Bad P*ssy

How an alternative medical paradigm contests conceptualizations of female sexual health and healing in conventional medicine

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Introduction

Hello vagina. I am going to make a movie about you. In that movie, I am going to say that we don't get along very well. I don't understand you, and I would actually like to ask you… What are you doing? What is wrong *with you? (Van Campenhout, 0:44-1:30)*

Although the most reliable available numbers point out that between 1 and 20% of women experience significant pain during intercourse at least often (Fugl-Meyer et al. 84), female sexual health is an underserved medical issue. Within the medical field, there are still discussions on the categorization of some symptoms and the nature of that which causes them. As a result, there is little conclusive evidence on fully effective treatments or therapies for such discomforts. Conventional medicine is not, however, the only institution that dedicates its analytical power to these issues: there are several so-called 'alternative' paradigms within which female sexual discomforts can be analysed and attended to. These alternative paradigms distinguish themselves from conventional medical thought in conviction, practice or even world-view and advocate for different methods to heal female sexual health problems.

What justifies the existence and survival of an alternative healthcare paradigm? Is not modern medical science that which will provide society with a cure if there is one to be found – making other health practices redundant? Such positivist notions of science – wherein it is assumed any form of science is capable of finding the singular 'truth' or, in the medical context, cure that exists in the physical world – have faced extensive criticism. Indeed, are facts not constructs that are reliant on language, and thus not as immutable nor as irrefutable as one might imagine?

Language itself is an attempt at categorizing and structuring the complex multitude of stimuli that constitute the individual experience, rather than a neutral vessel within which self-apparent realities are contained. Furthermore, as will be discussed more comprehensively, it has been convincingly argued that all knowledge is dependent on particular assumptions. In other words: facts are made with language, and exist by the grace of assumptions and structures which define certain statements as sensible and others not. This would provide grounds for different perspectives on health, that may be able to construct different kinds of knowledge on health and healing.

In this research I seek to elucidate how an alternative paradigm contests convictions that lie at the root of the modern conventional medical paradigm on the (female) body, sexual health and illness, and appropriate treatments. As a result, I intend to make visible and denaturalize these convictions and contextualize their constructed-ness within a historical/ historiographical framework of gendered power struggles. The critique that springs from my research is a critique on the level of

discourse and language, wherein it may be clarified what can be conceptualized and therefore understood in conventional paradigms, and what 'truths' may remain inaccessible as a result of that. My research question is: How is the epistemology of contemporary conventional medical science contested by a Western alternative healing method for the female sexual dysfunction vaginismus?

In order to answer this question, I will first elucidate what conventional views on healing, health and appropriate measures are by examining the definitions of health and illness and recommended courses of action within representative medical research papers and literature reviews. From these views I seek to learn what kind of images of the body and of illness are constructed, which conventional medicine needs tot sustain as part of their epistemology. This process is repeated for two alternative health doctrines or 'paradigms'. Thereafter I will seek how the alternative paradigms allow for different knowledge on illness, the body and healing to be produced, as well as how this knowledge may contest oppressive discursive structures around the female body and female sexuality.

I will make use of discourse analysis in my research. With discourse analysis, one can elucidate how the physical world is organized and classified through language. In the notion of discourse, language is assumed to perform a certain function: "Discourses arise from the coherence of description and evaluation of actions and events." (Frost and Elichaoff 47). Language, in this sense, facilitates the possibility to make sense of actions and the world at large through the ways "meaning is given to the concepts it constructs." (Frost and Elichaoff 47). As such, discourse analysis is predicated on the poststructuralist assumption that there are multiple 'truths', or knowledge as a construction of experience. Discourse is the result of the way one seeks to 'make sense' of the self and of the world through, or by the grace of, language. Since language is shared, however, so is this project of sense-making: it is strongly affected by cultural and historical influences. In the process of interpreting one's experiences, one is already faced with dominant, shared interpretations that are inscribed in the language (in the structure of cohesion between terms, concepts and ideas, in the connotations words carry) that is at one's disposal.

Discourse analysis "has a focus on questioning the questions that are asked about women's experiences rather than on looking for answers," (Frost and Elichaoff 46) which allows for an investigation into the power dynamics that lie at the root of the way the world is given structure and thus decide which questions are relevant and sensible and which are not. Through discourse analysis one can show how certain discourses perpetuate oppression and offer alternative discourses that are less discriminatory. Indeed, it is not my intention to argue what knowledge is 'really true', rather I wish to explicate how conventional medical care could not find the truths of alternative healers because of the way (historical) gendered power relations have influenced the genesis and continued existence of

what we now call conventional medicine. I intend to make visible and denaturalize basic assumptions within medicine and contextualize their constructed-ness within a historical/historiographical framework of gendered power struggles. The critique that springs from my research is a critique on the level of discourse and language, wherein it may be clarified what can be conceptualized and therefore understood in conventional paradigms, and what 'truths' may remain inaccessible as a result of that.

For my analysis, I have selected works from conventional medicine that are peer-reviewed and connected to the medical faculties of a university. In order to keep the scope of my analysis manageable, I will focus on the female sexual dysfunction of vaginismus. Vaginismus is defined as such on the U.S. National Library of Medicine-owned website Medline Plus:

> "Vaginismus is a spasm of the muscles surrounding the vagina that occurs against your will. The spasms close the vagina and can prevent sexual activity and medical exams." ("Vaginismus", Medline Plus)

The three most important sources are a research paper by Peter Pacik and Simon Geletta, a critical literature review written by Yitzchak M. Binik and a research paper written by a Dutch research team led by Moniek M. ter Kuile. Peter Pacik, M.D., FACS, is a now retired plastic surgeon who pioneered one of the most successful treatments for vaginismus. His treatment is now performed at Maze Women's sexual health institute and is said to have a success rate "well over 90%" (Maze Women's Health, "Dr. Peter Pacik"). Yitzchak M. Binik is professor of Psychology at McGill University, Emeritus professor and founder of the institute Sex and Couple Therapy Service and of the research institute Laboratory for the Biopsychosocial Study of Sexuality, both of which are connected to McGill University ("Yitzchak (Irv) M. Binik"). His work offers a thorough critical discussion of the available knowledge about vaginismus, as well as the way this knowledge is handled in the official diagnosis of vaginismus. Finally, Moniek M. ter Kuile holds a doctorate in Psychology and is associate professor of gynaecology at Leids Universitair Medisch Centrum ("dr. M. M. ter Kuile"). The research team she led has developed one of the most successful treatments for vaginismus as of yet and thus her work is included in my analysis.

For the sources on alternative paradigms, I have chosen M.D. Christiane Northrup's 'Women's bodies, women's wisdom'.

Christiane Northrup is an American OB/GYN health care practitioner, who has expanded her understanding of female health to a holistic view that includes lifestyle and mindset, focusing especially on what she calls one's "inner wisdom". The 2006 edition I selected is the third, revised version of her earlier work that came out in 1994 and that immediately became a New York Times best-seller. She creates a framework for female sexual health that foregrounds a woman's agency and

ideology. She draws from years of experience from her own holistic clinic, in which she treated women for many different sexual health problems. I selected Northrup's work because she focuses on women's health issues specifically, connecting them explicitly to misogynist power structures that shape the way medicine is practiced and that, in a wider context, shape women's bodies and affect their health; furthermore, the popularity of her work exemplifies its great relevance to many women.

Because there is also a historical dimension to discourse, I chose to focus as well on the history of medicine throughout the text. Although there have been many changes since, medicine as we know it has come to be from early practice in the thirteenth century and extensive revision during the sixteenth and seventeenth century, also known as the 'Age of Reason' (Ehrenreich and English 33). Throughout these ages, a new gender and sex division solidified, as well, which have influenced scientific developments as well. Throughout the text, there will also be quotes from Anne van Campenhout's 2017 documentary about vaginismus, *My Fucking Problem*. These serve to contextualize my work in the physical reality and experience of vaginismic women.

Firstly, in the theoretical framework I will discuss the definition of conventional and alternative medicine, and after that I will give a more extensive discussion on 'truth', facts, and their place in scientific practice, which will lead to an introduction of the paradigm as defined by Kuhn, as well as how this term relates to my research. In the main analysis, conventional medicine is discussed first: how vaginismus is discussed and what the most often used treatments are. After that, Northrup's theory and her recommendations for healing are discussed. Finally, I will critically discuss the implications of Northrup's intervention from a feminist viewpoint; using Judith Butler's theorizations of the construction of the body, I argue in favour of nuanced feminist discussion on the subject of what constitutes a 'healthy' vagina, the connections between health and normalcy, as well as between illness and deviancy and inferiority.

Theoretical framework

Definitions: alternative and conventional

Although there is no standard given definition of alternative medicine, generally it is understood to be any way of restoring and conserving health that is not part of mainstream or regular medicine (which is also called evidence-based medicine (EBM) or 'biomedicine'). Bodeker and Burford define 'TCAM' (traditional, complementary and alternative medicine) as "medicines used traditionally in [non-Western indigenous peoples'] cultures" (xv) and "healthcare approaches [in the West] that fall outside what has been considered mainstream medicine" (idem). An anthropologist definition of alternative medicine is as follows: "It is an eclectic array of healing resources, methods, and practitioners that exist mostly outside the dominant system of health care of a particular society at a particular point in time," (Ross 1) emphasizing the relativity of the meaning of the term and its inherent partaking in hierarchical social structures.

EBM or biomedicine relies in theory on treatments that have been scientifically proven to work: furthermore, the best evidence comes from double-blind placebo-controlled medical trials (Ross 5). At its core lies the conviction that clinical decisions must be informed and supported by the latest scientific insights and evidence (Goldenberg 2622). Objectivity in medical research purportedly guarantees usable knowledge: knowledge that is universally true, regardless of cultural differences; knowledge that only addresses the natural, or the physical (Bivins 37).

However, there is an issue with the meaning – and legitimacy – of 'objectivity', as the term has been criticized both within the philosophy of science and critical feminist theory. 'Objective' knowledge is "dispassionate, unbiased, and free of unacknowledged assumptions." (Bivins 37). Feminist critique, however, concludes that none of the three characterizations are ever applicable to any kind of generated knowledge (Goldenberg). 'Objectivity' is used to create and sustain power imbalances: white and male people are supposedly better at, or even the only ones capable of, generating such objective knowledge. The latter assertion is sustained by the figuration of the 'modest witness':

> "the protagonist of the dramas of the Scientific Revolution who testifies without prejudice to new facts, [who] had to be constructed in sufficiently detached and abstracted terms to make plausible the unusual situation where *his* experiences could somehow represent everyone's and no-one-in-particular's experiences."
> (Goldenberg, 2005, 2624-2625)

The elucidation of the construction of the modest witness reveals (beyond its exclusionary politics) the assumption that underlies it: that there exists some "dislocated, disinterested" (Goldenberg 2625) observer. However, every human being is undeniably embodied, so the legitimacy of 'objectivity' is contestable at best. As science is ultimately practiced by human beings, all knowledge generated within the framework of science cannot be considered 'objective'.

My thesis will concern the practicalities of treatments and cures that are used in 'regular' medicine, with the explicit intention to contrast them with alternative treatments. However, what remains of the theoretical definition of regular medicine, outlined above, when the legitimacy of 'objectivity' is undermined? This definition may be re-conceptualized as an ideology that medical practitioners and students as well as laypeople share. In order to establish a working definition for the purpose of my thesis that will allow me to identify certain texts and practices as regular or alternative medicine, I focus on the physical loci where medical practice is informed by the ideology of EBM or biomedicine. Regular medical dominance is established through universities or other forms of 'formal' training (Ehrenreich and English, Bivins). Other physical locations where regular medicine eventually found its place were the hospital and the laboratory (Bivins 36). As time passed, medical practice became increasingly complex, which resulted in a quickly increasing amount of specializations (Bivins): gynaecology and psychology are most relevant for the subject of my thesis.

I elect to call regular medicine 'conventional' medicine. 'Regular' has connotations of 'normalcy' or ordinariness; as such, the term can be seen as a normalizing, naturalizing one. I wish to emphasize the constructed-ness of 'regular' medicine, and its relativity in meaning across time and regional space. 'Conventional' means "formed by agreement or compact … according with, sanctioned by, or based on convention," ("Conventional" Merriam-Webster) and thus shows the common agreement on biomedicine's or EBM's dominance to be the source of its legitimacy. In accordance with the physical loci of conventional medicine, I understand conventional medical care to be that which is practiced in hospitals, specialized gynaecological establishments and medical science practiced in universities or medical research facilities that are connected to hospitals, universities or both. Any healing method that does not match that description is by definition 'alternative'.

Kuhn and the Paradigm: on facts and assumptions

Science philosopher Alan Chalmers points to two general assumptions on the relation between science and 'facts': first, facts are assumed to be directly available for unbiased perception; second, facts precede theory and are wholly independent of it (Chalmers 26). However, one's perception of

something in the outside world is dependent on the knowledge or experiences one already has. Furthermore, facts do not precede theory (Chalmers 27-30). Facts do not exist outside of the minds of those who know them; they must be formulated with language, which is often itself dependent on previously existing theories to provide the thinker with proper vocabulary. Additionally, methodology, which depends on theory, defines what information is worth being filtered out of – or even sought out from – the multitude of information available. Thus, theory shapes facts, not the other way around.

Science philosopher Kuhn seeks to incorporate these critiques in a new vision on science. He asserts that a scientific field requires a particular framework of basic assumptions, instruments and their associated techniques, theories and observations or facts that give aim to the practice of scientists and researchers operating within that field (Chalmers 133). This framework is called the 'paradigm'. Should that paradigm be unable to explain too many observations or facts, the paradigm is replaced by a new one through 'scientific revolution'. Otherwise, unexplained events are simply called anomalies and abandoned.

Medical science, then, becomes a collective project rather than a natural process: a way of creating 'facts' on the human body and the ways to alter, enhance or repair it by the grace of a thought-up collection of basic assumptions that have not (yet) faced too many contradictions. Kuhn's paradigm thus enables my analysis first on the level of power relations that the paradigm in medical science is subject to, and second on the level of the discourse that gives and restricts access to the formulations of different kinds of facts.

Neither Kuhn nor Chalmers offer an investigation on the topic of the connection between the paradigm and questions of power: therefore it is necessary for me to add this dimension to the term. There is tension between Kuhn's work and feminist philosophy of science, as investigated comprehensively by Helen Longino. She notes:

> "While [Kuhn] gave feminist scientists a way to talk about the ways in which a socially shared gender ideology had colored observation of males and females of all biological species, his analysis of scientific revolutions did not give them a language or rubric for describing the kinds of changes they wished to recommend." (Longino, p. 266).

Kuhn argues that the only way a paradigm can fall into disuse is through scientific revolution, when it appears that there are too many phenomena and observations that the current paradigm cannot explain. Therefore, feminist scientists and philosophers of science could not rely on Kuhn's theoretical procedure of terminating a paradigm because the androcentric paradigms they agitated against could, according to its own guidelines, account for many phenomena and observations – enough to merit its continued use (Longino 277). Although feminist philosophers of science have offered multiple possible

solutions to this obstacle, truth remains that Kuhn's approach to meaning as theory-laden is ultimately not helpful for feminist purposes because "it leaves [feminists] unable to criticize the misrepresentations of gender as incorrect for anyone, regardless of their gender ideology." (Longino 276). This raises the question from what (alternative) paradigm the truths in science that feminists identified as problematic may be identified. I cannot give a definitive answer to this, but Kuhn's theory is still very well suited for my research because I explicitly intend to evaluate the conventional medical paradigm from the viewpoint of alternative paradigms.

Kuhn's paradigms are useful to my research because they show that scientific knowledge is not based on 'truth'; rather, it is dependent on the proper language to explicate it with, which is in turn dependent on theories and assumptions already available. As such, the paradigm as a concept goes to show the constructed-ness of knowledge. Although Kuhn himself did not engage with power dynamics in his work, focusing rather on how a paradigm served goals such as accuracy, simplicity and 'fruitfulness', I would like to consider the way societal and cultural power structures shape and reinforce a paradigm. In order to keep the possibility that both conventional and alternative paradigms have merit in medicine open, there must be a modification to the paradigm as conceptualized by Kuhn. According to Kuhn, there can only be one paradigm that is considered legitimate. Counter to this, I consider the possibility of epistemological pluralism: Longino, in favour of epistemological pluralism, argues that it is not unusual for science to encounter a subject so complex it requires multiple scientific approaches: "Both a gene-centered account and an environmental account of the development of some trait [in organisms] may be correct but partial. Their theoretical structures are such that they cannot, however, be combined into a single account." (277) Perhaps female sexual health is such a complex subject that warrants seeing multiple perspectives as equally legitimate.

Analysis

Function/dysfunction

Anne: At a party, someone asked me what I was working on and I said that I'm making a movie about women for whom penetration is painful. And then he said: yuck, I think those bitches are so weird! (Van Campenhout, 6:54-7:00)

Anonymous forum commenter: women shouldn't complain so much and just open their legs. (Van Campenhout 17:33-17:35)

Vaginismus is classified as a sexual dysfunction (Binik 286): through this term, its opposite (sexual *function*) is defined. In the DSM-IV, vaginismus is defined as a "recurrent or persistent involuntary spasm of the musculature of the outer third of the vagina that *interferes with sexual intercourse*." (American Psychiatric Association as quoted by Binik, emphasis mine) Although vaginal penetration is a broad term that can apply to tampons and menstrual cups, speculums, dildos, fingers and penises, it is the latter that is given most attention. Treatments are designed to allow patients to partake in penetrative sex (see: Ter Kuile et al., Pacik and Geletta, Fugl-Meyer et al.) Female sexual function, then, is to be able to accommodate a penis during penetrative, heterosexual intercourse.

Vaginismus remains difficult to define. For 150 years, vaginismus has been conceptualized as an involuntary spasm of the pelvic and vaginal muscles by any attempt at penetration "as to form a complete barrier to coition" (Sims 1861 qtd. in Binik 279). However, the "diagnostic formulations for vaginismus were almost entirely based on expert clinician opinion." (Binik 280): recent research has pointed out that the spasm does not actually occur. Vaginismic women were asked as part of medical research whether they experienced spasm for the first time in 2004: 76% said they did not (Binik 282). Researchers may not discuss the same phenomenon when referring to 'vaginismus': Fugl-Meyer et al. state that not every woman who is diagnosed with vaginismus "[reports] introital passage obstacle" (86) whereas Reissing et al. maintain that the core characteristic of vaginismus is that the sufferer is not able to experience penetration and that the 'obstacle' is thus the defining trait of vaginismus (1210). As such, it is not definitively clear whether vaginismus is different from dyspareunia, a condition wherein a woman experiences genital pain during intercourse for seemingly no reason (Binik 284), which is why in the DSM-V, the two diagnoses have been combined into Genito-Pelvic Pain/Penetration Disorder (GPPPD).

Mechanical interventions: physiological approaches to vaginismus

Anne: I have stretched my vagina out, tightened it, filled it up and inflated it. (Van Campenhout, 8:11-8:18)

The most often used tool in physiological-based treatment is a dilation set (Rapkin et al. 311): these are insertable cylindrical objects that progress in length and diameter. Some clinicians argue that the dilators "are used to restore vaginal capacity [and] to expand the vagina in width and depth," (Kellogg Spadt et al. 12). The vagina is approached as a lifeless pliable object here, stretched

up by the dilator like an earlobe during gauging. Evidently even the cervix can be pushed into a new position deeper in the body to accommodate the length of the dilator. The cervix, however, generally rests relatively low in the vagina and only rises significantly during sexual arousal (Levin 409); arousal is not part of dilator training, which is generally uncomfortable. Thankfully, Kellog Spadt et al.'s work is not of the highest quality as it is not peer-reviewed: however, the sentiment behind their remark is reflected still in the design of the vast majority of vaginal dilators, which all progress in length, as well – as though they could indeed make the vagina deeper. Additionally, this conviction is still present in non-medical discourse, as the website Vaginismus.com (a well-visited, accurate American informational website about vaginismus) feels the need to clarify: "The falsely perpetuated idea that vaginismus treatment is simply about inserting graduated dilators to stretch the vaginal opening has caused many women unnecessary heartache and lost years. … Treatment is less about stretching [the vaginal opening] and more about learning how to control and override underlying problems with involuntary pelvic reflexes." ("Using dilators without a program?")

This false idea may come from historical constructs of the vagina. In the eleventh century, the Italian physician Trotula of Salerno commented on "the tightening of the vulva so that even a woman who has been seduced may appear a virgin" (qtd. in Reissing et al. 1209): this is likely the first mention of vaginismus. In Salerno's view, the vulva (which includes the vaginal opening) stretches out over time (or 'use') after its initial 'breaking-in' of the first (penetrative) sexual encounter, envisioning the vagina as devoid of any character of its own – the way it moves, changes, regenerates, indeed *lives* – but static, available for reconfiguration by the elements. This usual chain of events contrasts starkly with this odd case, wherein the already 'broken in' vagina returns to its virginal, tight state.

Recent research by plastic surgeon Peter Pacik has shown that intravaginal injections with Botox-A in combination with progressive dilation under partial anaesthesia allowed 71% of patients to have intercourse (Pacik and Geletta, abstract): this makes it the most successful physiological approach to vaginismus yet. Botulinum-toxin A is a neurotoxin that prevents muscles from contracting; administered in this way, the pelvic floor and vaginal muscles are incapacitated. This then allowed them to be stretched up with a dilator set. Participants were asked to continue using the dilators, also at night. In this treatment, the patient's body was manipulated so that it could no longer display symptoms: tensing was disabled through botox and pain was disabled through anaesthesia and Ibuprofen. As such, the problem of vaginismus is eliminated, which evidently constitutes a successful cure.

Besides Pacik's approach, there are other physiological methods: Fugl-Meyer et al. note that tricyclic antidepressants may help and that "women usually respond well" (Fugl-Meyer et al. 90). It

remains unclear what that means. Local anaesthetics have been tested as well; topical application showed 'moderate effect' and oral medication "reduced persistent coital pain to the same level as placebo (33%)" (Fugl-Meyer et al. 90). Here is an attempt, as well, to prevent the body from displaying symptoms. Pelvic floor rehabilitation is an often-used treatment that focuses on improvement of the pelvic floor functions through physical therapy. The effectiveness of pelvic floor rehabilitation for female genital pain in general has never been proven. The very possibility of its usefulness for women with vaginismus may be doubtful, as they may not even differ in pelvic floor tone or tension from non-vaginismic women (Fugl-Meyer 90; Binik 281). It is striking that physical therapy is still used despite a lack of scientific evidence and that multiple scientific articles contradict each other, because this is opposite to conventional medicine's ideology.

Ill-logical: you're not thinking right

Dorrit: The sexuologist said: a next step is body-focused psychotherapy. So even more psychotherapy… Which I also found vaguely insulting, or something.
Older lady: "Madam it's between your ears…" I clearly feel pain between my legs. So at some point you think: am I crazy, or are you crazy? (Van Campenhout, 24:12-24:25)

Psychological approaches define mental health with notions of the 'logical' mind. In this vein, vaginismus becomes the result of an illogical mind. As noted earlier, other potential characteristics of vaginismus have been suggested, such as pain and fear of penetration. However, "the descriptive characteristics of the pain were never specified nor was the relationship of the pain to muscle spasm. Moreover, pain never supplants muscle spasm as the crucial diagnostic factor. … pain is not assigned any crucial diagnostic significance." (Binik 280). The inability to accommodate a penis during penetrative sex is awarded more importance than the experience of the afflicted (pain). Fear or phobia are considered more significant: "Fear of pain or fear of penetration also features prominently in many clinical descriptions," (Binik 280) and "vaginismus … is probably best described as a phobic defense mechanism." (Fugl-Meyer et al. 86) A phobia is "an *exaggerated usually inexplicable and illogical* fear of a particular object, class of objects, or situation," (Merriam-Webster, "Phobia"). In the determination of vaginismus as a phobic state, the cause of the pain is already contained within the definition of the illness. Binik notes that this is "not in line with the general strategy of the DSM-IV-TR to classify by symptoms rather than by presumed cause or mechanism." (281). Additionally, this cause is characterized as irrational and exaggerated.

In 1974, Kaplan says: "[Patients] with vaginismus are also usually phobic of coitus and vaginal penetration. This phobic avoidance makes attempts at coitus frustrating and painful. … sometimes the penetration phobia antedates the vaginismus." (qtd. in Binik 280) Despite Kaplan's observation that the phobia antedates the spasm only "sometimes", he feels justified to assert that the phobia causes "frustrating and painful" intercourse. However if phobia usually comes after the spasm (and thus pain), the fear is not irrational at all. By presenting the problem of vaginismus as Kaplan has done, however, it seems as though the woman creates the problem by acting and thinking in an illogical way, allowing her emotions to ruin a situation that would be fine if only she were to let go of her unjustified inhibitions. As such, the application of the term phobia to the aetiology of vaginismus may firstly downplay the importance of the female painful physical experience as it centralizes instead an internal cause of that pain (fear/phobia) in the description of vaginismus, and secondly, it prematurely closes off an investigation into another cause either the pain or the fear may have as there is assumed to be none.

Binik and Reissing et al., however, have since elected to use the term 'fear' instead of phobia, which eliminates the problematic implications I outlined above as fear does not have connotations of psychopathological irrationality. Ter Kuile et al. introduce a more nuanced use of the term 'phobia': they argue that the fear-based aetiology may be used to conceptualize vaginismus as "akin to a specific phobia," (1808) thus not a phobia of itself, but in certain aspects *like* one. Either author team argues that the fear *is* the vaginismus. Medical discourse on vaginismus asserts that the vaginismic woman is afraid of something that she logically need not be afraid of: "[Negative] penetration beliefs are maintained because avoidance prevents disconfirmation of the catastrophic penetration beliefs. … When catastrophizing is reduced and eventually eliminated, avoidance behaviour as a coping strategy is no longer necessary." (Ter Kuile et al. 2015 1816) In theory, the fear causes increased pelvic muscle tension, which in turn results in failed penetration attempts, and those affirm the fear. The fear-avoidance model has received some empirical support but is not definitively proven to be precisely true (Ter Kuile et al. 2015 1808). What logic underlies the hypothesis of the fear-avoidance model?

Ter Kuile et al. have carried out a study on the efficacy of cognitive behavioural therapy (CBT)-based exposure on lifelong vaginismus. Exposure works through exposing the patient to the feared stimulus: in this case, vaginal penetration with dilators. It must be noted that the dilators were used not as 'stretchers' but exposure tools, which is more in line with the recommendation made on Vaginismus.com, as well as contemporary images of the vagina and pelvic floor rather than outdated images of the vagina as a pliable 'lump'. What made the recent approach of Ter Kuile et al. unique was the incorporation of *therapist-aided* exposure as all of the treatment was done under

guidance of a (female) therapist, and with the patient's partner present. This treatment is created to address the condition of distress or fear the woman is in rather than downplay it. The aim of the treatment is to diminish the distress the woman is in by encouraging her (and her partner) to make explicit the harmful thought patterns they have in order to challenge those. In a description of the CBT used in the earlier trial, the researchers state: "[Participants] were taught how to identify irrational cognitions, beliefs (e.g., "My vaginal entry is just too tight"), and self-talk, and how to convert these into more rational cognitions. A new cognition was considered more rational when it proved helpful in performing [relaxation and exposure] exercises." (Ter Kuile et al. 2007 362).

It is striking that the authors felt the need to use the notion of 'rationality': in the endeavour to distinguish the two types of cognitions, the authors could also have used other terms, like helpful and unhelpful. These terms would be more closely aligned with the authors' intended meaning concerning cognitions that caused pain and distress and cognitions that caused relaxation, comfort and desire. Thus 'rationality' indeed holds relevance in the categorization of 'healthy' and 'dysfunctional' cognitions. The vaginismic woman is irrational. However, if one's experience has always been that the vaginal canal is too narrow for entrance, it is not irrational to hold such a belief; it is in fact rather empirical. So at once, the vaginismic woman's feelings and emotional state are taken seriously and conceptualized not as a frivolous error she simply has to stop making, but as a condition which requires support; and simultaneously, the treatment is explicitly rooted in the conviction that a woman's dedication to illogical cognitions causes sexual malaise.

The above analysis is complicated by the discursive connection that characterizes phobic behaviour or otherwise mentally 'dysfunctional' behaviour as *bad*, which turns the indication of a maladaptive psyche into a personal affront: this is problematic in and of itself. I do not wish to advocate for or perpetuate any condemnation of people who genuinely suffer from phobias or other psychological issues. Indeed, if the fear-avoidance model is true and gives rise to a treatment that helps women, nuance is imperative lest discussions of what is problematic overshadow this success. To argue that calling a complaint psychological necessarily equals insisting that said complaint is somehow 'made up' by the patient is to leave unexamined a notion of mind-body dualism. This dualism asserts that the logical mind can accurately register the 'truth' as it happens and is in the 'real' world, the outside world. If a complaint is psychological, then, the patient's mind is experiencing or registering something that is *not* part of the 'real', physical world. The patient's mind is illogical and thus *unreliable*. Indeed, the mind-body dualism emerged in a time wherein Western patriarchy solidified: the characterization of women as illogical and overtly emotional enabled men's control over women as they surely could not make choices for themselves (Federici 100-101). As

shown in the quote at the beginning of this chapter, the assertion that the complaint is 'between one's ears' may be used to delegitimize the significance of the complaint which offends the patient.

So on one hand, it is important to realize that the assertion that psychological complaints are made up and not 'real' or legitimate is problematic. On the other hand, mind-body dualism still holds power in medical and non-medical discourse. It may lead to a devaluation and de-legitimization of the female (vaginismic or other) experience as illogical and thus inferior, and an indication of an unreliable mind that requires outside control. It has not been verified that all doctors consider psychosomatic complaints as equally legitimate to physical ones: in fact, in a web-based survey, only 25% of female respondents reported feeling validated when they sought medical help for sexual function complaints in general (Berman et al. 576). So the assertion that vaginismus is, in essence, fear, gives rise to two interpretations for an appropriate medical response: either the fear is that which requires earnest treatment, or it indicates that there is no 'real' problem and the woman need only be told to "Go home and have a glass of wine" (Berman et al. 573).

Northrup: the mind-body

Older lady: It feels as though I've accepted it, nevertheless, I still feel sad about it when I'm in bed with my boyfriend. It's just the sadness that's in you, I think.
Anne: Sadness that we have… over our body that doesn't… That doesn't cooperate.
Older lady: Yes [voice cracks] something like that. (Van Campenhout, 25:48-26:11)

Northrup argues that the body and the mind are co-dependent on each other to such an extent that they are co-*constructed* by each other, or even one and the same: "matter is the most dense form of mind, and mind the lightest form of matter." (Northrup 60) In this paradigm, the physical experience and manifestation of emotional reactions can no longer be divorced from a disembodied mind: the mind-body is inherently emotional. Northrup criticizes the conceptualization of the body as inferior to and at the disposal of the mind. In such a constellation, the ill body becomes the enemy, which may lead to resentment of the body. The health and vigour of our physical selves are closely connected to that of our mental-emotional selves: chemicals secreted by our nervous system, that our organs respond to, "influence the way thoughts and emotions have a direct influence on our bodies." (*Ibid.* 66) Illness, then, becomes a matter of the mind as much as one of the body, mediated through emotions. Physical illness can best be seen as a message from the body about issues in the mind: once those are resolved, the body – which regenerates, and is in

constant flux – heals by itself. Thus, Northrup also calls for a re-conceptualization of the body as a process, rather than a fixed entity.

This has particular implications for women's (sexual) health. Northrup does not hesitate to pose that "the patriarchy loudly proclaims that the female body is inferior, and that it should be kept under control." (Northrup 35) Sexuality is one of such fields through which this oppression and control is mediated. Dominant gender ideologies dictate what is 'normal' in (heteronormative) sexual encounters: even though women experience physical pain and fewer orgasms than men, they usually report the same amount of sexual satisfaction as men because pain and few orgasms are to be expected for women (McClelland 667-668, 670). In a non-academic opinion article, a journalist even maintains – conceding that her source is a non-academic Twitter poll – that "when most women talk about 'bad sex,' they tend to mean coercion, or emotional discomfort or, even more commonly, *physical pain*." (Loofbourow, emphasis in original) Physical hurt and possibly even coercion (the latter of which would signify sexual assault) are normalized parts of female sexual functioning and experiences. Thus, likely the vast majority of women experience sexual violence, but are not counted in official numbers: for women, sex is dangerous. Northrup also exemplifies (and criticizes comprehensively) other ways in which women are still devalued: constantly having to take care of others before themselves, continuously being assumed they are not as intelligent as men, and so on.

The introduction of mind-body dualism into the very foundations of modern medicine has historical roots in a time where, indeed, men sought to subjugate and control the female body and its sexual and reproductive qualities. After the social devaluation of all women's work, reproduction was the only serious 'job' women had left. The womb, along with women's other sexual organs, were no longer body parts belonging to a living person; they were an economical resource allotted to the husband. The woman became not just unable to refuse sex: all of her desires were entirely irrelevant to her genitalia. Considering Northrup's intervention in light of this scholarship, it becomes apparent that Northrup has accurately named the dysfunctionality of Cartesian thinking in medical science, connecting it explicitly to the oppression of women in general and the generation and appreciation of non-'objective' knowledge in contemporary medical science. Northrup argues that the very culture one lives in affects not only the mind, but the very physical structure of the body, as well.

Function/dysfunction revisited

Anne: When I imagine what painless penetration would be like, I can already feel it inside of me. I am not sure how it's possible, but my body knows that feeling. Is it a combination of all the delicious moments that we practiced, or is it something I make up myself entirely? Maybe it is some sort of primal desire that we get at birth. (Van Campenhout 24:44-25:24)

In the first segment of this text, I showed how normative ideas on the female body and female sexual organs may be perpetuated through the medical diagnosis of vaginismus. Indeed, Binik notes that the diagnosis is a "problematic situation" wherein it is attempted to "define a problem based on the absence of a behavior (penile vaginal intercourse or the equivalent) that some would argue should not even be promoted because it is too male oriented." (286). However, why is penile vaginal intercourse male oriented when it requires two participants?

Is it bad for medicine to define vaginismus and seek to treat it? Is the motivation for vaginismic women to get 'cured' based only on socially conditioned ideals of what their vagina is 'supposed' to be like? Indeed, are women supposed to desire penetrative sex? A large portion of feminist critique has concerned itself with 'medicalization', or "medicine's tendency to define normal events in women's lives … and natural states … as pathological and requiring medical attention." (Purdy 249). As a result of such medicalization, medicine can "[control] women as it provides care." (Purdy 250). Is vaginismus perhaps not also a normal state, part of the variety of life? It is certainly true that medicalization can be and has been used to control women and (re)instate gender and sexual norms: this, again, also shows how 'ill' is rather synonymous to 'bad'.

One may interpret the classification of vaginismus as a diagnosis as a ploy of the patriarchy that prods women into having sex by normalizing and naturalizing the idea that women really want to have, and should have, heterosexual, penetrative (reproductive) sex. There is great issue taken with the fact that a penis cannot enter a vagina. Indeed, historically, female sexuality has been commodified to the point that women became breathing incubators (Federici).

I advocate for nuanced discussion on the matter. The relation of the body to the cultural – or of sex to gender – has inspired extensive discussion within feminist theory. Judith Butler contributed the theory of the performativity of gender, wherein the gendered subject performs its gender according to approved cultural norms, thereby perpetuating them – although the performance also offers opportunities for agency, wherein the subject can reject the norms through a different performance (Butler 1988). Since then, Butler re-examined her theory, and concludes: "Such a willful and instrumental subject, one who decides *on* its gender, is clearly not its gender from the start and fails to realize that its existence is already decided *by* gender." (Butler 2011 ix). The performativity of gender assumes some subject beneath the performance, some physicality that is the foundation

upon which constructions are built, and that can *choose* which constructs it carries and which it rejects. Butler rejects such a humanist conceptualization of the self, however: the result is that the subject itself – that beneath the gender – must be understood as profoundly impacted by that gender. Through this adjustment, Butler touches upon how perhaps physicality itself is constructed: "I want to ask how and why "materiality" has become a sign of irreducibility, that is, how is it that the materiality of sex is understood as that which only bears cultural constructions and, therefore, cannot be a construction? What is the status of this exclusion?" (Butler 2011 4). Butler admits that of course, there is a certain 'necessity' to the materiality of the body as it sleeps, eats, feels and dies: the meaning of the word 'constructed', then, has to be re-thought as well. To argue that something is constructed, to Butler, is not to argue that it is of "artificial and dispensable character," (Butler 2011 x).

One might argue within a feminist framework that vaginismus should be de-medicalized because the idea that a penis must be able to enter the vagina is a cultural construct that serves the patriarchy. However, this implies that a woman who has vaginismus is such because that is her natural state and that the medicalization of her state is a cultural misogynist aggression. In this argument, one assumes that there is such a thing as a natural *state* of any body beneath the cultural construction imposed upon it. Indeed:

> "[In] daily life feminists justifiably angered by sexist pressures to conform to current standards of 'health' or beauty (for women the two tend to be conflated), often interpret any attempt to change the body as capitulation. Thus 'the natural' still exerts substantial power over us," (Purdy 253-254).

Especially Northrup's work seeks to demonstrate the way society's cultural methods of oppression shape the constitution of the body. The natural within medicine has led medicalization to "usually [imply] the negative phenomena of reducing political, personal and social issues to medical problems thereby giving scientific experts the power to 'solve' them within the constraints of medical practice." (Sawicki as cited by Purdy 150-151) like when a vagina is forced wider with botox and painkillers while the male partner was often unaware that the woman *really* did not have control over her vaginal muscles, implying bad communication at best (Pacik and Geletta 119). The natural naturalizes the bodies that are the result of a particular way of life, passing by the fact that "our bodies are always at least partially constructed by our own choices, the choices of others, and by the environment." (Purdy 154) The natural can indeed be problematic, but it may be an indispensable part of any paradigm because without it, we cannot create meaning: as Butler phrases it, "What are we to make of constructions without which we would not be able to think, to live, to make sense at all, those which have acquired for us a kind of necessity?" (2011 x) Although it can (or should) not be

proven that it is a woman's 'natural' state to desire and enjoy penetration, it can be simply argued that enjoying things is nice.

Furthermore, I would like to add a more personal perspective on *low libido*: noticing it is not always a sudden observation made relevant and visible only by discourse on how often we should do 'it'. In my case, it was the sensation of genuinely wanting, but having any desire evaporate as soon as I turned my attention away from daydreams and onto my own body, constantly out of reach but close enough to upset me. In the above feminist doctrine, the longing that I felt come from somewhere inside of me (mirrored as well by the quote at the beginning of this paragraph) is inscribed by the patriarchy: although unverifiable to be true or false, it is not an interpretation I can side with.

Sadly, the concept of female sexual pleasure can and has been co-opted by the patriarchy, from normalizing abusive relationships through Fifty Shades of Grey to attempts at rape apologism based on notions of women 'actually wanting it'. Women can not safely and freely proclaim that they want sex because that endangers their capacity for consent. The male sexual presence, or the penis as a physical, symbolic derivative thereof, may very well be considered a *logically* frightening entity to women. The incapability to desire sex on one's own terms may affect women's very physical responses to sexual stimuli, or their sexual constitution. In order for this reasoning to become logically invalid, one would have to assume that bodies are simply 'made' a certain way, rather than profoundly culturally inscribed.

From this point of view, then, what can be said of vaginismus? One might argue that vaginismic women who seek a cure do this because of patriarchal ideas about what their vagina should and should not be like. However, this does not investigate the discursive relation between 'illness' and 'wrongness', instead taking them at face value and failing to demonstrate their constructed-ness in the service of the very oppressive regime they seek to criticize, nor do they offer space for the formation of a female sexual desire that is not mediated by heteropatriarchal interests. To accept oneself the way one is and maintaining hope or effort to change (from vaginismic to non-vaginismic) may not be mutually exclusive. Another practical footnote is that vaginismus obstructs menstrual cup or tampon use as well: to disregard this, as all my gynaecologists have done, is to affirm that the vagina only exists in the context of penetrative sex.

The diagnosis of vaginismus or GPPPD, although as demonstrated not entirely unjustified, is reflective still of archaic ideals of the female body and appropriate ways to treat it. Conventional medicine still does not focus on female sexual pleasure: vaginismus research does not address whether women enjoy penetration once it is accomplished and although 36% of women who report 'sexual function complaints' experience 'lack of genital sensation', there is no diagnosis (and thus, help offered) for this issue. This would be unthinkable for men: lack of sensation in 36% of sexually

dysfunctional men would not go unnoticed. Why does medicine accept so readily that it is normal (natural) for most women to not actually enjoy (penetrative) sex? The method of conventional medicine gains new meaning in the context of the treatment of female sexual function complaints. Conventional medicine works by disciplining the body: as a result, there is more research on botox for the pelvic floor than there is on the effect of oral contraception on genital pain.

Conclusion

Conventional medical care is predicated on convictions on the human body and health that are reminiscent from old Christian doctrine and Renaissance thought. Firstly, the human body is seen as static: *made* a certain way, rather than a 'process'. Secondly, the purpose of the female body is still to accommodate penetrative sex, a remnant from the purpose of the female body as incubator. I argue in favour of nuanced feminist discussion on the ways one may challenge this notion.

The body is a static entity that is not conceptualized as one that may heal on its own. Once sick, it requires outside intervention and manipulation in order to heal. 'Healing' is understood to be any method of manipulating the body or mind which makes symptoms disappear.

Vaginismus is presumed to be the result of 'illogical' thought: it is the woman who causes her illness. By defining the thought patterns of vaginismic women as illogical, even though they are quite empirical, which then justifies the psychologist's intervention to create logical thought instead, the cause of the illness is contained within the person. This eliminates the need to contextualize the problem of vaginismus in a social or cultural framework. The interpretation of social or cultural issues as medical ones, in order to focus on and control the individual, is something medicine in general is accused of by feminist scholars. This focus, which eludes the influence of the environment, also creates an image of the body as rather static: the vaginismic woman simply *is* vaginismic, chiefly because of her nervous and irrational predispositions (which are equal part of who she *is*).

Mind-body dualism asserts that the mind and body are separate, and that logic is the great virtue of the mind. Historically, this dualism was used by men to seize control over women by asserting that women generally lack logic and are instead too deeply bound to the emotional body. Although this dualism hails from the 16th century, it still holds relevance: the assertion that vaginismus is likely a wholly psychological issue carries implications that the mind is creating a problem where in the 'real', physical world, there is none. In other words, the mind is ill, illogical and thus inferior. This may lead physicians as well as others to downplay the importance of the illness as it is 'not real' but a fabrication

of an untrustworthy mind. However, in the CBT-based exposure trial, the mental state was taken seriously as a harmful condition in and of itself. However, it was also still conceptualized as 'illogical'.

Northrup argues that the mind and body should be seen as an integrated whole. This allows her to argue that the social and cultural context a person is in affects their health. This has particular implications for women's sexual health: Northrup does not hesitate to state that contemporary Western culture is a patriarchy, and that women are conditioned into harmful thought patterns. For instance, they are supposed to always think of others before themselves. I have shown that this extends to sexual practices as well: in sexuality, male pleasure is a lot more self-evident than female pleasure. Moreover, female pain and discomfort is a naturalized part of sexual encounters. This socio-cultural context leads to sexual health problems in women, which ostensibly includes vaginismus.

Although both Northrup and ter Kuile et al. argue that vaginismus is really a mental-emotional issue, Northrup argues that the 'toxicity' that allows for the illness to develop is an outside force of harmful, taught normative ideas rather than internal issues with logic. As such, Northrup can show how the mind might 'cause' physical illness without accusing ill people of creating their own problem, blaming them. As such, her paradigm offers a way for ill people to feel more compassionate towards themselves: at once they see how they can do things differently in order to help themselves, as well as how they came to such harmful habits. In this paradigm, illness is transformed from something that requires removal to something that shows how one is (unwittingly) hurting themselves, or being hurt by a particular environment. To conceptualize illness as something to be eliminated may lead to self-rejection in patients: even though 'the illness' is a separate concept from the self, its existence is ultimately enabled through the body. Vaginismus may be the tension and pain in the vaginal and pelvic muscles, it is those muscles that enable the tension's existence: for the patient, the symptoms are inseparable from the body. If the illness is bad, and must be removed, what does that say about the vaginismic vagina? The vaginismic vagina is then bad, itself, as well: it fails its owner by not cooperating. However, conceptualizing the self as a mind-body leads one to see that the vagina is as much 'self' as the thoughts about that vagina: thus it is not there to 'serve' the self because it is the self, and it also becomes impossible for the vagina to fail the woman because it is the woman.

From Northrup's theorization, it follows that the body is more changeable than generally assumed: its very structure changes in response to its environment. This reflects Butler's interrogation of the assumed given-ness of the materiality of the body: indeed, why is it assumed that the physicality of the body comes before any construction, or that it is that solid and unchangeable ground upon which construction is built? Northrup re-imagines the mind-body as a process, rather than a static given: it regenerates and changes constantly. This allows firstly for a greater focus on the body's self-healing properties, but also has implications for a feminist discussion of the diagnosis of vaginismus.

One might argue that the diagnosis reinforces patriarchal standards wherein the vagina must be available for reproductive penetrative sex: indeed, the treatments I reviewed were not concerned with whether the women for whom penetrative sex became possible enjoyed it. There is greater concern with whether a penis can finally go into the previously unavailable vagina than with the woman's experience of her sex life. If the vaginismic woman is part of the natural variety of life, affected by cultural constructions of the 'proper' woman and vagina, then there is still assumed to be some natural state for this individual to be in. However, if bodies are a process and constantly changeable and changing, the natural 'state' of any body no longer makes sense: the state of the body is devoid of meaning. If some of the mind-bodies are affected by, as many feminists would agree, a sexually violent patriarchal society – their sexual organs hurt – it might even be un-feminist to argue that a woman seeking out pleasure despite vaginismus is affected only by a bad case of patriarchy. Perhaps penetrative sex is only male-centered when it is allowed to be; perhaps rejecting a condition of not being able to enjoy sex can very well be feminist.

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