledge that interpretation plays an important role in how people make sense of their experience in the world, they aim to limit interpretation, and to place focus on 'that which lies before one in phenomenological purity' (Husserl 193: 262 cited in Willig, 2022 p.98). However, I considered that the interpretative elements of IPA would allow for engagement with other forms of knowledge and existing theoretical constructs (Larkin et al., 2006). The findings, therefore, would be well placed to contribute to existing research around the processes involved in psychosexual therapy for women with vaginismus

2.6 Personal Reflexivity

As discussed in the previous section, IPA takes the symbolic interactionist position. The acknowledgement of the role of the researcher in producing the data and the analysis process is integral to its methodology (Willig, 2022). Personal reflexivity encourages a researcher to consider how their own values, beliefs, experiences, and interests may influence the research (Willig, 2022). Throughout the research process, I aimed to engage in reflexive practice by keeping a reflective journal and using peer supervision. I was guided in my personal reflexivity by a list of questions suggested by Landridge (2007). This was especially important for the bracketing process, which involves a researcher, as much as possible, bracketing their own assumptions as they make sense of the participants making sense of their experience (Smith et al., 2022). Finlay (2014 p.123) encourages the researcher to be "empathic and genuinely curious", whilst also being "reflexively mindful" of their own position and perspective.

My interest for this research project came from my work as a trainee counselling psychologist doing a placement in a psychosexual service. During a team meeting one day, we were discussing the lack of an outcome measure exploring sexual wellbeing. Whilst the service often used outcomes measures, focussing on sexual function and satisfaction for example, the lack of a sexual wellbeing outcome measure had a detrimental impact on the services ability to gain a more holistic understanding of how clients benefited from psychosexual therapy.

As a team, we considered what a sexual wellbeing scale might include, and I started to think about what sexual wellbeing looked like for people experiencing sexual problems. I considered the way that clients made sense of sexual norms and attitudes, especially in relation to the prioritisation of penetrative sex and beliefs about being good or bad at sex, as well as how these impacted on their sexual self-confidence. During the research process, it has therefore been especially important for me to reflect on what I hoped to achieve in the context of my beliefs about how social norms and attitudes around sex can potentially shape how a woman experiences her sexual self.

Vaginismus is an embodied experience. Over the course of designing and carrying out this research project I have had two children. These experiences have changed, and continue to change, the way I experience and relate to my own body. I found that it was really important to remain open to how this may potentially influence the way I interpreted participant's bodily experience, whilst also remaining reflexive of an initial assumption that a change in the way they related to their bodies could be a part of their experience of psychosexual therapy.

In the service, I supported women with vaginismus, and often reflected on what their experience of psychosexual therapy and change meant for them. I was not able to find much research exploring the experience of vaginismus in depth, and I felt strongly that being able to access a range of literature into this would have really helped me with my clinical practice. I decided to do an IPA study exploring women's experiences of receiving psychosexual therapy for vaginismus because I was keen to understand what it was like for them, especially considering that some women in the service continued to struggle with difficulties around vaginal penetration at the end of their treatment.

2.7 Sampling Considerations

In line with IPA guidelines, purposive will be used to select participants for the study with the aim to recruit a homogenous group of participants (Smith et al., 2022). Participants were therefore carefully selected based on a pre-determined set of inclusion criteria:

- They had received 6 or more sessions of psychosexual therapy for support with their experience of vaginismus
- They were over the age of 18
- They were living in the UK

Exclusion criteria for the study included:

- They did not live in the UK
- They had received less than six sessions of psychosexual therapy
- They were still receiving psychosexual therapy for vaginismus.

Crowley, Goldmeier & Hiller, 2009) identify that vaginismus can either be lifelong (primary) or occur after penetration has previously been possible (secondary). Some women are able to tolerate some penetration with discomfort and pain (partial vaginismus), or they were unable to tolerate penetration with any object before beginning psychosexual therapy (total vaginismus) (Crowley, Goldmeier & Hiller, 2009). Similar to an existing IPA study exploring the experience of vaginismus (Svedhem et al, 2013), this study did not select participants based on the type of vaginismus they experienced. This is because the focus of the study is on participant's experiences of psychosexual therapy for vaginismus rather than the experience of vaginismus.

Furthermore, and for the same reasons, it was not necessary for participants to have been given a diagnosis of vaginismus. Their experience was relevant to this study if they had received psychosexual therapy for support with their difficulties with penetration and they understood their experience to be called vaginismus. After discussions with my supervisor and the wider research team, it was agreed that even if an individual's symptoms may be more indicative of another sexual pain condition (e.g., dyspareunia) than vaginismus, they have still experienced psychosexual therapy for something they considered to be vaginismus, and their experience is therefore still equally relevant. Furthermore, research has indicated that practitioners have struggled to distinguish between vaginismus, dyspareunia and vulva pain in making a diagnosis (Lahaie et al., 2010). It is therefore possible that some women may have experienced a sense of confusion over their own diagnosis of vaginismus, which, in turn, may be a relevant aspect of their experience of psychosexual therapy for vaginismus.

In comparison to the abovementioned study, there was also no exclusion criteria based on relationship status, gender identity or sexual orientation. The focus is on the shared experience of receiving psychosexual therapy for vaginismus it was therefore felt that the criteria for homogeneity would be met despite potential differences in relationship status, gender identity and sexual orientation. Importantly, this is the first known UK based qualitative study to specifically explore women's experience of psychosexual therapy for vaginismus, however, as discussed in more depth in the discussion, future studies may benefit from using different inclusion and exclusion criteria. The decision to only include participants who had received 6 or more sessions of psychosexual therapy was based on the minimum number of sessions usually offered by NHS sexual health or psychosexual services (e.g., NHS Solent).

2.8 Recruitment

Participants for this study were recruited through an online support group called The Vaginismus Network. I originally contacted The Vaginismus Network with an introductory email (see appendix a), attaching a copy of my recruitment flyer (see appendix b). I then spoke to a member of the team for The Vaginismus Network on the phone. I explained my project in more detail and they expressed their interest in supporting me with recruiting participants. The recruitment flyer was then sent out to their mailing list and I received more than 30 emails from potential participants expressing their interest. Having received more interest than I expected, I decided to stage my responses, and originally replied to the first 8 responses to check whether they met the inclusion criteria. Women did not meet the inclusion criteria for a number of reasons: they did not live in the UK; they had not received 6 or more sessions of psychosexual therapy; or they were still receiving psychosexual therapy for vaginismus. For the women who did meet the inclusion criteria, I then sent them an information sheet (see appendix c), which provided them with more information about the aims of the study, and exactly what would happen if they decided to participate. Potential participants were given the option to contact me to let me know if they still wished to be involved in the study and a follow up telephone call was organised to discuss the project, confirm that participants met the inclusion criteria, and to provide participants with the opportunity to ask any questions. If potential participants were still keen to be involved, we scheduled a date for the interview, however, they were also informed that they could change their mind at any point and without needing to give a reason.

My aim was to recruit 8 participants, as suggested by Smith, Flowers and Larkin (2009) as an appropriate number for a professional research doctorate. IPA, as an idiographic approach is committed to an in-depth and detailed understanding of an individual's experience, and therefore, it was felt that 8 participants would be small enough a sample size to provide the depth of understanding required whilst also large enough to be able to generate themes across cases. I therefore responded to the emails I received from women expressing their interest in chronological order and once I had recruited 8 participants, I emailed the rest to thank them for their interest and to let them know that recruitment for the study had finished. Of the eight participants originally recruited, one participant dropped out later on in the process for personal reasons.

2.9 Participants

Seven participants in total took part in the study. Participants were asked to provide background information regarding their age range and how they would describe their ethnic background. This information is presented on table 1 below. However, for one participant, I forgot to ask her about her ethnic background. Whilst I realised this data was missing during the write up stage, due to the length of time since the interview, it did not feel appropriate to go back to collect this information.

The online support community for vaginismus is relatively small, and therefore, in order to protect participant anonymity, only demographic data related to age range and ethnic background was collected. Participants were also informed that they did not need to provide this information if they preferred not to do so. Participants received a range from 6 to approximately 100 sessions of psychosexual therapy (see table 1) from a range of sources, including: NHS based sexual health clinics or specialist psychosexual services; sexual health charities; and privately working psychosexual therapists. To protect their anonymity, all participants were provided with pseudonyms, whilst all other personal identifying details have been changed or omitted throughout the research project.

I initially aimed to obtain background data regarding type of vaginismus (e.g., lifelong or secondary). However, I considered that participants might not be aware of the different categories of vaginismus, and that questions around this may be confusing for them, and could potentially result in them feeling like they were receiving an additional diagnosis. I therefore decided that this was not appropriate, particularly as participants were from the community rather than already based within a clinical setting.

Table 1:

Pseudonym	Age range	Ethnicity	No. of sessions of psychosexual therapy received	Period of time since ending psychosexual therapy
Alex	25-30	White-British	Approx. 30 sessions	6 years
Tasha	30-35	Unknown	More than 100 sessions	4 years
Poppy	25-30	White-British	20 sessions	7 months
Lucy	30-35	Mixed White and Black Caribbean	6 sessions	9 months
Mya	25-30	Black British	7 sessions	7 months
Kate	25-30	White-British	8 sessions in an NHS clinic and 24 sessions with a private psychosexual therapist	8 months
Rhian	25-30	White-Welsh	Approx. 14 sessions	8 months

2.10 Data collection:

The data was collected through semi-structured interviews, which aimed to capture how participants made sense of their experience of psychosexual therapy for vaginismus. Smith et al., (2021) explain that interviews encourage participants to provide rich and detailed accounts of their experience, allowing them to speak freely and at length, in turn eliciting stories, thoughts and feelings about the specific phenomenon being explored. Due to the Covid-19 pandemic, it was decided that interviews would take place online using Microsoft Teams, at a time most convenient for the participants and at a time they were able to assure they had a confidential space. Seven, one-to-one, semi-structured interviews were conducted online lasting between fifty and eighty minutes. Interviews were recorded using an encrypted and secure Dictaphone, which I then personally transcribed. Recordings were encrypted and transcripts were stored separately on a password protected device.

As the interviews were taking place online, participants received the consent form (see appendix d) by email a few days before the interviews. At the beginning of the interviews, I checked that a consent form had been signed by both myself and the participant. I then reiterated the aim of the interview within the wider context of the research project's aims. I gave the participant some information about the interview style, e.g., there is no right or wrong answer and the purpose is to gather information about what their experience of psychosexual therapy was like for them. I explained that at times I may say very little and that I was interested in them and what they wanted to say about their experience of psychosexual therapy. I felt that this was important having conducted similar styles of interviews in the past and feeling that occasionally participants wanted to answer in the 'right way', however, putting participants at ease in this way is also supported by guidelines from Smith et al., (2022).

I also took down some background information including demographic details (age and ethnic background) alongside specific details regarding length of time and source of psychosexual therapy (see table 1). I let participants know that this information was useful in order to contextualise the research, that it would not be used to identify them in anyway, and they did not need to answer these questions (or any questions throughout the interview) if they did not wish to do so. Finally, I informed participants of the limits of confidentiality and explained that they could withdraw from the study at any point up until the analysis of the data. I checked whether they had any further questions and when I was sure that the participant was happy to continue, I set the Dictaphone to record and started the interview.

I followed a semi-structured interview structure developed based on guidance provided by Smith et al., (2022). The same authors explain that having a guide encourages researchers to think about the phrasing of questions and how to introduce potentially sensitive topics. After designing the initial interview schedule, I sent a copy to my supervisor and a psychologist working in an NHS psychosexual service for them to provide some feedback. I made alterations to the schedule based on the feedback I received, which included ensuring that my questions were open-ended and adding some further questions to encourage the participant to reflect on how they feel things are different as a result of their experience of psychosexual therapy (see appendix e for the finalised interview structure). This process was particularly helpful for encouraging me to think about the wording of my questions. As Smith et al., (2022) emphasise, open and expansive questions are important for generating rich data. Throughout the process, I reminded myself to remain focussed on the participant, which helped me to 'bracket' my own concerns, and to introduce relevant questions from the position of active listening (Smith et al., 2022). I found my counselling skills helpful for establishing a rapport and making sure I gave the participant time to reflect on their answers. I found that my guide was used in a flexible manner and often used prompts such as "can you tell me more about what you mean?" and "how did that make you feel?" to encourage richer accounts.

After the interviews, I emailed the participants a debrief sheet (see appendix f). I also asked them about how they found the interview and the type of questions they were asked. I found this to be especially important during the beginning stages as I became more confident approaching interviews and learning from any difficulties I experienced. I also found that it was important to take the time after each interview to listen back and reflect on how I could improve my questioning style to elicit more in-depth accounts from the participants. Noting moments when I missed an opportunity to prompt a participant to explore further helped me to be aware of such moments in subsequent interviews. Transcribing each interview personally then allowed me to get to know the data. As suggested by Smith et al., (2022), I transcribed all spoken words, pauses, false starts and other aspects worth noting (such as laughter).

2.11 Ethics

Adhering to ethical practice is an important aspect of the whole research process. Before I began carrying out the research, I submitted an ethics application and obtained ethical approval from the City University Research Ethics Committee (ethical approval code: ETH2223-230). The British Psychology Society have outlined clear ethical principles for conducting research with human participants (BPS, 2014), and these principles have been considered during each stage of the design process. Importantly, they include issues around valid consent, confidentiality, giving advice, deception and debriefing. This section will discuss how these been considered in the context of this research project.

Prior to agreeing to take part in the study, participants were sent an information sheet providing them with details about the research process, including what would be expected of them. It also described an honest and transparent description of the project's aims, making it clear that any information collected would only be used for the purpose of the research. Participants then had the opportunity to ask me any questions, and if they agreed to take part in the study, they were asked to sign a consent form. This provided them with specific information about their rights. I also made sure that they understood they could withdraw from the study at any time up until the point of analysis, and without having to give any reason. Participants consented to the research being written up as part of a Doctorate in Counselling Psychology, as well as for the possibility of further publication.

Before the interview, participants were provided with information regarding confidentiality and its limitations. I let them know that I may need to break confidentiality and inform relevant services if any risk issues arose during the interview. More specifically, if I felt that they or any other person was at risk of serious harm. I also assured them of their rights to anonymity. Each participant was assigned a pseudonym and they were informed that any personal details or identifying information would be changed or omitted to protect their anonymity. All data from interviews was transferred and stored on a password protected USB stick, and transcripts of the recordings were stored in a password protected file. All personal information, including consent forms, were stored separately to research data. After completion and assessment of this research project, all data and personal information will be securely destroyed.

Due to the sensitive nature of the topic being discussed, the possibility of participants experiencing some level of distress during the interview was considered. I offered participants the opportunity to see the interview schedule before so they had an idea of what type of topics would be discussed and they could let me know in advance if there were any questions that they did not feel comfortable answering. For participants who did want to see the schedule, this helped them to manage their worries about what would be expected of them. I also let participants know they could stop the interview or take a break at any time.

Using the skills I developed throughout my training as a counselling psychologist, I aimed to carry out my interviews in a sensitive manner. When difficult subjects arose, I was supportive in my response. I aimed to monitor how the participants were affected by the interview, paying particular attention to non-verbal cues (Smith et al., 2022).

After the interviews had finished and I turned off the dictaphone, I gave participants the opportunity to ask any questions they may have, discuss any concerns, and reflect on how they found the experience. I found that participants were keen to express that they appreciated the opportunity to talk about what it was like to receive psychosexual therapy for vaginismus. I also emailed participants a debrief sheet, which signposted them to relevant support networks and mental health support lines at the end of the interview. Before taking part in the research, participants were also provided with the option to be informed of the research outcomes, which all participants were keen to receive. There was a specific box for them to tick on the consent form allowing their personal data to be kept for this specific purpose.

2.12 Analytic Process

Smith et al., (2022) highlight flexibility during the analysis stage, suggesting that researchers will develop their own processes over time. As this was the first time that I have carried out an IPA research project, I decided to use their guidelines as a basis for the analytic procedure. Importantly, and in order to meet the idiographic commitments of IPA, each transcript was analysed in depth on its own before the cases were integrated. Furthermore, Smith et al., (2022) emphasise that the analytic procedure in IPA is an iterative process and I continuously rearranged and reflected on my themes, moving from the individual to the group and back again.

I began the analytic process by transcribing the interviews, which allowed me to fully immerse myself in the data. Whilst doing this, I noted any preliminary thoughts and observations which came to mind on a separate piece of paper. This helped me to capture them, but also be aware of any subsequent effect they may have on the analytic process (Smith et al., 2022). Once the interview was transcribed, I read it though a number of times whilst making some more detailed exploratory notes in the right-hand margin. Initial exploratory comments were descriptive or linguistic, and comments became more conceptual as I moved through the process (Smith et al., 2022).

For descriptive comments, I recorded the key words, phrases and terminology employed by the participant, focussing on the context of what they said (Smith et al., 2022). For Linguistic comments, I considered the participant's use of language and how it was used, in order to think about the meaning of what matters to them (Smith et al., 2021). As suggested by Smith et al., (2022), I considered the use of pronouns, pauses, laughter, as well as tone, and degree of fluency. As powerful linguistic devices, I also reflected on the participant's use of metaphor, which provided the opportunity for links to be made between descriptive and conceptual analysis. Finally, I also made conceptual comments by moving away from the explicit claims made by participants and towards a deeper interrogation of the data. This involved asking questions and shifting my focus to thinking about an overarching understanding of the participant's experience, whilst making sure that any interpretations made where linked to the text. I commented on similarities and differences, contradictions, and amplifications within the text (Smith et al., 2022). Finally, I discussed some of my exploratory comments with my supervisor to check the depth of my engagement with the data.

During the next stage of the analytic procedure, I identified experiential statements in the left-hand margin (Smith et al., 2022). This involved shifting my analytic focus away from the transcript and to the exploratory comments. The experiential statements I made aim to relate directly to the participants experience or their experience of making sense of what happened, whilst also reflecting the most important features of the exploratory comments. I tried to make them a concise summary of what was important at a particular point in the text but also influenced by the whole transcript. This reflects the hermeneutic circle: the part is interpreted in relation to the whole and the whole is interpreted in relation to the part (Smith et al., 2022). I attempted to ensure that experiential statements represented both the participants original words as well as my interpretation of them (Smith et al., 2022). See appendix h for an example of this.

The next stage involved mapping how these statements interconnected to capture the quality or 'essence' of participant's accounts of their experience (Smith et al., 2022). To do this, I wrote down all the experiential statements in chronological order and clustered them into groups, combining similar statements, and moving them around until they felt right. I considered similarities and differences between them, as well as how they related to my research question. I then created a title reflecting the characteristics of each group of experiential statements, and put them into a table. These are referred to as the table of Personal Experiential Themes (PET's), with most PET's also having subthemes (Smith et al., 2022). I completed the same steps for each of my interview transcripts until I had a similar table for each participant. Smith et al., (2022) explain that it is inevitable that a researcher will be influenced by the emerging themes from each case, however, in keeping with IPA's idiographic commitment, I tried, as much as possible, to analyse each case on its own terms. See appendix I for an example of a participant's Personal Experiential Themes.

After analysing each transcript, I moved on to searching for shared patterns of themes across all the cases (Smith et al., 2022). I collected all of the themes together and then spent some time exploring different possibilities. I aimed to look for points of convergence and divergence across the cases. This involved reconfiguring, collapsing, renaming, and eliminating themes until I ended up with a final table of Group Experiential Themes (GET's), each with subthemes, and associated experiential statements linked to words or phrases in the relevant transcripts (Smith et al., 2022) (see appendix j for an example of this). This is what Smith et al., (2021) refer to as the evidence trail, which provides the supporting information to ensure that each GET is clearly grounded in the data. GET's aim to demonstrate convergence in participant's experiences, as well as the particular and unique way that each participant reflects that shared quality. I decided to name the subthemes with direct quotes from the participants as I felt that these were most able to capture the essence of the experiential theme.

2.13 Reliability and Validity

Compared to quantitative research, the assessment of reliability and validity is very different in qualitative research, however, it is equally as important. Smith et al. (2022) explain that reliability and validity in qualitative research refers to the extent to which a study is meaningful and credible. They suggest that it involves assessing whether the methods producing the analysis are appropriate and allow for an intelligible contribution to the wider literature. Yardley (2000) helpfully provides four principles to guide researchers in ensuring their research is both valid and reliable: sensitivity to context; commitment and rigour;

coherence and transparency; and impact and importance. This section will discuss each of these and how they relate to the study in more detail.

Sensitivity to context involves situating the research in its wider socio-cultural context. My first aim was to contextualise my rationale for the project within a clear and critical examination of the existing literature. During the analytic process, I aimed to ensure that the findings were clearly embedded in the data and any interpretations made could be traced back to the participant's accounts. Finally, when discussing my findings, I aimed to contextualise them within the existing literature, highlighting similarities, differences and novel findings. Throughout the process, I remained aware of the socio-cultural context of the research project, and how it is central to the meaning making process.

When considering the principles of sensitivity to context and whilst carrying out the interviews, I remained sensitive to the experiences of my participants, demonstrating empathy, and being ready to step in if I felt they were finding the discussion too difficult. I also reflected on my influence as both a researcher and psychological practitioner, using the clinical skills I have developed to support participants to feel able to share their experiences, which holding in mind the boundary between researcher and therapist (Smith et al., 2022). This became an important aspect of maintaining reflexivity throughout the research process.

In committing to the principles of rigour and commitment, I provided a clear account of the purposive sampling procedure used to recruit a homogenous sample with lived experience of receiving psychosexual therapy for vaginismus. I also attempted to demonstrate how I carried out the interviews in such a way as to produce an in-depth and rich account, clearly focussing on the experiential, and how the participants made sense of their experience, e.g., through developing a rapport, active listening, and asking probing questions. This also involved reflecting on my process between interviews with the aim of improving my interview style. Finally, I aimed to carry out extensive analysis of the data, as well as thoroughly describing the process associated with this, and using supervision to identify points in the analysis where more interpretation was required.

Coherence and transparency are vital as they allow the reader to see the decisions made and processes carried out leading a researcher to produce their findings (Yardley, 2000). I was keen to make sure that I provided a detailed description of the research process, including any changes that occurred, e.g., in the way I collected data through interviews as I became more confident. When deciding on my methodology, I aimed to have a good grounding in the philosophy of IPA, and ensure that it was a good fit for my own epistemological and ontological positioning, as well as being clearly set out in the research. Finally, I aimed to ensure that the reader was clearly able to follow my reasoning in the results section, linking my interpretations back to the specific descriptions in the text, and making sure results were drawn from a range of interview transcripts.

In respect to the principles of impact and importance, Yardley (2000) expresses that the "decisive criterion by which any piece of research must be judged is, arguably, its impact and utility" (Yardley, 2000 p. 223). She goes on to explain that even if a piece of research has developed a "sensitive, thorough and plausible" (P.223) analysis, this becomes irrelevant if the ideas produced by the research have no impact or influence. My decision to carry out this study was influenced by own experiences working in a psychosexual service and difficulties finding research which provided insight in women's experiences of vaginismus so I could gain a better understanding of what this experience might be like for my clients. My aim was to collect rich data about the experience of receiving psychosexual therapy for vaginismus and I attempted to contribute important knowledge to the field of counselling psychology, as well as we sex and relationship therapy. I was keen to produce interesting and useful findings, which could support counselling psychologists or other professionals better understand the potential experience of their clients who may be experiencing vaginismus.

The analysis

3.1 Overview

This chapter is an in-depth exploration of the experiential themes which emerged from analysing the data. Three Group Experiential Themes (see Table 2) emerged through the analysis, and these are represented by the detailed examination of 12 corresponding subthemes, alongside verbatim quotes from participants. Some of the data from the interviews could have been incorporated under more than one theme, highlighting the existence of some overlap between themes.

Participant quotes are presented in italic and include a reference to their assigned pseudonym, along with the page and line number from their interview transcript. Table 1 in the methodology chapter provides a list of participant pseudonyms and relevant demographic data. Whilst pauses, hesitations or petering out of speech are represented by three dots … omissions are represented by three dots inside of square brackets […] and finally, any additional necessary information such as tone of speech or the presence of laughter will be in brackets.

I have made comments in connection with each quote, and these reflect my cautious interpretation of the participants making sense of their experience (Smith, Flowers and Larkin, 2022). According to guidelines by Smith et al., (2022), the comments and interpretations I have made are exploratory, linguistic or conceptual in nature. A more detailed description of what each of these involve has been provided in the methodology chapter.

Table 2

Help Seeking	**The Embodied Experience**	**Living with Vaginismus**
“I thought I was the only one in the world going through this”	“I was just trying to fix it”	“It doesn’t mean you’re broken”
“It’s obviously a huge relief because you have a word”	“I felt like I didn’t even have a vagina”	“It was the start of my whole journey”
“I had no idea what to expect from it”	“I felt like I had to overcome myself”	“I feel more confident in my ability to help myself”
	“It’s just like learning not to be hard on yourself”	“It’s just nice to have people who have actually experienced it”

Group Experiential Themes are in bold with experiential subthemes below.

3.2 Help Seeking

This Group Experiential Theme, which captures the challenges participants faced seeking help for their vaginismus, explored their sense of isolation, as well as their struggles to communicate their experiences around vaginal penetration. It reflects the relief participants experienced to learn about vaginismus for the first time, and their subsequent mixed feelings towards psychosexual therapy.

3.2.1 “I thought I was the only one in the world going through this”

This experiential subtheme reflects participant’s experience of isolation and loneliness prior to psychosexual therapy. This includes their experience of uncertainty and self-doubt about what their difficulties with penetration meant, and associated resistance to seeking support.

Mya, for example, spoke about how lonely she felt because she did not feel able to talk to other people in her life about vaginismus:

> *Vaginismus is, it's the most loneliest time of your life, you feel cut off from society because it's not really something you go round talking to people about. I didn't tell any family members, I couldn't tell any friends in my direct peer group, and I think it was mainly because I wasn't dating someone, I was married so I had to protect my marriage and also protect the privacy of my spouse (Mya p.17, 384-390)*

This account provides a sense of how lonely and isolated Mya felt, especially as she was not able to talk to her friends or family – people you imagine she would usually be most likely able to share her experiences with. Her powerful description of someone with vaginismus being "cut off from society" suggests a sudden shift in the way she experienced herself in the world, possibly as someone who became an outsider. Mya explains that it isn't something "you go round talking to people about" indicating that it felt like a social taboo to discuss it with others. I imagine that Mya must have felt a strong need to share her experiences, but resisted doing so to protect her marriage and the privacy of her spouse.

Rhian also reflects on her experience of not being able to talk to anyone about her symptoms of vaginismus:

> *I couldn't talk to anyone about it, no one knew about it, like I couldn't talk to my mum about it, I couldn't talk to my sister about it, and I thought I needed someone to talk to and…who understood it (Rhian, P.2, 28-32)*

Rhian's repetition that she was not able "to talk about it" with anyone emphasises how impossible it felt for her to open up about her experiences, and it suggest that there was something stopping her. I wonder if Rhian felt like there was a stigma attached to experiencing difficulties with vaginal penetration, which prevented her from opening up. This interpretation is supported by her reflection that she "needed" to talk to someone who understood it, which possibly also highlights how isolated she felt.

Alex describes her struggle to communicate her difficulties around penetration:

> *I googled random things, which I think now would throw up vaginismus, you know like, maybe if I like had been able to have sex but had pain, maybe if I had googled pain during sex it would have, you know I would have found something. Because I couldn't have sex, so as far I am concerned it wasn't painful, it more felt like I didn't have a vagina (laughs), so I think I was probably just googling the wrong things because I was googling "can't have sex and stuff". (Alex, p.18-19, 428-434)*

Alex refers to her uncertainty about what it was she was experiencing and, in turn, the challenge of articulating her experiences to seek more information and support. I get the impression that Alex found this process to be quite frustrating, as her specific experiences around penetration were not recognised, even by google. Alex also states that for her it felt like she didn't "have a vagina", and her laughter as she expresses this possibly reflects her understanding that her experience was different or unusual. Alex later refers to her associated experience of doubting herself:

> *but before I just thought you know it was just like some...ummm...I thought that either I was making it up, which doesn't make any sense, but that's what I thought, or that it was just you know some horrible physical flaw just specifically for me. (Alex, p.19, 439-442)*

Alex's reference to how it felt like she was "making it up" provides a sense of how destabilising it felt, as she could not even be sure that her experience was real. By explaining that it doesn't "make any sense", Alex appears to be now recognising how significant it was that she was doubting herself in this way. Her previous belief that it was a "horrible physical flaw just specifically" for her, suggests that she felt some shame around her difficulties, especially as she did not have the context to understand them. I imagine it would have been difficult for her to reach out for support whilst feeling so confused and uncertain.

Poppy describes feeling like she was alone in experiencing the symptoms of vaginismus:

> "*learning that I wasn't the only person going through this [...]and I'm sure if you've spoken to other people about it [...] a lot of people will say "I thought I was the only one in the world going through this." (Poppy, p.2, 38-41)*

Through aligning herself with a shared experience for women with vaginismus of believing that they are “the only one in the world going through this”, you get a sense of how isolated Poppy felt. However, from her acknowledgment that other people struggled in the same way she did, I get the impression that Poppy now feels more compassionate towards her own struggle.

Lucy spoke about her difficulties acknowledging and sharing her experience of painful sex in the context of a prevailing discourse for woman that sex will be painful.

> *As a woman, I think we are told a lot growing up oh you know sex will hurt, the first time it will be a bit painful, the first few times, that’s fine, don’t worry, and so we kind of talk...don’t say anything about it if it hurts and just let a guy carry on regardless of if it hurts, you know that’s sort of how we are taught [...]you think that it might be you, you think that maybe you know all these things go through your head...you think maybe you’re just a bad girlfriend, maybe you just don’t want to have sex, you know all of this. (Lucy, p.2, 28-32)*

Lucy explanation that when her pain continued, she worried that she may be “just a bad girlfriend”, or that it meant she didn’t “want to have sex”, gives the impression that she felt responsible for her difficulties around penetration, and she felt some guilt because of this. From this passage, you get a sense of how much Lucy was doubting her sexual self and her role as a partner during this period, and I imagine this made it harder for her reach out for support. Lucy’s use of the third person “you” throughout this account demonstrates her understanding of this to be a shared experience for woman with vaginismus, indicating that like Poppy, she also feels some compassion for how she felt in the past and less isolated because of it.

3.2.2 “It's obviously a huge relief because you’ve got a word”

Most of the participants spoke about the relief they experienced when finding out about vaginismus for the first time. For some, having a name was a relief because it meant they did not need to question themselves anymore. Participants also described their relief to know that they were not alone, and that support was available to them. The experience of relief for one participant also appears to be complicated by how having a diagnosis made them feel about themselves.

Alex explains that it meant that it was a "real thing" and she wasn't "making it up":

> *I think like in the moment I had a little bit of a meltdown, but then it's obviously a huge relief because you've got a word which you can go and ask people about, and then obviously it means it's not, it's a real thing so it's not just you making it up, and other people presumably have it too (laughs). (Alex, p.29, 445-450)*

This highlights how much she was questioning herself and her reality before learning about vaginismus. Importantly, it appears that her relief was connected to the fact that she no longer needed to doubt herself. Her description of "a little bit of a meltdown" provides an impression of how her psychological distress may have been building before this moment.

Like Alex, Lucy also describes her experience of learning about vaginismus for the first time, and the relief she felt to know that it wasn't "made up":

> *It felt like a relief, because to finally know like (...) So to actually hear that it's a real condition, it's in your head in terms of you know it's psychological as well, but it's not in your head it terms of being made up (Lucy, p.2, 32-34).*

This identifies how she was also doubting the reality of her experiences, and I get the impression that it was an incredibly confusing time for her. Later in the in the interview, Lucy again reflects on her experience of relief:

> *the relief of just knowing that someone can help you [...] there's a name for what's happening to you, somebody understands what that is and that person can help you, and the relief of even just knowing that you have started that journey is so like big, that sounds really silly, I can't explain it, it's just like (exhale), it feels like a huge weight of your shoulders. (Lucy, p.9, 208-215)*

Lucy's repetition of how it meant that there was "someone" or "somebody" who could help her highlights how alone and vulnerable she felt before this. Lucy associates her relief with knowing that she has started a journey, and I get the impression that she also felt stuck before finding out about vaginismus. Whilst Lucy expresses that it is difficult to explain what this was like for her, she demonstrates how it felt physically with an exhalation, and reaches for the description of it as a "huge weight of her shoulders". Lucy's difficulty finding a way to describe this experience might indicate that words were not enough to reflect how unique and significant this moment was for her. The significance of it may also be contextualised by how little social awareness there is around vaginismus and her associated sense of uncertainty.

Poppy also refers to the "comfort" she felt to know that she wasn't the only person experiencing her symptoms of vaginismus, and that support was available:

> *That was a huge comfort in a way, to know that it wasn't just me, and I think that also gave me comfort in that like it wasn't me going to get help for some really random thing that no Doctor or therapist had ever heard of […] so that gave me the courage. (Poppy, p.3, 45-50)*

Poppy's repetition of the word "comfort", and subsequent description of how it gave her courage, indicates how much she needed this reassurance as it helped her to feel less afraid of her difficulties and what they meant.

Mya also refers to the relief she experienced to learn about vaginismus, which, like both Lucy and Poppy, is connected to knowing that she could then get help for it, as well as feeling more hopeful:

> *I think I was probably quite relieved because at least I could put a name to it and then that kind of gave me hope that I could get help for it, because I actually knew what it was as opposed to just not having a clue. (Mya, p.3 55-59)*

Her use of "probably" and "kind of" indicates that she was hesitant in describing her experience of relief. During the interview, Mya describes her mostly negative experience of psychosexual therapy, and it is possible that this has made it harder for her to relate to her initial feeling of relief and hope, which did not correspond with her actual experience of psychosexual therapy.

Tasha also reflects on how she felt in response to learning about vaginismus:

> *She gave me a word for this and finally I had some sort of explanation, but I didn't want to associate myself with any sort of ummm... syndromes, or any sort of names, so I said no I don't have it. (Tasha, p.2, 44-48)*

From her use of the word "finally" when describing how she had some "sort of explanation" you get the sense that Tasha did feel some relief when she learnt about vaginismus for the first time, however her "sort of" suggests that the explanation did not fully make sense to her at that time. She goes on to speak about how she did not want to acknowledge that vaginismus was something that she had as she didn't want to associate herself with any "syndromes". This indicates that her sense of relief was complicated by how being diagnosed made her feel about herself. She also later refers to how she had hoped her difficulties would disappear:

> *It was very difficult because I didn't want to even acknowledge that it is something which I have. I was really hoping that it is something that which, going to go away, because I probably am just so tense and I can't relax (Tasha, p.2, 58-61)*

It appears that understanding her difficulties as a consequence of how tense she felt allowed Tasha to feel some distance from them, but having a name meant that they became more connected to who she was, and this was a difficult experience for her. I also get the impression that this also left Tasha with a sense that her difficulties were more real and therefore harder to ignore.

3.2.3 "I had no idea what to expect from it"

This experiential subtheme captures the common experience for the participants of being uncertain of what therapy would be like and fearful of what would be expected of them. It also reflects the associated experience for some participants of feeling like they did not make an active decision to do psychosexual therapy, and their frustration because of this.

Poppy, for example, explains that she did not know what to "expect" from therapy, as well as how anxious she felt because of this:

> *I had no idea what to expect from it, I had never heard of psychosexual therapy before [...] I went in, I was a bit nervous because I wasn't sure like how far back I'd have to think, like I just said my memory is so bad, so I was like what am I going to have to talk about. (Poppy, p.3 56-62)*
>
> *And*
>
> *I think I sat there in the first session and was like I really don't know what I am supposed to be talking about, I don't know what the plan is, I don't know how we are going to fix this ummm, it was all quite negative. (Poppy, p.45, 1054-1057)*

Poppy's reflection that she didn't know what she was "supposed to be talking about" gives the impression that she felt a lot of pressure going into therapy to meet this unclear expectation. From her description of being concerned about how far back she would have to think, I get the sense that her anxiety was also linked to negative assumptions about not being able to do therapy. Poppy's repetition of "I don't know" emphasises her uncertainty, indicating she felt quite helpless at the beginning, and I wonder if she also experienced a sense of powerlessness.

Lucy reflected on what it was like for her to make a decision to begin psychosexual therapy: *"they had just told me that psychosexual therapy was the first point of call for that so I just kind of did it because that's what they recommended as the start of any sort of treatment" (Lucy, p1, 14-17).* From this, I get the sense that she did not feel actively involved in her decision, and like she did not have much agency over her treatment plan. This interpretation is supported by her explanation during the interview that she was required to do the sessions to progress with other treatment. She later goes on to describe her negative thoughts and feelings towards therapy at the beginning:

> *I was really cynical and dubious about therapy. I have been through a lot in my life anyway, [...] but everyone had always said to me oh with everything you have been through you should go to therapy, you know, and my sort of attitude to it if you like*

> *was what's the point in raking up everything that has happened, it's done and I'm over it and I just need to move on and get on with my life. (Lucy, p3, 42-49)*

Lucy's use of the words "cynical" and "dubious" to describe her attitudes towards therapy suggests that, like Poppy, she also held negative assumptions around what therapy would be like. This also gives the impression that she did not feel like she could trust therapy, and I wonder how safe she felt at the beginning, especially as her involvement did not seem to be an active decision. Her use of the metaphor "raking up every that has happened" to describe her understanding of what therapy would be like evokes a strong image of things becoming unsettled, indicating that Lucy was possibly fearful of the impact therapy might have on her mental wellbeing.

Kate also spoke about her lack of awareness around what it was she was being referred to:

> *But I think one of the things I really want to say is actually I had no idea it was therapy and even if in the same [...] I didn't...I have never done therapy before...I didn't really understand how it worked, and I think it really framed my reception to the whole treatment, was not really understanding how therapy works. (Kate, P.5 97-105)*

It is clear how important it was for Kate to be able to speak about her experience of uncertainty around what psychosexual therapy involved and why she was being referred to it. Kate explains that her experience of not knowing how therapy worked "framed" her "reception to the whole treatment", indicating the negative impact of this. I get the impression that she felt left out of the process, and frustrated about this. I wonder if this also left her feeling quite helpless and powerless.

Similar to Kate and Lucy, Alex also reflects on how she did not feel involved in her decision to begin psychosexual therapy: "*it's just like the thing that my GP referred me to, and then I was like obviously well this is the treatment that I'm getting, so there we are (laughter)" (Alex, P.1, 20-24).* Alex's laughter as she expresses this suggests that she now understands it to be absurd that she was not given a choice. Later on in the interview, Alex elaborates on what this was like for her:

> *I didn't know why we were doing it, so I was like a combination of really just like confused and sort of stand offish […] also just like I say just like irrationally feeling just like really angry about it, so it's like it just doesn't make sense, and I just want to fix this, and I don't want to have to... this is going to take ages, and I just want to fix it now, and so yeah I was very like, I was very like cross about it (Alex, p.17-18, 395-408)*

Alex's reference to how therapy didn't "make sense" indicates that her experience of therapy did not match her understanding of vaginismus at that time. She repeats how angry or cross she felt about this, and it gives the impression of her anger building as she remembers and reflects on her experience. I wonder if looking back, Alex is making sense of this, and feeling a sense of injustice about the lack of autonomy she experienced around her treatment.

Mya also describes her lack of awareness around psychosexual therapy and what it involved prior to beginning psychosexual therapy:

> *I don't think I actually knew fully what it was before getting involved so (sigh) yeah, […] they referred me for the psychosexual therapy, and I thought why not? I'll just give anything a try at this stage, so that's kinda how I got into it. (Mya, p.1, 14-20)*

Mya's sigh whilst describing her experience gives the impression that she feels regretful that it was not clear to her what she was getting involved in, which can be contextualised by the overall negative experience of therapy she describes throughout the interview. Mya describes thinking that she would give anything a try "at this stage", and there is a sense that she felt driven into psychosexual therapy by her circumstances. This interpretation is supported by a comment she makes later on in the interview about how vaginismus made her "so frantic" and how she felt "very desperate, very hopeless":

> *What influenced my decision? ummm I think I had got to the place of just feeling very desperate, very hopeless, […]it just makes you so frantic, after a while like I found it very emotionally distressing and I felt like I had exhausted other avenues and so I thought this would be the next best thing (Mya, p.1, 7-13)*

Mya's explanation that she had "exhausted other avenues" emphasises how psychosexual therapy felt like her only option, and, in the context of how "emotionally distressing" her experience of vaginismus was, I imagine it must have felt like she didn't have a choice.

Tasha reflects on making a decision to begin psychosexual therapy and her mixed feelings around this:

> *At the time the therapy just felt like something I have to do [...] You know I was, I was really not ready to go to therapy, and obviously you know going to therapy is automatically a little, little, little bell that there is something wrong with you, and I never wanted to associate myself with anything, which is like there is nothing wrong with me (Tasha, p.23-24, 284-292)*

Tasha's description of therapy feeling like something she "had to do" gives the impression that her decision also did not feel like a choice. She goes on to explain that she did not feel ready, and you get a stronger sense of her ambivalence towards the process. She also explains that she associated it with a "little, little, little bell" that something was wrong with her, which suggests that she felt some shame around being in therapy for vaginismus. Her use of metaphor here also evokes the image of an alarm bell, giving the impression that she experienced some fear, and I wonder if this was related to a belief that therapy would be exposing.

3.3 The Embodied Experience

This GET considers how participant's make sense of a mind-body connection for vaginismus, and their experience of being in and relating to their own bodies. It also captures the resistance many participants experienced around body-focussed psychosexual exercises, such as using dilators, as well as their changing relationship to them, including their experience of becoming more comfortable with them.

3.3.1 "I was just trying to fix it"

Many of the participants spoke about their hope or expectation that psychosexual therapy would "fix" or "cure" their vaginismus. This sub experiential theme captures participant's experiences of understanding their vaginismus in physiological terms and their associated difficulties make sense of the potential role of psychology. Some participants reflected on their need to be open to a psychological way of thinking about vaginismus, whilst others did not experience this way of thinking as helpful.

Kate, for example, explained her belief that if she could learn all about vaginismus, then she could “fix it”:

> *I am quite nerdy and (laughs) it was actually really interesting ummm to learn it and I felt like if it was something I could learn, then it was something that I could fix, so obviously that’s not really the same thing. (Kate, p. 308-311)*

The use of the word “fix” has connotations with a broken object, and I get the sense that Kate possibly felt like her vaginismus was something external, almost like it was happening to her. This feels similar to how people think of other physiological conditions, for example people may talk of “getting an infection”, and it suggests that Kate perceives her vaginismus in similar terms as something that she has got, and that she can get rid of or “fix”. At the end of the passage, Kate’s expresses “so obviously that’s not really the same thing”, indicating that overtime she may have related to her experience of vaginismus differently, possibly as something to manage rather than “fix”.

Mya also spoke about the way she made sense of vaginismus as a “physical problem”, and how she didn’t think psychological interventions were very helpful for its treatment:

> *It just overall felt a bit silly, because I was just thinking how are we meant to solve this physical problem, and I know like the research that we have, people will link it to the mind, they think it is a mental thing, I get that, but at the same time it is very much a physical problem, it is manifesting in a physical problem ummm....so yeah, I just...I just don’t think it is necessarily helpful in treating vaginismus. (Mya, p.16, 474-381)*

Mya’s use of the word “silly” to describe her feelings around psychosexual therapy suggests that it felt pointless to her, and this is supported by her subsequent comment “I just don’t think it is necessarily helpful”. Whilst referring to research linking vaginismus to the mind, Mya states that she “gets that”, but explains that it is “manifesting as a physical problem”. I get the impression that Mya feels that her experience of vaginismus was misunderstood, and that she experienced a struggle to feel validated in a psycho-therapeutic environment.

Similarly, Alex also spoke about going into therapy with an understanding of vaginismus as a "physical problem":

> *Yeah, I mean as far as I was concerned, you know it was just a physical problem, and I was just trying to fix it, and that was it ummm, so and I didn't really, yeah, that, that was it in my head so... (Alex, p.41, 969-972)*

Like Kate, Alex also describes her difficulties as something that she was trying to "fix", which suggests that she also understood them as separate from her. Alex references the phrase "in my head" when explaining her thoughts here, which is often used when someone expresses a belief that either they consider to be incorrect or they know others to consider to be incorrect. It is also connected to the sentiment "it's all in your head", which has dismissive and loaded connotations. It is possible that Alex has felt like she was battling the assumptions of others in regards to how she made sense of vaginismus. Alex goes on to link her "black and white" understanding of vaginismus as something to "fix" with her "binary" understanding of sex at that time, it's either "PIV" (Penis in Vagina) or its not:

> *It was black and white and binary in my head [...] I think because also like that's what the whole world, yeah until that point, teaches you, isn't it? It is, you know sex is binary, it's that sort of, it's, it's PIV or it's not, and ummm you can do it or you can't, if you can't then you're, you don't have any value as a woman ummm, which is obviously insane, but that's kinda like the subliminal messaging that you have at the point, so it's very hard I think to like breakdown that like...maybe it's more than that...(Alex, p.42, 976-987)*

Alex's reference to the fact that because she was not able to have penetrative sex, she did not feel like she had any value as a woman, suggests that, for her, the consequences of not being able to "fix" her vaginismus were existential. She appears to be explaining why it was so important for her to believe that vaginismus was a physical problem that she could "fix", as well as why her thinking was so rigid or "black and white" around this. Her use of the past tense throughout the account suggests that she may now have a more flexible understanding of her experience of vaginismus.

Like Kate and Alex, Tasha references similar language of wanting to "be fixed" to explain her expectations around therapy: "*I was hoping to be fixed in like 5-10 sessions. I was hoping to get cured...basically" (Tasha, p.3, 70-71).* Tasha's use of language here gives the impression that she also felt disconnected from her experience of vaginismus, and it is possible that she felt quite passive in the process to "resolve it". This is emphasised by her later description of vaginismus as a "big dark cloud", reflecting an image of it as a separate entity hanging over her:

> *Obviously as anything if there is any problem in your life you sort of like want to solve it as best as possible and get rid of it and so vaginismus looked like a big dark cloud and I really wanted to resolve it and just be like ahhh I never had it, it's all good. (Tasha, p.18. 556-560)*

"A big dark cloud" also provides a sense of something being concealed, and in this passage, it may be concealing the specificity of her experience. I wonder if this represents Tasha's understanding that she minimised or found it difficult to communicate how uniquely challenging and distressing the experience was for her at that time. I wonder if externalising or objectifying her difficulties allowed Tasha to feel less overwhelmed by them.

Poppy also used the same language as Tasha, Alex and Kate, referring to her vaginismus as something that needed "fixing". However, she also reflects on how she now understands it differently, as something to "overcome" instead:

> *I didn't know it was a thing three days ago so absolutely because if there is a way for me to understand what it is and ummm a way to overcome it which is how I've started saying instead of fixing it because there's nothing wrong with ...ummm then absolutely I want to do it. (Poppy, p.2, 26-30)*

Poppy's explanation that she has stopped referring to "fixing it" because there is nothing wrong with her suggests that she now feels more conscious of the language she uses around her vaginismus. I get the impression that this helps her to feel more self-compassionate.

Poppy's differentiation between "fixing it" and "overcoming it" also appears to indicate a difference in how she relates to her vaginismus. Her use of the term "overcome" possibly indicates that Poppy is looking to have or feels more autonomy in the process. Poppy's use of the present tense may also indicate that this is a learning she has taken from therapy, and internalising it is an active and ongoing process.

Lucy similarly reflects on the process of becoming more "open" to understanding how psychology could potentially be helpful for understanding and managing her vaginismus. During a discussion about using dilators, Lucy describes her struggle to understand the "psychological connection" for vaginismus in comparison to her previous belief that it was "just a physical thing":

> *I have to just be open to it now, and understand how it's not just a physical thing [...] you have to be open to the fact that your mind is controlling some of it, because I think that previously I'd struggle to see the psychological connection with vaginismus, ummm and so I think I just had to be open to that, and now I finally understood that there was a psychological connection. (Lucy, p.20, 463-470)*

Lucy's describes needing "to be open" to the fact her "mind" is controlling some of it. I imagine that she is talking about her thoughts and possibly feelings, which suggests she is making sense of the idea that there is a relationship between her thoughts or feelings and her symptoms of vaginismus. Her following explanation that she now "finally" understood there was a psychological connection, indicates that she struggled for a long time, and also highlights the strength of her belief that her symptoms of vaginismus were "just a physical thing". I get the impression that, for Lucy, the first step involved taking a leap of faith and trusting in the therapeutic process, despite not being able to fully believe in the potential role of psychology. Her mixing of tenses throughout this account suggests this may be an ongoing process for her.

3.3.2 It felt like I didn't even have a vagina

This experiential sub theme captures the way that participants described feelings of being disconnected from their bodies, including their vaginas, most commonly expressed by comments such as “it felt like I didn’t even have a vagina”. Some participants also reflected on how therapy helped them to develop a sense of bodily connection.

Tasha spoke about what her relationship to her body was like:

> *I later understood vaginismus women probably feel, not probably, certainly feel so much more disconnected with their bodies umm and you know I always kind of imagined that I don’t really exist below my bel...my waist. I literally just kind of like no there’s nothing there...vagina...no. You know like I was just this kind of like full of shame and umm something which doesn’t belong to you at all. (Tasha, p.8, 226-232)*

Tasha’s reference to how women with vaginismus “certainly” feel disconnected from their bodies, indicates that this is also part of her experience, which is emphasised by her description of how she felt there was “nothing there…vagina…no”. Her use of the phrase “full of shame” to describe her feelings towards her body evokes the sense that her shame took over everything, and made her want to disown her body, so that it was like it didn’t “belong” to her.

Poppy uses similar terminology to describe how she experiences her body, and her vagina in particular. In the passage below she explains how she didn’t “associate” her vagina with anything:

> *there was a lot of me kind of trying to explain, you know like old school barbies, you know like barbie doll that kind of area is just almost like a box, that’s how I used to associate myself with my vagina, like I know I have one, very clearly have one, but ummm I didn’t associate it with anything like I didn’t...I don’t look at it, I didn’t look at it, I do now ummm but yeah (voice becomes quieter.) (Poppy, p.25-26, 598-603)*

Poppy’s explanation that there was a lot of her “trying to explain” provides an impression of how confused and uncertain she felt when trying to makes sense of and communicate her experiences of her body. As an inanimate object, her reference to an “old school barbie doll” suggests that her vagina didn’t feel real, or like it belonged to her. Poppy’s change in tense throughout the passage as she expresses “like I know I have one” suggests that she may continue to struggle with this sense of connection to her body. This interpretation is supported by the fact that Poppy becomes quite hesitant and her voice becomes quieter towards the end of the passage as she explains “I didn’t look at it, I do now ummm but yeah”.

During a discussion about using dilators, Mya reflects on how uncomfortable she found the idea of it. She explains that she had never explored or looked at her genitals, describing the thought of it as “weird”:

> *I just never really had any curiosity to explore down there and it wasn’t because of any sort of religious background because, I didn’t grow up religious anyway but I just didn’t…I didn’t feel a need to…I didn’t feel a need to look down there. I never did. I found it weird ummm I never like got a mirror and tried to see what was there, I kind thought ohhh no thanks, I’ll just wait, I’ll leave that. (Mya, p.13 282-293)*

Mya’s repetition throughout this account that she did not feel a “need” to “look or “explore” “down there” emphasises how disconnected she felt from her vagina. Her explanation that she would think to herself “I’ll just wait, I’ll leave that”, indicates that she was very resistant to the idea of self-exploration, and that she avoided it as a result. Mya’s use of the word “weird” also appears to be important. It gives the impression that, whilst it felt unfamiliar to her, she also struggled to make sense of her feelings around her vagina. In addition, her clarification that her lack of “curiosity” towards her vagina was not because of “any sort of religious background” suggests that she has previously needed to battle the assumptions of others when trying to make sense of how she connects to her body. This may have been part of her experience exploring these feelings in psychosexual therapy.

Later on in the interview, Mya also mentions that it felt she “didn’t even have a vagina” or a “vaginal canal” and explains that it was weird to find an “opening”:

> *I sounds silly but I felt like I didn’t even have a vagina, I didn’t have a vaginal canal, it felt like it wasn’t there, so it was weird to like find this opening. (Mya, p13, 281-289)*

This highlights how, for Mya, it was not just about the experience of muscle tension in the vaginal wall, but it was also about acknowledging that her vagina and the “vaginal canal” existed, and knowing where it is. This again emphasises her sense of disconnection, and appears to be an experience shared by both Tasha and Poppy as reflected in their descriptions of feeling like a "barbie doll" and like they didn't "exist below the waist".

Kate reflects specifically on how difficult she found psychosexual exercises, which focussed on developing an awareness of her body:

> *I can do the whole close your eyes and imagine you are by the sea thing but as soon as it was connected to how that would actually physically impact like a muscle (laughs) I just couldn't, I just couldn't make that connection at all, so I can do like clench and unclench like in anything – we do that in choir not with your vagina but with your shoulders normally ummm - but I just really struggle with any exercise that involves that and I guess that's part of the problem so (sighs) I don't know (voice becomes quiet). (Kate, p.17, 388-398)*

During the interview, Kate spoke about a visualisation exercise which involved imaging her vagina to be like a flower opening up, and this appears to be one of the exercises she is referring to in this passage. Her use of repetition to explain how she "just couldn't make that connection" suggests that it felt like a barrier, which felt impossible for her to overcome. I imagine this was a frustrating and confusing experience for her. The comparison Kate makes to the other types of relaxation exercises that she is able to do indicates how she is trying to emphasise and, in turn, make sense of the distinct nature of her difficulties when it comes to connecting with her vagina. This interpretation is further supported by her reference to "I guess that's part of the problem" and her voice also goes quiet as she expresses "I don't know". I get the impression she has become quite thoughtful and possibly wistful as she reflects on her struggle and how it may be related to her experience of vaginismus.

Alex also expresses her relationship to her vagina in similar terms, explaining that it felt like she didn't have a vagina, however, she appears to directly link this to the fact that she was not able to have penetrative sex: "b*ecause I couldn't have sex, so as far I am concerned it wasn't painful, it more felt like I didn't have a vagina" (Alex, P15, 337-339).*

Some participants reflected on their experience of feeling more connected with their bodies during the course of psychosexual therapy. Tasha, for example, spoke about what it was like to look at her vagina in the mirror for the first time:

> *When I was asked to do that I was like okay this is disgusting, why would I wanna look at something there, like, but then eventually I did and she asked me to like just see how did you feel about it and you know I feel like okay fine I might have seen bits of it at times, but I didn't really, didn't entire picture and yeah, okay, I wasn't disgusted or anything. It was part of me, it was fine (laughs). (Tasha, p.8, 235-241)*

Here, Tasha's describes her response to the idea of using a mirror to look at her vagina: "okay this is disgusting". This indicates that she initially experienced disgust in association with her vagina. However, she goes on to state that in reality she didn't feel "disgusted or anything", highlighting the difference between her expectations and the reality of what this was like for her. This appears to be an important moment for Tasha, whereby her negative expectations around using a mirror were disconfirmed. From her explanation that it was "part of" her, you get a powerful sense of how this was associated with her feeling more of a connection to her vagina. This interpretation is supported by Tasha's reflection later on in the interview about how therapy helped her to understand and connect with her body:

> *I feel like therapy developed my confidence. Not...you know to the extent where I could understand my body a little better, that I could really connect with my body (Tasha, p.13 381-385)*

Poppy describes what it was like for her to feel more of a connection with her body, and specifically her vagina, during the course of psychosexual therapy.

> *But this time it was like literally visualise your vagina, visualise, breathe in, visualise your vagina and just breathe into that image, and that kind of helped me feel a lot calmer because before I think...before when my vagina was very much like...almost like a very blury image, like there was no clear definition of my vagina, it's so weird to say this now, like If you had asked me three years ago like to talk about it this, I would have no idea what to say, like there is a very blury vision, picture or my vagina*

> *and my relationship with it, now it's not entirely crystal clear but getting there. (Poppy, p.19, 730-739)*

Poppy's reference to breathing into an image of her vagina, and how this helped her to feel a lot "calmer", highlights her experience of anxiety associated with thinking about her vagina. Her description of how her image of her vagina was previously "blurry" in her mind possibly suggests that she may have avoided thinking about it, and that breathing exercises helped her to feel like she could manage her anxiety, and overcome some of her avoidance. Poppy's reference to how three years ago she would "have no idea what to say" in response to this topic emphasises her experience of change around her connection to her body, as well as her sense of this feeling specific and measurable. Her use of the phrase "it's not entirely crystal clear but getting there" evokes the image of a picture coming into focus, and you get a visceral sense of this developing connection, as well as how it is ongoing

3.3.3 "I felt like I had to overcome myself"

This experiential subtheme relates to how challenging participants found psychosexual exercises, such as using dilators, body awareness and visualisation tasks. It reflects participant's experiences of a "block" or resistance within themselves, and needing to overcome this to progress. It explores what it was like for participants to feel like they were not making progress. The theme also captures the extent to which some participants disliked or hated the exercises.

Poppy describes how challenging she found psychosexual exercises, and specifically the process of dilating:

> *I like external deadlines if someone gives me to do work and you know okay by June you will have x amount of savings or something because that is something you can literally physically do but when the problem is...when the issue and the block lies within yourself (inaudible) ummm it's a lot harder to face and a lot harder to do and so I struggled with the hardest...the hard...the easiest deadline that I can give myself I really struggled because I was like I feel like a pressure on myself. (Poppy, P9, 202-209)*

Poppy emphasises how it is a lot harder when the “issue and the block lies within yourself” by making a comparison to meeting an “external” deadline. This indicates that she experienced something within herself as an obstacle that she needed to overcome, and I wonder if she is referring to her feelings of anxiety and fear around dilating. It is possible that by referring to her fear as a “block”, she is externalising it, and this makes it feel more manageable.

It also appears that Poppy experienced more anxiety when under pressure to meet goals around dilating and she later reflects on how she struggled to cope with not making any progress: “*I crack because I was like...I don’t like, I don’t like standing still or going backwards a million steps. I hate it. I feel like...I felt like I was failing myself (Poppy, p.10, 218-220).* Poppy’s explanation that it felt like she was “failing” herself when she wasn’t able to make progress may possibly highlight her tendency towards perfectionism. Her use of the metaphor “I crack” to describe what this was like for her evokes the image of something delicate, like an egg, and indicates how vulnerable Poppy possibly felt around using dilators in psychosexual therapy.

In the passage below Mya reflects on how “mentally” challenging she found the experience of self-exploration and dilating, and you get the sense that, like Poppy, she also experienced a barrier within herself:

> *When it came to having to like look at everything and like try and insert stuff, which I found very ummm...not...well it was physically uncomfortable but mentally it was uncomfortable. I...I didn’t like the idea of that so that whole process was just a challenge for me (laughs). I felt like I had to overcome myself ummm so that’s when I just, you know, having to really prep my mind, psyche myself up, take deep breaths. I think there was almost like a fear because I wasn’t...I had no idea of like what the sensations were like down there, I was sort of scared I might hurt myself, things like that...I just felt very delicate and tender ummm ...so it was just weird.* ***(Mya, p.13, 295-303)***

Mya identifies how her fear of exploring herself and dilating was linked to an uncertainty of what it would be like or how it would feel. She also identifies her fear of hurting herself, and her use of the words “delicate” and “tender” gives the impression of someone who is quite vulnerable. Mya’s references to needing to “prep her mind” and “psyche” herself up in order to do the exercises, phrases usually associated with athletes before an event, highlights how challenging she found the exercises, alongside the courage she experienced in order to do them.

Like Mya and Poppy, Tasha also describes the significant challenges she experienced when using dilators.

> *She was trying to talk me into using dilators, which was so emotionally hard. I could not understand how you could even insert a dilator...it was just, it was just something I could not understand, I’m like this thing is not going anywhere near me. (Tasha, p.5, 147-150)*
>
> And
>
> *Just we were working a lot on relaxation because she could see how anxious and tense I was. So, dilating at a point was a really big challenge for me. I couldn’t relax enough to do anything. (Tasha, p.7, 193-196)*

Tasha’s reflection on how using dilators felt so “emotionally hard”, and her subsequent reference to how her therapist could probably see how “anxious and tense” she was, both identify her feelings of fear around dilating, and indicate how overpowering this was. This interpretation is also supported by her comment that she did not want a dilator to go “anywhere near” her, almost like to even be close to it felt anxiety provoking. Her explanation that she couldn’t “relax enough” also indicates that she felt this as a tension and resistance in her body.

Alex refers to how much she hated dilators, which she emphasises by stating that she “absolutely loathed them”.

> *I hated them so much, I feel like I’ve never like heard or spoken to anyone who didn’t hate the dilators like (laughs) it’s just so ummm like medicalising and kind of like, it made me feel like such an idiot, ummm, I absolutely loathed them (laughs) and they*

> *just didn't work, like it didn't work at all...ummm...until I had the botox injections so it was just like this horrible kind of like exercise I had to do all the time that made no difference. (Alex, p.6-7, 139-146)*

Alex describes her experience of them as "medicalising", which gives the impression that she felt like a patient being treated, and possibly that she lacked a sense of autonomy and agency around the dilating process. This interpretation is supported by her comments that they made her feel like an "idiot" and that they were an exercise she "had" to do all of the time. Her repetition of how they "just didn't work" provides a sense how frustrated she felt by having to do an exercise, which she didn't experience as helpful. Her final reference to Botox injections demonstrates her experience of dilators being unhelpful, especially in comparison to another treatment option. At another point of the interview, she confirms this by letting me know she eventually overcome her vaginismus after having Botox injections.

3.3.4 "It's just like learning not to be hard on yourself"

This experiential sub theme reflects how some participants felt more positively about and connected to psychosexual exercises, specifically using dilators, during the course of therapy. It identifies their experience of feeling a pressure to make progress, and associated sense of failure, whilst also capturing their increased acceptance of the challenges they faced, and acknowledgement of different types of progress.

Lucy, for example, appears to experience less pressure around dilating, as it was no longer something she "had" to do:

> *Again, it made me feel more in control, it wasn't this thing that I had to do, it was something I could do when I felt like I wanted to, when I felt like I could, I could stop if I started and it didn't feel right (Lucy, p.17, 392-395)*

From her description that she felt more in control, I get the sense that feeling in control was important to her when it came to dilating, and I imagine that it was quite scary for her to feel out of control. Lucy's explanation that she understood she was able to stop if it "didn't feel right", suggests that before this she felt that she should carry on despite discomfort, and she started to feel like she had more agency around dilating. It also indicates that she became more accepting of, and compassionate towards the difficulties she experienced with dilating.

Rhian also describes a process of being more accepting and kinder to herself whilst using dilators: *"I just need to you know breathe half the time, but you know I just need to be gentle with myself"* (Rhian, P.26, 604-606). I get the impression that Rhian is speaking to herself in the present, and that she is actively engaging in a way of relating to herself which is kind and supportive. Rhian goes on to explain how her feelings associated with dilating have changed, identifying that before she would feel "frustrated and so angry", giving an overall sense of how emotionally distressing the process previously was for her:

> *Before, if I couldn't, If I like started like on the number 3 dilator and then the night I couldn't do it, I would be so frustrated and so angry about it, whereas like now I'm like oh you know, bodies change, you know, this might be...I might be stressed, it might be something else so it's just like learning not to be hard on yourself, and you know a bit of patience, it will happen and like I said there are other ways of like you know having pleasure and stuff, it doesn't have to be all about that so... (Rhian, p.26-27, 604-616)*

Rhian's reference to how she has learnt not to be so hard on herself indicates she feels more acceptance of herself and the difficulties she experiences around dilating. Her explanation that there are other ways of experiencing pleasure and that it doesn't need "to be all about that" appears to be a reference to how penetrative sexual activity isn't the only way of enjoying sex. It seems that her shift in thinking about sex has helped her to respond more flexibly to challenges around dilating, and feel less pressure around making or maintaining progress.

During the interview, Kate spoke about her therapist's recommendation to integrate dilating with other enjoyable activities, such as having a bath or using a bullet, and what this was like for her: "*if you think vagina equals bad because it hurts, you don't really think about it because it's all just such a horrible idea to you" (Kate, p.38, 893-896.)*. It appears that Kate's experience of pain meant that she previously only had negative associations with her vagina, which prevented her from considering integrating dilating with enjoyable or pleasurable activities. However, later on, Kate explains how her thinking shifted after combining dilating with enjoyable or pleasurable activities:

> *Cos you would combine it with something more fun and more pleasurable at least you didn't feel like...before when you'd try and use the larger size and it will just hurt and it will be horrible, at least it wasn't a complete loss. (Kate, p.40, 926-929)*

Her explanation that she no longer considered it a "complete loss" suggests that prior to this Kate made sense of dilating in "all or nothing" terms – as either good or bad. It appears that, like Rhian, Kate also felt more able to respond flexibly, and with greater acceptance, to painful or more difficult dilating experiences.

Tasha reflected on her experience of making progress in psychosexual therapy, and during the interview, she told me how happy she felt when she was able to use a dilator for the first time. In the passage below, she is reflecting on what it was like to understand that her progress after that moment was not as fast as she expected it or hoped it would be.

> *I am so frustrated [...] you know in my head I'm like once I can put one in, everything else should just fit, what that take me, that took me another couple of years to understand how your body works, that's it's a muscle as well and the vaginismus is such a different experience for every woman, that for some woman it takes 3 months, but my body is just clenched so hard and there are so many other things that you know I am still sometimes on dilator 2, and I am like what is wrong with you? (laughter). (Tasha, p.14, 430-438)*

Like Rhian, Tasha describes her pressure to move through the dilators quickly and how "frustrated" she felt about her lack of progress. Tasha's explanation that it took her a couple of years to understand how the "body works" and how hers is "clenched so hard", demonstrates that she became more able to make sense of vaginismus and her unique experience of it. This is emphasised by her recognition that dilating is "a different experience of every woman", which suggests that she became more accepting of and compassionate towards her own experience. This interpretation is supported by her laughter as she expresses "I am like what is wrong with you", which gives the impression that she affectionately teasing herself, again, highlighting her sense of self-compassion and self-acceptance.

All participants in the study described their dislike of the NHS dilators, and those who used other dilators such as the Shhh! dilators spoke about preferring them. Poppy considers experience of choosing the best dilators for her, which indicates her increased sense of agency around the dilating process:

> *I put myself in the mind of okay I am going to try dilating, If you gave me a choice, I would always choose the Shhh! ones, I would now choose the, I think the Ann Summers ones that I have just bought because they look really pretty as well (Poppy, p.28, 644-6511)*

I get the impression that this has helped her to feel more positive about using dilators and, in turn, managing her vaginismus.

3.4 Living with Vaginismus

The Group Experiential Theme captures what it has been like for participants to live with vaginismus since psychosexual therapy, and how this changed during the course of therapy. Many of the participants spoke about understanding the impact vaginismus had on their lives during therapy, whilst other participants spoke about not having the opportunity to do so and what that meant. The theme captures the on-going experience for some participants of developing self-acceptance and feeling empowered, whilst continuing to manage the symptoms of vaginismus. It also captures how some participants felt about their future, especially around sex, dating, relationships and overcoming their vaginismus. Finally, the theme explores the experience for some participants of developing connections to others with vaginismus.

3.4.1 “It doesn’t mean you are broken”

This experiential sub-theme captures participant’s experiences of low self-worth and beliefs that they were to blame for their difficulties with penetration. It also reflects the experience for some participants of becoming more accepting of themselves and their vaginismus during the course of psychosexual therapy, whilst acknowledging how this opportunity was missing for other participants.

Kate reflects on how psychosexual therapy helped her to re-examine how she related to herself in the context of vaginismus.

> *A lot of it was learning stuff like well it doesn't mean you're broken, and although you still think that some days obviously but ummm and also she was quite good at not just talking about...I know this isn't necessarily therapy therapy, but explaining like other sexual dysfunctions, or not even dysfunctions, but things people have with their bodies, and ummm, which was actually like oh why don't we talk about this more. (Kate, p.21, 473-480)*

Kate's explanation that psychosexual therapy helped her to understand that having vaginismus did not mean she was "broken", suggests she previously felt like she was "broken". The word "broken" has connotations with an object that doesn't work, and I wonder if Kate chose this word because of how she felt in the context of not being able to have penetrative sex. From this, I get the impression that Kate's felt a sense of being objectified due to her difficulties with penetration. Her use of the third person throughout this passage indicates that she is acknowledging this to be a shared experience for woman with vaginismus. However, it also has a distancing effect, almost like she sometimes still struggles to really believe it. This is supported by her comment that she still thinks she is broken "some days".

From Kate's subsequent reference that her therapist was "good" at talking about sexual health generally, it appears she felt like her experiences were normalised in therapy, and I wonder if this helped her to feel more accepting of them, and in turn, herself. Similarly, Lucy also considered how the way she related to herself changed during her experience of psychosexual therapy:

> *just realising that you know I've always just kind of...I suppose it terms of not being very kind to myself, I'd always sort of beat myself up about things a lot, and you know rather than thinking of why it might be happening automatically, or like oh well there's obviously something wrong with you, and you know you kind of put it on yourself in that way you know the way that only you can be as mean to yourself*

> *as...but like no one could ever be as mean to you as you are in your own head you know. (Lucy, p.10, 218-226)*

In this passage, Lucy describes the way she blamed herself for her difficulties with penetration, stating her belief that it meant that there was "obviously something wrong" with her. Her reference to how she would "beat" herself up evokes the image of someone being in a battle with themselves, and you get the sense that she previously experienced her "own head" as an unsafe place. Her subsequent reference to the fact that no one could be as mean to her as she is to herself seems to reinforce this perception. Lucy goes on to express what it was like to realise it wasn't her "fault":

> *So hearing that you know [...] this can happen to any woman regardless of whether they've got any condition, ummm you know previously and it will just happen or it won't, and it's nothing I did you know, I didn't do anything that made it happen, it's just happening to you and ummm yes, it's not my fault really (laughs) was the nice thing to learn from it. (Lucy, p.10, 226-234)*

Lucy spoke about her experience of having vaginismus alongside a specific medical condition and it appears that she previously assumed her vaginismus was a result of this. She reflects on how "nice" it was to learn that it wasn't her "fault", and her laughter when she mentions this appears to reflect a release of tension, possibly indicating her sense of relief that she does not need to feel any more guilt around her difficulties with penetration. This interpretation is supported by another comment she made earlier on in the interview where she references how "overwhelmed" she felt to understand that it wasn't all on her: *"I remember leaving feeling quite hopeful and feeling quite overwhelmed that this wasn't all on me you know, so I found the whole experience much more emotional than I thought I would" (Lucy, p.9, 198-199).*

Similar to Lucy, Poppy also spoke about understanding that it wasn't her fault: *"It's helped me understand that it's not something that I've done wrong I think, it's not something that happened to me because I did something bad" (Poppy, p.20, 469-471).* I get the impression that like Lucy, Poppy also felt a lot of shame and guilt around her difficulties with penetration, and that she felt able to make sense of and manage these feelings during psychosexual therapy.

Like Kate and Lucy, Rhian also reflects on how her feelings about herself and her life changed during psychosexual therapy:

> *It's just...yeah, she just helped me loads like just how I see life really and I feel okay about having vaginismus, it's alright, it's not the end of the world. It doesn't define me. (Rhian, p.12, 272-274)*

Rhian reflects on how she now feels "okay" about having vaginismus, and this suggests that she experiences more acceptance towards herself and her body. Rhian appears to link this change to her understanding that it is "not the end of the world", and it seems like she previously felt stuck. I get the impression that psychosexual therapy helped Rhian to feel able to move forward, which is also indicated by her comment "it doesn't define me I guess".

Alex reflects on how much she was affected by her experience of vaginismus at the time she was receiving psychosexual therapy:

> *I think it was assumed that it wasn't as bad as it was and obviously like looking back, it was silly how much of an impact it had, like, but I think that's, it's not silly of me, it's silly because you know there's so much pressure, like societal pressure, to you know be sexual as an 18 year old girl (Alex, p.34, 791-795).*

She identifies the "societal pressure" she experienced to be sexual as an 18-year-old, contextualised by the culture she lived in, and explains how difficult she found it to "process" her experience of vaginismus because of this. Later on in the interview, Alex reflects on how this pressure left her feeling like she didn't any "value": "*it's like, you know, well yeah like I basically have no value anymore, like it's obviously insane but that's I think that's probably relatively common as well*" *(Alex, p.44, 1034-1036).* Alex highlights that whilst its "obviously insane" that she felt this way, she believes that it is likely to be a common experience for woman with vaginismus. This indicates her sense of compassion towards her experience of embodieds expectation and associated low self-worth during her teenage years.

Alex goes on to explain that it did not seem like her therapist understood how much she was being affected by vaginismus:

> *I think she was saying "when you're 40 you're going to look back at this part of your life and it's not going to be that big a deal" and I was like "you have no idea" (laughs) so yeah I don't think that was, it was assumed that it wasn't having as much of an impact as it was. (Alex, p.34, 800-805)*

Alex laughs as she describes her response to her therapist's belief that she would look back on her experience as if it was not a big deal, which indicates how she found this quite shocking. It also suggests that she experienced the therapeutic environment as invalidating, and it is possible that this compounded the negative impact vaginismus had on her life. Whilst Alex's experience of therapy was 7 years ago and she no longer experiences vaginismus, it appears that, unlike her therapist's suggestion, she continues to feel that vaginismus did have a significant impact on her life.

Later on, Alex also reflects on how it may have been helpful if she had been able to explore the impact vaginismus was having on her life: *"I think that it might have been, I think quite useful ummm in turns of like my behaviour at the time, maybe I would have been a bit less of a disaster (laughs) for a while" (Alex, p.35, 821-823).* It appears that Alex did not feel able to cope with her feelings around vaginismus, and its impact spread to other aspects of her life, such as her behaviour. I get the impression that she now feels frustrated and resentful that she did not have the opportunity to explore her feelings further in therapy.

Like Alex, Tasha also reflects on how vaginismus contributed to her experience of low self-worth:

> *I really needed that support to get me out of this black emotional hole that you know I'm like not worthy, I'm different. I have all these many other things on my side, but yeah, I feel like it sort of helped me, it helped me so much to develop my confidence (Tasha, p.13, 393-397)*

The phrases "not worthy" and "no value" both refer to a lack of something and it appears that for both Alex and Tasha, the experience of vaginismus resulted in them feeling less than. In comparison, however, to Alex's depiction of an invalidating therapeutic environment, Tasha spoke about how therapy provided her with the support to get out of a "black emotional hole". Her use of metaphor here evokes a powerful image of hopelessness, and it appears that the support Tasha received through therapy helped her to feel more hopeful. This is also indicated by her reference to knowing that she has "other things" on her side, suggesting that, like Rhian, she stopped feeling life she was defined by vaginismus.

Unlike Alex, Poppy also reflects on how the therapeutic environment helped her to explore and make sense of the impact vaginismus was having on her life:

> *It just provided such a great safe space to talk about vaginismus and anything that it relates to as well, because it does impact relationships and your confidence and things like that, and it really helped me learn that you know it doesn't control me yeah it doesn't control me, it doesn't define me, it's not...I'm not defined by Vag...I am not vaginismus like. I think that's what a lot of woman have to say...so it was almost like a mantra, not the right word, but whatever cos it really isn't, it is just a part of who you are. (Poppy, p.40-41, 950-969)*

Poppy's reference to how "it" provided "such a great safe space", indicates that she felt comfortable talking about vaginismus, and that she found the therapeutic environment to be validating. She explains that it helped her to learn that it doesn't "control" and "define" her, suggesting that she previously felt like vaginismus was taking over her life. Poppy explains that a lot of women have to say that they are not defined by vaginismus, almost like a "mantra", and despite her reference to it not being the right word, her repetition of how she is not defined by, controlled by, or is "not vaginismus" through this passage does feel similar to a mantra. The word mantra alludes to something that is hard work and repetitive. I get the sense that Poppy is still involved in an active and at times challenging process towards self-acceptance. This interpretation is also supported by her shift in tense from the past to the present during the passage.

3.4.2 "It was the start of my whole journey"

This experiential sub-theme captures participant's experiences of hope and their feelings about the future, including their increased sense of comfort and confidence around sex and dating with vaginismus, which is commonly linked to their changing understanding of what sex is. However, it also reflects their mixed feelings around what this might look like in practice. Whilst experiencing progress helped some participants to feel more positive about the future, other participants felt hopeless because they did not feel like they were making progress.

Kate reflects on both her feelings of anxiety and increased confidence associated with the idea of dating in the future:

> *I think the second round, which was input by other things that I read or experienced in between, was you can have sex with this without having penetrative sex, and you can...I haven't put a lot of this into practice, I am not going to lie, it's all still panic that next time I try and date someone [...]*

Kate explains that she was able to understand that that there are "other ways" of having sex, and she appears to feel more comfortable with idea of dating because of this. However, her reflection that she hasn't put "a lot of this into practice" provides a sense of how unsure she still feels. Kate later explains that her fears around relationships were linked to her belief that she was "denying" the person something, and you get an idea of how social norms around sex meaning penetration impacted on her sexual self-esteem:

> *It was understanding a lot about a lot of my fears around relationships with it, and that does change day to day [...] I always felt like I was denying the person something, whereas now I feel that I have the confidence, although again not that I have done that in a while, but to be like well actually you're also...this is also great for you. (Kate, p.24-25, 554-582)*

Whilst Kate reflects that she now feels she has the "confidence" to know it could be great for them too, she reiterates how her feelings around this "change day to day". I get the impression that she is keen for me to know that her worries haven't gone away, and I wonder if she is concerned about what it might mean to trust that dating could be okay. This interpretation is supported by a comment Kate makes later on about her experience of being "ghosted" by someone after telling them about her vaginismus:

> *I think I told one person about it and then he ghosted me ummm and I haven't really got to that stage with many people and I think it is really stopping me from dating so that is something I am...I do need to work on but I have forgotten your question. (Kate, 9.26, 599-603)*

The term "ghosted" in this passage refers to someone stopping communication without explanation, and it appears that Kate felt that this person stopped communication because of her vaginismus. Her explanation that this negative experience is "really stopping" her from "dating", indicates that she is struggling to trust that it won't happen again. Kate seems to tail of as reflects on how it is something she needs to "work on", before expressing that she has "forgotten" my question. It appears that Kate has become lost in her thoughts, and I get the impression she is processing this fear as we speak. It appears that Kate feels a tension between her thoughts around what dating could be like and her difficult feelings relating to how it has been in the past. This is also indicated by Kate's subsequent reflection that she feels more hopeful "in theory": *"a bit more hopeful yeah so that's all I...yeah that's it really. A bit more hopeful in theory" (Kate, p.26, 608-609).*

Poppy also expresses her mixed feelings towards dating in the future:

> *I do occasionally have moments when I'm like oh god I'm never going to meet anyone, If I do they are only going to want to have penetrative sex. There are moments when I'm like, I am never going to meet anyone who is going to be understanding, and then I'm kind of like well lurve off, you will, you're fine, chill, I think I have been able to control my worry a lot more since psychosexual therapy (Poppy, p.40, 944-950)*

Poppy is reflecting on her concerns about meeting someone in the future who is understanding about her vaginismus, and accepting of different ways of having sex. She appears to be describing her internal thought processes, which reflect a dialogue between her negative assumptions about the future and her self-encouraging responses to these. I get the sense that whilst she feels quite anxious about dating in the future, she also experiences self-compassion, and this helps her to manage her anxiety. This is also supported by her explanation that she has been able to control her worry, suggesting she does not feel overwhelmed by it anymore.

Rhian also spoke about what it was like to realise that there were different ways of having sex and how it did not need to involve vaginal penetration:

> *I'm single now, even if I find a partner who is more understanding of something like that, it makes you feel that you can have fun, you can have sexual experiences and stuff without necessarily just having sex [...] I've always just assumed like oh boys, they only want to have sex, so it does make me feel like I can be a bit more normal and I can like participate in more like sexual activities (Rhian, p.11, 242-251)*

Rhian's repetition of how it makes her feel like she "can" throughout this passage provides a sense of a future opening up to her. It appears that she previously felt cut off from her sexual self and, in turn, from her desire to be in an intimate relationship. However, through broadening her thinking around what sex is, Rhian seems to feel more able to see the worth in her own sexual pleasure and connected to her sexual self. She appears to be more hopeful and confident about being in an intimate relationship that works for her. This interpretation is supported by a discussion later on in the interview where Rhian identifies how she now feels about dating: "*I definitely feel like happier maybe like dating [...] because that I know now that it's not all just about sex. My mind set has changed (Rhian, p.15, 321-336").* There is something definite and concrete in the way she explains her "mindset has changed".

Lucy describes what it was like to feel like she was making progress in therapy:

> *It means everything, it was the start of my whole journey, without that therapy I wouldn't be...you know things like me and my partner have managed to attempt penetration a few times now, which is huge progress you know that's somewhere I never thought I'd be with vaginismus and without the therapy. (Lucy, p.33, 770-775)*

Like Rhian, Lucy's reference to how therapy was the start of her "whole journey" also provides a sense of her future opening up to her. She goes on to express that she has managed to "attempt penetration" with her partner a few times, and changes to the past tense to explain how she never expected this to be something she would be able to do. This appears to emphasise her shift in thinking towards what is possible and highlights that she now feels more positive about her future.

Whilst it appears that Lucy, Rhian, and Tasha felt more hopeful due to their experience of therapy, accounts from the interviews with Mya and Alex indicate that their mostly negative experience of therapy contributed to them feeling hopeless about their future with vaginismus.

During the interview, Mya spoke about her belief that therapy was a waste of time. In this passage below I have asked Mya how it felt to think about therapy in this way:

> *So because I was in such a desperate situation, it was just like argh, what's next, what do I do now like, I really wanted it to work and at that point it feels like there are no other options, so you just feel kind of trapped and I remember just sort of discussing it with my husband, the whole psychosexual therapy, he wasn't really sure about it so that also made me panic as well cos I didn't want him to like loose faith in it so I was trying to...I was thinking like we should really give it a try for as long as we can and just see. (Mya, P.10, 223-231)*

Mya's explanation that she felt "trapped" because she was already in "such a desperate situation" indicates how therapy compounded her experience of distress, and indicates that she possibly felt powerless about overcoming her vaginismus. Mya identifies that worrying about her husband loosing "faith" made her panic. It also appears to have made her feel protective of the possibility of therapy being helpful, and she explains "I was thinking like we should really give it a try". I also get the impression that it was really important for Mya that her husband was able to feel hopeful that she would be able to overcome her difficulties with penetration, and I wonder if she was feeling uncertain about her future with him, and what it would look like.

Alex spoke about her therapist entering her into a Botox Injection trial for vaginismus and how after this it felt like she had a plan for managing her vaginismus in comparison to before when things felt "endless": "*I think like having a sort of plan or direction like milestones was really important to me, especially at the time I think because everything felt so like (pause) endless" (Alex, p.25, 581-583).* Throughout the interview, Alex spoke about the difficulty she experienced feeling like she didn't know what the plan for therapy was, and here Alex is highlighting how important it was for her to feel there was a "sort of plan or direction" in therapy. Alex's explanation that things felt "endless" suggests that, like Mya, during psychosexual therapy she felt hopeless about being able to manage or overcome her vaginismus because of the lack of a plan and direction.

3.4.3 "I feel more confident in my ability to help myself"

This experiential subtheme reflects the participant's experiences of feeling more capable and confident to cope with and manage their vaginismus by themselves. It reflects their sense of accomplishment and empowerment from the knowledge they gained, and the positive impact of psychosexual exercises. Participants also spoke about understanding the need to take responsibility for the overcoming process, as well as how therapy gave them the tools to do so.

Tasha considers how therapy helped her to make sense of the way she managed her vaginismus as "*something which sort of like organises your vaginismus in your head, sort of like... sort of like builds up this little path and like sort of gives you the idea of what you should do" (Tasha, p.26, 814-816.* Her explanation in this passage that it "sort of like organises" her vaginismus in her head is a powerful representation of what therapy meant for her. It evokes the idea of something becoming decluttered and, in turn, less overwhelming. It appears that therapy helped her to feel able to cope with her vaginismus. Tasha goes on to explain that it "builds up this little path" and there is something quite hopeful about this image, almost like therapy helped her to see a way through.

Rhian reflects on her experience of therapy coming to an end, and what it was like to manage her vaginismus by herself:

> *At first I was like oh no, I don't know if I can not have her but I have kept it up, you know I kept up the dilators, and stuff she has said has like stuck with me, so it's like doing it on my own now, which I feel like I can do, but if I did even need her again, I know she would be at the end of an email. (Rhian, p.23-24, 541-546)*

Rhian's use of language when she explains that she is "doing it on her own", which is something she "can do", emphasises her sense of feeling capable. Her use of the present tense also indicates how immediate and real this feeling is for her. She also explains that she knows that she can contact her therapist again if she needs to, which appears to also provide her with a sense of comfort, and indicate how validating she found the therapeutic environment.

Rhian goes on to expresses her surprise that she hasn't "fallen of the sort of like wagon": "*I thought it would have been the case that I would have fallen off the sort of like wagon a little bit and gone back to square one, but I haven't and ummm yeah I still like really look after myself that kind of way" (Rhian, p.23 550-555).* She appears to be comparing her experience to those managing problems with addiction, and this suggests she understands the process of managing vaginismus to be ongoing and to require hard work and commitment. It also gives the impression that she feels quite proud of herself for continuing to manage vaginismus by herself.

Like Rhian, Lucy also makes reference to the fact that you need to work hard at managing vaginismus:

> *Just yeah be really open to it and be ready to work because it's not somebody waving a magic wand for you, it's somebody giving you tools to then go away, and use yourself to improve your situation and also help you, so be ready to work. (Lucy, p.31, 738-741)*

Lucy is answering a question relating to what advice she would give to others beginning psychosexual therapy for vaginismus. Her reference to how it is "not somebody waving a magic wand for you" highlights her realisation that she needs to take responsibility for managing her vaginismus. During another discussion in the interview, Lucy is reflecting on what it felt like to know she had the techniques and the capability to manage her vaginismus:

> *I feel quite proud of myself afterwards, even just in the beginning where I was only practicing the psychological techniques, and I wasn't actually physically inserting the dilators […] I felt like "oh, I did it, I was successful, it worked" and so that's quite cool to know that know, you did that, (Lucy, p.28-29, 689-696)*

Lucy's mixing of tenses in this passage suggests she continues to feel proud of herself for using psychological interventions to manage her vaginismus. Lucy's is also expressing her surprise at finding that the exercises "worked" for her, which is particularly important in the context of her scepticism going into therapy, as discussed in the "Help Seeking for Vaginismus" GET. Lucy's use of language in her following reflection that it felt "quite big, quite empowering" to be able to do the exercises herself, emphasises how important it was for her to feel a sense of empowerment: "*I suppose initially it was because the therapist taught me those techniques, but in that moment you are doing that yourself you know, that's quite big, quite empowering again" (Lucy, p.30, 698-699).*

Poppy also spoke about what she was able to get out of therapy. In this passage below she is describing what it was like to tell her mum about her vaginismus for the first time:

> *It was almost like I was this fountain of knowledge about vaginismus, when like six months before hand I actually had no idea what it was ummm, and I just kinda got into it, and just really started talking about it (Poppy, p.20 453-456)*

Poppy highlights how much knowledge she gained through therapy by making a comparison to herself six months before when she had "no idea". Her description of herself as like "a fountain of knowledge", with its positive connotations of release, plenty and abundance, emphasises how valuable, and possibly cathartic the experience of sharing her knowledge felt. I get the impression that she also felt empowered by this experience. Later in the interview, Poppy reflects on how, despite the fact is still not able to use the dilators, she has gained confidence through therapy:

> *Despite the fact that I haven't actually dilated, I think like I said I have become a lot more confident. I feel less anxious about it like, I think right now like this week has been really stressful and I have felt really anxious but I don't associate it anymore with vaginismus […] I like treat them quite separately now because I know what I can do and I know I have the support whereas other stuff, my mood dips, all that kind of stuff I want that external help, so I feel much more confident in my ability to help myself. (Poppy, p.39-40, 919-932)*

Poppy’s explanation that she feels less anxious about her vaginismus because she is comfortable with the support options available to her seems to be important of the context of her not yet being able to use dilators. It highlights that she now feels hopeful about her abilities to manage vaginismus, and able to take responsibility for it. This interpretation is also supported by the comparison she makes to seeking support for managing her mood, which she does feel like she needs “external support” for. Poppy also mentions that she doesn’t associate feeling anxious with her vaginismus anymore, and I get the impression that she has been able to make sense of her vaginismus in a way which has meant it is no longer the most significant aspect of her life.

Kate’s references the fact that she hasn’t “fully overcome anything”, highlighting that she also continues to experience difficulties with vaginal penetration: *“I don’t think I have ever fully overcome anything, it’s things have become easier to deal with, but I wouldn’t say they have become overcome” (Kate, p.28, 640-642)*. However, her explanation that things have become “easier to deal with”, indicates that like Poppy, Tasha, Lucy and Rhian, she feels more able to cope with the symptoms of vaginismus.

3.4.4 “it’s just nice to have people who have actually experienced it”

Some of the participants spoke about how they were encouraged to connect with external sources of help and support. This experiential sub-theme explores what this was like for them. Participants referenced their experience of knowing that someone else could relate, and they were not alone.

Kate describes her experience of going to a shop selling sex-based products for women. She explains that the shop made products for woman experiencing the same problem as her, and describes it as one of the most helpful aspects of therapy: “*so actually that was probably one of the helpful things that came out of that...seeing that therapist was that she gave me a card to go to Shhhh! The shop” (Kate, p.20, 459-462).* Kate’s use of the word “actually” provides an indication of the tangible, positive impact this had, and perhaps in comparison to a less clear sense of progress she experienced in other aspects of her therapy. Kate also expresses that it was “terrifying” and it took her a “couple of times” before she spoke to anyone:

> *It was terrifying but to go and actually see this place, which was actually for woman and actually made products for woman with this problem, and that I wasn't the only person that had it, and that the people in the shop were super nice, and it took a couple of times of going to the...to actually talk to anyone (Kate, p.20, 459-466)*

This highlights how she overcame a personal barrier to connect with the store, and people working there, and provides a sense of why it may have been such a meaningful experience for her. She also refers to being able to understand that she was not the only person with vaginismus, and describes the people in the shop as "super nice". This suggests that Kate experienced more acceptance of her difficulties, and possibly more compassion to herself because of this experience.

Poppy spoke about how helpful it felt to be able to connect to other woman with vaginismus:

> *I can literally just be like okay look I am going to give it a go...what are your tips for like actually inserting it...now I could do that, now I can ask people all these questions, before I could only depend on the therapists with the NHS who were great. (Poppy, p.30, 705-710)*

She refers to the possibility of being able to get tips for using the dilators from other woman who have also used them. Poppy's repetition of how she can "now" get this support, and the comparison she makes to before where she could "only depend" on the NHS therapists, highlights it distinct value for her. Her repetition of "I can" or "I could" throughout this passage also suggests that being connected to others has been an empowering experience for her.

Rhian compares her experience of talking to her family members about vaginismus to her experience talking to other woman with vaginismus:

> *They don't really understand it, like they…I guess I probably wouldn't if it wasn't me in this situation, if someone else was saying that, you know I didn't know about it until I researched it […] cos I'm on that group on facebook, it's easy to actually speak to people...and I've made like friends through it […] I just don't speak about it with them, and that's no reflection on my mum or my sister, because they want to*

> *help, but it's just nice to have people who have actually experienced it. (Rhian, p.13, 289-302)*

Rhian describes her difficulties opening up to her mum and sister because they don't "really understand it", and reflects that she also wouldn't if she was in their position. This suggests she feels there to be something specific and unique to the experience of vaginismus, which makes it particularly difficult for other people to relate to. Like Poppy, this highlights how important it is for Rhian to know that she is sharing with someone who can relate. I wonder if Rhian has felt like an outsider for a long time, and that connecting with other people with vaginismus has allowed her to feel like she is not alone in the outsider position.

Discussion

4.1 Summary of Aims

Through my research question "How do women make sense of their experience of receiving psychosexual therapy for vaginismus?" I aimed to explore women's individual experiences, including any changes in how they felt about themselves and their vaginismus, in relation to psychosexual therapy. I hoped this would provide a greater insight into an under-researched female sexual difficulty, and its treatment, whilst giving woman experiencing vaginismus a voice. I hope that the findings from this research can contribute to an existing body of knowledge informing practice, and enable counselling psychologists and other health professionals feel more able to support woman with vaginismus.

4.2 Chapter Overview

This chapter will begin with a summary of my findings before contextualising them with the existing literature. This will be followed by a critical evaluation of the research, including strengths and limitations, as well as methodological and epistemological reflexivity. Finally, ideas for future research and implications for the counselling psychology profession will be considered.

4.3 Summary of Analysis

The analysis chapter explored in-depth the themes which emerged from interviews with seven women about their experiences of receiving psychosexual therapy for vaginismus. The first Group Experiential Theme – "The Help Seeking Process" - describes the participant's experiences of struggling to understand and communicate their difficulties with penetration, as well as their associated relief to learn about vaginismus and to know there are options for support. However, for some, this was complicated by how it felt to have a name for their difficulties. It also captures their uncertainty about what psychosexual therapy would be like and their mixed feelings towards it.

The second Group Experiential Theme – "The Embodied Experience" - explores participant's experience of making sense of the mind-body connection in vaginismus. It capture's their experience of feeling disconnected from their bodies, and particularly their genitals. It also reflects their resistance towards psychosexual exercises, and their associated sense of pressure to progress. Finally, it explores the experience for some participants of a more positive relationship to psychosexual exercises, by integrating them into their daily lives, and becoming more accepting of any challenges they encounter.

The final Group Experiential Theme – "Living with Vaginismus" – captures how participants made sense of their experience of vaginismus in the context of psychosexual therapy. It reflects the experience for some participants of gaining insight into the impact vaginismus was having on their lives, and comparatively, how this opportunity was missing for other participants. It encompasses participant's experiences of feeling hopeful, and negotiating their futures with vaginismus, including sex and relationships. Whilst it also captures the experience for other participants of feeling stuck and hopeless about the future. Furthermore, it highlights the experience for many participants of feeling more confident around managing vaginismus on their own, and their associated sense of empowerment. Finally, it considers how valuable and meaningful it has been for participants to connect with others with similar experiences.

4.4 Contextualising Findings with Existing Research

Vaginismus in an under-researched area of sexual health (Laskowska and Gronowski, 2022), and consequently there is little research exploring women's experiences of communicating their difficulties, and receiving support. However, vaginismus has similar social consequences to sexual pain problems such as dyspareunia and vulvodynia due to its impact on a women's ability to engage in or enjoy penetrative intercourse. Despite distinctions between the two, there is also some overlap, as discussed in the literature review, and reflected in their recent integration into a single diagnostic category (GPPPD) for the DSM (Lahaie et al., 2010; APA, 2013). This section will therefore contextualise the findings from the current study with existing literature around vaginismus, and when relevant, with findings from the wider sexual pain literature.

4.4.1 The Help-Seeking Process

All participants spoke about their experience before they started psychosexual therapy, and of seeking help for vaginismus. Whilst the focus of the study was on their experience of psychosexual therapy, this Group Experiential Theme (GET) felt important because it provides the context to their experience of therapy. It will hopefully provide a greater insight into what it may be like for women with vaginismus before they arrive at their first session. Pithavadian, Chalmers, and Dune (2023) conducted an integrative review of qualitative and quantitative studies identifying the experience of help seeking for vaginismus around the world, highlighting its potential impact on a women's sense of self, experience of the therapeutic alliance, and treatment journey.

The *Help Seeking for Vaginismus* theme considers the sense of isolation participants experienced as they sought help for their difficulties. There is low social awareness around vaginismus (Laskowska and Gronowski, 2022, McEvoy, 2021) and a number of participants in this study spoke about their sense of feeling like no one else was going through what they were going through. One participant, in referring to her own experience, explained that a lot of women with vaginismus will probably tell you how they feel like they are "the only one in the world" with their particular difficulties, and another participant described her experience of trying to find the words to articulate what it was she was experiencing so she could search for more information about it on google.

Svedhem et al., (2013), in their IPA study exploring the experience of vaginismus (term used GPPPD) for woman in a heterosexual relationship living in Sweeden also reported participant's experience of loneliness. Woman in their study said that it took them a long time before they found out about vaginismus, or met anyone else with the same experience. In a qualitative study**,** Stelko (2015) used a feminist constructionist perspective to analyse data from online support forums and individual interviews with woman about the 'overcoming process' for vaginismus. She described how vaginismus is not only "surrounded by silence in public spaces, but also in private spaces of personal networks" (Stelko, 2015 p.40), and highlighted how difficult the women in her study found it to open up about their vaginismus to the other people in their lives.

Pithavadian et al., (2023) reported that when seeking help for vaginismus, women had to "negotiate their personal reservations and social taboos" (p.14) around opening up about sexual matters, before they felt able to seek help. Participants in the present study described feeling isolated because they did not feel able to talk to their friends or family, which for one participant, also appeared to be related to her belief that others would not understand.   There is significant stigma and shame associated with sexual problems (Vosper et al., 2023), and women may find it harder to share their experiences because of this (Pithavadian et al., 2023).

One meta-ethnography of qualitative studies exploring the experience of genital and sexual pain (term used vulvodynia) reported that woman "seemed to understand that they needed to stay silent" (Shallcross et al., 2018). The authors reported that women became isolated due to their feelings of shame around their genital pain, and its impact on their sexual experiences (Shallcross et al., 2018). One participant in the present study described feeling "cut off from society" and unable to share her difficulties due to her wish to protect her marriage. In addition, for other participants, shame and self-criticism in the context of their uncertainty around what it was they were experiencing, prevented them from sharing their experiences. For example, one participant described thinking it was just "a horrible physical flaw" especially for her, and another participant identified her belief prior to learning about vaginismus that there was "something wrong" with her and she was a "bad girlfriend". McEvoy et al., (2021) called for more qualitative studies exploring why women do not go for help with vaginismus, and the results from this study indicate a potential reason being their doubt and uncertainty about what their difficulties mean, as well as their beliefs that they are the only ones "in the world" with these experiences.

Relatedly, many of the participants in this study reflected on their sense of relief to learn about vaginismus, because it meant that they were not alone, and their difficulties were real. As one participant expressed: "it wasn't in my head". Similarly, Macey et al., (2015), in their thematic analysis study exploring the experience of using dilators for vaginismus, reported that women had to overcome "doubts about the legitimacy of their problem" (p.4), and that not knowing whether their pain was 'normal' dissuaded them from seeking help. Regarding the experience of receiving a diagnosis more generally, one IPA study exploring the diagnosis journey for vulvodynia identified how some woman felt a relief to have a name for their symptoms of pain as it allowed them to put some sense to how they were and know they were going in the right direction (Shallcross et al., 2019). In the present study, similar experiences were reported, for example, one participant spoke about feeling a “comfort” and “courage” to know that it wasn’t just her, whilst another explained that it meant she was no longer felt “lost” or “stuck”.

All participants appeared to feel a relief in relation to learning about vaginismus, however, for some participants, this was also complicated by what it meant to confront their difficulties with vaginal penetration. For one participant, having a label or a name made them harder to avoid, whilst for another participant, it meant acknowledging that she may not be able to cope with her difficulties on her own. Due to the small amount of qualitative research around the treatment journey for vaginismus, it is not possible to contextualise this with other findings. However, it does point to the need for more in depth research exploring what it is like for woman to receive a diagnosis or to learn about vaginismus for the first time, especially considering this appears to follow a period of them feeling isolated and experiencing self- doubt.

A significant aspect of the participant’s experiences in the present study included their uncertainty around what to expect from psychosexual therapy. For example, one participant expressed “*I think one of the things I really want to say is actually I had no idea it was therapy […] I didn’t really understand how it worked”,* and another participant spoke about how therapy “*didn’t make sense*” to her whilst reflecting on how cross she felt about it. In their mixed methods study exploring the help seeking experiences for women with vaginismus, Odgen and Ward (1994) reported a varied response from woman regarding their experience of professional interventions, including medical and psychosocial. The authors suggested that a possible incongruence between the beliefs of the health professional and the woman experiencing vaginismus may help to explain the range of experiences reported. They identified how a mutual understanding regarding the experience of vaginismus and the expectation of the therapeutic intervention was important for the women in their study. In the present study, unclear of what therapy might involve or how it could be helpful, some participants appeared to lack a sense of agency around their treatment journey.

4.4.2 The Embodied Experience.

All participants spoke about their embodied experience in relation to receiving psychosexual therapy for vaginismus. In their Grounded Theory study, Koops and Briken (2021) explored the experience of 18 women with either dyspareunia or vaginismus (sexual pain or difficulties with penetrative intercourse). The authors described the participant's experiences of *othering the body*; locating their 'self' in their heads, whilst bodily processes were construed as outside of their control. Their bodies were portrayed as a "kind of apparatus with parts, functions, and purposes" (p.714). In the present study, many of the participants spoke about going into therapy with the notion of 'fixing' or 'curing' their vaginismus, indicating their understanding of vaginismus as a physical problem. This also gave the sense of them externalising or objectifying their difficulties, almost as if they felt separated from them.

Whilst all participants in the present study appeared to initially consider their experience of vaginismus as something to 'fix', some participants reflected on their experience of becoming more open to how their difficulties may be linked to how they think and feel – a more psychologically informed understanding of vaginismus. For example, one participant explained "*so I think I just had to be open to that, and now I finally understood that there was a psychological connection"*. In a Grounded Theory study exploring the experiences of women with vaginismus and their partners, as well as health professionals who support women with vaginismus, McEvoy (2021 cited in McEvoy et al., 2023) highlighted that the couples interviewed indicated a "turning point in their journey" where they began to understand vaginismus as a "physical manifestation of something psychological".

However, two participants in the current study expressed their understanding that vaginismus was a physical problem, and for them, psychology-based interventions didn't "make sense". It seemed like they found the psychotherapeutic environment to be frustrating and invalidating. Koops and Briken (2021) also reported a contrast in how participants made sense of their difficulties as either located in the body or in the mind. In addition, McEvoy (2021 cited in McEvoy et al., 2023) reported that women who described a successful experience of psychological therapy considered their difficulties to be attributed to psychological causes. Like Odgen and Ward (1995), McEvoy (2021 cited in McEvoy et al., 2023) also highlight the importance of matching beliefs around vaginismus with outcomes.

Koops and Briken (2021) reported that participants in their study experienced physical explanations as a relief as they meant that there would be an easy, practical solution, which reflects a similar experience to participants in the present study. For example, one participant explained "*I felt like if it was something I could learn, then it was something that I could fix"*. Some participants also described their experience of realising that it was not like this, as one participant expressed "*that was like really daunting to go to sessions and still realise you know oh I still have it, so... or I still have to deal with it*". Macey et al., (2015), similarly reported that women in their thematic analysis study were disappointed to learn there was no simple cure for their difficulties around penetration.

In the present study, women described their experiences of feeling disconnected from their bodies, which, for some participants, was reflected in the way that they related to their genitals. For example, many participants spoke about feeling like they didn't have a vagina. In their case-controlled study, Koops et al., (2021) reported that women with vaginismus and dyspareunia (term used GPPPD) were more likely to demonstrate greater difficulties with perception and experiences of their bodily self when compared to a group of women without sexual difficulties. Koops and Briken (2021) similarly reported a tendency towards an "objectification of the body" for participants in their Grounded Theory study, and based on the findings from their meta-ethnography, Shallcross et al., (2018) reported the mind-body split to be a relevant and consistent feature of women's experiences. Furthermore, Koops and Frith (2021) completed a metaphor analysis of the biographical interviews used for the aforementioned grounded theory study, and highlighted how participants used a number of metaphorical concepts to convey an "absence of a lively body perception" and describe their experience of a split body and 'self'. The authors suggest that future research could provide a better understand of the role of body-mind dissociation for difficulties with penetration.

These findings are also reflected in the way participants described their relationship to their body in the present study. For example, one participant reflected on her experience of her vagina as like a "barbie doll […], almost like a box". Participants also struggled to make sense of and articulate their experiences of disconnection. One participant linked it to the fact that she couldn't have penetrative sex, which meant she didn't have a vagina. Kaler (2006) analysed interviews with 20 women and web based open ended interactions with 70 women with vulva pain (vulvodynia). The aim of her study was to explore how ideas about gender and heterosexuality were involved in the lived experience of women with vulva pain. Kaler

(2006) reported that women in her study imagined themselves as objects when talking about the impact of their sexual pain. She reflects that because sexuality is so closely linked to gender and therefore selfhood, women experienced their vulva pain as a “disorder of their essential self” (p.66). She suggests that, for women experiencing difficulties around penetration, a mind-body split may develop from their wish to “disconnect their troubled body from the real, essential self” (p.67).

Some participants in the present study also reflected on their experience of developing a connection with their bodies during the course of psychosexual therapy. For example, one participant described her understanding of her vagina as being “a part of” her, whilst another participant conveyed a sense of her vagina coming into focus. This identifies the potential helpfulness of psychosexual therapy for supporting woman to manage dissociative experiences around their bodies. In a Grounded Theory study, McEvoy (2021) reported that therapy helped participants to understand a connection between their thoughts, feelings and their bodies. However, there are no other known studies exploring women’s embodied experiences in relation to psychosexual therapy for vaginismus, although, an increased awareness of and sense of connection to the body are important aspects of mindfulness-based treatments for sexual pain (Brotto, Basson, Carlson and Zhu 2013).

Dilators are considered to be an important aspect of the “overcoming process” for women experiencing vaginismus (Stelko, 2015; Pacik, 2014). In their thematic analysis of using dilators for vaginismus, Macey at al., (2015) reported on how emotionally hard participants found the experience because they had to face the reality of their penetration difficulties. In the present study, participants similarly described how challenging they found using dilators, this included references to experiencing a “block within” and needing to “overcome” themselves. This is similar to the finding reported by Koops and Firth (2021) that participants spoke about a ‘blockade’ or ‘resistance’ located within their body, but also sometimes located in their ‘head’.

Feelings of fear around dilating also appeared to an important aspect of this experience, and one participant specifically referenced finding them “so emotionally hard”, reflecting on how she didn’t even want to go “anywhere near” one, indicating her desire to avoid them completely. In their IPA study, exploring the experience of vaginismus for women in a heterosexual relationship, Svedhem et al., (2013) identified *Fear* as one of their superordinate themes, and this included a fear of pain. They reported that it was common for participants to avoid situations which caused them to feel fearful. According to the Fear Avoidance Model of Vaginismus (FAM-V), negative cognitions around vaginal penetration, such as pain catastrophising and concerns about loosing control, result in a fear of penetration and contribute to avoidance of it (Reissing, 2021).

Incorporating theory from Compassion Focussed Therapy (CFT), Vosper et al., (2023) hypothesise that women experiencing pain with penetration might have an over active Threat system and down regulated Soothing and Drive system associated with sex. Compassion Focused Therapy (CFT), developed by Gilbert (2010), originated from clinical observations that some individuals struggled with particularly high levels of shame and self-criticism, and the impact of this on the therapy process. CFT integrates techniques from a range of evidence-based therapies, such as breathing exercises and cognitive challenging from CBT, imagery work from trauma-focused therapies, chair work from Gestalt and Emotion-Focused Therapy, and relational/process work from psychodynamic approaches (Vosper et al., 2023). CFT aims to effect change through the development of a "compassionate mind" and compassion is defined as "a sensitivity to the suffering of self and others, with a commitment to try to alleviate or prevent it" (Gilbert, 2013).

CFT identifies three emotional systems: the Threat System associated with fear, anxiety, disgust and anger in response to perceived danger; the Drive System associated with the pursuit of goals; and the Soothing System associated with fostering kindness, warmth and compassion to support emotional wellbeing. Through developing self-compassion, CFT aims to balance these systems (Gilbert, 2014). Vosper et al., (2023) suggest that using established CFT methods to increase skills of psychosexual compassion could be helpful for down regulating the Threat system and activating the Soothing and Drive system associated with sex.

Many of the participants in the present study reflected on their experience of frustration around not making progress. This is similar to the findings from Macey et al., (2015), that treatment using dilators required time and commitment, which participants found especially difficult to maintain when they did not make progress, or progress was slow. However, for some participants in the present study, their experience of dilating also involved becoming more accepting that progress was not what they expected it to be like, and less self-critical of the difficulties they faced. For example, one participant expressed: "*Before, if I couldn't, If I like started like on the number 3 dilator and then the night I couldn't do it, I would be so frustrated and so angry about it, whereas like now I'm like oh you know, bodies change, you know, this might be...I might be stressed, it might be something else".* This finding supports the suggestion from Vosper et al., (2023) that integrating Compassion Focussed Therapy with more traditional psychosexual therapy can help individuals develop a more compassionate attitude towards their difficulties, allowing them to make the steps towards improving their sexual wellbeing. The authors highlight how self-criticism can hinder progress in psychosexual behavioural tasks, such as using vaginal dilators, and working with the inner critic (an important aspect of CFT) may be helpful and improve motivation for engaging in these exercises.

Many of the women in the current study also reflected on the way they integrated psychosexual exercises, such as using dilators, into their life. This involved putting less pressure on themselves, and making it part of a relaxation routine. For example, dilating alongside other more pleasurable experiences, or through exercising choice over the type of dilators they used. Stelko (2015) highlighted how women in her study developed a personal knowledge about their bodies; for them the overcoming process involved learning how to relax "their whole selves" (p.44), and not just their PC muscles. The author referenced participant's experiences of making relaxation "a habit, rather than an ability" (p.44), and women in the study interpreted and developed relaxation techniques to suit their own needs and personality. CBT based psychosexual intervention studies have also highlighted the importance of testing or disconfirming negative penetration cognitions contributing through combining relaxation exercises with gradual exposure exercises such as using dilators. (e.g., Zarski et al., 2021).

4.4.3 Living with Vaginismus

All of the participants spoke about the impact of vaginismus on their sense of self, and many of the participants reflected on how they were able to understand and manage this during the course of psychosexual therapy. In their IPA study, Svedhem et al., (2013) described the participant's experiences of feeling like a "failure as a person", like they didn't function in the way they should. In their mixed methods study, Ward and Odgen (1994) also reported their participants experiences of low self-esteem and poor self-worth. In the present study, participants expressed how experiencing vaginismus left them feeling defective in various ways, for example: “there is obviously something wrong with you”; “I basically have no value”; “I’m not worthy”; and “I’m different”. However, some participants reflected on how the therapeutic environment helped them to re-evaluate this, for example, participants expressed their understanding that vaginismus didn’t “define” them; it didn’t mean they were “broken” and how it wasn’t their “fault”. It appears that a validating and supportive therapeutic environment, as well as normalising vaginismus and other sexual problems, were both helpful for participants in managing their feelings of shame and self-criticism.

Engman et al., (2010) explored levels of self-worth for participants before and after a CBT intervention for vaginismus, and reported higher levels post treatment, however, this is the only known intervention study examining changes in self-worth for women with vaginismus. Furthermore, no known qualitative studies have explored the experience of self-to-self relating and psychosexual therapy or help seeking for women with vaginismus (Pithavadian et al., 2023). The results from this study are therefore not able to be contextualised by the existing literature around vaginismus, however, one thematic analysis of an intervention group for sexual pain reported a theme of normalisation (Brotto et al.,2013). The authors identified how women linked some of the benefit from the intervention to their understanding that they were not alone in their suffering. Another study examined the impact of a CFT orientated psychosexual therapy group for women with sexual pain, and the most valued intervention for participants involved being able to compassionately address their associated experiences of shame (Saunders et al., 2022). Vosper at al., (2023) also highlight the important process of providing a “normalising and non-shaming” formulation for people with sexual problems so that they are able to develop a more compassionate perspective towards their difficulties. Importantly, in the present study, two participants expressed their experience of an invalidating therapeutic environment, and one participant specifically identified how this meant she was not able to explore the impact vaginismus was having on her psychological wellbeing.

Kaler (2006) identifies a prevailing discourse around sex that implies vaginal intercourse is ‘real sex’, and in her study, women understood intercourse “as the essence of being heterosexual”. A number of participants in the present study reflected on their changing attitudes around sex, specifically their understanding that sex could mean many things, and not just penetrative intercourse. They reflected on how this encouraged them to feel more comfortable with the idea of dating in the future. For example, one participant explained: “*I* *always felt like I was denying the person something, whereas now I feel that I have the confidence".* Some women in the study carried out by Svedhem et al., (2013) and Kaler (2006) described their experiences of challenging discourses around sex, and being able to enjoy other types of sexual activity, which they also considered to be 'real sex'. Svedhem et al., (2013) argue that if there existed a sexual norm that sex could be great in many different forms, then women with vaginismus may not feel like they were failing, and would be likely to experience more self-worth as a woman and a sexual partner.

In their CBT based psychosexual intervention study, Zarski et al., (2021) reported that not all participants benefited equally from the intervention, highlighting that women with higher levels of pain before the intervention were less likely to engage in gradual exposure exercise. The authors suggest that for some women a focus on expanding sexual activity to improve sexual satisfaction may be more important than focussing on exercises orientated towards the ability to have penetrative sex. Similarly, Vosper et al., (2023) highlights the benefits of integrating a critical systems approach within a CFT informed psychosexual therapy, with its focus on the experiences of shame associated with sexual difficulties, and on whether they even need to be considered sexual problems at all.

Whilst some participants did describe their increased sense of confidence around the future and intimate relationships, they also appeared to express some associated uncertainty. For example, one participant expressed: "*there are moments when I'm like, I am never going to meet anyone who is going to be understanding, and then I'm kind of like well lurve off, you will, you're fine, chill*". This suggests that perhaps without experiential evidence, it was difficult for some participants to fully trust that it would be okay. For two participants, their feeling about the future during psychosexual therapy appeared to be in direct contrast. They described feeling hopeless and trapped, and linked this to their experience of psychosexual therapy being unhelpful and "endless", with no plan or direction. As one participant described it: "*I really wanted it to work, and at that point it feels like there are no other options, so you just feel kind of trapped".*

Many of the participants in the present study, however, also spoke about feeling more capable and empowered in relation to managing their vaginismus by themselves, as one participant expressed: "*so it's like doing it on my own now, which I feel like I can do".* Participants associated this with the knowledge they gained around vaginismus and its treatment. Women in the thematic analysis study carried out by Macey et al., (2015) also reported that their treatment journeys left them with a “wealth of knowledge”. A sense of control over their own recovery also appeared to be important for them, and they identified that telling others about what facilitated their progress helped them to experience this. In addition, Stelko (2015) highlighted the importance of knowledge about vaginismus for women in her study, explaining that it provided them with information about what was happening during attempts at penetration. Stelko (2015) describes how women continued gathering knowledge, especially around anatomy of the reproduction system, throughout the process of managing and overcoming their vaginismus. The author highlights how this allowed them to get to know their bodies better than other women may usually know theirs, and their feelings of empowerment because of this.

Participants in the present study reflected on how managing their vaginismus involved taking responsibility and hard work, as one participant expressed “*it’s not somebody waving a magic wand”.* In addition, some participants spoke about their sense of pride and accomplishment when they made some progress. Stelko (2015) described similar experiences for women in her study, reporting on their perception of the overcoming process as “hard and long”, as well as how they encouraged each other to feel “proud of themselves after every accomplishment” (p.46). Similar findings have been also been reported by qualitative studies exploring the experience of living with genital and sexual pain. Sadownik, Seal & Brotto (2012) identified the increased “sense of empowerment” for participants who engaged in a multi-disciplinary group intervention for vulvodynia, whilst Brotto et al., (2013) identified an improved “sense of self-efficacy” for participants engaging in a similar type of group intervention.

In the present study, participants spoke about their experience of connecting to other woman with vaginismus, and the positive impact of this peer support. Participants identified how important it was to know they were not alone and others could relate to their experience. It also helped some participants to feel more confident knowing they could ask for tips, and seek support from others, as one participant explained “*now I can ask people all these questions, before I could only depend on the therapists”.* Macey et al., (2015) reported similar findings, and women in their study highlighted the importance of meeting others who understood, and the opportunity to ask for advice. Within the sexual pain literature, group therapy has also encouraged women to explore ways of coping together (e.g., Brotto et al., 2013).

4.5 Methodological reflexivity

During the research process, I aimed to identify and bracket my own values and beliefs, as well as my assumptions, expectations and existing knowledge about vaginismus and psychosexual therapy. I did this by keeping a reflexive diary and using peer supervision. However, I acknowledge that they would have inevitably influenced the data collection and analytic process. I aimed to ensure as much as possible that my interpretations were grounded in the data, and accordingly I have also provided the extracts of quotations related to each piece of analysis. This allows the reader to follow and evaluate my interpretations of the participant making sense of their experience. This section explores this process in more depth, especially how my specific beliefs and values may have had the potential to influence the analytic process.

Whilst conducting the analysis, my theoretical understanding of the hermeneutic circle in IPA came to life. For example, one moment I would be focussing closely on the meaning of a single word, before taking a step back to view it in the context of the sentence, and taking a further step back to view it in the context of the whole transcript. At the end I would then go back to word and see if its potential meaning felt different to me. I often found that my understanding of what something meant to a participant changed depending on the angle from which I perceived it. For me, part of the process was accepting the possibility of a multitude of meanings in flux at different points of the interview, and depending on how the participant was arriving at a particular discussion.

One thing I found particularly difficult was moving between interview transcripts, and starting the analysis process again, whilst bracketing off the assumptions that I took with me. Even after carrying out the interviews and before beginning the analysis process, I found myself being drawn towards possible emerging themes. I held these in mind by writing them down, and trying to bracket them, as I analysed each transcript. I aimed to make sure that emerging findings from one interview did not conceal potential meanings to explore in another interview.

There were moments when I felt overwhelmed by the number of Experiential Statements being produced for each participant, and I struggled to cluster these into Personal Experiential Themes. Whilst I found the process of reconfiguring and renaming Experiential Statements to be creative and satisfying, I was also continually questioning myself and my motives. This was again my experience when clustering Personal Experiential Statements into Group

Experiential Statements. I was interested in why I was making decisions about including and not including particular themes, and what this meant about my intentions for the research. I think this was particularly important because two participants had a mostly negative experience of psychosexual therapy, and four participants had a mostly positive experience, with one participant having a mixed experience. I was keen to make sure I was reflecting this variation, and providing an overall sense of each participant's experience.

As a result of my experience as a trainee counselling psychologist in a psychosexual service, I was keen to examine my own beliefs around the benefits of psychosexual therapy for woman with vaginismus, and why someone might not benefit from the experience. I was also mindful of how these were influenced by the beliefs and values of the service I worked in. This encouraged me to remain open to the many different ways participants may experience psychosexual therapy, including those which were positive and negative. A specific difficulty related to naming the subthemes in a way that was able to reflect this tension. I decided to use direct participant quotes as I found these were most able to reflect the texture of the participant's experience.

Developing Group Experiential Themes felt quite dynamic. I tried various iterations, moving subthemes around until they felt right. Whilst writing up the analysis and discussion, I was able to contextualise the results in the wider literature, which encouraged me to continue experimenting with re-arranging subthemes. For example, in The Embodied Experience experiential theme, I initially had two subthemes reflecting the mind-body experience, one to reflect experiences of disconnection and another to reflect experiences of connection. However, as I was writing the analysis, I felt that these worked well together to reflect the active process of reconnecting with the body.

Understanding that there is very little qualitative research exploring the lived experience of vaginismus, giving voice to an under-represented female experience felt incredibly important. I was consequently weary and cautious of imposing meaning on the data, and at times I also struggled to move beyond the descriptive to make interpretations. However, I was also keen to make sure I was exploring the participant's sense making process at a depth which provided a rich insight into what their experience of psychosexual therapy was like for them.

4.6 Epistemological reflexivity

Taking a critical realist ontological position, the research is grounded in the assumption that a reality exists independently of a human's perception and construction of it. However, it also recognises that this reality cannot be directly observed. Furthermore, the epistemological position is phenomenological. Its aim was to produce knowledge about the subjective experience of research participants, rather than about the underlying mechanisms and structures which shapes these experiences. Mediated by an individual's own thoughts, beliefs, assumptions and feelings, the same event can be experienced in many different ways. Relatedly, I have been very aware that the interviews reflect participants making sense of their experience at a particular moment. If I had been to interview the participant on a differently day, we may have discussed and explored their experience from a different perspective. This research also acknowledges that there can be multiple interpretations of the participants making sense of their experience of receiving psychosexual therapy.

For Smith, Flowers and Larkin (2022), the understandings accessed in interviews are not held to be 'the truth', but they are understood to be 'meaning-full'. Interviews, as interactions, only provide us with a "snapshot" of a participant making sense of their experience, however, the quality of these snapshots can be improved by managing "conditions with sensitivity" (p.63). For Smith et al., (2022), this involves some "highly engaged listening and well-timed questions" (p.64). I found that my technique and confidence improved significantly over the course of interviews. I listened back to interviews before conducting the next interview, and reflected on missed opportunities to encourage the participant to reflect further, helping me to become more comfortable with the timing of probing questions (e.g., "what was that like for you?"). As I became more comfortable, I also found it easier to remain focussed on the participants, whilst being able to hold in mind important issues to return to later on in the interview.

During the interviews, I was also mindful of managing the boundary between therapist and researcher. To encourage participants to feel comfortable to reflect openly it was important to establish a good rapport. This involved using some of the therapeutic skills I had developed through my clinical training, however, I was also sensitive to the possibility of developing a therapeutic dynamic. I tried to put participants at ease, and help them to feel able to reflect openly by explaining there were no right or wrong answers, and letting them know that I may be silent at times in order to allow them time to reflect and express their experiences. I was keen to emphasise that I was interested in what the experience was like for them.

At the beginning of the interviews, I asked participants if they had any questions, and many of them asked my motivations for doing the research. I wondered if they were keen to know whether I had also experienced vaginismus, and I expect that the fact that I had not may have changed how they related to me, and in turn, how they made sense of their experience during the interviews. Similarly, participants knew that I had experience of working in a psychosexual clinic and it is possible that their knowledge of me as a professional may have influenced how they considered their responses to topics discussed in the interview.

4.7 Limitations

Specific to qualitative and IPA research, one limitation relates to the fact that findings cannot be generalised to the wider population of women with vaginismus. This study used purposive sampling, and, whilst there is diversity in the self-selecting sample with regards to racial background, there are no Asian women or women from minority ethnic backgrounds. Therefore, participants cannot be said to represent the general population of people with vaginismus. This is particularly important considering existing research which has highlighted the relevance of cultural factors in the development of vaginismus (McEvoy et al., 2021).

Furthermore, participants in the study were self-selecting, and due to the significant number of responses I received from an initial email, all participants were selected from a single support network. Consequently, it is possible that this group of participants are more aware and reflective of relevant issues and shared experiences around vaginismus, and its treatment. Women who have not been involved with an online support community may make sense of their experience of psychosexual therapy differently. Therefore, whilst it is possible to suggest potential ways of working with woman experiencing vaginismus, and ideas for future research, it is not possible to make broader claims based on results from this study.

The sample was homogenous in as far as all women had received six or more sessions of psychosexual therapy for vaginismus. The focus of the research was on their experience of psychosexual therapy for difficulties with vaginal penetration, which they understood to be called vaginismus. Participants were therefore not required to have an official diagnosis of vaginismus to be included. For reasons discussed in the methodology chapter, it is not known whether participants experienced lifelong vaginismus or whether it occurred after penetration had been possible (secondary), as well as whether they were able to tolerate some penetration with discomfort and pain (partial), or they were unable to tolerate penetration with any object before beginning psychosexual therapy (Crowley, Goldmeier & Hiller, 2009). Furthermore, the severity of vaginismus for each participant is also not known. It is therefore possible that women with more severe or lifelong vaginismus may have different experiences of psychosexual therapy compared to women with less severe or secondary vaginismus, and therefore any differences in these factors may have complicated the findings. A group of participants who all received psychosexual therapy for lifelong vaginismus may produce a different pattern of data. Nevertheless, taking into account some variation, participants in the study did report common experiences of receiving psychosexual therapy.

In IPA research, data is contextualised by an individual's particular social and cultural environment, and whilst these factors are therefore taken into consideration, being a phenomenological approach, its focus is on the lived experience of participants (Smith et al., 2022). Consequently, it is not able to provide any causal explanations for participant's experiences, for example, why particular experiences emerged, as well as how historical, cultural or social factors may have contributed to them (Willig, 2022).

Another possible limitation of the study relates to the fact that for two participants, their experience of psychosexual therapy ended more than two and a half years ago. This may have impacted their ability to remember and reflect on their experience. However, I found that all participants were able talk extensively about how they felt about psychosexual therapy. Furthermore, a relevant aspect of their experience involved the meanings they attached to their difficulties with penetration in the context of their experience of psychosexual therapy, which they have direct access to. Finally, despite the fact that all participants were no longer in psychosexual therapy, managing and overcoming vaginismus was an ongoing experience for many of them.

4.8 Strengths

This is the first known qualitative study to specifically explore the experience of receiving psychosexual therapy for women with vaginismus, and it therefore provides valuable information about the kind of challenges women may experience, as well as how they may benefit from the support they receive. It also provides an insight into their experience of change in how they relate to themselves, and the way they make sense of vaginismus. Furthermore, the findings from the study support those from existing qualitative research, including IPA, into women's experiences of vaginismus and sexual pain problems. As an IPA study, it provides an in-depth exploration of how women make sense of receiving psychosexual therapy for vaginismus. This is one of its strengths as it allows for the voice of women with vaginismus to be heard, which is significant as vaginismus is an under-researched area of female sexual health.

Ponterotto (2006) highlights the goal of qualitative research as providing a thick description of phenomena. This refers to an exploration of the meaning attached to the phenomena being understood, in comparison to observations being made about it. Willig (2019) describes the ability of thick description to "bring life to abstract psychological constructs" (p.802), such as "anxiety" or "stress". Furthermore, IPA is particularly useful for exploring sexual experiences and difficulties as it allows for their complexity to be fully explored. A number of scholars have highlighted how this is missing from the recent predominance of a biomedical approach to sexual problems (e.g., Tiefer, 2001). Sexual experiences involve a complex relationship between social, cultural and relational factors, and a strength of IPA research is its ability to locate an individual's experience within their social and cultural context (Larkin, Watts, & Clifton, 2006). Another specific strength of IPA methodology is its idiographic focus, which means it is able to highlight individual, as well as shared experiences (Smith, Flowers & Larkin, 2022). In the present study, an IPA methodology provided the space to explore each participant's experience in depth first before moving on to identifying points of convergence and divergence between participants in relation to their experience of receiving psychosexual therapy for vaginismus. This also reflects a strength of the research as a contribution to the field of counselling psychology, which is rooted in humanistic values, and prioritises the subjective experience of individuals (Woolfe, 2016).

Willig (2019) also highlights the unique ability of qualitative research in being able to contribute to psychological knowledge by challenging existing assumptions and narratives around human experience. A strength of this study involved its ability to identify participant's experiences of challenging social discourses around what sex means and how doing so changed the way they related to themselves and made sense of vaginismus. This can be viewed in comparison to intervention research for vaginismus, which priorities the ability to have penetrative sex as the primary outcome evaluated. Finally, Willig (2019) also identifies how being idiographic and bottom-up, IPA is able to contribute to the development of new theories by reflecting the "particularities of human experience-in-context" (p.802). A further strength of the current study, in providing more information about the experience of receiving psychosexual for vaginismus, is its potential to contribute to the development of future theories, for example, around potential mechanisms of change and psychosexual therapy.

A final strength of the study can be found in the responses of the participants. At the end of each interview, there was an opportunity for a feedback discussion, and many participants expressed how positive they found they found it to discuss their experience of vaginismus for the purposes of research. This appeared to be especially important in the context of their own experiences of feeling isolated and confused due to a lack of publicly available information about vaginismus.

4.9 Implications for future research

As previously discussed, this study did not ask participants about their relationship status, gender identity or sexual orientation. Whilst there is one IPA study (Svedhem et al., 2013) exploring the experience of sex and love for heterosexual women with vaginismus (term used GPPPD) who are in a relationship, there are no qualitative (or IPA) studies specifically exploring the experience of women who are single, or with diverse sexual and gender identities. The findings from my study illustrate the possible experience of single women with vaginismus, and how they think and feel about sex and dating, which suggests it would be interesting to explore this further. Furthermore, the study also highlighted the potential impact of heteronormative ideas around sex for women with vaginismus, and it would therefore also be interesting to explore the experience of vaginismus for individuals who may not place such importance on these particular social scripts.

This is the first known IPA study to specifically explore the experience of receiving psychosexual therapy for women with vaginismus. It was therefore quite broad in scope, as identified by the three Group Experiential Themes (GET) illustrating a range of associated experiences. It would therefore be interesting to explore each GET in more depth, using an interpretative phenomenological approach which brings depth to understanding individual and shared lived experiences. There are currently no known IPA studies exploring the process of seeking help or the journey to diagnosis for women with vaginismus. McEvoy et al., (2021) suggest there is a need for more qualitative studies exploring why women do not go for help with vaginismus. However, studies of this nature exploring the experience of women with sexual and genital pain have produced interesting findings, which may be relevant for women experiencing vaginismus (Shallcross et al., 2019).

The second GET described participant's embodied experiences of vaginismus, including a sense of disconnection from and objectification of the body. Koops and Birkin (2021) similarly reported on the *othering of the body* for participants in their Grounded Theory study, and they suggested that future research would benefit from exploring this dissociative experience in more depth. The findings from the present study suggest that it would be valuable to explore how women with vaginismus make sense of their bodily experiences during the overcoming process. Current quantitative intervention research does not pay particular attention to embodied experiences for women experiencing vaginismus (see Maseroli et al., 2018 for a review). Furthermore, Tiefer (2006) identifies a lack of explicit attention in sexuality theory or research to the area of the body-mind, despite it being "obvious that much of the benefit in sex therapy consists of changes in subjective experience and physical reaction patterns brought about by physical practice sessions" (p.369). Future research in this area may benefit from examining the impact of psychological interventions on the embodied experiences of women with vaginismus. For example, the Scale of Body Connection has already been used to explore potential body awareness and bodily dissociation differences between people with and without sexual difficulties (Carvalheira, Price & Neves 2017). This suggests it may be a useful measure for examining any changes in body awareness and bodily dissociation for women receiving psychological interventions for vaginismus, whilst qualitative studies may provide a more in-depth understanding of their embodied experience.

The final GET highlighted what it was like for participants to continue living with and managing vaginismus during and after psychosexual therapy. Importantly, the theme identified the complex way that experiencing vaginismus can impact on a women's sense of self, especially in the context of particular social norms and values around sex. The theme identified the experience for some participants of challenging social norms, whilst developing acceptance of their difficulties, and becoming more self-compassionate. Future research could explore the experience of self-compassion for women with vaginismus in more depth, and specifically in relation to the process of managing vaginismus. Vosper et al., (2023) highlight the potential contribution of integrating compassion focussed approaches with psychosexual therapy, and the results from the present study indicate this may also be beneficial for women with vaginismus. Vosper et al., (2023) explain that a current study is underway to evaluate a CFT psychosexual integration approach for women with sexual pain.

4.10 Implications for counselling psychologists and psychotherapists supporting women with vaginismus

The findings identify a number of potential help-seeking barriers for women experiencing vaginismus, including doubts regarding the reality of their difficulties, self-blame and social taboos around talking about sex and sexual problems. Improving the availability of comprehensive information materials about penetration difficulties including vaginismus would therefore be beneficial. Schools, GP surgeries, sexual health clinics, hospitals, libraries and other relative public spaces may be appropriate locations to place such material. Training would also provide professionals with the knowledge to recognise an individual's experience of sexual difficulties, such as vaginismus, so they can share appropriate information, and signpost women experiencing difficulties to relevant support if appropriate.

The findings also illustrate what it might be like for women going into their first session of psychosexual therapy. Specifically, how uncertain they may feel about their decision and what the process will involve. They also indicate how women may feel alone and isolated by their experience of vaginismus, and as a result they may feel particularly vulnerable as they begin psychosexual therapy. It is therefore important that counselling psychologists are aware of and sensitive to this when they begin working with a woman experiencing vaginismus. Furthermore, some women experiencing difficulties with vaginal penetration may seek support from a more general psychologist or psychotherapist rather than a psychosexual specialist as they may have different presenting issues. Findings from this study provide counselling psychologists with a greater understanding of what their difficulties with penetration may mean and how they may be impacted by them, even if it is not the specific reason why they have sought therapy. Meana and Bink (2009) highlight how the marginalisation of sex therapy from other types of psychotherapy perpetuate the notion that it is a special type of therapy requiring specialist training. They argue that this potentially reinforces a social discomfort with sexuality and suggest the benefits of integrating treatment of sexual problems into general psychotherapy.

The difficulties experienced by participants who held different expectations and beliefs around the therapeutic process from their therapists were also identified. They described feeling frustrated, stuck and invalidated. Odgen and Ward (1995) similarly highlight the importance of congruent expectations between client and therapist based on the findings of their questionnaire study into help seeking for women with vaginismus. This indicates the importance for psychosexual therapists and counselling psychologists to be aware of the extent to which their beliefs around vaginismus and expectations for therapy are the same as or different to their clients, as well as what this may mean for how clients may engage in the therapeutic process.

Supported by the findings from the present study, a number of studies exploring heterosexual women's experiences of sexual pain and vaginismus have reported on the negative consequences of social narratives and constructs around sexuality, such as the prioritisation of penetrative sex, for how women feel and think about themselves. However, this study also illustrated how challenging sexual norms and scripts encouraged the participants to feel more accepting of their difficulties, and positive about their futures. As self-reflective practitioners, counselling psychologists need to be aware of the social and cultural context of their work (Woolfe, 2016). Whilst working with woman experiencing vaginismus, it would therefore be helpful for counselling psychologists to reflect on their own assumptions around sex and gender. Furthermore, the findings highlight the potential benefit of discussions in the therapeutic setting, which re-examine and re-evaluate social constructs around sex and gender, and reflect of different forms of sexual expression. Pithavadian et al., (2023) states how this could "strengthen a women's sense of self to believe in themselves, even when the treatment journey is trying" (p.15). This could, for example, involve integrating techniques from narrative therapy (White, 2007) - a constructionist approach - into a more traditional CBT based psychosexual therapy.

The findings also indicate the potential of supporting woman in fostering a self-compassionate perspective during the process of managing and overcoming vaginismus. It may therefore be beneficial for psychosexual practitioners and counselling psychologists to integrate compassion focussed therapy (CFT) exercises into other psychosexual interventions, such as those challenging self-criticism and shame, which may be part of a woman's experience of vaginismus. Vosper et al., (2023) have identified the potential of this for women experiencing pain with penetration, and a recent intervention indicated that it may be a valuable integration to CBT-based psychosexual treatment (Saunders et al., 2022).

Counselling psychologists value the "capacity for self-determination and personal responsibility" of their clients (Strawbridge, 2016 p.26). Findings from the current study identify the experience for some participants of feeling capable and empowered to continue managing vaginismus by themselves, suggesting the potential value of considering self-efficacy models when working with woman experiencing vaginismus. Brotto et al., (2013) conducted a qualitative study to explore the experience of women who took part in a multi-disciplinary intervention for support with their experience of genital and sexual pain. One of the main gals of the intervention was to develop self-efficacy, which included instilling hope that women could play an active role in coping with and managing their pain. The authors reported increased self-efficacy in the narratives of women taking part in the study, and alongside the findings from the present study, this indicates the potential value of similar interventions for women experiencing vaginismus.

Reflecting their embodied experience, participants described a sense of disconnection from and an objectification of their bodies. A finding that has been consistently found in other qualitative studies exploring women's experience of sexual pain and difficulties with penetration (Shallcross et al., 2018; Koops & Birkin, 2021). Whilst using dilators appears to be a regular element of psychosexual therapy for vaginismus, these findings point to the benefits of further therapeutic exercises involving the body, such as sensate focus exercises (Avery-Clark, Weiner, & Adams-Clark, 2019).

Speaking about sexuality is important in counselling psychology as the profession is aligned with the values of humanism and pluralism (Woolfe, 2016). Recognising the diversity of human experience, counselling psychologists aim to work holistically and inclusively with clients. Despite playing an important role in an individual's well-being and identity, sexuality is not often discussed in therapy, and this may be associated with a psychologist's discomfort and limited training in the area (Cruz, Greenwald and Sandil, 2017). Talking openly about sexuality allows counselling psychologists to provide holistic support that considers all aspects of a client's life. Furthermore, discussions around sexuality can be normalising and contribute to a safe and non-judgemental therapeutic environment, where clients feel more comfortable discussing their experiences without fear of stigma or shame (Metz, Epstein & McCarthy, 2017). This research highlights the importance of training in sexuality and sexual health for Counselling Psychologists so that they may feel more confident discussing intimate topics like sexual wellbeing with their clients.

4.11 Conclusion

Vaginismus is characterised by a persistent tension in the muscles of the vaginal wall, making penetration difficult or impossible, and it is an under-researched area of female sexual health. The experience of vaginismus can spread to many aspects of a woman's life, including their sexual and psychological wellbeing, as well as their relationship with others, and their sense of a connection with their bodies. Whilst there are a small number of good quality intervention studies exploring outcomes from psychological interventions for vaginismus, there are few qualitative studies exploring what it is like to receive treatment – including psychosexual therapy - or engage in the overcoming process for vaginismus.

This IPA study provided an in-depth exploration of 7 women's experiences of receiving psychosexual therapy for vaginismus. Its findings highlighted how counselling psychologists can better support women experiencing vaginismus. This includes remaining sensitive to and aware of their possible vulnerability going into therapy; paying attention to their unique embodied experience; and supporting them to develop compassion towards their difficulties and the challenges they experience in the overcoming process. The experience of vaginismus can impact on a women's self-worth, and, importantly, this study also points to the potential role of counselling psychologists in supporting women to re-evaluate the social norms around sex reinforcing this.

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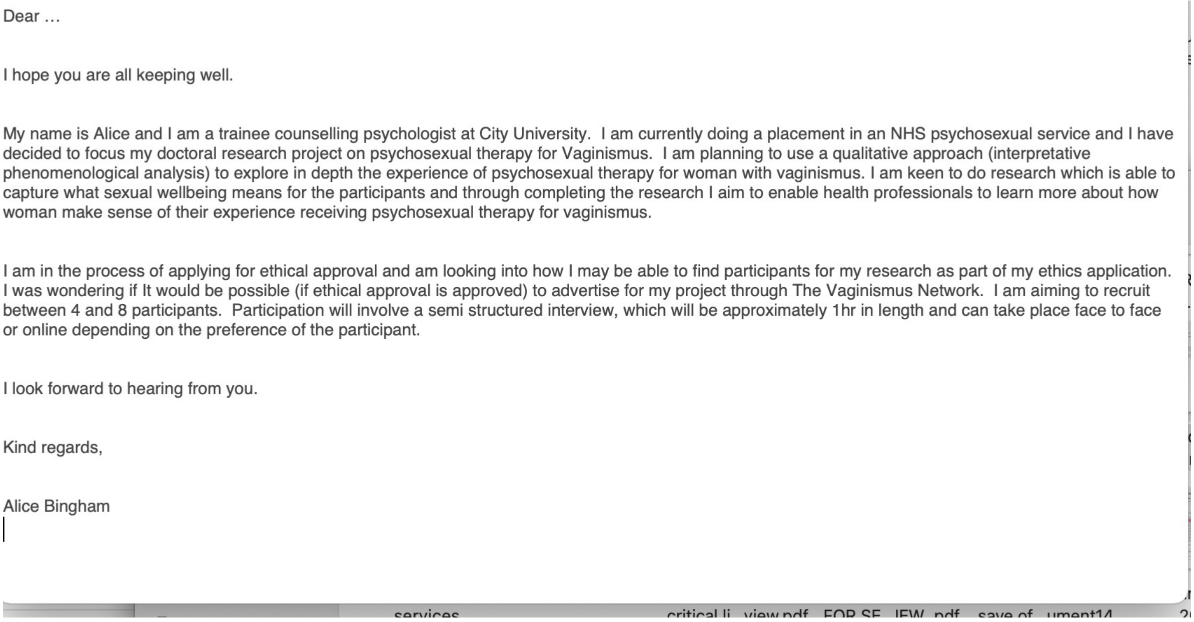
Appendices

Appendix a: Introductory Email



Dear …

I hope you are all keeping well.

My name is Alice and I am a trainee counselling psychologist at City University. I am currently doing a placement in an NHS psychosexual service and I have decided to focus my doctoral research project on psychosexual therapy for Vaginismus. I am planning to use a qualitative approach (interpretative phenomenological analysis) to explore in depth the experience of psychosexual therapy for woman with vaginismus. I am keen to do research which is able to capture what sexual wellbeing means for the participants and through completing the research I aim to enable health professionals to learn more about how woman make sense of their experience receiving psychosexual therapy for vaginismus.

I am in the process of applying for ethical approval and am looking into how I may be able to find participants for my research as part of my ethics application. I was wondering if It would be possible (if ethical approval is approved) to advertise for my project through The Vaginismus Network. I am aiming to recruit between 4 and 8 participants. Participation will involve a semi structured interview, which will be approximately 1hr in length and can take place face to face or online depending on the preference of the participant.

I look forward to hearing from you.

Kind regards,

Alice Bingham

Appendix b: Recruitment Flyer

CITY UNIVERSITY
LONDON

Department of Psychology
City University

Have you received therapy in relation to your experience of Vaginismus and would you like to share your experience of this?

We are looking for participants to take part in a study exploring how women make sense of their experience receiving psychosexual therapy for vaginismus.

Your participation would involve taking part in an informal online video interview lasting between 60 and 90 minutes in which you will have the opportunity to share your experience.

Your participation will be anonymous and you will have the right to withdraw from the study at any point before analysis of the data begins.

For more information about this study, or to take part, please contact:
Alice Bingham (under the supervision of Dr Angie Cucchi)
Email: [redacted]

This study has been reviewed by, and received ethics clearance through the research ethics committee, City University London

If you would like to complain about any aspect of the study, please contact the secretary to the University's Senate Research Ethics Committee on [redacted]

Appendix c: Information Sheet

ETH1920-1767, 1st February 2021, version 4

Participant Information Sheet

Title of study: **Psychosexual Therapy for Vaginismus: An Interpretative Phenomenological Analysis**

Name of principal investigator/researcher**: Alice Bingham**

We would like to invite you to take part in a research study. Before you decide whether you would like to take part it is important that you understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

What is the purpose of the study?
The aim of this study is to explore in depth the experience of receiving psychosexual therapy for vaginismus. The study is being undertaken as part of a professional Doctorate in Counselling Psychology and it will be submitted to City University London. It will involve the analysis of data collected though online interviews with women who have received psychosexual therapy for vaginismus and it is estimated that the duration of the study will be between 10-12 months. It is hoped that results from the study could inform professionals supporting women experiencing vaginismus.

Why have I been invited to take part? You have been invited to participate in this study because you are currently living in the UK, you are 18 years or older and in the past you have received 6 or more sessions of psychosexual therapy for vaginismus. In total there will be no more than 8 participants in the study.

Do I have to take part?
Participation in the project is voluntary. If you decide to take part you are still free to withdraw at any time up until the point that the interviews are being transcribed and without giving a reason.

What will happen if I take part?

- If you decide to take part in the study you will be interviewed once online by the lead researcher using Zoom video conferencing technology at a time that is convenient for you.
- The interview will be audio recorded and will last between 60 and 90 minutes.
- Before beginning the interview, you will be asked some background information questions regarding how long you experienced symptoms of vaginimsus for before beginning psychosexual therapy, how many sessions of psychosexual therapy you received and how long it has been since you finished psychosexual therapy. You will also be asked two demographic information questions in relation to your age and ethnicity.
- During the interview, you will be asked about your experience of psychosexual therapy. This will involve questions such as what was your experience of psychosexual therapy like and how do you think things would be different if you had not received psychosexual therapy?
- You will be free to refuse to answer any questions you do not feel comfortable with and stop the interview at any point. You will also be able to turn off the video if you wish to do so at any time in the interview.

What are the possible disadvantages and risks of taking part? Because you will be asked about your experience of therapy, it is possible that you may find some of the subject matter upsetting. Your wellbeing will be considered throughout the interview and you will be signposted to details of relevant organisations for additional help and support if needed.

What are the possible benefits of taking part? Some people find the space to reflect on their experiences helpful. Your involvement in the study also provides the opportunity to contribute to existing knowledge around vaginismus, which is an under researched area of sexual health.

What should I do if I want to take part? If you would like to take part in the research please email the lead researcher Alice Bingham at [redacted] to arrange a telephone conversation.

Will my taking part in the study be kept confidential?

- The audio-recordings of the interviews, the transcripts, and all of your personal information will be stored securely and separately on a password-protected laptop and in a locked drawer. All personal data will be destroyed after the study ends and the degree has been rewarded. Anonymised data will be kept indefinitely. No information that can lead to the identification of any individual will be reported in relation to the project.
- The interview will take place on Zoom using a private and secure Zoom link and the Zoom meeting will be encrypted. The interview will be recorded using a password protected encrypted Dictaphone and the Zoom recording option will be switched off to ensure that the audio and video content of the meeting is not stored by Zoom itself. The researcher will be the only person who has access to the audio recordings. The researcher and the research supervisor will be the only people who have access to the transcripts and personal information.
- All personal information shared during the interview will remain confidential unless the researcher suspects that the participant is at risk of serious harm to self or others.

What will happen to the results?
The results of the analysis of the data will be published as part of the researcher's Doctoral thesis in the City University Library and potentially in any relevant academic journals. All identifying information will be changed so that anonymity is maintained. If participants wish to receive a copy of the publication/summary of the results their contact details will need to be retained and they will be required to explicitly consent for their data to be kept for this purpose.

Who has reviewed the study?
This study has been approved by City, University of London Psychology Research Ethics Committee.

What if there is a problem?
If you have any problems, concerns or questions about this study, you should ask to speak to a member of the research team. If you remain unhappy and wish to complain formally, you can do this through City's complaints procedure. To complain about the study, you need to phone [redacted] [redacted] You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is: Psychosexual Therapy for Vaginismus: An Interpretative Phenomenological Analysis

You can also write to the Secretary at:

[redacted]
Secretary to Senate Research Ethics Committee Research Office, E214
City University London
Northampton Square
London
EC1V 0HB
Email: [redacted]

Further information and contact details

If you have any further questions about the study you may contact the researcher at [redacted] or Dr Angie Cucchi at [redacted]

City University London holds insurance policies which apply to this study, subject to the terms and conditions of the policy. If you feel you have been harmed or injured by taking part in this study you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone's negligence, then you may have grounds for legal action.

Appendix d: Consent Form

CITY UNIVERSITY
LONDON

Consent form

Name of principal investigator/researcher

REC reference number: ETH1920-1767, 1st February 2021, version 3

Title of study: Psychosexual Therapy for Vaginismus: An Interpretative Phenomenological Analysis

1	I confirm that I have read and understood the participant information dated 1/02/21 (version 4) for the above study. I have had the opportunity to consider the information and ask questions which have been answered satisfactorily.	
2.	I understand that my participation is voluntary and that I am free to withdraw without giving a reason without being penalised or disadvantaged.	
3.	I understand that I will be able to withdraw my data up to the time of transcription.	
4.	I agree to the interview taking place online using Zoom videoconferencing platform and being audio recorded using a password-protected encrypted Dictaphone.	
5.	I agree to City recording and processing this information about me. I understand that this information will be used only for the purpose(s) explained in the participant information and my consent is conditional on City complying with its duties and obligations under the General Data Protection Regulation (GDPR).	
6.	I would like to be informed of the results of this study once it has been completed and understand that my contact details will be retained for this purpose.	
7.	I agree to take part in the above study.	

________________ ______________________ __________

Name of Participant Signature Date

________________ ______________________ __________

Name of Researcher Signature Date

When completed, 1 copy for participant and 1 copy for researcher file.

Appendix e: Interview Schedule:

ETH1920-1767, 3rd August 2020 version 2

Interview Schedule

1. Can you tell me about how you came to make your decision to have psychosexual therapy for your experience of vaginismus?
Prompts:
How did you hear about it?
What influenced your decision?
Why did you decide to begin psychosexual therapy?
How did you feel about having psychosexual therapy before you started? (Positive/ negative)
What did you hope to get out of the experience?
What did you imagine it would be like? What were you expecting it to be like?
How did you learn about vaginismus?

2. What was your experience of psychosexual therapy like?
Prompts:
Can you describe what it involved?
How did you feel about your experience?
What did you think about it?
What, if any, exercises were you asked to do between sessions?
Which, if any, exercises were you given to do (e.g. self-focus, dilator training, sensate focus)?
What topics/themes did you explore?
What did you think about this?
How did you feel about this?
How helpful did you find these?

3. How do you think things would be different if you had not had psychosexual therapy?
Prompts:
What changes, if any, did you experience during or as a result of psychosexual therapy?
How do you think therapy contributed to any changes you experienced?
Can you tell me about any specific moments when you noticed a change?
What do these changes mean to you?
What did you learn as a result of psychosexual therapy?
What did you find helpful or unhelpful, if anything, about psychosexual therapy?

4. Can you tell me about any difficulties you experienced during psychosexual therapy?
Prompts:
Can you describe what happened?
Why do you think you experienced these difficulties?
How did you overcome any difficulties you experienced?

5. Can you tell me a bit about your relationship with your therapist?
Prompts:
How would you describe the relationship with your therapist?
How did you feel about the relationship?
What were your thoughts about the relationship?

6. How did you feel about ending therapy?
Prompts:
Why did it come to an end?
How do you feel about your experience of psychosexual therapy now?
What did your experience of psychosexual therapy mean for you?

7. What, if anything, would you like to have been different about your experience of psychosexual therapy?
Prompts:
What advice would you give to someone else who is about to begin psychosexual therapy?
Is there anything you would have done differently?

Is there anything about your experience of therapy you would like to add which we haven't covered?

Prompts:
Paraphrase
Can you me a bit more about that?
What do you mean by _____?
Can you tell me what you were thinking at the time?
What was that like for you?
How did that feel?

Appendix f: Debrief Sheet

Psychosexual Therapy for Vaginismus: An Interpretative Phenomenological Analysis

DEBRIEF INFORMATION

Thank you for taking part in this study!

The aim of this research is to give women who have experienced vaginismus the opportunity to share their experience of psychosexual therapy. It is hoped that this will provide more information about the psychosexual therapeutic process for women with vaginismus and have an impact on how support is provided in the future as well as lead to more research in this currently under-researched area of sexual health.

Below are some organisations you can contact if you feel that you need any additional help or support following your participation in this study. You can also contact your GP.

- The Vaginismus Network: https://www.thevaginismusnetwork.com/
- Vaginismus Awareness: http://www.vaginismusawareness.com/
- Samaritans: www.samaritans.org (08457 909090)
- Mind: https://www.mind.org.uk/

We hope you found the study interesting. If you have any other questions please do not hesitate to contact us at the following:

Alice Bingham (researcher) [redacted] Dr Angie Cucchi (research supervisor) [redacted]

Ethics approval code: ETH1920-176714/15 201, 9th September 2020, version 2

Appendix g: Letter Confirming Ethical Approval

City, University of London

Dear Alice

Reference: ETH2223-2302

Project title: Psychosexual therapy for vaginismus: an Interpretative Phenomenological Analysis

Start date: 7 Oct 2020

End date: 1 Jun 2024

I am writing to you to confirm that the research proposal detailed above has been granted formal approval from the Psychology low risk review. The Committee's response is based on the protocol described in the application form and supporting documentation. Approval has been given for the submitted application only and the research must be conducted accordingly. You are now free to start recruitment.

Please ensure that you are familiar with City's Framework for Good Practice in Research and any appropriate Departmental/School guidelines, as well as applicable external relevant policies.

Please note the following:

Project amendments/extension

You will need to submit an amendment or request an extension if you wish to make any of the following changes to your research project:

- Change or add a new category of participants;
- Change or add researchers involved in the project, including PI and supervisor;
- Change to the sponsorship/collaboration;
- Add a new or change a territory for international projects;
- Change the procedures undertaken by participants, including any change relating to the safety or physical or mental integrity of research participants, or to the risk/benefit assessment for the project or collecting additional types of data from research participants;
- Change the design and/or methodology of the study, including changing or adding a new research method and/or research instrument;
- Change project documentation such as protocol, participant information sheets, consent forms, questionnaires, letters of invitation, information sheets for relatives or carers;

- Change to the insurance or indemnity arrangements for the project;
- Change the end date of the project.

Adverse events or untoward incidents

You will need to submit an Adverse Events or Untoward Incidents report in the event of any of the following:

a) Adverse events

b) Breaches of confidentiality

c) Safeguarding issues relating to children or vulnerable adults

d) Incidents that affect the personal safety of a participant or researcher

Issues a) and b) should be reported as soon as possible and no later than five days after the event. Issues c) and d) should be reported immediately. Where appropriate, the researcher should also report adverse events to other relevant institutions, such as the police or social services.

Should you have any further queries relating to this matter, please do not hesitate to contact me. On behalf of the Psychology low risk review, I do hope that the project meets with success.

Kind regards

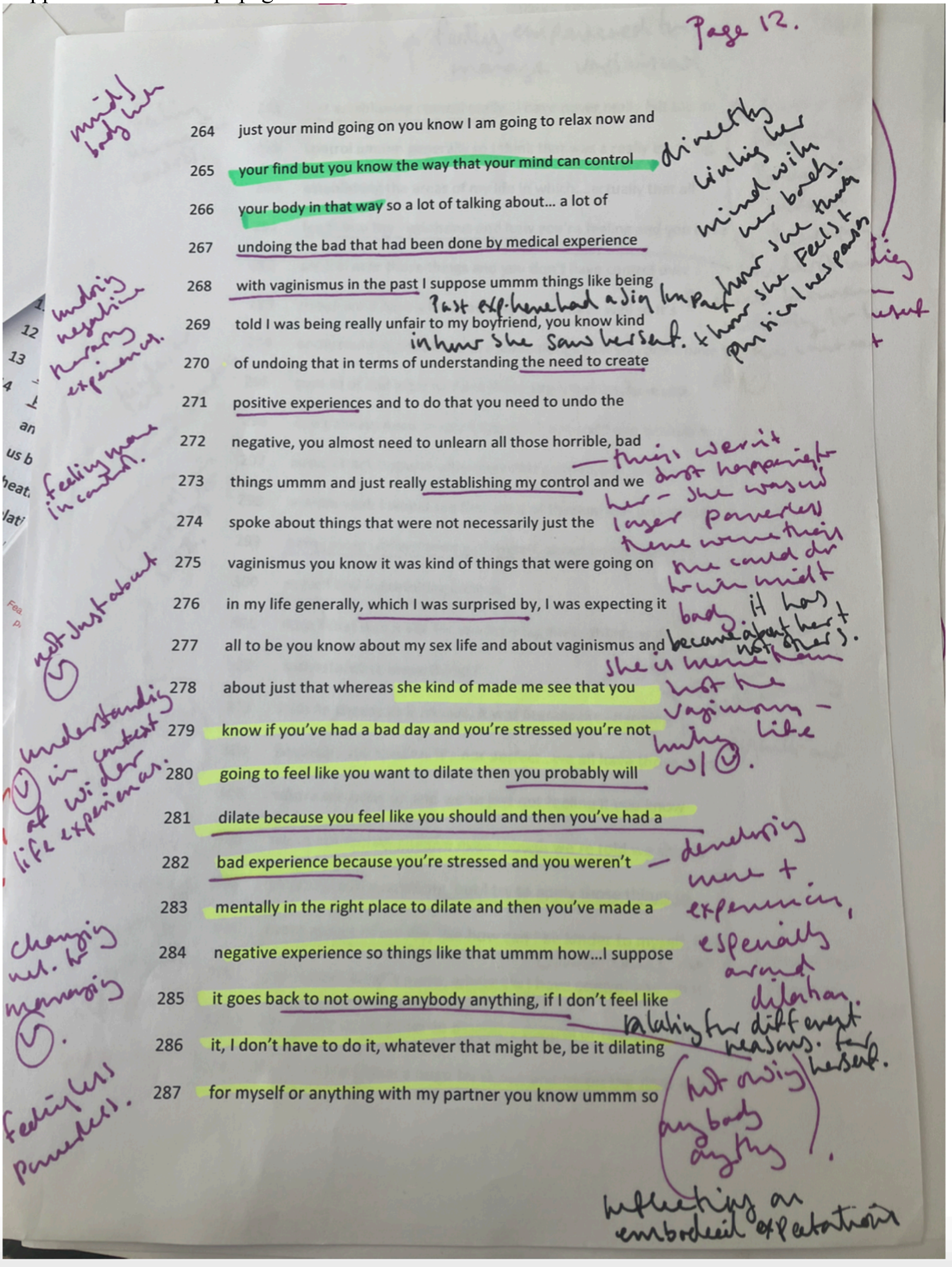
[redacted]

Psychology low risk review

City, University of London

Ethics ETH2223-2302: Miss Alice Bingham (Medium risk)

Appendix h: transcript page



Page 12.

just your mind going on you know I am going to relax now and your find but you know the way that your mind can control your body in that way so a lot of talking about… a lot of undoing the bad that had been done by medical experience with vaginismus in the past I suppose ummm things like being told I was being really unfair to my boyfriend, you know kind of undoing that in terms of understanding the need to create positive experiences and to do that you need to undo the negative, you almost need to unlearn all those horrible, bad things ummm and just really establishing my control and we spoke about things that were not necessarily just the vaginismus you know it was kind of things that were going on in my life generally, which I was surprised by, I was expecting it all to be you know about my sex life and about vaginismus and about just that whereas she kind of made me see that you know if you've had a bad day and you're stressed you're not going to feel like you want to dilate then you probably will dilate because you feel like you should and then you've had a bad experience because you're stressed and you weren't mentally in the right place to dilate and then you've made a negative experience so things like that ummm how…I suppose it goes back to not owing anybody anything, if I don't feel like it, I don't have to do it, whatever that might be, be it dilating for myself or anything with my partner you know ummm so

mind/body link

directly linking her mind with her body.

undoing negative narrating experiences.

Past exp. here had a big impact in how she saw herself. + how she thinks + how she feels + physical response

feeling more in control.

– this is where it didn't happen to her – she was no longer powerless there were things she could do to win midst bad.

it has become about her + not others.

not just about ✓

she is more than just the vaginismus – living life w/ ✓.

✓ understanding in context of wider life experiences.

– developing more + experiences, especially around dilation.

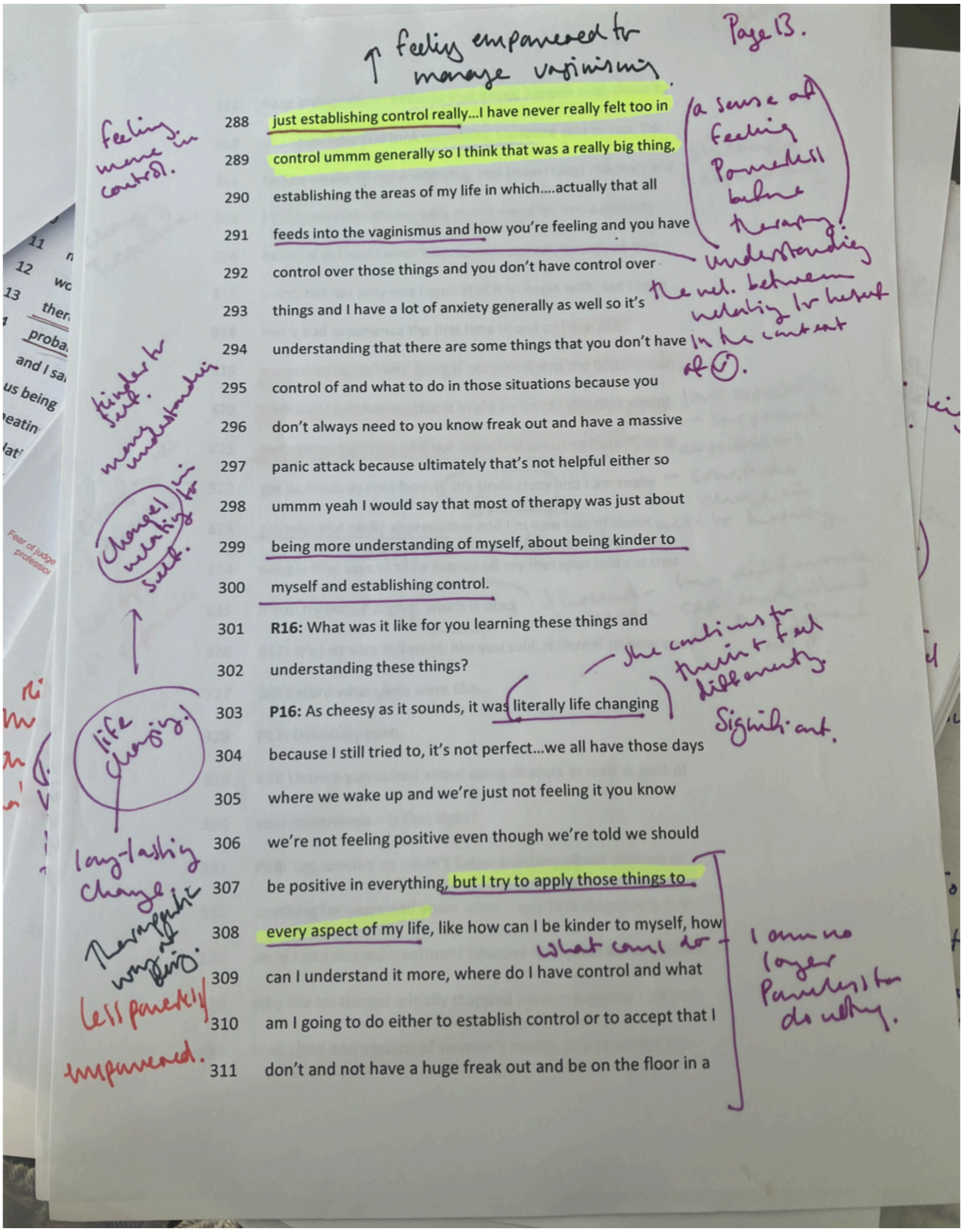
changing rel. to managing ✓.

dilating for different reasons. for herself.

(not owing anybody anything).

feeling less powerless.

reflecting on embodied expectations



↑ feeling empowered to manage vaginismus.

Page 13.

just establishing control really...I have never really felt too in control ummm generally so I think that was a really big thing, establishing the areas of my life in which....actually that all feeds into the vaginismus and how you're feeling and you have control over those things and you don't have control over things and I have a lot of anxiety generally as well so it's understanding that there are some things that you don't have control of and what to do in those situations because you don't always need to you know freak out and have a massive panic attack because ultimately that's not helpful either so ummm yeah I would say that most of therapy was just about being more understanding of myself, about being kinder to myself and establishing control.

R16: What was it like for you learning these things and understanding these things?

P16: As cheesy as it sounds, it was literally life changing because I still tried to, it's not perfect...we all have those days where we wake up and we're just not feeling it you know we're not feeling positive even though we're told we should be positive in everything, but I try to apply those things to every aspect of my life, like how can I be kinder to myself, how can I understand it more, where do I have control and what am I going to do either to establish control or to accept that I don't and not have a huge freak out and be on the floor in a

feeling more in control.

a sense of feeling powerless before therapy.

understanding the rel. between relating to herself in the context of Ⓥ.

kinder to self.

more understanding

changes relating to self.

life changing.

long-lasting change.

therapeutic ways of being.

less powerless

empowered.

she continues to train + feel differently.

Significant.

what can I do

I am no longer powerless to do nothing.

Appendix I: Personal Experiential Themes (PET) for one Participant

PET 1: Ambivalence	
Relief and resistance towards diagnosis	p. 2 p.12 p.23
Readiness for Therapy	p.1, p.9, p.26
“little little little bell” Therapy as a constant reminder	p.5, p.9, p.18
PET 2: Developing self-compassion	
A shift in thinking about V	P.2, P.13, P.14, P.24
Therapy as a safe place to talk about V/therapy as a place to be yourself	p.11, p.12, p.4, p20, p.22
Becoming part of vaginismus community	p.8, p.9
PET 3: Managing expectations	
Wanting to be fixed	p.3, p.9, p10, p18
The expectations of others	p.12, p.15, p.11, p.17, p.23
Wanting to make progress (dilators are so emotionally hard)	p.4, p.8, p.14
PET 4: beginning of something”: hope	
Therapy “sort of organises your vaginismus”	p.12, p.15, p.9, p.4
Becoming more bodily confident	p.3, p.8, p.13, p.14
Developing resilience	p.7, p.13, p.26

Appendix j: Example of Table of Group Experiential Themes with Subthemes

Table of Group Experiential Themes, Subthemes, and Quotations

Help Seeking	
	“I thought I was the only one in the world going through this”
Mya	vaginismus is, it’s the most loneliest time of your life, you feel cut off from society because it’s not really something you go round talking to people about. I didn’t tell any family members, I couldn’t tell any friends in my direct peer group, and I think it was mainly because I wasn’t dating someone, I was married so I had to protect my marriage and also protect the privacy of my spouse and so I didn’t really want to go round telling everyone, yeah we just got married and we can’t have sex. Ummm...so it’s just very lonely, it’s really, really horrible. It’s traumatic. like you just feel very...just alone...it’s just very annoying because you kind of think well this is never going to be fixed then is it because you don’t even know what it is you feel very vulnerable, ummm...you don’t feel normal because you feel like every woman (laughs) should be able...like her body should work ummm so you are walking in with those feelings and then you have to go and speak to a stranger about it
Lucy 22-32 241-242	because I think this is the thing as well as a woman I think we are told a lot growing up oh you know sex will hurt, the first time it will be a bit painful, the first few times, that’s fine, don’t worry and so we kind of talk...don’t say anything about it if it hurts and just let a guy carry on regardless of if it hurts, you know that’s sort of how we are taught so when it does...when it doesn’t stop hurting it’s kind of like no there is a problem here but you think that it might be you, you think that maybe you know all these things go through your head...you think maybe you’re just a bad girlfriend, maybe you just don’t want to have sex, you know all of this.
Alex 425-438 439-442	I think I tried, I googled random things, which I think now would throw up vaginismus, you know like, ummm, maybe if I like had been able to have sex but had pain, maybe if I had googled pain during sex it would have, you know I would have found something. Because I couldn’t have sex, so as far I am concerned it wasn’t painful, it more felt like I didn’t have a vagina (laughs) so I think I was probably just googling the wrong things because I was googling “can’t have sex and stuff” but before I just thought you know it was just like some...ummm...I thought that either I was making it up, which doesn’t make any sense...ummm...but that’s what I thought or that it was just you know some horrible physical flaw just specifically for me.

Poppy 1362- 1372	learning that I wasn't the only person going through this and I think...and I'm sure if you've spoken to other people about it or if you do in the future obviously a lot of people will say "I thought I was the only one in the world going through this" and then there's a BBC article about it and you're like, wait this thing...what I am going through has a name, there are other people and there are people who help you through this, so obviously it's not...you're not alone. I had no idea about vaginismus because my sex ed was non-existent…I just think there should be a lot more awareness about vaginismus and related things…it took, it took so much reading to find out what this was…I just think there should be a lot more awareness
Rhian 29-31 34-40	...I couldn't talk to anyone about it, no one knew about it, like I couldn't talk to my mum about it, I couldn't talk to my sister about it, and I thought I needed someone to talk to and...who understood it. I think talking is really important and obviously I couldn't talk about it with anyone but ummm...so that was what kind of pushed me to it and I just wanted to...I guess the main thing I wanted from it is to be able to talk about it with...as like be normal because like I couldn't just talk about any...cos people just don't understand it but obviously speaking to a psychosexual therapist, like that's what she's trained in.
	"It's obviously a huge relief because you have a word"
Poppy 38-53	That was a huge comfort in a way, to know that it wasn't just me and I think that also gave me comfort in that like it wasn't me going to get help for some really random thing that no Doctor or therapist had ever heard of...like there are people who specifically specialise in this and so that gave me the courage. (page 3) There was no doubt, there was no question...when the GP was like do you want me to put you through and I was like yes, what are you waiting for, do it, do it (p.2-3 38-53).
Rhian 47-52 55-58	I was very emotional, my first session with her I cried the whole hour, I was really, really emotional because I guess it was real then because I know...I always knew I...I never knew about vaginismus until ummm yeah until about 2019 ummm so when I found out about it I thought I could just cope with it myself but I couldn't, but it was...yeah I was very, veryemotional...really, really emotional. Yeah, yeah cos it just brought...I sort of put it to the back of my mind a little bit really cos I wasn't like dating or anything like that yeah it...ummm yeah it did just become real. I was like oh my gosh, someone actually knows about it.

Tasha 44-48 58-61 378-379	She gave me a word for this and finally I had some sort of explanation, but I didn't want to associate myself with any sort of ummm... syndromes, or any sort of names, so I said no I don't have it. And she was like, well, I think maybe there is some sort of...yeah... you probably, probably do. yeah, It was very difficult because I didn't want to even acknowledge that it is something which I have. I was really hoping that it is something that which, going to go away, because I probably am just so tense and I can't relax. Ummm I feel like psychosexual therapy helped me a lot. First of all it introduced me to this word vaginismus
Alex 445-450	ummm, I think like in the moment I had a little bit of a meltdown, but then it's obviously a huge relief because you've got a word ummm who you can go and ask people about and then obviously it means it's not, it's a real thing so it's not just you making it up and ummm other people presumably have it too (laughs).
Lucy 33-39 197-198 208-216 702-708	I remember leaving feeling quite hopeful and feeling quite overwhelmed that this wasn't all on me you know so I found the whole experience much more emotional than I thought I would the relief of just knowing that someone can help you in whichever way whether it's to give you tips or to make you feel better whatever that it, somebody...there's a name for what's happening to you, somebody understands what that is and that person can help you and the relief of even just knowing that you have started that journey is so like big, that sounds really silly, I can't explain it, it's just like "aaahhhh" (a sound of someone relaxing), it feels like a huge weight of your shoulders. felt like a relief, you know it felt like oh maybe this is possible, maybe this is something that I can work at and get over you know because initially when you don't know that there is a name for it or treatment or whatever you just have this feeling of dread, of oh god there's this condition that I am going to have to deal with for the rest of my life
Mya	I think I was probably quite relieved because at least I could put a name to it and then that kind of gave me hope that I could get help for it because I actually knew what it was as opposed to just not having a clue, feeling really lost and stuck so I thought oh okay, this is like the beginning of seeking help and ummm it was sort of nice to like go online and search for stuff related to that ummm see other people who had gone through it, that was really comforting, I'd just read up about it because before I just had no clue really.
	"I had no idea what to expect from it"

Poppy 56-62 74-76 1055-1075	I had no idea what to expect from it, I had never heard of psychosexual therapy before ummm the doctor did try to explain it but I couldn't tell you what they said because I have a really bad memory (laughs). Ummm, but errr they...I went in, I was a bit nervous because I wasn't sure like how far back I'd have to think, like I just said my memory is so bad so I was like what am I going to have to talk about I was quite nervous beforehand because I just didn't know what was expected of me, what I should expect of the therapist, what I should expect of therapy generally I think I sat there in the first session and was like I really don't know what I am supposed to be talking about, I don't know what the plan is, I don't know how we are going to fix this ummm it was all quite negative
Kate 50-55 97-105	My decision to begin…oh well I didn't know that was what it was the first time, so I was just referred and was told this is where we treat vaginismus and this is the sessions…so it wasn't really an active decision to seek psychosexual therapy, that was what I was referred to. But I think one of the things I really want to say is actually I had no idea it was therapy and even if in the same…in the first session it was kind of explained to me how it works and what the combination of treatment was…it is a physical thing and potentially a mental thing as well, like a psychological thing, I didn't…I have never done therapy before…I didn't really understand how it worked and I think it really framed my reception to the whole treatment, was not really understanding how therapy works
Rhian 95-104	ummm I guess, yeah, that's the thing I actually didn't know what to expect, I thought it was going to be ummm...I guess my condition like vaginismus, I thought it was going to be like really hands on myself. I thought she was going to like make me do things that I just didn't want to do, but it wasn't.
Tasha 278-292	It was, but I never treated it that way at the time. I think when I was rethinking how the therapy is supposed to help me to beat the vaginismus, this is, this what I came up with but at the time the therapy just felt like something I have to do. You know I was, I was really not ready to go to therapy and obviously you know going to therapy is automatically a little, little, little bell that there is something wrong with you and I never wanted to associate myself with anything, which is like there is nothing wrong with me and when my therapist said oh you've got vaginismus, I'm like "I don't".
Alex 19-24 396-406	So, then I went to my GP and she was like oh yes and just like referred me to the place where I then got psychosexual therapy, so I didn't really like decide that's what I should do, it's just like the thing that my GP referred me to ummm and then I was like obviously well this is the treatment that I'm getting so there we are (laughter).

	...maybe it helped in some way if there had been more of a discussion of like what are we doing, why and some sort of evidence that it helped and like, I don't know, some sort of like context setting, but because we went straight from like you know, you know like an initial kind of examination, "oh okay yes you've got vaginismus" to like talking about therapy stuff and I didn't know why we were doing it, so I was like a combination of really just like confused and sort of stand offish because oh why would we have this conversation and, and also just like I say just like irrationally feeling just like really angry about it, so it's like it just doesn't make sense
Lucy 42-42	I was really cynical and dubious about therapy. I...have been through a lot in my life anyway, but everyone had always said to me oh with everything you have been through you should go to therapy, you know, and my sort of attitude to if you like was what's the point in raking up everything that has happened, it's done and I'm over it and I just need to move on and get on with my life so hearing that there was psychosexual therapy for vaginismus, I was kind of like, what's talking about it going to do
Mya	What influenced my decision? ummm I think I had got to the place of just feeling very desperate, very hopeless, like I think...I don't know how it is for others but my personal experience of vaginismus, it just...it just makes you so frantic, after a while like I found it very emotionally distressing ummm and I felt like I had exhausted other avenues and so I thought this would be the next best thing

PART B: Publishable Article

"It's just like learning not to be hard on yourself": An IPA Study of Women's Experiences of Receiving Psychosexual Therapy for Vaginismus

Foreword

The intention is to submit this paper to the *Health and Psychology* Journal with the aim to reach a wider of audience of health professionals. See appendix k for submission criteria. Some details have been changed to fulfil the requirements of the portfolio.

Abstract

Vaginismus is characterised by involuntary muscle spasms in the vaginal walls, making penetration painful, difficult, or even impossible. It is an under-researched area of female sexual health, and can have significant implications for a women's psychological and sexual wellbeing. This study therefore aims to give voice to women with vaginismus, to provide an in-depth exploration of their experiences of psychosexual therapy. Data was collected from seven participants using semi-structured interviews and analysed using Interpretative Phenomenological Analysis (IPA). From this analysis three main Group Experiential Themes emerged: "Help Seeking", "The Embodied Experience", and "Living with Vaginismus". Findings from the study highlighted the challenges participants experience around psychosexual exercises supporting them to develop a connection with their bodies, and their changing relationship to these. They also indicated the potential of psychosexual therapy to help women make sense of and manage the impact of vaginismus on their lives, improve their sense of self-worth, feel more empowered to manage vaginismus, and hopeful about the future. For the purposes of this article, only the findings about The Embodied Experience and Living with Vaginismus will be explored. Implications for counselling psychologists and other health care professionals are discussed in regards to both research and practice.

Introduction

Whilst the term vaginismus was officially included in the Diagnostic and Statistical Manuel of Mental disorders (DSM) in 1980 (APA, 1980), its use can be dated back to the 19th century (Pacik, 2014). The definition of vaginismus has evolved over the years, from an initial focus on the presence of muscle spasms, to a more recent focus on the related difficulties with penetration (Basson et al., 2004). Vaginismus can be lifelong or can develop later on after vaginal penetration has been possible; it can occur in every situation (global) or be specific to certain situations (situational); and an individual may be able to tolerate some penetration (partial) or none at all (total) (Crowley et al., 2009). Due to the overlap between vaginismus and dyspareunia, they have recently been brought together under a single diagnostic category called Genito-Pelvic Pain Penetration Disorder (GPPPD) (Lahaie, Boyer, Amsel, Khalife & Binik 2010). GPPPD is characterised by a range of symptoms associated with difficulties around penetration, including pain, fear of pain, and anxiety (APA, 2013). There have been some issues raised around the ability of GPPPD to differentiate women with lifelong vaginismus who may not experience pain or fear of pain in association with vaginal penetration (Reissing et al., 2014). Despite these changes, vaginismus remains a clinically and theoretically meaningful term, and will therefore be the term referred to throughout this research project, however, when cited research refers to the term GPPPD this will be acknowledged.

There is limited research, social awareness and understanding around female sexual problems such as vaginismus (McEvoy, 2021: Pithavadian, Chalmers & Dune, 2023). Women may therefore struggle to recognise and articulate their symptoms to health care professionals. Alongside the societal normalisation of pain and social taboos around discussing sex, this makes it difficult to establish prevalence rates for vaginismus (Odgen and Ward, 1995: Pacik, 2014). Prevalence rates vary from 0.8% in Denmark to much higher in conservative cultures such as Turkey and Iran (42.9% and 26.7% respectively) (Andresen, Graugaard, Andersson, Bahnsen & Frisch, 2022: Oksuz & Malhan, 2006: Safarinejad, 2006).

Whilst here is lack of systematic research focussed on developing an understanding of vaginismus (Reissing, 2021), Meana and Binik (2022) explain that it is difficult to determine an aetiology of sexual pain conditions (including vaginismus) due to their complex relationship with psychological and relational well-being. They refer to this as bio-psycho-social puzzle of painful sex, specifying that a wide range of characteristic have the potential to cause, influence or a be a consequence of vaginismus (term used GPPPD).

From a psychological perspective, recent research has conceptualised vaginismus as a defensive phobic reaction (Fugl-Meyer et al., 2012). Recognising the emotional function of the pelvic floor, anxiety and other threat based emotional are understood to influence the characteristic autonomic muscular contractions (Dias-Amaral & Marques-Pinto 2018). This theory has been supported by research highlighting increased pelvic floor muscle activity in response to threatening stimuli in women with and without vaginismus (Van der Velde & Everaerd 2001). Research has also highlighted increased levels of disgust around penetration for women with vaginismus (Borg, de Jong & Schultz, 2010). Studies have reported that women with vaginismus demonstrate more negative beliefs around penetration in comparison to women without vaginismus (Banaei, Kariman, Ozgoli, Nasiri & Khiabani 2021), which can contribute to avoidance of penetration or intercourse (Cherner & Reissing, 2013: Molaeinezhad et al., 2014: ter Kuile et al., 2007).

Bringing together the evidence from these studies examining the role of emotions, beliefs and behaviour for women with vaginismus, a Fear Avoidance Model of vaginismus (FAM-V) has been developed (Reissing, 2021). According to FAM-V, negative and catastrophic beliefs about penetration result in a fear of penetration, which in turn leads to avoidance of penetration behaviour or hypervigilance to information supporting negative beliefs. For example, hypervigilance may involve increased focus on physical sensations and emotions facilitating or potentiating pain during sexual activity (Cherner and Reissing, 2013). Fear, hypervigilance and negative emotions can then result in the involuntary and defensive contraction of pelvic floor muscles, leading to difficulties and pain associated with vaginal penetration, and confirming negative and catastrophic beliefs about penetration (Reissing, 2021). Avoidance of vaginal penetration and sexual activity is proposed to be a maintaining factor in this model in as far as it works to temporarily reduce fears and negative emotions, preventing the disconfirmation of the negative penetration beliefs perpetuating the cycle (Reissing, 2021).

Research has demonstrated how the prevalence rates of vaginismus vary across different cultures, highlighting how its development may also be influenced by cultural norms, religious beliefs and societal attitudes to sex (McEvoy et al., 2021). For example, cultural values emphasising an expectation of virginity may contribute to a fear and anxiety surrounding penetration (Dogan, 2009). Limited sex education may reinforce myths around sex and contribute to experiences of fear (Van Lankveld et al., 2010: Reissing, 2021). Parental attitudes may also shape a women's experience of shame and fear around sex and their own sexuality (McEvoy, 2021). Social, cultural and religious factors may therefore intersect with psychological and relationship factors to influence a women's experience of vaginismus.

The experience of vaginismus can spread to many aspects of a women's life including their sense of self, relationships with others and their sexual wellbeing (Pithavadian, Chalmers and Dune, 2023: Ward and Odgen 2010). Women with vaginismus can experience low self-esteem and low self-worth, and they may also feel isolated, fear the rejection from their partners, and have doubts over their relationships (Svedhem, Eckert and Wijma, 2013: Ward and Odgen 2010). This can be reinforced by social norms and expectations surrounding sex and womanhood, for example, those that prioritise penetrative sex and equate it with 'real sex' (Kaler, 2006 : Koops and Brikin, 2021). Associated with their experience of fear and discomfort, women have also reported a loss of sexual desire and avoidance of sexual activity (Svedhem, Eckert and Wijma, 2013). Finally, women experiencing vaginismus may also feel disconnected from their bodies (Koops & Birkin: Koops & Frith). Despite this, some women have also described their positive experiences of challenging prevailing discourses around sex, and experimenting with different types of sexual activity, which they consider to be 'real sex' (Svedhem et al., 2013).

Psychosexual therapy is a specialised talking therapy specific to sexual problems. It is influenced by a range of psychological models, including Masters and Johnson's behavioural interventions, Cognitive Behavioural Therapy (CBT), systemic, narrative and psychodynamic approaches (Tabatabaie, 2014). Psychosexual interventions for vaginismus typically integrate CBT, such as cognitive restructuring and exposure to feared stimuli, with traditional psychosexual behavioural exercises, such as progressive desensitisation with dilators (Reissing, 2021).

The studies evaluating these interventions have had mixed results in regards to their primary outcome of ability to have penetrative sex post intervention. One Randomised Controlled Trial (RCT) for a group CBT intervention demonstrated modest success (Lankveld et al., 2006), whilst another RCT trial revealed significant improvement with a therapist guided exposure intervention (ter Kuile et al., 2009). Furthermore, a recent internet-based CBT intervention also demonstrated significant changes regarding participant's ability to have penetrative sex (Zarski et al., 2021). However, there was a high level of drop out in the intervention group and women experiencing higher pre-treatment levels of pain were less likely to benefit from the intervention.

These studies have also reported significant differences for the intervention group regarding secondary outcomes including sexual functioning and penetration related behaviours (ter Kuile et al., 2009: Zarski et al., 2021). However, some participants continue to experience pain during penetration and, importantly, it is not known whether participants who are able to engage in penetrative intercourse are able to enjoy it or find it pleasurable. Furthermore, it is not known whether outcomes are linked to the individual goals of participants. This highlights the benefit of focussing on more than the ability to engage in penetrative sex and considering wider psychosocial factors which may contribute to sexual wellbeing.

For some researchers, evaluating intervention outcomes in terms of ability to have penetrative sex reflects the predominance of a biomedical approach to sexual difficulties, which does not capture the unique lived experience of women and the multi-dimensional nature of sexual wellbeing (Tiefer, 2012; Kleinplatz, 1998). Kleinplatz (1998) argues that there are limitations and consequences of "success" being measured by the ability to have penetrative sex, which is criticised as being "mechanistic, reductionist and objectifying". For Kleinplatz (1998), if the goal is to eliminate the barriers of "normal" sexual functioning, the focus is on reducing symptoms regardless of the possible meaning behind them. Rather than helping women to become more aware of the social context to their experience of vaginismus, it encourages them to conform to a narrow understanding of sexual norms. She suggests that a sex therapist should explore alternative goals which prioritise and value the clients experience of "sexual meaning and fulfilment". For ter Kuille et al. (2013), however, an inadvertent consequence of taking the focus away the ability to have penetrative sex is the implicit fostering of avoidance regarding penetration behaviour. The authors argue that it therefore advisable to carry out exposure therapy whilst preserving a person-centred approach.

There is little research into how women manage vaginismus, and no known research specific to the experience of receiving psychosexual therapy for vaginismus. The mixed findings from RCT's also highlight a need to understand how women make sense of this experience. One UK based thematic analysis study explored women's experiences of vaginal dilator training (Macey, Gregory, Nunns and Das Nair, 2015). The study highlighted barriers into treatment, which included feeling of embarrassment around discussing sexual issues and a lack of understanding from health professionals. Women in their study also spoke about how emotionally demanding and challenging they found using dilators. A Grounded Theory study based in Ireland found that women who related to a psychological understanding of their difficulties had a more positive treatment experience, and this helped them to develop a connection between their thoughts, feelings and the body (McEvoy 2021 cited in McEvoy et al., 2021).

Another qualitative study involved the interviews of women with vaginismus about their experience of the 'overcoming process' and analysed the data through a feminist constructionist lens (Stelko, 2015). The women in this study reflected that having vaginismus allowed them to get to know their bodies in a way they may not have otherwise, experiencing this as an advantage. For example, one woman explained: "I think knowledge empowers you. Empowers us (...) as a group of women" (Stelko, 2015 p.43). This was experienced as more than general knowledge, instead becoming a personal experience of their own bodies. In regards to their experiences of pelvic floor exercise, many women in the study described this as being about more than relaxing their pelvic floor muscles, but relaxing 'their whole selves'(p.44), making relaxation a habit rather than an ability. Finally, an integrative review of the help seeking process for women with vaginismus emphasised how societal expectations impacted a women's sense of self. The authors identified the importance of normalising different types of sexual expression (Pithavadian et al., 2023).

Qualitative research, and Interpretative Phenomenological Analysis (IPA) in particular, can provide a greater insight into individual and shared experiences (O'Mullan Doherty, Coates & Tilley 2019). Whilst there is limited research around the experience of receiving psychological interventions for vaginismus, existing research into vaginismus highlights the complex relationship between psychological, social and cultural factors. Furthermore, IPA can provide a more authentic insight into how social and cultural factors may impact on how a women's makes sense of the therapeutic process for vaginismus (Smith, Flowers & Larkin 2009). For these reasons, this study will interview 8 women who have or have had vaginismus about their experience of psychosexual therapy, and IPA will be used to analyse data from the interviews. The research aims to contribute to process and outcome research. It also aims to inform practice, support professional's sensitivity to their client's experience, and guide them in tailoring their interventions for individuals.

Methodology

Haverkamp & Young (2007) describe a distinct characteristic of qualitative research as its ability to explore phenomena in depth. As a qualitative research approach, this study employed Interpretative Phenomenological Analysis (IPA), which is underpinned by three philosophical traditions: phenomenology, hermeneutics, and idiography (Smith, Flowers & Larkin, 2022). IPA allows individual and shared voices to be heard, and is therefore a useful approach for developing a more in-depth understanding of women's experiences of sexual difficulties, including vaginismus (O'Mullan, 2019). This study aimed to capture how women make sense of their experience of psychosexual therapy for vaginismus.

The study involved purposive sampling and seven woman who have previously received psychosexual therapy for vaginismus were recruited though an online support network for women with vaginismus. All participants had received six or more sessions of psychosexual therapy, either through the NHS, a sexual health charity or privately. The period of time since participants ended their psychosexual therapy ranged from 7 months to six years. Pseudonyms were used throughout to protect the participants' confidentiality and relevant demographic details for the participants in the study can be found in table 1 below.

Ethical approval was obtained from the Department of Psychology Ethics Committee at City University of London (ethics approval code: ETH2223-2302). The research followed the ethical guidelines set out by the BPS and HCPS. After expressing their interest in the study, participants were sent an information sheet providing them with more information about the study, as well as the opportunity to ask any questions. If they decided to take part in the study, they were then asked to sign a consent form. Data was collected through online one-to-one semi-structured interviews, which lasted between 50 and 80 minutes. Questions were open-ended and used as guide only to encourage participants to discuss what was important and meaningful for them. Regarding the reliability and validity of the research, it followed the criteria set out by Yardley (2000).

Table 1:

Pseudonym	Age range	Ethnicity	No. of sessions of psychosexual therapy received	Period of time since ending psychosexual therapy
Alex	25-30	White-British	Approx. 30 sessions	6 years
Tasha	30-35	Unknown	More than 100 sessions	4 years
Poppy	25-30	White-British	20 sessions	7 months
Lucy	30-35	Mixed White and Black Caribbean	6 sessions	9 months
Mya	25-30	Black British	7 sessions	7 months
Kate	25-30	White-British	8 sessions in an NHS clinic and 24 sessions with a private psychosexual therapist	8 months
Rhian	25-30	White-Welsh	Approx. 14 sessions	8 months

The analytic process followed guidelines set out by Smith et al., (2022). Regarding the commitment to idiograpy, each transcript was initially analysed individually. Preliminary observations were made whilst transcribing each interview. The first step then involved making descriptive, linguistic and conceptual comments for each interview, and the second stage involved identifying experiential themes to reflect the comments made. These were then clustered and renamed into Personal Experiential Themes (PETs) to represent shared patterns in the data. Finally, PET's were explored across cases and consolidated into Group Experiential Themes (GETs). Time was taken to ensure that each theme was grounded in the data, and that they were able to capture both the shared and individual experiences for women receiving psychosexual therapy for vaginismus.

Findings

The findings from this study provide an account of the experiences of women receiving psychosexual therapy for vaginismus. Table 2 presents the two distinct, but overlapping, Group Experiential Themes (GET's), and 8 sub-themes, which emerged from analysis. These are also supported by direct quotations from participant's accounts.

Table 2:

The Embodied Experience	**Living with Vaginismus**
"I was just trying to fix it"	"It doesn't mean you're broken"
"I felt like I didn't even have a vagina"	"It was the start of my whole journey"
"I felt like I had to overcome myself"	"I feel more confident in my ability to help myself"
"It's just like learning not to be hard on yourself"	"It's just nice to have people who have actually experienced it"

Group Experiential Themes are in bold with experiential subthemes below.

The Embodied Experience

This GET considers how participant's make sense of a mind-body connection for vaginismus, and their experience of being in and relating to their own bodies. It also captures the resistance many participants experienced around body focussed psychosexual exercises, as well as their changing relationship to them.

"I was just trying to fix it"

Many of the participants spoke about their hope or expectation that psychosexual therapy would “fix” or “cure” their vaginismus. This sub experiential theme captures participant’s experiences of understanding their vaginismus in physiological terms and their associated difficulties make sense of the potential role of psychology.

Kate, for example, explained her belief that if she could learn all about vaginismus, then she could “fix it”:

> *I am quite nerdy and (laughs) it was actually really interesting ummm to learn it and I felt like if it was something I could learn, then it was something that I could fix, so obviously that’s not really the same thing. (Kate, p.308-311)*

The use of the word “fix” also has connotations with a broken object, and I get the sense that Kate possibly felt like her vaginismus was something external, almost like it was happening to her. This feels similar to how people think of other physiological conditions, for example people may talk of “getting an infection”, and it suggests that Kate perceives her vaginismus in similar terms as something that she has got, and that she can get rid of or “fix”.

Mya also spoke about the way she made sense of vaginismus as a “physical problem”, and how she didn’t think psychological interventions were very helpful for its treatment:

> *I know like the research that we have, people will link it to the mind, they think it is a mental thing, I get that, but at the same time it is very much a physical problem, it is manifesting in a physical problem ummm....so yeah, I just...I just don’t think it is necessarily helpful in treating vaginismus. (Mya, p.16, 474-381)*

Whilst referring to research linking vaginismus to the mind, Mya states that she “gets that”, but explains that it is “manifesting as a physical problem”. I get the impression that Mya feels that her experience of vaginismus was misunderstood, and that she experienced a struggle to feel validated in a psycho-therapeutic environment.

Whilst Poppy also referred to her vaginismus as something that needed “fixing”, she also reflects on how she now understands it differently, as something to “overcome” instead:

> *I didn’t know it was a think three days ago so absolutely because if there is a way for*

> *me to understand what it is and ummm a way to overcome it which is how I've started saying instead of fixing it because there's nothing wrong with ...ummm then absolutely I want to do it. (Poppy, p.2, 26-30)*

Poppy's explanation that she has stopped referring to "fixing it" because there is nothing wrong with her suggests that now feels more conscious of the language she uses around her vaginismus. I get the impression that this helps her to feel more self-compassionate. Her use of the term "overcome" possibly indicates that Poppy is looking to have or feels more autonomy in the process.

"It felt like I didn't even have a vagina"

This experiential sub theme captures the way that participants described feelings of being disconnected from their bodies, including their vaginas, most commonly expressed by comments such as "it felt like I didn't even have a vagina".

For example, Tasha spoke about what her relationship to her body was like:

> *I later understood vaginismus women probably feel, not probably, certainly feel so much more disconnected with their bodies umm and you know I always kind of imagined that I don't really exist below my bel...my waist. I literally just kind of like no there's nothing there...vagina...no. You know like I was just this kind of like full of shame and umm something which doesn't belong to you at all (Tasha, p.8, 226-232)*

Tasha's reference to how women with vaginismus "certainly" feel disconnected from their bodies, indicates that this is also part of her experience, which is emphasised by her description of how she felt there was "nothing there…vagina…no". Her use of the phrase "full of shame" to describe her feelings towards her body evokes the sense that her shame took over everything, and made her want to disown her body, so that it was like it didn't "belong" to her.

Mya also mentions that it felt she "didn't even have a vagina" or a "vaginal canal" and explains that it was weird to find an "opening":

> *I sounds silly but I felt like I didn't even have a vagina, I didn't have a vaginal canal,*

> *it felt like it wasn't there so it was weird to like find this opening. (Mya, p13, 281-289)*

This highlights how, for Mya, it was not just about the experience of muscle tension in the vaginal wall, but it was also about acknowledging that her vagina and the "vaginal canal" existed, and knowing where it is.

Some participants also reflected on how therapy helped them to develop a sense of bodily connection:

> *If you had asked me three years ago like to talk about it this, I would have no idea what to say, like there is a very blury vision, picture or my vagina and my relationship with it, now it's not entirely crystal clear but getting there (Poppy, p.19, 730-739)*

Poppy's reference to how three years ago she would "have no idea what to say" emphasises her experience of change around her body, as well as her sense of this feeling specific and measurable in comparison to another period of time. Her use of the phrase "it's not entirely crystal clear but getting there" evokes the image of a picture coming into focus, and you get a visceral sense of this change for her, as well as how it is ongoing.

<u>"I felt like I had to overcome myself"</u>

This experiential subtheme reflects participant's experiences of a "block" or resistance within themselves surrounding body-focussed psychosexual exercises, and what it was like for participants to feel like they were not making progress.

Poppy describes how challenging she found the process of dilating:

> *when the issue and the block lies within yourself (inaudible) ummm it's a lot harder to face and a lot harder to do and so I struggled with the hardest...the hard...the easiest deadline that I can give myself I really struggled because I was like I feel like a pressure on myself (Poppy, P9, 202-209)*

It appears that Poppy experienced something within herself as an obstacle that she needed to overcome. I wonder if Poppy is referring to feelings of anxiety and fear around dilating, and this reflects her process of externalising fear. It appears that she felt more anxiety when under pressure to meet goals around dilating.

Mya reflects on how she felt about self-exploration:

> *I just, you know, having to really prep my mind, psyche myself up, take deep breaths. I think there was almost like a fear because I wasn't...I had no idea of like what the sensations were like down there, I was sort of scared I might hurt myself, things like that...I just felt very delicate and tender ummm ...so it was just weird. (Mya, p.13, 295-303)*

Mya identifies how her fear of exploring herself and dilating was linked to an uncertainty of what it would be like or how it would feel. She also identifies her fear of hurting herself, and her use of the words "delicate" and "tender" also give the impression of someone who is quite vulnerable. Mya's references to needing to "prep her mind" and "psyche" herself up in order to do the exercises, phrases usually associated with athletes before an event, highlights how challenging she found the exercises, alongside the courage she experienced in order to do them.

Tasha also describes her fear around using dilators.

> *She was trying to talk me into using dilators, which was so emotionally hard. I could not understand how you could even insert a dilator...it was just, it was just something I could not understand, I'm like this thing is not going anywhere near me. (Tasha, p.5, 147-150)*

Tasha reflects that she did not want a dilator to go "anywhere near" her, almost like to even be close to it felt anxiety provoking. You get a sense of her fear around dilating and how overwhelming this was for her.

"It's just like learning not to be hard on yourself"

This experiential sub-theme reflects participant's changing relationship to psychosexual exercises and making progress in therapy, including their increased acceptance of the challenges they experienced.

Lucy, for example, appears to feel less pressure around dilating:

> *Again, it made me feel more in control, it wasn't this thing that I had to do, it was something I could do when I felt like I wanted to, when I felt like I could, I could stop if I started and it didn't feel right (Lucy, p.17, 392-395)*

Lucy expresses that she felt more in control, and I get the sense that she felt like she had more agency around dilating. Lucy's explanation that she understood she was able to stop if it "didn't feel right", suggests that before this she felt that she should carry on despite discomfort. This indicates that she became more accepting of, and compassionate about the difficulties she experienced with dilating.

Rhian explains that before she would feel so "frustrated and so angry" with dilating:

> *it's just like learning not to be hard on yourself, and you know a bit of patience, it will happen and like I said there are other ways of like you know having pleasure and stuff, it doesn't have to be all about that so... (Rhian, p.26-27, 604-616)*

Rhian's appears to feel more acceptance of herself and the difficulties she experiences around dilating. It seems that her shift in thinking about sex has also helped her to respond more flexibly to challenges around dilating, and feel less pressure about making or maintaining progress.

Kate explains how her thinking shifted after combining dilating with enjoyable or pleasurable activities:

> *Cos you would combine it with something more fun and more pleasurable at least you didn't feel like...before when you'd try and use the larger size and it will just hurt and it will be horrible, at least it wasn't a complete loss. (Kate, p.40, 926-929)*

Her explanation that she no longer considered it a "complete loss" suggests that prior to this Kate made sense of dilating in "all or nothing" terms – as either good or bad. It appears that, like Rhian, Kate also felt more able to respond flexibly, and with greater acceptance, to painful or more difficult dilating experiences.

Living with Vaginismus

This GET captures what it has been like for participants to live with vaginismus, and how this changed during the course of psychosexual therapy. It reflects their experience of understanding the impact vaginismus had on their lives, as well as their increased self-acceptance and sense of empowerment.

“It doesn’t mean you are broken”

This experiential sub-theme captures participant’s experiences of low self-worth and beliefs that they were to blame for their difficulties with penetration. It also reflects the experience for some participants of becoming more accepting of themselves and their vaginismus during the course of psychosexual therapy, whilst acknowledging how this opportunity was missing for other participants.

Kate reflects on how psychosexual therapy helped her to understand that it didn’t mean she was “broken”:

> *A lot of it was learning stuff like well it doesn’t mean you’re broken, and although you still think that some days obviously but ummm and also she was quite good at not just talking about...I know this isn’t necessarily therapy therapy, but explaining like other sexual dysfunctions, or not even dysfunctions, but things people have with their bodies (Kate, p.21, 473-480)*

The word “broken” has connotations with an object that doesn’t work, and I wonder if Kate chose this word because of how she felt in the context of not being able to have penetrative sex. From this, I get the impression that Kate felt a sense of being objectified due to her difficulties with penetration, and that psychosexual therapy helped her to make sense of this by normalising sexual difficulties.

Lucy expresses what it was like to realise it wasn’t her “fault”:

> *So hearing that you know this can happen to any woman regardless of whether they’ve got any condition, ummm you know previously and it will just happen or it*

> *won't, and it's nothing I did you know, I didn't do anything that made it happen, it's just happening to you and ummm yes, it's not my fault really (laughs) (Lucy, p.10, 226-234)*

Lucy spoke about her experience of having vaginismus alongside a specific medical condition and it appears that she previously assumed her vaginismus was a result of this. She reflects on how "nice" it was to learn that it wasn't her "fault", and her laughter when she mentions this appears to reflect a release of tension, and possibly indicates how significant this felt.

Similar to Lucy, Poppy also spoke about understanding that it wasn't her fault: *"It's helped me understand that it's not something that I've done wrong I think, it's not something that happened to me because I did something bad" (Poppy, p.20, 469-471).* I get the impression that like Lucy, Poppy also felt a lot of shame and guilt around her difficulties with penetration, and that she felt able to make sense of and manage these feelings during psychosexual therapy.

Alex reflects on how it may have been helpful if she had been able to explore the impact vaginismus was having on her life:

"I think that it might have been, I think quite useful ummm in turns of like my behaviour at the time, maybe I would have been a bit less of a disaster (laughs) for a while" (Alex, p.35, 821-823).

It appears that Alex did not feel able to cope with her feelings around vaginismus, and its impact spread to other aspects of her life, such as her behaviour. I get the impression that she now feels frustrated and resentful that she did not have the opportunity to explore her feelings further in therapy.

"It was the start of my whole journey"

This experiential sub-theme captures participant's increased sense of comfort and confidence around sex and dating with vaginismus, which is commonly linked to their changing understanding of what sex is. However, it also reflects their mixed feelings around what this might look like in practice.

Lucy describes what it was like to feel like she was making progress in therapy:

> *It means everything, it was the start of my whole journey, without that therapy I wouldn't be...you know things like me and my partner have managed to attempt penetration a few times now, which is huge progress you know that's somewhere I never thought I'd be with vaginismus and without the therapy. (Lucy, p.33, 770-775)*

Lucy's reference to how therapy was the start of her "whole journey" provides a sense of her future opening up to her. She goes on to express that she has managed to "attempt penetration" with her partner a few times, and changes to the past tense to explain how she never expected this to be something she would be able to do. This appears to emphasise her shift in thinking towards what is possible, and in turn, provides sense of her feeling more positive about her future.

Kate explains that her fears around relationships were linked to her belief that she was "denying" the person something, and you get an idea of how social norms around sex meaning penetration impacted on her sexual self-esteem:

> *it was understanding a lot about a lot of my fears around relationships with it, and that does change day to day [...] I always felt like I was denying the person something, whereas now I feel that I have the confidence, although again not that I have done that in a while, but to be like well actually you're also...this is also great for you. (Kate, p.24-25, 554-582)*

Whilst Kate reflects that now she feels she has the "confidence" to know it could be great for them too, she reiterates how her feelings around this "change day to day". I get the impression that she is keen for me to know that her worries haven't gone away, and I wonder if she is concerned about what it might mean to trust that dating could be okay.

Poppy also expresses her mixed feelings towards dating in the future:

> *I do occasionally have moments when I'm like oh god I'm never going to meet anyone, If I do they are only going to want to have penetrative sex. There are moments when I'm like, I am never going to meet anyone who is going to be understanding, and then I'm kind of like well lurve off, you will, you're fine, chill (Poppy, p.40, 944-949)*

Poppy is reflecting on her concerns about meeting someone in the future who is understanding about her vaginismus, and accepting of different ways of having sex. She appears to be describing her internal thought processes, which reflect a dialogue between her negative assumptions about the future and her self-encouraging responses to these. I get the sense that whilst she feels quite anxious about dating in the future, she also experiences self-compassion, and this helps her to manage her anxiety.

"I feel more confident in my ability to help myself"

Reflecting their sense of accomplishment and empowerment from the experiential knowledge they gained, this subtheme captures the participant's experiences of feeling more capable and confident to cope with and manage their vaginismus by themselves

Tasha considers how therapy helped her to feel more able to manage her vaginismus:

> "*something which sort of like organises your vaginismus in your head, sort of like... sort of like builds up this little path and like sort of gives you the idea of what you should do" (Tasha, p.26, 814-816).*

This powerful representation of what therapy meant for her evokes the idea of something becoming decluttered and, in turn, less overwhelming. There is something quite hopeful about this image, almost like therapy helped her to see a way through.

Rhian expresses her surprise that she hasn't "fallen of the sort of like wagon":

> *I thought it would have been the case that I would have fallen off the sort of like wagon a little bit and gone back to square one, but I haven't and ummm yeah I still like really look after myself that kind of way. (Rhian, p.23 550-555)*

She appears to be comparing her experience to those managing problems with addiction, and this suggests she understands the process of managing vaginismus to be ongoing and to require hard work and commitment. It also gives the impression that she feels quite proud of herself for continuing to manage vaginismus by herself.

Describing what it was like to tell her mum about her vaginismus for the first time, Poppy also identifies what she was able to get out of therapy:

> *It was almost like I was this fountain of knowledge about vaginismus, when like six months before hand I actually had no idea what it was ummm, and I just kinda got into It, and just really started talking about it (Poppy, p.20 453-456)*

Poppy highlights how much knowledge she gained through therapy by making a comparison to herself six months before when she had "no idea". Her description of herself as like "a fountain of knowledge", with its positive connotations of release, plenty and abundance, emphasises how valuable, and possibly cathartic the experience of sharing her knowledge felt. I get the impression that she also felt empowered by this experience.

Discussion

Vaginismus in an under-researched area of sexual health (Laskowska and Gronowski, 2022), and consequently there is little research exploring women's experiences of communicating their difficulties, and receiving support. However, vaginismus has similar social consequences to sexual pain problems such as dyspareunia and vulvodynia due to its impact on a women's ability to engage in or enjoy penetrative intercourse. This section will therefore contextualise the findings from the current study with existing literature around vaginismus, and when relevant, with findings from the wider sexual pain literature.

The Embodied Experience

In their Grounded Theory study, Koops and Briken (2021) explored the experience of 18 women with either dyspareunia or vaginismus (sexual pain or difficulties with penetrative intercourse). The authors described the participant's experiences of *othering the body*;

locating their ‘self’ in their heads, whilst bodily processes were construed as outside of their control. In the present study, many of the participants spoke about going into therapy with the notion of ‘fixing’ or ‘curing’ their vaginismus, indicating their understanding of vaginismus as a physical problem, and giving a sense of them externalising or objectifying their difficulties. However, some participants also reflected on their experience of becoming more open to a psychologically informed understanding of vaginismus. In a Grounded Theory study exploring the experiences of women with vaginismus and their partners, as well as health professionals who support women with vaginismus, McEvoy (2021 cited in McEvoy et al., 2023) highlighted that the couples interviewed indicated a “turning point in their journey” where they began to understand vaginismus as a “physical manifestation of something psychological”.

In the present study, women described their experiences of feeling disconnected from their bodies and more specifically, their genitals. Both qualitative and quantitative studies have reported that women with vaginismus and dyspareunia (term used GPPPD) are more likely to demonstrate greater difficulties with perception and experiences of their bodily self when compared to a group of women without sexual difficulties (Koops & Briken, 2021; Shallcross et al., 2018). Participants also struggled to make sense of and articulate their experiences of disconnection. Kaler (2006) suggests that, for women experiencing difficulties around penetration, a mind-body split may develop from their wish to “disconnect their troubled body from the real, essential self” (p.67).

Some participants in the present study also reflected on their experience of developing a connection with their bodies during the course of psychosexual therapy, identifying the potential helpfulness of psychosexual therapy for supporting woman to manage dissociative experiences around their bodies. An increased awareness of and sense of connection to the body are also important aspects of mindfulness-based treatments for sexual pain (Brotto, Basson, Carlson and Zhu 2013).

Dilators are considered to be an important aspect of the “overcoming process” for women experiencing vaginismus (Stelko, 2015; Pacik, 2014). Macey at al., (2015) reported on how emotionally hard women found the experience because they had to face the reality of their penetration difficulties. In the present study, participants similarly described how challenging they found using dilators, this included references to experiencing a “block within" and needing to "overcome" themselves. Feelings of fear around dilating also appeared to an important aspect of this experience. Svedhem et al., (2013) similarly identified fear, and specifically fear of pain, as an important aspect of the experience of living with vaginismus. Incorporating theory from Compassion Focussed Therapy (CFT), Vosper et al., (2023) hypothesise that women experiencing pain with penetration might have an over active Threat system and down regulated Soothing and Drive system associated with sex.

For the participants in the study carried out by Macey et al., (2015), treatment using dilators required time and commitment, which participants found especially difficult to maintain when they did not make progress, or progress was slow. Many of the participants in the present study also reflected on their experience of frustration around not making progress, however, for some participants this also involved becoming more accepting that progress was not what they expected it to be like, and less self-critical of the difficulties they faced. Vosper et al., (2023) argue that integrating Compassion Focussed Therapy with more traditional psychosexual therapy can help individuals develop a more compassionate attitude towards their difficulties, allowing them to make the steps towards improving their sexual wellbeing. The authors highlight how self-criticism can hinder progress in psychosexual behavioural tasks, such as using vaginal dilators, and working with the inner critic (an important aspect of CFT) may be helpful and improve motivation for engaging in these exercises.

Living with Vaginismus

All of the participants spoke about the impact of vaginismus on their sense of self, and many of the participants reflected on how they were able to understand and manage this during the course of psychosexual therapy. In their IPA study, Svedhem et al., (2013) described the participant's experiences of feeling like a "failure as a person", and Ward and Odgen (1994) also reported their participants experiences of low self-esteem and poor self-worth. Engman et al., (2010) explored levels of self-worth for participants before and after a CBT intervention for vaginismus, and reported higher levels post treatment, however, this is the only known intervention study examining changes in self-worth for women with vaginismus. Furthermore, no known qualitative studies have explored the experience of self-to-self relating and psychosexual therapy or help seeking for women with vaginismus (Pithavadian et al., 2023). In the present study it appears that a validating and supportive therapeutic environment, as well as normalising vaginismus and other sexual problems, were both helpful for participants in managing their feelings of shame and self-criticism. Vosper at al., (2023) also highlight the important process of providing a “normalising and non-shaming” formulation for people with sexual problems so that they are able to develop a more compassionate perspective towards their difficulties.

Kaler (2006) identifies a prevailing discourse around sex that implies vaginal intercourse is ‘real sex’, and in her study, women understood intercourse “as the essence of being heterosexual”. A number of participants in the present study reflected on their changing attitudes around sex, specifically their understanding that sex could mean many things, and not just penetrative intercourse. They reflected on how this encouraged them to feel more comfortable with the idea of dating in the future. Some women in the study carried out by Svedhem et al., (2013) and Kaler (2006) described their experiences of challenging discourses around sex, and being able to enjoy other types of sexual activity, which they also considered to be ‘real sex’. Svedhem et al., (2013) argue that if there existed a sexual norm that sex could be great in many different forms, then women with vaginismus may not feel like they were failing, and would be likely to experience more self-worth as a woman and a sexual partner. Similarly, Vosper et al., (2023) highlights the benefits of integrating a critical systems approach within a CFT informed psychosexual therapy, with its focus on the experiences of shame associated with sexual difficulties, and on whether they even need to be considered sexual problems at all.

Many of the participants in the present study also spoke about feeling more capable and empowered in regards to managing vaginismus, which they associated with the knowledge they gained about vaginismus and its treatment. Macey et al., (2015) also reported that women felt their treatment journeys left them with a “wealth of knowledge”. A sense of control over their own recovery also appeared to be important for them, and they identified that telling others about what facilitated their progress helped them to experience this. In addition, Stelko (2015) highlighted the importance of knowledge about vaginismus for women in her study, explaining that it provided them with information about what was happening during attempts at penetration. Stelko (2015) describes how women continued gathering knowledge, especially around anatomy of the reproduction system, throughout the process of managing and overcoming their vaginismus. Similar findings have been also been reported by qualitative studies exploring the experience of living with genital and sexual pain. Sadownik, Seal & Brotto (2012) identified the increased “sense of empowerment” for participants who engaged in a multi-disciplinary group intervention for vulvodynia, whilst

Brotto et al., (2013) identified an improved “sense of self-efficacy” for participants engaging in a similar type of group intervention.

Participants in the present study reflected on how managing their vaginismus involved taking responsibility and hard work, as well as their associated sense of pride and accomplishment when they made some progress. Stelko (2015) described similar experiences for women in her study, reporting on their perception of the overcoming process as “hard and long”, as well as how they encouraged each other to feel “proud of themselves after every accomplishment” (p.46). Furthermore, Macey et al., (2015) recommend the potential helpfulness of considering self-efficacy models for psychological interventions supporting women with vaginismus.

Implications for clinical practice

Alongside the current study, a number of other studies exploring heterosexual women’s experiences of sexual pain and vaginismus have reported on the negative consequences of social narratives and constructs around sexuality, such as the prioritisation of penetrative sex, for how women feel and think about themselves. The findings highlight the potential benefit of discussions in the therapeutic setting, which re-examine and re-evaluate social constructs around sex and gender, and reflect of different forms of sexual expression. Pithavadian et al., (2023) states how this could “strengthen a women’s sense of self to believe in themselves, even when the treatment journey is trying” (p.15). This could, for example, involve integrating techniques from narrative therapy (White, 2007) - a constructionist approach - into a more traditional CBT based psychosexual therapy.

The findings also indicate the potential of supporting woman in fostering a self-compassionate perspective during the process of managing and overcoming vaginismus. It may therefore be beneficial for psychosexual practitioners and counselling psychologists to integrate compassion focussed therapy (CFT) exercises into other psychosexual interventions, such as those challenging self-criticism and shame, which may be part of a woman’s experience of vaginismus. Vosper et al., (2023) have identified the potential of this for women experiencing pain with penetration, and a recent intervention indicated that it may be a valuable integration to CBT-based psychosexual (Saunders et al., 2022).

Findings from the current study identify the experience for some participants of feeling capable and empowered to continue managing vaginismus by themselves, suggesting the potential value of considering self-efficacy models when working with woman experiencing vaginismus. Brotto et al., (2013) conducted a qualitative study to explore the experience of women who took part in a multi-disciplinary intervention for support with their experience of genital and sexual pain. One of the main gals of the intervention was to develop self-efficacy, which included instilling hope that women could play an active role in coping with and manging their pain. The authors reported increased self-efficacy in the narratives of women taking part in the study, and alongside the findings from the present study, this indicates the potential value of similar interventions for women experiencing vaginismus.

Reflecting their embodied experience, participants described a sense of disconnection from and an objectification of their bodies. A finding that has been consistently found in other qualitative studies exploring women's experience of sexual pain and difficulties with penetration (Shallcross et al., 2018; Koops & Birkin, 2021). Whilst using dilators appears to be a consistent element of psychosexual therapy for vaginismus, these findings point to the benefits of further therapeutic exercises involving the body, such as sensate focus exercises, in the treatment of vaginismus (Avery-Clark, Weiner, & Adams-Clark, 2019).

Strengths and limitations

This study used purposive sampling, and, whilst there is diversity in the self-selecting sample with regards to racial background, it does not include any Asian women or women from minority ethnic backgrounds, and therefore cannot be said to reflect the general population of women with vaginismus. Furthermore, participants in the study were self-selecting, and due to the significant number of responses I received from an initial email, all participants were selected from a single support network. Consequently, it is possible that this group of participants are more aware and reflective of relevant issues and shared experiences around vaginismus, and its treatment. Whilst it is possible to suggest potential ways of working with woman experiencing vaginismus, and ideas for future research, it is not possible to make broader claims based on results from this study.

In addition, the severity of vaginismus for each participant is also not known. It is therefore possible that women with more severe or lifelong vaginismus may have different experiences of psychosexual therapy compared to women with less severe or secondary vaginismus, and therefore any differences in these factors may have complicated the findings. A group of participants who all received psychosexual therapy for lifelong vaginismus may produce a different pattern of data. Nevertheless, taking into account some variation, participants in the study did report common experiences of receiving psychosexual therapy. Finally, IPA research is not able to provide any causal explanations for participant's experiences, for example, why particular experiences emerged, as well as how historical, cultural or social factors may have contributed to them (Willig, 2022).

This is the first known qualitative study to specifically explore the experience of receiving psychosexual therapy for women with vaginismus, and it therefore provides valuable information about the kind of challenges women may experience, as well as how they may benefit from the support they receive. It allows for the voice of women with vaginismus to be heard, which is significant as vaginismus is an under-researched area of female sexual health. A further strength of this study was its ability to identify participant's experiences of challenging social discourses around what sex means, and how doing so changed the way they related to themselves and made sense of vaginismus. This can be viewed in comparison to intervention research for vaginismus, which priorities the ability to have penetrative sex as the primary outcome evaluated.

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Appendix k

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