



Practicing vaginistic femininity: Doing bodies, enacting normative heterosexuality

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Abstract

Vaginismus is a female sexual pain disorder, characterized by contractions of the pubococcygeus (PC) muscle that surrounds the outer third of the vagina, which makes penetrative penile-vaginal intercourse (coitus), insertion of a finger or tampon and gynecological examinations hard or impossible, and painful for the woman. The condition is believed to be associated with negative beliefs, attitudes or experiences related to sex. Vaginismus has important social repercussions in everyday life, which acquire meaning in the context of hegemonic heterosexuality. In line with theories of performativity, heterosexuality and gender are normatively and performatively linked sets of practices, with coitus being the central practice of heterosexuality and thus defining for one's gender. Thus, the inability of vaginistic women to perform coitus impairs their performance of normative heterogender. In this article I address gender experiences of women with primary vaginismus, by looking at social and bodily practices they engage in. In the first part of the article, I explore how women with primary vaginismus do (vaginistic) heterogender. In the second part I address the practices they do in order to 'overcome' vaginismus, thus improving their performance of normative heterogender, and argue that these practices are gendering themselves.

Keywords

Coital imperative, doing vaginismus, hegemonic heterosexuality, 'overcoming' practices, practicing heterogender

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Introduction

'Sex' may evoke various feelings and various associations in different people. For some, it means pleasure, for others power and for others again love; it may provoke feelings of proudness for some, and shame for others, and it may be associated with pain and fear. Although statistics vary, most of them agree that about 30% of women experience some kind of sexual pain at one point in their life, while about 15% is affected by a long-term sexual pain disorder, which, apart from making coitus (penetrative penile-vaginal intercourse) painful, hardly performed or impossible to perform, may also cause problems in wearing tampons or visiting gynecologists.

Studies of female sexual pain disorders that I have had the opportunity to review, as well as blogs, videos and newspaper articles addressing the issue, report women experiencing feelings of inadequacy and isolation, low self-esteem, secrecy, shame, guilt and loss of femininity. These negative feelings acquire meaning in the context of normative heterosexuality. Many authors have argued not only that heterosexuality is normative, but that it also has an enormous regulatory power (Kaler 2006: p.52 and there mentioned authors) which is exercised through "a hegemonic and naturalized set of practices" (ibid: p.53). A central practice, and thus the most hegemonic and most naturalized one, is penetrative penile-vaginal intercourse, whose centrality has been called the 'coital imperative' (Jackson 1984). This imperative is so deeply enrooted into people's perceptions of sex that even today, after the sexual liberation and female rights movements, and despite the separation of reproduction and sexuality, people still equate 'real sex' with coitus (McPhillips et al. 2001), "have difficulty thinking of 'sex' without reliance on insertion and penetration" (Kaler 2006: p.59, referring to Annie Potts), and want to conceive their children 'naturally' or 'in love' (Kaler 2006: p.62).

Heterosexuality implies the existence of 'men' and 'women' (Kaler 2006), and is thus inseparable from the notion of 'normative gender'. West & Zimmerman (1987) argued that gender is not a natural set of traits or variables, but rather "the activity of managing situated conduct in light of normative conceptions of attitudes and activities appropriate for one's sex category" (West & Zimmerman 1987: p.127). According to them, gender is a product of social doings, it is constituted through interaction (ibid: p.129) and it is *done* through "a complex of socially guided perceptual, interactional, and micropolitical activities that cast particular pursuits as expressions of masculine and feminine 'natures'" (ibid: p.126). 'Masculinity' and 'femininity' are considered to be *expressive behaviors*, i.e. an evidence of male and female "essential natures"; since people internalize this notion, they "conduct themselves to fit their own notions of expressivity" (Goffman according to West & Zimmerman 1987: p. 129). As Butler (1988) puts it, people are not born women and men – they engage into corporeal acts that make them *become* what is socially regarded as a 'woman', or a 'man'.

According to Kaler (2006: p.54), Butler does not only ground gender, as well as heterosexuality, in performance, but she also depicts them as performatively and normatively indistinguishable. Thus, taking into account the centrality of the coital imperative for heterosexuality, we could say that *becoming* a 'woman' or *expressing* ones

'femininity' in a heteronormative surrounding means having coitus with men. Indeed, it can still be heard in informal talks that 'a girl has become a woman' after getting the menarche (i.e. when she became able to bare children and is thus 'biologically' ready for sexual intercourse) or after having engaged into coitus (i.e. having 'lost her virginity'). Several feminist scholars have as well pointed that "to be a 'woman' in heterosexist society means to have sex with men. The category of 'women' thus has no meaning outside heterosexuality" (see Kaler 2006: p.54 and there mentioned authors). In order to encompass the notion of gender within a heteronormative surrounding, many authors (see Kaler 2006) use the term 'heterogender'², and so will be done in this article. In the same way as gender, the category of 'female body' draws most of its meaning from heterosexuality, and coitus specifically. Braun & Kitzinger (2001), for example, show that people evaluate vaginas as 'good', 'too tight' or 'not tight enough' – categories that make sense only in reliance to coitus, which implies that coitus is in fact the purpose of a vagina. Further, since there appears to be a "commonsense relationship between genitals and gendered identity" (Braun & Wilkinson 2005: p.518), it can be concluded that in order to 'properly' do female heterogender or enact hegemonic heterosexuality (Kaler 2006: p.53), one must engage into coitus with men and, obviously, have a vagina that enables this practice.

At this point, it is important to add that the 'micropolitical activities' that constitute female-male interaction and define the performance of 'femaleness' and 'maleness' reflect, according to West & Zimmerman (1987), power relations among women and men, i.e. they reflect the social subordination of women. It can be noted in the structure and dynamic of female-male conversations (where the male is dominant) or in the distribution of housework. When it comes to coitus, Holland et al. (2000) suggest that coitus is much more empowering for men who mostly see it as a 'gain', while women have ambiguous feelings towards it, experiencing it as a 'loss' (especially the 'first time'), and sometimes as a risk – of pregnancy, disease or violence. But, it is 'not only differently experienced by men and women, it is socially different' (ibid p. 130), since males achieve manhood through access to a female body (ibid). In her seminal article, Jackson (1984: p.44) critically examines sex research, arguing that it emerges from and supports a male-oriented (dominant) view on human sexuality, depicting the activity that is most pleasurable to men as a biological imperative which has evolved to ensure the reproduction of the species. It is argued, with dubious logic, that because coitus is 'natural' it must be pleasurable; if it were not so, reproduction would not occur and the species would die out.

Thus, being a woman means having penetrative intercourse with man (or 'providing' men with this activity) and, preferably, enjoying it.

This article addresses stories of women who, due to vaginismus, one of the known sexual pain disorders, have troubles with both mentioned 'requirements'. Apart

² A neologism coined by Chrys Ingraham in order to acknowledge the interconnection of heterosexuality and gender, built upon Butler's argument that they are performatively and normatively indistinguishable (see Kaler 2006).

from vaginismus, the most commonly mentioned disorders (in medical and social science literature, as well as in articles about female sexual health available from other sources) are vulvodynia, and dyspareunia. Vulvodynia is the official name for chronic vulvar pain; in cases of dyspareunia, the pain occurs during attempted penetration, while vaginismus is characterized by contractions of the pubococcygeus (PC) muscle that surrounds the vagina. The muscle can be constantly tense, or it may contract during (attempted) penetration and thus, depending on the level of tensity, make penetration hard or impossible, and in any case painful for the woman. The muscle contracts as a consequence of anticipated pain (or fear of pain); since the muscle is tense, penetration indeed becomes painful and confirms the anticipated pain – this is called the ‘circle of pain’ (see for example Sterling 2015). In some cases, this happens only during attempted intercourse, while in others the same happens during gynecological exams or attempts of inserting a tampon. The etiology of vaginismus is considered unclear (Jeng 2004), but there is a number of triggers that are believed (by medical professionals and affected women) to cause vaginismus, all related to negative feelings, attitudes or experiences of sex³. When vaginismus occurs after a woman has been able to engage in painless coitus for a certain period of time, it is classified as secondary vaginismus; if, on the other hand, it starts to occur from the first attempts of coitus, it is considered as primary. Vaginismus may or may not co-exist with vulvodynia and dyspareunia; in any case, despite of the differences in the medical definitions of the conditions, they all have quite similar social consequences, related to the inability to engage in or enjoy coitus.

In their studies of women experiencing vulvodynia – chronic vulvar pain, Kaler (2006) and Ayling & Ussher (2008) present two seemingly similar but essentially different interpretations of their participants’ gendered experiences. Kaler reports that her participants, ‘excluded from sexual intercourse, [they] describe themselves as effectively ‘genderless’ or ‘degendered’. In their descriptions, they invoke images of gender failures, of women who are not really women’ (2006: p.51). Many of them reported having problems bonding with other women as well as relating to men as ‘real’ women (ibid: p.65), and changing the way they dress so that they would not attract men since they could not ‘follow through’ (ibid: p.63). On the other hand, Ayling & Ussher report their participants feeling as *inadequate* sexual partners and *inadequate* women. As sexual partners, they felt ‘not normal’, ‘worthless’, ‘useless’, ‘broken’ and ‘dysfunctional’ since they were unable to satisfy their partners’ perceived needs – which emerge from the discourse that men ‘need’ coitus (Ayling & Ussher 2008: p.298). As women, they felt inadequate compared to the normative ‘good’ woman which is ‘sexually passive or receptive, as well as caring and nurturing in relation to men’ (ibid), but they also felt immature, inexperienced and constrained ‘compared to the popular representations of permissive women as adventurous, skilful, and eager for sex’ (ibid and there mentioned

³ Such as strict (religious) or overprotective upbringing, traumatic experiences of STIs, UTIs or childbirth, feelings of abandonment by a partner, sexual abuse or rape, misinformation or ignorance, as well as the way in which sex is talked about in society and media – in terms of danger from getting pregnant, being raped or ‘used’, getting infected etc. (see for example Jeng 2004, Ward & Ogden 2007, Meana 2009)

authors). Yet, despite the feelings of inadequacy, guilt and shame, Ayling and Ussher do not see their participants as deprived of their gender as Kaler does, nor they deny their status as ‘women’.

Inspired by the discussed literature and driven by personal interests, in the study presented in this article I address gender experiences of women with primary vaginismus. In the first part of the article, I explore how women with primary vaginismus do (vaginistic) heterogender. Since in the case of vaginismus, unlike vulvodynia, there is quite a developed set of practices that women may choose to do in order to become able to engage in coitus⁴, in the second part of the article I address the practices they do in order to improve their performance of normative heterogender.

Methodology

When it comes to reaching participants and gathering data for studies of sensitive health-related issues, Internet-mediated approach has been proved to have several advantages, including facilitation of access to otherwise difficult-to-access groups, diffusion of embarrassment, feelings of being judged or shyness and enhancement of disclosure (Whitehead, 2007: 783), since people find it easier to “tell their failed selves” online (McDermot, 2015). Thus, from November 2014 to May 2015 I did ‘digital ethnography’, a method that, according to Murthy (2008: p.839), “not only gives researchers a larger and more exciting array of methods to tell social stories, but also enables them to demarginalize the voice of respondents in these accounts”. Indeed, going virtual enabled me to reach women I would not have been able to reach otherwise. This ethnography included ‘hanging out’ in virtual spaces of women’s blogs, web-sites of treatment centers, documentaries, disclosure videos etc., as well as in an online support group dedicated to vaginismus (OSG). At the same time, I am aware that “access to these technologies remains stratified by class, race, and gender of both researchers and respondents” (ibid), i.e. that women I could reach had access to Internet, knew how to use social networks and could speak English.

In the moment I joined it, the OSG counted about 400 members among which there were women of all ages (the youngest one to my knowledge was 16 and the eldest one was in her fifties), from all continents, with various religious, economic, sociocultural and educational backgrounds; married, single or in a relationship; suffering from, having overcome⁵ or dealing with both primary and secondary vaginismus⁶, caused by very

⁴ There are several treatment methods, the most common one being progressive dilation – women gradually learn to insert dilators of different sizes, starting from smaller ones (it will be explained in details later in the article). Some of the other methods are physical therapy or treatment with Botox injection that unable the muscles to contract, but these methods are usually combined with progressive dilation or/and psychotherapy. Such treatments are possible in cases of vaginismus because they ‘deal’ with muscles, while vulvodynia refers to pain or discomfort in the vaginal area for unknown causes and thus the described methods are not advised in its treatment.

⁵ ‘Overcoming’ is the term commonly used for ‘curing’ vaginismus

⁶ Even though the group was aimed at vaginistic women’s partners as well, during my fieldwork there were no active partners.

different triggers. These diversities did occasionally cause some frictions in the group, since sexuality is a sensitive topic and these women had different attitudes towards it⁷. Yet, most of the time members tended to provide support to each other, since all of them (but one, to my knowledge) had the same aim – to be able to engage in penetrative sex with a man.

I assumed that the ability or inability to refer to a personal experience of penetrative sex would make experiences of primary and secondary vaginismus fundamentally different. I chose to focus on women with experiences of primary vaginismus out of personal interests. By the end of my fieldwork, I managed to do in-depth interviews with 12 women who had the experience of coping with primary vaginismus. In addition to 10 women members of the support group, two of my informants were reached through personal networks. Five of them were from the USA, six were from different European countries and one from Israel. Three interviews were done face-to-face, 6 of them virtual-face-to-virtual-face, i.e. via Skype and three of them by e-mail correspondence.

The variety of my informants' profiles is not problematic in the context of this study, since the social surroundings all these women come from share two traits essential for this topic: they exist in a “time and place of heterosexual hegemony” (Kaler 2006: p.51) and “have a long history of suppressing female sexuality and placing high values on female virginity which (...) means keeping the vagina closed against any penile or foreign body penetration” (Ng 2007: p.12).

Names of informants have been changed in order to ensure their anonymity (except if they wished otherwise). For the same reason, the full name of the support group will not be mentioned and I will refer to it just as ‘support group’ (SG).

Finally, during fieldwork and the writing process, I was aware of my positioning – one of a European female anthropologist in her early twenties, with personal interests and concerns about sexuality and gazing the issue from a feminist constructionist point of view.

Doing vaginistic heterogender

During my fieldwork, many women have indeed reported feeling ‘less of a woman’. Megan, for example, struggled with a strong feeling of being “a freak of nature” and “not fully a woman”; even after having overcome vaginismus and despite the fact that she is the one who financially supports her and her husband, she still carries a burden of being a “bad wife” (and even though her husband is trying to convince her of the opposite). Lavender, on the other hand, claimed never to have experienced feelings of gendered inadequacy, although she was told by a former partner that she was not a ‘real woman’ because of vaginismus. According to her, this happened because she ended their relationship – something that his ego could not support – and thus he reacted out of affect. While they were still seeing each other, on the other hand, he told her that she

⁷ For example, deeply religious women had different opinions about sex and marriage-related topics than women who considered themselves as ‘liberal’ or ‘feminist’.

was very sensual and that sexual experiences were “much more fun” with her despite vaginismus, then with women who could have intercourse, but would “just lay down”. She did feel very sad about his insult, but still opposed: “You’re not a woman because you have a vagina!” Most of my informants were somewhere between Megan and Lavender; as Lotte put it, “sometimes you do feel a bit broken”, but in general vaginismus did not cause feelings of de-genderness. Only Matea claimed that when, for example, gender inequality is discussed, she does not feel addressed – as if something of concern for ‘women’ is not of her own concern.

Yet, gendered performance includes more than just sexual behavior – there are many other practices that are considered as ‘feminine’ or ‘masculine’. Thus, I will try to depict two opposite situations. Megan and Matea both claimed that vaginismus influenced the way they dressed. Megan used to wear shoes with high heels – “the higher the better” – but stopped after her struggle with vaginismus started. She had a lot of clothes that she used to wear before getting married that were just hanging in the wardrobe⁸. “Why should I start something I couldn’t finish?”, she asked, perceiving that ‘something’ as ‘provocative’ dressing or even kissing, practices that she felt might lead to sex. Matea’s experience was similar: she had phases in her life when she would wear only baggy clothes, and became hesitant about any kind of sexual intimacy, eventually losing her sexual desire almost completely. On the other hand, Lavender described herself as very passionate during sexual encounters and enjoyed outercourse very much. She also likes wearing dresses and dressing in a typical feminine way – “I’m a girly girl”, she concluded. Similarly, Cecilia claimed not to have feelings of gendered inadequacy and that she would feel feminine “when I dress up I guess [laugh], go to the spa or get my nails done or whatever...that’s when I feel like a lady [laugh]”. Ines never felt ‘less of a woman’ and claimed that vaginismus did not impact her gendered expression, except in one instance: “I just felt that I had so much energy that I needed to put out, you know...to...to express, and I couldn’t find the means to express it, sexually at least”.

Doing dating

Half of my informants found out about their inability to engage in intercourse after getting married, while the other half was in quite stable relationships⁹. Their partners were mostly supportive at the beginning, while thinking that they were just afraid of the ‘first time’ and that it will ‘get better’. But, once realizing things were not going to ‘get better’ that quickly and that their partner suffered from something called vaginismus, their reactions could change. Women are usually very concerned about how their partners would position themselves, and this issue is often discussed in the SG.

⁸ She found out about having vaginismus after having got married.

⁹ Only Veronica does not want to have sexual activities yet, but because of her inability to use tampons, fear of GEs and attitudes towards sex, she believes she has vaginismus.

'Will he have patience?'

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

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

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

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

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

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

Lotte found out about vaginismus after getting married to her ex-husband. In their relationship, he acted "as if he couldn't breathe" (Lotte) and she felt very pressured because of his behavior. Now she is in a relationship with another man who is 'fine with her' as she is. As she explained, instead of having sex, they can always sit on the couch together and watch television. When Sarah told her partner about her condition, he gave an answer that thrilled her: "I'd much rather go ballroom dancing with you!" Even though

they never went ballroom dancing, they stayed committed to each other and, as she explained, had a great time together outside of bed – that is in fact, as she concluded, most of the time people actually do spend together (she did overcome vaginismus eventually).

‘How to let him know?’

Some women do not manage to overcome vaginismus while being in a relationship with the partner they first tried to have intercourse with. These women find themselves on the ‘dating market’ again, knowing that intercourse is not something they can offer. Thus, these women have to think about how to let their new or potential partner know that they have vaginismus.

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

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

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

‘What kind of man do I want?’

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

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

Lotte's opinion was shared by more women. Not being able to have intercourse enabled them to find a partner who loved them for more than just sex – which was evaluated as a desirable trait by women.

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

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

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

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

Playing other roles: female child, friend, acquaintance

Most women have never heard the word ‘vaginismus’ when they attempted to have intercourse for the first time, and to some of them it took years to find out why were they unable to do it (Pacik 2014: p.1615-1616). During my fieldwork, most people who would ask me about my research would hear about vaginismus for the first time from me and, as noted by a blogger in her *Dilator Diaries*, neither does Microsoft Word recognize the word. Here, I do not see the fact that vaginismus is rarely talked about in public as a lack of agency or absence of meaning. On the contrary, I see this silence as a cultural practice (Woolley 2012, Ling 2003). In other words, the rare presence of discourses about vaginismus is indicative of society's attitudes towards (problematic) female sexuality and sexual pain is still often perceived as taboo for a reason¹⁰.

Vaginismus is not only surrounded by silence in public spaces, but also in private spaces of personal networks. Indeed, many women reported how hard it was for them to open up about their vaginismus, not only to their partners, as discussed earlier, but also to other people that are parts of their lives. According to Sarah, “you make yourself very

¹⁰ A detailed analysis of the reasons of this silence exceeds the scopes of this article.

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

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

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

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

In general, most women talked about the inability of other people to understand what was going on in their lives. Some were irritated by their mother’s or friend’s benevolent comments such as ‘you just have to relax, it’s all in your head’. Vaginistic women felt that other people just could not grasp the full complexity of their situation. For some, this became the very reason not to talk about it. Cecilia felt

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

Taking this into account, it is not surprising that a post such as ‘I have no one else to talk to’ emerged quite often in the SG. Indeed, some members of the SG have called the group ‘a blessing’, because that was the only ‘place’ where they could talk about it completely openly and share their experiences with other women who were going through the same struggle and understood how hard it was. The SG and other virtual spaces provided women a possibility to ‘reach out’, keeping their anonymity at the same time. Many women wanted to “scream on the top of my lungs: hey, this is out there and it’s hard for me!” (Cecilia), but were held back by this practice of silence. In the virtual spaces, they could scream under a pseudonym and an avatar. Having a long and intense experience of participating in online spaces dedicated to vaginismus, Sarah claimed to have noticed a pattern: women who were still struggling with vaginismus usually had problems opening up about it and felt very ashamed; once they would overcome, their wish to ‘reach out’ and ‘spread the word’ would rapidly increase. In this way, even after having overcome it, women would still keep engaged with vaginismus.

Doing vaginistic bodies

As mentioned earlier, there are several treatment methods for vaginismus that women may choose to go through, and they also come up themselves with products or activities that they find helping. In fact, apart from being an impairment to normative performance of gender, vaginismus is a ‘condition’, and it can be treated. Yet, as suggested by Mol & Law (2004), ‘conditions’ are also *done*, i.e. when dealing with ‘conditions’, people are required to *do* different practices with their bodies, with other people, food, liquids or certain tools. Through these practices, people *enact* their ‘conditions’, and ‘conditions’ in turn *enact* their bodies. As it will be shown, enacting their bodies in order to overcome vaginismus, women enact hegemonic heterosexuality. On one hand, they decide to go through treatment in order to improve their performance of heterogender, and on the other hand, their gender identity proceeds from the bodily practices they do while ‘treating’ vaginismus. In the following part of the article, I will address different practices through which vaginistic women enact their female bodies.

The practice of knowing

For Mol & Law, the first important mode in which hypoglycaemia, the example they discuss, is *done*, is by *knowing it*; thus, they see knowledge as a practice (2004: p.5). Knowing does not only encompass acquiring facts, but also ‘training one’s inner-sensibility’¹¹. Indeed, most women start their overcoming process by acquiring knowledge, on female anatomy in general and on vaginismus in specific.

While some women reported initially thinking that they ‘have no hole’, that their vaginal orifice does not ‘stretch enough’ or that their vaginas were ‘just too tight’, others said that, when realizing that something was ‘wrong with them’, they did not know how

¹¹ In the case of hypoglycaemia, people learn how to measure their blood sugar level and how to regulate it, but also how to ‘sense’ its changes without actual measurement (Mol&Law 2004: p.9).

to explain to themselves why they were not able to engage in penetration. As Megan said, “I didn’t even think of the word vaginismus, I just thought I’m a freak of nature!” Whatever their initial thoughts, getting to know that there was a ‘condition called vaginismus’ helped them a lot. Not only they became aware of the fact that they were not ‘freaks of nature’ and ‘alone in this problem’, but it also provided information about what was actually happening during attempts of penetration and about available treatment options. The first important information for them is that what causes the tightness are contracted PC muscles. What follows is to learn where these muscles are located and how to relax them. From my data it seems women keep gathering information about the female reproductive system throughout their whole ‘overcoming process’ and later. In fact, in the SG, women very often posted links to educative websites or videos that would enable them to understand what is the ‘vagina’ consisted of (the term ‘vagina’ is usually misused, meaning: vulva – outer and inner labia and clitoris, vaginal orifice and the vagina itself) and how its texture feels like. Very often women would post articles dispelling myths about vulvas (for example, that there is no ‘normal’ or ‘standard’ vulva), vaginas (that intercourse does not make vaginas loose up), hymens (that it is not a very thick membrane that ‘breaks’ and causes immense pain during the first intercourse) and intercourse (that it is not supposed to hurt, not even the ‘first time’). A lot of women saw this process of gathering anatomical knowledge in a positive light; some of them even stated that, because of vaginismus, they got to know their bodies much better than many other women get to know their, and saw that as an advantage. “I think knowledge empowers you. Empowers us (...) as a group of woman”, Megan told me. This is why she started ‘Facts Fridays’ – every Friday she posts in the SG some resources with facts about vaginismus, similar conditions or the female body in general.

Indeed, it seems that many women become interested in the female body in general, sharing non-vaginismus related resources about it. Megan, for example, is using a natural contraception method that made her engage with her ‘female body’ a lot. Articles were posted in the SG about ‘lunaception’¹², ‘the benefits of sleeping naked’, ‘fertility foods’ etc. Also, women used to post pictures of fruits that looked like a vulva in order to show vulvas/vaginas as natural and beautiful parts of the body.

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

¹² A method that makes women’s menstrual cycles align with the moon phases and thus enables them to know when are they going to ovulate, menstruate etc.

Exploring genitalia

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

'Active relaxation'

According to medical views, the key to overcoming vaginismus is muscle relaxation. Except for Botox treatment, every other treatment method requires women to learn how to relax their muscles themselves. They need to learn how to *feel* their muscles contracting or being tense, and also how to relax them. The most commonly suggested technique that is supposed to help women realize which muscles are at stake and how to relax them are Kegel's exercises. Originally developed for incontinence prevention, women are sometimes advised to do these exercises in order to 'keep their vagina tight'¹³, and vaginistic women in order to learn how to control their PC muscles. Some have argued that rather than doing 'standard' Kegel's exercises (aimed to strengthen the PC muscles, which is not what vaginistic women want), they should do 'reverse Kegel's' – instead of keeping their muscles contracted for as long as they can, they are supposed to keep them *relaxed* as long as they can.

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

Finally, both practices – learning to *feel your muscles* and *be relaxed* – seem to be very personal; all women find or develop their own ways that fit them best and even though there are techniques that are widely used, still it seems that every women interprets and experiences them slightly differently from others, and adapts them to their

¹³ Mostly in 'mondane' women's magazines, although some scientists have argued that vaginas do not become 'loose' due to intercourse or even childbirth, only when women come to a certain age when all of their muscles become less strong – and then there is also risk of incontinence.

own personality. Whatever the method or its adaptation, however contradictory it may sound, relaxation is something that these women actively engage in. As Sarah explained, tenseness is her ‘natural’ state, so she has to ‘actively relax’ all the time.

Dilation

“Every day I have an emotional standoff with a piece of plastic... five pieces of plastic, if we’re being technical”, says a blogger in her *Dilator Diaries*. This is a reality for many women. Progressive dilation seems to be the most common treatment method for vaginismus. It is consisted of gradual insertion of dilators of different sizes, starting with smaller ones. Women are usually advised, by their therapists or more experienced members of the SG, not to move on to a bigger size before they are completely comfortable with the smaller ones. The sets of dilators usually contain five to eight, plastic or silicone dilators, the smallest one being of the size of a pinky finger, while the biggest one is thought to be ‘bigger than an average human penis’. Once women, with a little help of ‘lube’¹⁴, manage to insert a dilator, some of them ‘keep it in’ for at least 10 minutes, others do it for a few hours or even sleep with them, while some women ‘thrust them’ and ‘take out’. However it is done, dilation is something that they should do every day.

The first time a woman manages to insert a dilator can feel quite empowering. After not managing to make any progress in 13 years of relationship because of the pressure she felt¹⁵, the again-single Lavender decided to make a trip on her own, traveled to another country and brought her dilators with her. Coming back into the apartment in which she was staying alone, after having spent a beautiful day, Lavender felt it was the right time:

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

¹⁴ As lubricants are usually referred to by members of the SG. Types of lubricants were discussed in more occasions in the SG – medical lubricating jellies can be oil- or water-based, while some women prefer to use olive or coconut oil.

¹⁵ Pressure to have intercourse with her husband

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

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

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

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

Perceiving it as a quite hard and long process, women in the group often remind each other to ‘celebrate every little step’ and to feel proud of themselves after every accomplishment, even if it means that they managed to get the dilator one millimeter more ‘in’ than ever before.

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

Managing gynaecological exams

Visiting a gynaecologist is another practice central to the enacting of female heterogender¹⁶ problematic to vaginistic women. Many of them indeed visited a gynecologist after realizing that they were unable to perform penetration. Even though some of them got a diagnosis of vaginismus and advice for further steps from their gynecologists, many of my informants reported having negative experiences with

¹⁶ Due to the existing reproductive biopolitics that tend to control and monitor female bodies in a great extent (see Findlay 1993)

gynecologists – they thought them to be uninformed, rude, ungentle and sometimes even forceful.

Sarah suggests that what women should do when going to an appointment with a gynecologist, even after having overcome vaginismus, is to take a leaflet with information about vaginismus and pelvic pain with them and ask their gynecologist to read it and inform themselves about the issue. They should approach the gynecologist and ‘take charge’ over the situation, not letting themselves to be victimized.

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

Exemplifying their claim that the ‘condition’ helps to enact the body, Mol & Law (2004: p. 12), argue that “living with asthma makes people acutely aware of the air they breathe”, while “trans-sexuality comes with an overwhelming sense of living in a sexed body”. Rather than making women acutely aware of their sexed bodies, vaginismus makes them aware of their *sexual* and *sexualized* bodies. And not only their own, but everybody they encounter in their physical and virtual surroundings. Susanne, for example, explained that “because of my vaginismus, I am so fixated on sex that...when I hear that a friend is pregnant or had children, I think: oh my God, she had sex! [laugh]”.

Many women reported feeling jealous of pregnant friends or relatives. They would feel bad for not being able to be sincerely happy for the future mother, but could not help themselves – it was making them acutely aware of their inability to have intercourse and bare a child. Megan told me that she and her husband used to watch a television show about pregnant teenagers, which would make her angry because “they’re kids and they shouldn’t be having sex and I’m a grown up and I can’t do it”. Television and other media were rubbing salt on her wound and making her think: “What person can’t have sex, sex is everywhere, on the TV, there are pregnant teenagers walking around, everyone can have sex, but I can’t, something is definitely wrong with me!” (Megan). Sexualizing media were a source of frustration for other women too. Sarah, for example, criticized the way sex, sexual and romantic relationships were depicted in most television series and movies. During her curing cycle, she was following a very popular series¹⁷ and at a certain point realized that it had a really bad impact on how she received herself, sexuality and men. She said she would literally clench up while watching it and that there was “no one single normal, loving and caring relationship in the whole series”, so she stopped following it. In her opinion, “for someone who is sensitive, especially in that aspect”, this kind of series can be traumatic.

Finally, some of my informants reported not only being angry and disappointed about sexualizing media, but also about the way sex is talked about in society in general, especially when it comes to sexual education, which is, in their opinion, mostly inappropriate or lacking important parts. To summarize their thoughts, they all felt that sexual education was based on a ‘danger discourse’, while lacking useful information

¹⁷ The series indeed caught public attention for scenes of violence, a great part of which was specifically sexual violence and abuse.

about sexual consent and performance, such as whether sex should hurt, when does it hurt and what to do if pain is unbearable.

Conclusion

First of all, stories of women reported in this article only make sense in a context where heterosexuality is normative, and penetrative penile-vaginal intercourse is normative to heterosexuality. Since sexuality has strong links with gender and may even serve as a basis of one's gender identity, coitus is an extremely gendering practice. Vaginismus, tightness of PC muscles that makes coitus, as well as other penetrative activities, painful, hard or even impossible, may represent an issue for the (re-)shaping of one's gendered identity in two ways.

First, due to vaginismus, one's performance of normative heterogender is impaired, because vaginistic women cannot engage in sexual activities most satisfying to their partners and because they cannot enjoy coitus themselves (which is normatively regarded as 'natural'). For some women, it is also because they cannot participate in other practices essential for proper gender performance, such as using tampons or visiting gynecologists. The inability to have penetrative sex may also affect the way these women do other gendered practices, such as flirting, kissing or dressing, estranging them even more from the 'standard' performance of femininity. Yet, it does not necessarily have to be so – despite their 'non-standard' way of *doing sex*, some women reported to still feel like 'normal women' and it does not affect other ways in which they express their gender identity.

Second, gendered identity does not only derive directly from (normative) practices, but also from (normative) bodies. It was argued earlier that coitus is socially regarded as 'natural' and thus vaginas are evaluated in relation to coitus. In this context, vaginistic vaginas are 'too tight' or 'closed' – characteristics that imply deviancy from what is considered as '*biologically normal*', as 'natural' for women.

To my knowledge, all but one women in the SG wanted to overcome vaginismus, i.e. wished to *become* normative women. Thus, enacting their body in order to overcome vaginismus, implied enacting normative heterosexuality. And conversely, normative heterosexuality made women enact their bodies in a particular way through their wish for being 'normal women', 'empowered women', 'good wives' or 'romantic partners'¹⁸. Yet, treatment practices are not merely a tool for improving vaginistic women's performance of heterogender – they are gendering themselves, because they prompt women to engage with their femininity in ways that are not directly or explicitly related to coitus or men. Thus, we could conclude by saying that gender is not only constituted through interactions and relationships among people, but also through interactions and

¹⁸ These are the different discourses that women's narratives of overcoming were embedded in. Despite the slight differences among the discourses they used (due to differences in their backgrounds discussed in the methodology section), the basis for achieving their ideal was always the same – being able to engage in coitus with men, which is the main premise of normative heterosexuality.

relationships with one's own body. We could thus say that 'intimate doing' is also social in its nature.

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