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Multifactorial Evaluation of Vaginismus: Psychiatric Comorbidity, Personality Traits, and Psychosocial Correlates in a Preliminary Study

Necla Keskin Özdemir*, **Mehmet Diyaddin Güleken**

University of Health Sciences, Diyarbakır Gazi Yasargil Training and Research Hospital, Department of Psychiatry

ABSTRACT

To explore potential etiological factors in patients diagnosed with vaginismus, compare them with controls without lifelong vaginismus and/or painful sexual activity, and evaluate sexual satisfaction in both groups.

The study included 12 patients with vaginismus and 12 controls. A demographic and clinical data form was completed, and the Structured Clinical Interview for DSM-IV – Axis I disorders (SCID-I) was conducted. All participants completed the Eysenck Personality Questionnaire Revised-Abbreviated Form (EPQR-A), Childhood Trauma Questionnaire-28 (CTQ-28), Experiences in Close Relationships-Revised (ECR-R), and Golombok Rust Inventory of Sexual Satisfaction (GRISS).

Vaginismus patients were more likely to live in rural areas and extended families ($p<0,05$), had less adequate sexual education (often from friends, $p<0,05$), and half associated intercourse with pain, unlike controls who viewed it as a necessity. The vaginismus group had higher EPQR-A lying subscale scores ($p=0,033$). No differences were found in attachment styles or childhood trauma. The vaginismus group scored higher on the GRISS vaginismus subscale and overall scores ($p<0,05$).

Sexual experiences are shaped by sociocultural, psychological, and relational factors, underscoring the need for culturally sensitive, couple-focused interventions and comprehensive sexual health education. Routine assessment of sexual function during psychiatric evaluations, including psychological interventions and partner sexual health screening, is essential, as untreated sexual issues may persist in individuals without lifelong vaginismus.

Keywords: Vaginismus, comorbidity, childhood trauma, attachment

Introduction

Vaginismus is a type of genito-pelvic pain/penetration disorder characterized by persistent or recurrent difficulties in vaginal entry (1). It is associated with actual or anticipated pain and fear of vaginal penetration (2). It is estimated that vaginismus affects 1–7% of the female population worldwide, and the rate rises to between 5–17% in clinical settings (3,4). Vaginismus is the most prevalent female sexual dysfunction among Turkish women seeking sexual therapy, and cultural factors seem to play an important role in this situation (5).

The etiology of vaginismus remains unclear. Physical, organic, psychological, and sociocultural factors can contribute to the development of vaginismus (5-7). Vaginismus is associated with negative sexual attitudes, lack of sexual knowledge, psychological and/or physical trauma, sexual abuse, family history, relationship difficulties, fear and anxiety, phobic reactions, and sociocultural factors (5-7). Among the proposed etiological determinants, psychological and sociocultural factors have the strongest empirical support (5-7).

Fear and anxiety play a central role in vaginismus, with clinical features similar to a specific phobia characterized by conditioned fear, avoidance, and panic-like responses to vaginal penetration (6). Evidence indicates that the fear of pain is the predominant underlying factor (6). Sociocultural factors, such as restrictive attitudes toward female sexuality, sexual myths, emphasis on virginity, and inadequate sexual education, contribute to its development (5-7). Although relationship issues and partner sexual dysfunctions are often seen in vaginismus, current evidence does not demonstrate a clear etiological link between vaginismus and couple relationship factors (7). Likewise, sexual and/or physical abuse has been suggested as a cause, but findings are

***Corresponding Author:** Necla Keskin Özdemir, Diyarbakir Gazi Yasargil Training and Research Hospital, Department of Psychiatry, Diyarbakir, Turkey
E-mail: neclakeskin@yahoo.com.tr, Phone: 0 (532) 390 47 65
ORCID ID: Necla Keskin Özdemir: 0000-0003-3595-0746, **Mehmet Diyaddin Güleken:** 0000-0001-7861-6882
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inconclusive—most studies do not show increased prevalence, and only limited evidence shows a possible connection, highlighting the need for larger studies with well-defined measures (7).

The results of studies evaluating comorbid sexual dysfunctions in patients with vaginismus are contradictory. Contrary to studies reporting that women with vaginismus can have a satisfactory sexual life, several studies have found that the frequency of sexual dysfunction increases in vaginismus (8-10). On the other hand, some studies have suggested that other sexual dysfunctions seen in vaginismus occur secondary to chronic vaginal penetration difficulties (8-10).

Few studies have examined the interplay of sociocultural influences, psychiatric comorbidities, and sexual satisfaction in vaginismus within a Turkish cultural context using standardized psychometric instruments. To address this gap, we adopted a multidimensional, controlled design integrating psychological, sociocultural, and relational variables. The study aimed to investigate potential etiological determinants—including demographic characteristics, psychiatric comorbidities, personality traits, childhood trauma history, and attachment styles—in women diagnosed with vaginismus compared with controls without lifelong vaginismus and/or painful sexual activity, as well as to evaluate sexual satisfaction between the groups. We hypothesized that women with vaginismus would exhibit higher psychiatric comorbidity, greater exposure to psychosocial risk factors, and lower sexual satisfaction than controls.

Materials and Methods

Compliance with Ethical Standards: The study protocol was approved by the institutional review board (Van Training and Research Hospital Clinical Trials Ethics Committee, approval date: 14.12.2017; number: 2017/10) and the study was conducted following the principles outlined in the Declaration of Helsinki.

Study Setting and Subjects: Participants were recruited from the outpatient psychiatry clinic between January 2018 and January 2019. The study sample consisted of 12 women diagnosed with vaginismus and 12 control participants without a history of vaginismus and/or painful sexual activity. Inclusion criteria for the vaginismus group were: (1) a diagnosis of primary vaginismus according to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR); (2) admission to the outpatient psychiatry clinic; (3) at least a primary level of education to ensure comprehension of self-report measures; and (4) provision of written informed consent. Inclusion criteria for the control group were: (1) no lifetime history of vaginismus or painful sexual activity; (2) matching with the vaginismus group in terms of age, marital status, and educational status; (3) at least a primary level of education; and (4) provision of written informed consent. Current use of psychotropic medications was an exclusion criterion for both the vaginismus and control groups. Eligible hospital staff and their relatives who met the inclusion criteria were recruited as the control group. Although the DSM-5 was available at the time of the study, DSM-IV-TR criteria were used to ensure diagnostic consistency, as psychiatric comorbidities were assessed using the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I). In addition, DSM-5 conceptualizes vaginismus and dyspareunia under the single category of Genito-Pelvic Pain/Penetration Disorder, whereas the use of DSM-IV-TR criteria allowed for separate evaluation.

Procedures and Assessment Instruments: The study is a case-control trial aimed at comparing patients with vaginismus to controls regarding sociodemographic features, personality traits, attachment styles, history of childhood trauma, and sexual satisfaction. After providing written informed consent, a demographic and clinical data form was completed, and the Structured Clinical Interview for DSM-IV – Axis I disorders (SCID-I) was administered by staff psychiatrist to determine comorbid Axis I psychiatric disorders (11,12). The psychiatric and medical history of patients were obtained through patient interviews, hospital records and national electronic health system. Subsequently, all patients and controls completed the self-report questionnaires [Eysenck Personality Questionnaire Revised-Abbreviated Form (EPQR-A), Childhood Trauma Questionnaire-28 (CTQ-28), Experiences in Close Relationships-Revised (ECR-R), and Golombok Rust Inventory of Sexual Satisfaction (GRISS)] in a single session under clinical supervision.

The Sociodemographic and Clinical Data Form was developed by researchers and used to collect information on participants' sociodemographic characteristics, medical and psychiatric history, marital features, sexual development, sexual education, and sexual experiences. The form also assessed perceptions

of marital relationship quality, body satisfaction, and emotional responses related to sexual activity.

EPQR-A is a self-report inventory that consists of 24 items and four subscales measuring neuroticism, extraversion, psychoticism, and lying (13). The internal consistency, test-retest reliability, and validity of the Turkish version of EPQR-A have been demonstrated (14).

CTQ-28 is a self-administered, Likert-type scale that retrospectively assesses childhood traumas across five domains, including emotional, physical, and sexual abuse as well as physical and emotional neglect. It also includes three additional questions that evaluate minimization or denial, which do not influence the total score (15). Validation and reliability studies of the Turkish version of CTQ-28 have been conducted (16). The cut-off values are determined as follows: The cut-off values are determined as: >5 points for physical and sexual abuse, >7 points for emotional abuse and physical neglect, >12 points for emotional neglect, and >35 points for total score.

ECR-R is a 36-item, self-report questionnaire that measures adult attachment styles across two subscales: avoidance and anxiety. The ECR-R scale developed by Fraley et al. (2000) was translated and adapted into Turkish by Selçuk et al. (2005). Scores for the dimensions are calculated by averaging the items under each one (17,18).

GRISS is a 28-item self-report questionnaire that assesses the existence and severity of sexual problems (19). The questionnaire is available in both male and female forms. The female version provides a total GRISS score along with subscales for anorgasmia, vaginismus, non-communication, infrequency, avoidance, nonsensuality, and dissatisfaction. After converting the raw scores into standard scores, subscales that score 5 points or above indicate sexual dysfunction and reduce the quality of intercourse (19). The Turkish version of GRISS has demonstrated high reliability and good validity for both the overall scales and the subscales (20).

Statistical Analysis: The data were evaluated using the SPSS for Windows 21.0 statistical package program. Descriptive statistical analyses were conducted to assess the sample group. Frequencies and rates of categorical variables were determined. Chi-Square tests were used for the comparison of categorical variables, and the t-test was utilized to compare parametric continuous variables if the sample is normally distributed. The assumption of normality was tested through the examination of the Shapiro-Wilk test. In the event of a normality violation, and hence if the sample is not normally distributed, the Mann-Whitney U test is employed to compare differences between two independent groups when the dependent variable is ordinal or continuous. All p-values were two-tailed, and statistical significance was set at $p < 0,05$.

Results

The mean age and average age of marriage were 24,33±3,57 and 22,67±3,89 years, respectively, for women with vaginismus. There was no statistically significant difference between the vaginismus and control groups regarding age, years of education, employment status, economic status, history of physical illness, medication use, and family history of psychiatric disorders. The rate of residing in rural areas and living in an extended family unit lifetime was significantly higher in the vaginismus group ($p<0,05$). Although there was no statistically significant difference in financial status between the groups, the number of women reporting their income as sufficient was lower in the control group, reaching a statistically significant level ($p=0,035$). The detailed comparison of the socio-demographic characteristics of the groups is presented in Table 1.

The marital characteristics and sexual history of patients were compared with those of controls. The groups showed no differences in terms of age at marriage, partner's age at marriage, duration of marriage, time from first meeting to marriage, age of sexual education, age at first non-penetrative sexual activity, and age of menarche. No significant differences were found between the groups regarding having a regular menstrual cycle, prior knowledge of menstruation before menarche, and experiencing fear during the first menstruation. Although a higher proportion of individuals in the vaginismus group reported not using any contraception method, the difference between the groups was not statistically significant. None of the patients with vaginismus indicated that they married solely based on their family's decision, while two control subjects married against their will; however, this difference was not statistically significant. The groups did not differ in family attitudes toward sexuality, premarital sexual experience, premarital sexual problems, belief in preserving virginity until marriage, attitudes toward masturbation, sexual experiences on the wedding night, communication with partners about sexuality, self-reported

Table 1: Comparison of the Socio-Demographic Characteristics of Patients With Vaginismus and The Control Group

	Vaginismus	Control Group	P
Mean age (years) (mean ± SD)	24,33±3,57	26,5±3,77	0,163ᵗ
Education years* (median)**(25-75)***	11(8-15)	15(8,75-15)	0,339*
Economic status (N(%))			
Low	2(16,7)	0(0)	0,104ˣ
Mid	6(50)	3(25)	
High	4(33,3)	9(75)	
Employment			
Employed	7(58,3)	9(75)	0,386ˣ
Unemployed	5(41,7)	3(25)	
Finding the income sufficient	10(83,3)	5(41,7)	0,035ˣ
Place of birth			
Village	2(16,7)	3(25)	0,673ˣ
Town	5(41,7)	3(25)	
City	5(41,7)	6(50)	
Place of residence (mostly)			
Rural	6 (50)	1 (8,3)	0,025ˣ
Others	6 (50)	11(91,7)	
Family unit			
Nuclear	6(50)	12(100)	0,018ˣ
Extended	5(41,7)	0(0)	
Others	1 (8,3)	0(0)	
History of physical disorders	1(8,3)	1(8,3)	1,000ˣ
Family history of psychiatric disorders	3(25)	1(8,3)	0,273ˣ
Smoking cigaratte	1(8,3)	4(33,3)	0,132ˣ

Bold values indicate significance of p<0,05. SD: Standard Deviation ᵗStudent t test. ˣChi-square (χ^2) test *Mann Mann-Whitney U test. Median**. (25 percentiles-75 percentiles) ***

frequency of sexual intercourse, and orgasm. The percentage of participants reporting sufficient sexual education/information was significantly higher in the control group (p=0,041). Friends were identified as the main source of sexual information in the vaginismus group, while books, along with school and teachers, were the predominant sources in the control group. The difference between the groups was statistically significant (p=0,017). While half of the patient group associated sexual intercourse with pain and discomfort, half of the control group viewed sexual intercourse as a necessity. The groups did not differ in their perceptions of physical and mental health, as well as body satisfaction. While vaginismus patients described their marital relationship as very good, the majority of the healthy group rated their marital relationship as good. The difference between the groups was close to statistical significance. A quarter of patients with vaginismus believed that sexual intercourse was necessary on the first night of the wedding, and the same proportion of patients stated that they did not engage in sexual activity, showing no difference compared to healthy controls. The majority of patients and controls reported being satisfied with their appearance and femininity. 91.7% of controls indicated they were satisfied with their sexual life, and the difference between the groups was statistically significant (p=0,000). Most patients and controls reported that they did not masturbate after marriage, that their spouses generally initiated the relationship, and that they expressed their sexual desires. Women with vaginismus noted that their partners thought more about them in the relationship; however, controls reported that their partners also cared about them, with no statistically significant difference between the groups. 16.6% of patients with vaginismus and healthy controls reported never having an orgasm, while most members of both groups agreed that orgasm was important to

Table 2: Comparison of Marital and Sexual Features of Patients With Vaginismus and The Control Group

	Vaginismus	Control	p
Age of marriage (years)* (median)** (25-75)***	21(21-23)	24(21,25-26)	0,266*
Duration of marriage (years) (mean ± SD)	17,92±16,77	25,75±22,34	0,342[t]
Age of partner at marriage	27,58±4,73	27,08±2,90	0,758[t]
The duration from the first meeting to marriage	21,08±26,01	17,25±14,30	0,659[t]
Age of education on sexuality	19,45±5,16	16,67±2,49	0,110[t]
Age at first non-penetrative sexual activity	21,75±4,39	22,64±3,72	0,609[t]
Age at menarche	13,64±1,36	13,83±0,83	0,677[t]
Having a regular menstrual cycle	7(58,3)	10(83,3)	0,178[x]
Knowledge about menstruation before menarche	7(58,3)	10(83,3)	0,178[x]
Fear at first menstruation	6(50)	5(41,7)	0,726[x]
No contraception	8(66,7)	3(25)	0,077[x]
Sufficient premarital sexual education/information	3(25)	8(66,7)	0,041[x]
Source of sexual knowledge			
Family	2(16,7)	1(8,3)	
Friends	6(50)	2(16,7)	0,017[x]
School and teachers	0(0)	4(33,3)	
Books	1(8,3)	5(41,7)	
Others	3(25)	0(0)	
Initial associations with sexual intercourse			
Pleasure	2(16,7)	4(33,3)	
Necessity	1(8,3)	6(50)	
Pain/Discomfort	6(50)	1(8,3)	0,019[x]
Fear	3(25)	0(0)	
Others	0(0)	1(8,3)	
Wedding night			
Unable to engage in sexual intercourse	12(100)	3(25)	0,001[x]
Unable to continue due to pain and bleeding	0(0)	5(41,7)	
Experienced pleasure and reached orgasm	0(0)	4(33,3)	
Perception of one's marital relationship			
Very good	8(66,7)	5(41,7)	
Good	2(16,7)	7(58,3)	0,065[x]
Moderate	2(16,7)	0(0)	
Body satisfaction	9(75)	11(91,7)	0,465[x]
Satisfied with being a woman	11(91,7)	9(75)	0,333[x]
Satisfied with one's sexual life	2(16,7)	11(91,7)	0,000[x]
Feeling after sexual intercourse			
Relaxed	4(33,3)	11(91,7)	
Tense	5(41,7)	0(0)	0,016[x]
Dirty	1(8,3)	1(8,3)	
Guilty	2(16,7)	0(0)	

Bold values indicate significance of p<0,05. SD: Standard Deviation [t]Student t test. [x]Chi-square (χ^2) test *Mann Mann-Whitney U test. Median**. (25 percentiles-75 percentiles) ***

both partners. Although most controls reported feeling relaxed after sexual intercourse, approximately half of the women with vaginismus reported feeling tense, demonstrating a significant

Table 3: Psychiatric Comorbidities In Patients With Vaginismus and The Control Group

	Vaginismus	Control
Generalized anxiety disorder, current (N(%))	1(8,3)	0(0)
Generalized anxiety disorder, lifetime	1(8,3)	0(0)
Specific phobia, current	3(25)	0(0)
Specific phobia, lifetime	3(25)	0(0)
Unspecified anxiety disorder, current	2(16,7)	0(0)
Unspecified anxiety disorder, lifetime[a]	4(33,3)	0(0)

[a]Statistical analysis was not applicable due to to the presence of a zero count in control group

Table 4: Psychometric Properties of the Sample Group

	Vaginismus	Control	P[t]
EPQR-A (mean±SD)			
Neuroticism	4,08±1,83	4,33±1,61	0,726
Extraversion	3,41±1,78	3,0±1,04	0,492
Psychoticism	2,16±1,02	2,25±1,42	0,871
Lie* (median) (25-75)	5(4-5)	2,5(1-4,75)	0,033*
ECR-R (mean±SD)			
Avoidant	2,94±0,92	2,66±1,13	0,600
Anxious	3,72±0,90	3,48±1,21	0,513
GRISS (mean±SD)			
Infrequency	5,08±1,97	4,08±1,37	0,165
Non-communication	2,25±2,52	2,33±1,66	0,925
Avoidance	6,08±4,99	4,08±2,87	0,242
Non-sensuality*	5,5(3-6)	4(3-7,25)	0,662*
Dissatisfaction	5,25±4,15	4,25±3,07	0,510
Vaginismus	12,83±2,94	6,25±2,05	0,000
Anorgasmia	7,91±4,48	6,25±2,56	0,275
Total	43,83±12,88	31,33±10,53	0,016
CTQ-28 (n/%)			
Emotional abuse	2(16,7)	3(25)	0,615
Physical abuse	0(0)	3(25)	0,064
Sexual abuse	2(16,7)	3(25)	0,615
Physical neglect	2(16,7)	4(33,3)	0,346
Emotional neglect	1(8,3)	2(16,7)	0,537
Total	1(8,3)	3(25)	0,273

Bold values indicate significance of p<0,05. SD: Standard Deviation. [t]Student t test. [x]Chi-square (χ^2) test [*]Mann Mann-Whitney U test. Median[**]. (25 percentiles-75 percentiles) [***]

EPQR-A: Eysenck Personality Questionnaire Revised-Abbreviated Form, ECR-R: Experiences in Close Relationships-Revised, GRISS: Golombok Rust Inventory of Sexual Satisfaction, CTQ-28: Childhood Trauma Questionnaire-28. The cut-off values are determined as: >5 points for physical and sexual abuse, >7 points for emotional abuse and physical neglect, >12 points for emotional neglect, and >35 points for total score.

difference between the groups (p=0,016). Table 2 presents a comparison of the marital features and sexual history of the groups.

No participant in the control group met criteria for any psychiatric comorbidity based on the SCID-I; therefore, a statistical comparison between groups regarding psychiatric diagnoses could not be performed. This limitation is likely related to the small sample size, and future studies with larger samples are warranted to clarify group differences in psychiatric comorbidity. Descriptive statistics of psychiatric comorbidities assessed using SCID-I are presented in Table 3. Notably,

none of the participants were admitted for psychiatric treatment.

When the treatment applications of patients with vaginismus were examined, it was found that 91.7% of the patients deemed spousal support sufficient. More than half of them sought treatment without a referral and discussed the issue with others, except partner. Almost half of the patients attended their first polyclinic visit alone. It was noted that 66.7% of the patients described their spouses as consoling and highly empathetic. The patients reported decreased sexual desire and arousal, and one-third of their spouses had sexual dysfunction.

The psychometric properties of patients compared with controls. No notable differences were observed between the groups in terms of personality patterns. However, the lying subscale score of the EPQR-A was significantly higher in the patient group (p=0.033). Regarding the CTQ-28 subscales, there was no significant difference between the groups. No differences were detected in attachment styles as assessed by the ECR-R. The total GRISS score and the scores of all subscales, except for non-communication, were higher in the vaginismus group; however, statistically significant differences were observed only for the vaginismus subscale and the total score ($p<0,05$). The psychometric characteristics of the groups are presented in Table 4.

Discussion

Multiple probable etiological factors were investigated in our study. The higher rates of rural residence, extended family structure, limited and informal sexual education, and pain-related associations with sexual intercourse in the vaginismus group suggest a potential role of sociocultural influences in shaping maladaptive sexual beliefs. In contrast, the lack of differences in attachment patterns and childhood trauma supports the notion that vaginismus may not be primarily driven by early relational or traumatic factors, but rather by learned fear and avoidance mechanisms.

Vaginismus has been linked to various demographic and clinical factors in the literature, but research findings remain inconsistent across studies (21-23). We found that patients with vaginismus were more likely to live in a rural area and to reside in an extended family compared to controls. This may relate to traditional gender roles, limited access to sexual health education in rural areas, social pressures concerning sexual performance, and challenges in maintaining sexual intimacy within extended families. Despite no significant differences in income levels between the groups, patients with vaginismus were more likely to view their income as sufficient. This result may reflect cultural characteristics of the patient group.

Insufficient, inadequate, and fragmented sexual education, along with negative sexual cognitions, are often linked to the development of vaginismus (9,24). In our study, women who reported having no or inadequate sexual education were significantly more present in the vaginismus group, aligning with the literature. The groups also varied in educational resources, as vaginismus patients more frequently indicated they obtained information from informal sources, particularly friends. A systematic review noted that lack of sexual knowledge is a modifiable risk factor and that sex education can help prevent vaginismus and other female sexual dysfunctions (25).

Vaginismus has been associated with cultural factors such as suppressing female sexuality and emphasizing the importance of female virginity (26). Individuals with vaginismus tend to have more negative sexual beliefs, myths, and misconceptions, often due to a lack of sexual education and awareness (27). Although this study found no significant differences between patients and controls regarding attitudes toward virginity, premarital sex, masturbation, or family views on sexuality, patients with vaginismus primarily associated sexual intercourse with pain and discomfort, indicating maladaptive sexual cognitions, whereas controls viewed it as a necessity.

Our findings highlight a significant difference in wedding night experiences between women with vaginismus and controls. All women with vaginismus reported an inability to achieve sexual intercourse, compared to 25% of controls. Half of the controls reported being unable to continue due to pain and bleeding. These results suggest that sexual difficulties might be common even among women without a diagnosed sexual dysfunction. The study also showed that, although women with vaginismus experienced significantly lower sexual satisfaction than controls, they rated their marital relationships as good or very good at a higher rate, approaching but not reaching statistical significance. This may relate to the high level of perceived partner support (91,7%) and the positive attitudes of spouses, such as encouraging-understanding (25%) or consoling and highly empathetic (66,7%), as reported by patients. Davis

and Reissing (2007) reported that "sympathetic" partner responses contribute significantly to the persistence of sexual pain disorders, particularly in vaginismus (28). Further researches are needed for a better understanding of the relation between sexual dysfunction, partner support, and relationship outcomes in vaginismus.

A high prevalence of sexual dysfunction has been reported among the partners of women with vaginismus (9,29). In a study conducted in our country, 65,6% of the partners of women with vaginismus exhibited one or more sexual dysfunctions; premature ejaculation was the most common, followed by erectile dysfunction (29). Another study found that 27,8% of women with vaginismus reported sexual problems in their partners (9). Our study, based on patient reports, revealed that one-third of the vaginismus group indicated the presence of sexual dysfunction in their partners. The different rates may stem from reliance on patient reports, which could underestimate partner dysfunction due to underreporting or lack of awareness.

Sexual dysfunction in women has been related to psychiatric disorders, especially anxiety and depression (30). The presence of comorbid psychiatric conditions has been shown to complicate treatment and lead to worse clinical outcomes (31,32). In a study conducted in our country with 144 patients who had lifelong vaginismus, the prevalence of at least one comorbid anxiety disorder and/or depression was reported as 79,86%, and the most common comorbid disorder was specific phobia (63,9%) (30). None of the controls had psychiatric comorbidity, probably due to the small sample size, and statistical comparisons between groups were not conducted in the present study. Further studies with large samples are needed to adequately evaluate group differences in psychiatric comorbidity.

A study comparing women with vaginismus and their partners to women without vaginismus and their partners reported that insecure attachment in women and dismissing attachment in men predicted the diagnosis of vaginismus (33). In our study, attachment styles were assessed in two dimensions, and no significant differences were found between groups in terms of attachment styles. The small sample size and methodological differences may explain these results.

While some studies have reported that adverse childhood sexual experiences play a significant role in developing vaginismus, others have found no link between vaginismus and childhood trauma (10,21,34,35). A study examining childhood trauma in patients with vaginismus found that, as the duration of marriage increased, scores on scales measuring physical neglect, emotional neglect, and overall childhood trauma decreased (35). In our study, no significant differences were observed between the patient and control groups regarding childhood trauma.

In the literature, vaginismus has been linked to specific personality traits and disorders, such as perfectionism, rigidity, self-dramatization, emotional instability, impulsivity, and avoidant personality, implying that these characteristics may cause or maintain the condition (36). We found no significant differences between the patient and control groups in personality patterns measured by the EPQR-A; however, patients with vaginismus scored notably higher on the lying subscale, which assesses social desirability bias (13). The higher scores on the lying subscale indicate that self-report measures in vaginismus research should be interpreted carefully, and future studies might include additional methods.

The results of studies on sexual satisfaction and the comorbidity of other sexual dysfunctions in vaginismus are inconsistent. Contrary to studies that report women with vaginismus can have a satisfying sexual life, several studies have found that the frequency of sexual dysfunction increases in cases of vaginismus. However, some studies have suggested that other sexual dysfunctions associated with vaginismus arise secondary to chronic vaginal penetration difficulties (4,8,9). In the current study, scores for anorgasmia, vaginismus, infrequency, avoidance, nonsensuality, and dissatisfaction were higher, while non-communication scores were lower in the vaginismus group according to GRISS; however, only the total scores and the vaginismus subscale reached a statistically significant level. This may be a consequence of the small sample size.

This study has several limitations, and the findings should be interpreted in light of this constraints. The sample size was determined based on feasibility rather than a power analysis, which is a limitation of the study. The small sample size restricts the ability to generalize the findings, and reliance on self-report measures raises concerns about response accuracy. The lack of partner data limits a comprehensive analysis of relational dynamics. Although the findings emphasize the multifaceted nature of vaginismus, larger, longitudinal studies that include partner perspectives, observational measures, and clinician-rated assessments are needed to better

understand the development and the persistence of vaginismus and to develop more effective interventions.

Finally, while causal relationships cannot be established due to methodological limitations, this study provides a rare multidimensional evaluation of vaginismus using standardized diagnostic and psychometric tools. By demonstrating prominent sociocultural influences and the lack of differences in attachment patterns and childhood trauma, our findings support a model of vaginismus driven mainly by culturally shaped sexual beliefs and learned fears rather than early relational or traumatic factors. This highlights the importance of culturally sensitive, couple-focused interventions and improved sexual health education in both clinical and non-clinical settings. Formal sex education programs should comprehensively cover the physical, social, cultural, emotional, and cognitive aspects of sexuality. Vaginismus should be conceptualized and treated as a complex disorder that goes beyond penetration anxiety, encompassing broader dimensions of sexual health, partner dynamics, and psychologic vulnerability. Research indicates that even individuals without lifelong vaginismus can experience sexual function issues, though they might not seek treatment for these problems. This underscores the importance of routinely assessing sexual function during psychiatric evaluations and education programs.

Main Points

1. Patients with vaginismus are more likely to reside in rural areas and extended family units, have limited access to sexual health education, and face challenges in maintaining sexual privacy, with inadequate sexual education identified as a risk factor.
2. Individuals with vaginismus, relying on informal sources for sexual knowledge, associate intercourse with pain, unlike controls who perceive it as a necessity, underscoring the need for comprehensive sexual education to address maladaptive cognitions.
3. A higher rate of empathetic partner support among vaginismus patients highlights the disorder's complex nature, where relationship dynamics contribute to its persistence.

References

1. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, 4th ed., text revision (DSM-IV-TR). Washington, DC: American Psychiatric Association, 2000.
2. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, 5th ed., (DSM-5). Washington, DC: American Psychiatric Association, 2013.
3. Laskowska A, Gronowski P. Vaginismus: An overview. J Sex Med. 2022; 19(5): 228 - 229.
4. Pacik PT, Geletta S. Vaginismus treatment: Clinical trials follow up 241 patients. Sex Med. 2017; 5(2): e114 - e3.
5. Dogan, S. Vaginismus and accompanying sexual dysfunctions in a Turkish clinical sample. J Sex Med. 2009; 6(1): 184 – 192.
6. Er O, Özdel K. Özpolat Y, G Ayşe. Vajinismus. Kriz Derg. 2010; 18(3): 37 - 46.
7. Lahaie MA, Boyer SC, Amsel R, Khalifé S, Binik YM. Vaginismus: a review of the literature on the classification/diagnosis, etiology, and treatment. Womens Health (Lond). 2010; 6(5): 705 - 719.
8. Jeng CJ. The pathophysiology and etiology of vaginismus. Taiwanese J Obstet Gynecol. 2004; 43(1): 10–15.
9. Doğan S, Varol Saraçoğlu G. Yaşam boyu vajinismusu olan kadınlarda cinsel bilgi, evlilik özellikleri, cinsel işlev ve doyumun değerlendirilmesi. Trakya Univ Tip Fak Derg. 2009; 26(2): 151 - 158.
10. Konkan R, Bayrak M, Güçlü Gönüllü O, Şenormancı Ö, Sungur MZ. Vajinusmuslu kadınlarda cinsel işlev ve doyum. Düşünen Adam Psikiyatr Nöroloji Bilim Derg. 2012; 25: 305 - 311.
11. First MB, Spitzer RL, Gibbon M, Williams JBW. Structured clinical interview for DSM-IV clinical version (SCID-I/CV, version 2.0). New York: Biometrics Research Department: New York State Psychiatric Institute, 1997.
12. Ozkurkcugil A, Aydemir O, Yildiz M, Esen Danacı A, Koroglu E. DSM-IV eksen I bozuklukları için yapilandirilmis klinik gorusmenin Turkceye uyarlanmasi ve guvenilirlik calısması. Ilac Tedavi Derg. 1999; 12: 233 - 236.
13. Francis LJ, Brown LB, Philipchalk R. The development of an abbreviated form of the Revised Eysenck Personality Questionnaire (EPQR-A): its use among students in England, Canada, the USA and Australia. Pers Individ Dif. 1992; 13: 443 - 449.
14. Karancı N, Dirik G, Yorulmaz O. Eysenck Kişilik Anketi -Gözden Geçirilmiş Kısaltılmış Formunun (EKA-GGK) Türkçe Adaptasyonu. Turk Psikiyatri Derg. 2007; 18(3).
15. Bernstein DP, Fink L, Handelsman L, Foote J. Initial reliability and validity of a new retrospective measure of child abuse and neglect. Am J Psychiatry. 1994; 151(8): 1132 - 1136.

16. Şar V, Öztürk E, İkikardeş E. Çocukluk Çağı Ruhsal Travma Ölçeğinin Türkçe uyarlamasının geçerlilik ve güvenirliği. Turk Klin. 2012; 32(4): 1054 - 1063.
17. Fraley RC, Waller NG, Brennan KA. An item response theory analysis of self-reports measures of adult attachment. J Pers Soc Psychol. 2000; 78: 350 - 365.
18. Selçuk E, Günaydın G, Sümer N, Uysal A. Yetişkin bağlanma boyutları için yeni bir ölçüm: Yakın ilişkilerde yaşantılar envanteri-II'nin Türk örnekleminde psikometrik açıdan değerlendirilmesi. Turk Psikol. 2005; 8(16): 1.
19. Rust J, Golombok S. The GRISS: A Psychometric Instrument for the Assessment of Sexual Dysfunction, *Arch. Sex. Behav*. 1986; 15(2): 157 - 165.
20. Tuğrul C, Öztan N, Kabakçı E. Standardization study of golombok-rust inventory of sexual satisfaction. Turk Psikiyatri Derg. 1993; 4: 83 - 88.
21. Özkorumak Karagüzel E, Civil Arslan F, Tiryaki A, Osmanağaoğlu MA, Şimşek Kaygusuz E. Sociodemographic features, depression, and anxiety in women with life-long vaginismus. Anadolu Psikiyatri Derg. 2016; 17(6): 489 - 495.
22. Banaei M, Kariman N, Ozgoli G, Nasiri M. Bio-psychosocial factor of vaginismus in Iranian women. Reprod Health. 2021; 18(1): 210.
23. Hacıoğlu Yıldırım M. Socio-Demographical And Clinical Characteristics Of Vaginismus Comparison With Other Female Sexual Dysfunction. Turkish J Clin Psy. 2017: 20(1); 37 - 44.
24. Banaei M, Kariman N, Ghasemi V, Roozbeh N, Jahangirifar M. Component of sexual health services for vaginismus management: A qualitative study. PLoS One. 2023: 9; 18(8) : e0283732.
25. McCool-Myers M, Theurich M, Zuelke A, Knuettel H, Apfelbacher C. Predictors of female sexual dysfunction: a systematic review and qualitative analysis through gender inequality paradigms. BMC Womens Health. 2018; 22; 18(1): 108.
26. Dogan S. Vaginismus and accompanying sexual dysfunctions in a Turkish clinical sample. J Sex Med. 2009; 6: 184 – 192.
27. Güneş M, Uyar B, Tekin Şener Z, Çankaya İnan E. Evaluation of the level of belief in sexual myths of women with vaginismus and their partners. Psychiatry Behav. Sci. 2025; 15(1): 16 - 24.
28. Davis H, Reissing ED. Relationship adjustment and dyadic interaction in couples with sexual pain disorders: a critical review of the literature. Sex. Relatsh. Ther. 2007; 22(2): 245 – 254.
29. Dogan S, Dogan M. The frequency of sexual dysfunctions in male partners of women with vaginismus in a Turkish sample. Int J Impot Res. 2008; 20(2): 218 - 221.
30. Yıldırım EA, Hacıoğlu Yıldırım M, Karaş H. Prevalence of depression and anxiety disorders and their relationship with sexual functions in women diagnosed with lifelong vaginismus. Turk Psikiyatri Derg. 2019; 30.
31. Hawton K, Catalan J, Martin P, Fagg J. Long-term outcome of sex therapy. Behav Res Ther. 1986; 24(6): 665 – 675.
32. Özdel K, Yılmaz Özpolat A, Çeri Ö, Kumbasar H. Factors that might be predictive of completion of vaginismus treatment. Turk Psikiyatri Derg. 2012; 23(4): 248 - 253.
33. Çeri, Özge. Vajinismus tanısı alan kadınlar ve eşlerinde temel bilişsel şemalar ile bağlanma stillerinin incelenmesi. MS thesis, Sosyal Bilimler Enstitüsü, 2009.
34. Reissing ED, Binik YM, Khalifé S, Cohen D, Amsel R. Etiological Correlates of Vaginismus: Sexual and Physical Abuse, Sexual Knowledge, Sexual Self-Schema, and Relationship Adjustment. J Sex Marital Ther. 2003; 29: 47 - 59.
35. Arabacıoğlu T. Vajinismus Hastalarında Çocukluk Çağı Travma Yaşantılarının ve Disosiyatif Özelliklerin Araştırılması. Yüksek Lisans Tezi, Üsküdar Üniversitesi Sosyal Bilimleri Enstitüsü Uygulamalı Psikoloji Anabilim Dalı, 2017.
36. Elrassas H, Saad A, Fekry M. Elkholy H, Mansour O, Azzam L. Psychiatric comorbidity in a sample of Egyptian women with vaginismus. Middle East Curr Psychiatry. 2022; 29: 39.