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Experiences of women with symptoms of vaginal laxity – a qualitative study

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Abstract

Background Vaginal laxity (VL) is rarely discussed among patients and their physicians possibly due to the lack of evidence-based treatments, embarrassment, and lack of knowledge in recognizing this condition. We aimed to understand the meanings that women attribute to the sensation of VL.

Methods This is a qualitative study using in-depth interviews and thematic analysis. Sixteen participants were intentionally selected from February 2020 to December 2021. One researcher interviewed each participant in a private room guaranteeing that rapport was established. Two independent researchers performed a complete transcript of each interview immediately after its end. The sample size was achieved according to the Information Power analysis. We followed the thematic analysis proposed by Braun and Clarke.

Results Of 16 patients, only one did not undergo delivery. Her complaint was not different from the rest of the group. Five major themes and subthemes were identified: the long and lonely pathway: from the identification of symptoms of VL to diagnosis (from the invisibility of VL to the perception of their symptoms; “everything will fall out!”: shame, guilt and stigma as diagnosis barriers and “but I had no idea of looking for a treatment.” Women’s strategies to begin a help-seeking process), “the label of vaginal laxity is a heavy burden to bear” meanings associated with VL complaints, effect of VL on sexual intercourse and “I know it changed everything!” relationship with the partner.

Conclusion VL is a symptom that is still little understood by women, and little explored by health professionals, with repercussions on personal and marital life.

Keywords Vaginal laxity, Female sexual dysfunction, qualitative study, Sexuality

Background

Vaginal laxity (VL) is defined as a complaint of excessive vaginal looseness and is most commonly described as a decreased sensation during sexual activity [1]. The prevalence of VL from 24 to 38% and appears to be associated with young age, vaginal deliveries, symptoms of pelvic organ prolapse, and is therefore also somatic dysfunction [2, 3]. Other risk factors are foetal macrosomia, history of instrumental delivery (forceps), multiparity, and connective tissue changes [2].

VL is rarely discussed between women and health care professionals possibly due to the lack of evidence-based

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treatments, embarrassment reported by patients, and lack of knowledge to recognizing this condition by health care practitioners [4]. Despite this, there has been an increase in demand for the treatment of VL, especially in female genital cosmetic surgery [5, 6].

The diagnosis of VL is based on patient self-report. Although numerous instruments have been used for psychosexual assessment, to the best of our knowledge, only two instruments assess perceptions specifically for VL, which is the Vaginal Laxity Questionnaire (VLQ) and the ICIQ Vaginal Symptoms Questionnaire [4, 7]. Careful listening, a physical examination, and a psychosexual assessment are the initial steps in identifying patients with VL [8].

The fact that there is no consensus on a standard definition for VL, nor robust scientific evidence to explain the pathophysiology of this complaint, brings the need to search for other research tools that explore women's reports and perceptions. Another crucial point is to recognize the impact of VL on women's quality of life, how she correlates this complaint to herself and her partner, as well as the need to reinforce woman-centred care approaches that enable a deeper understanding of this situation. Qualitative analysis can help to fill this gap, enabling the study of future diagnostic tools. Thus, the aim of this study is to understand the meanings that women attribute to the sensation of VL and its impact on their perception of themselves, of their intimate affective relationships, and their sexuality.

Methods

We used a qualitative approach to understand the meanings that women attribute to the sensation of VL. The present study used in-depth interviews and followed the guidelines of the Consolidated criteria for reporting qualitative research – COREQ” as a support tool [9]. Local Institutional Review Board has approved the study (CAAE number 12919119.9.0000.5404).

Participants and settings

Women were selected before the randomization/allocation procedure from a randomized clinical trial (February 2020 – December 2021) that offered treatment to women complaining of VL [10]. Participants who agreed to participate in the study signed an informed consent form. We included women aged ≥ 18 years with a complaint of VL assessed by a direct question (yes/no) and the Vaginal Laxity Questionnaire (VLQ) [4] and excluded participants who did not consent to the conduction and recording of the interviews.

Data collection

Data were collected between August and October 2021 after the clinical trial allocation period. A physiotherapist

specializing in women's health with experience with patients complaining of VL (GMVP) contacted each participant via telephone and scheduled the interviews. Women were interviewed individually, face to face, in a private multidisciplinary office at Hospital da Mulher Professor Doutor José Aristodemo Pinotti - CAISM (University of Campinas - UNICAMP) which guaranteed all the security and privacy that the participants needed for the interview. After being comfortably accommodated, the participants answered open and semi-structured questions according to the interview guide (Additional file 1). The researcher (GMVP) took unstructured notes of the participants' behaviour during the interview, as well as non-verbal/facial expressions, and emotional responses to a given topic during the interview, and silences or pauses. The researcher could make adaptations whenever necessary, ensuring that the participants spoke freely about their life experiences and their perceptions about the sensation of VL. The researcher built a bond with the participants during the recruitment process of the clinical trial from which they were recruited; thus, we believe that rapport was established.

Two independent researchers (GMVP; ODRS, a psychologist with expertise in conducting qualitative studies) transcribed each interview verbatim immediately after the interview ended to ensure that no observations were lost while maintaining their original form. Files (full audio transcription and digital files) were stored in a database. The sample size of 16 interviews was appropriate for the present study as analysed by the Information Power Model [11]. No participant was excluded or withdrew their consent. Software to support the research of qualitative methods was used to assist organize the material, coding, and analysing the data (NVivo 11 - QSR International 2021).

Data analysis

We followed the thematic analysis proposed by Braun and Clarke [12]. This method characterized by its flexibility allows for identifying, analysing, and reporting patterns from a data set. Firstly, the transcript interviews were read several times to allow familiarization with the data. Subsequently, an initial code generation phase was carried out by two independent authors (GMVP and ODRS) after the identification of ideas and relevant information from the data set. The initial codes were revised through a systematic and exhaustive reading of the material to reflect on the participant's perceptions of the object of study. The NVivo 11 software was useful to organize, identify patterns through the data set and validate researchers' analysis. Through this software, a word cloud was created based on the frequency of words.

Next, we initiated the phase that allows searching for themes and sub-themes based on a process to group

codes. These themes were supported by quotes to appropriately reflect the participants' meanings and perceptions. To ensure the validity of the data, all processes were discussed with two senior researchers (LGOB, FGS), which allowed a collaborative discussion on the categorization process based on a situated and reflexive interpretation.

Sociodemographic and clinical data were collected to better understand the characteristics of the participants. All interviews were conducted in Brazilian Portuguese language and the quotes supporting each theme and sub-theme were translated into English by a fluent translator in both languages. The translation was performed immediately after the transcription to capture elements that could help during the equivalence translation.

Results

Sixteen women were interviewed for a total of seven hours and 25 min; Table 1 shows their sociodemographic and clinical-related characteristics. The participants' age ranged from 31 to 50 years. Most of women were married, premenopausal, multiparous, with previous vaginal delivery. The participants declared themselves to be of Asian background ($n=1$), Black background ($n=8$) and White Background ($n=7$).

We presented the main themes and sub-themes that were defined during the thematic analysis (Additional file 2 - presents the transcript for each theme and subtheme). As a result of this process, we constructed three major themes and their respective sub-themes represented in Fig. 1. Figure 2 contains the words that most frequently emerged from the women's transcripts.

Theme 1. The long and lonely pathway: from the identification of symptoms of VL to diagnosis

The pathway taken by women with VL symptoms until reaching the definition of the diagnosis and, consequently, access to treatments for the management of this condition, becomes a long and lonely process. VL symptoms are imbricated with the identification of a series of other pelvic floor symptoms that cause discomfort in women's daily lives.

This pathway to obtaining the diagnosis could be represented as a process where women face several barriers. In this theme, we cover the initial moments beginning with the VL social invisibility until perceiving the symptoms as a moment of encounter with themselves, the feelings that emerged, and the first steps that show the mobilization of behaviour in favour of seeking information in an attempt to find strategies to deal with the perceived symptoms. Thus, they became the first aspects experienced by the interviewees in this complex process.

Table 1 Sociodemographic and clinical characteristics of the included women ($n = 16$)

Participant	Age	Marital Status	Ethnicity	BMI	Education	Gestation	Type of Birth	Parity	Instrumental Delivery	Menopause	Duration of the Interview (min.)
1	39	Married	White Background	> 25 Kg/m ²	> 9 years	1	Vaginal	Primiparous	No	No	18:26
2	37	Married	White Background	< 25 Kg/m ²	> 9 years	3	C-section	Multiparous	No	No	14:17
3	48	Married	Asian Background	< 25 Kg/m ²	> 9 years	2	Vaginal; C-section	Multiparous	No	No	22:46
4	31	Married	Black Background	> 25 Kg/m ²	> 9 years	2	Vaginal	Multiparous	No	No	24:13
5	45	Married	Black Background	> 25 Kg/m ²	> 9 years	4	Vaginal	Multiparous	No	No	26:29
6	43	Married	Black Background	< 25 Kg/m ²	> 9 years	4	Vaginal	Multiparous	No	No	18:56
7	43	Married	White Background	> 25 Kg/m ²	> 9 years	2	Vaginal	Multiparous	No	No	23:02
8	35	Divorced	White Background	> 25 Kg/m ²	> 9 years	3	Vaginal	Multiparous	Yes	No	56:16
9	47	Single	White Background	< 25 Kg/m ²	> 9 years	1	Vaginal	Primiparous	No	No	19:10
10	48	Divorced	Black Background	< 25 Kg/m ²	> 9 years	4	Vaginal	Multiparous	No	No	28:31
11	36	Divorced	Black Background	< 25 Kg/m ²	> 9 years	7	Vaginal; C-section	Multiparous	Yes	No	23:31
12	39	Married	Black Background	> 25 Kg/m ²	< 8 years	2	Vaginal; C-section	Multiparous	Yes	No	29:04
13	50	Divorced	Black Background	> 25 Kg/m ²	> 9 years	2	C-section	Multiparous	No	No	41:31
14	48	Single	White Background	> 25 Kg/m ²	> 9 years	0	No	Nulliparous	No	No	24:04
15	44	Married	Black Background	> 25 Kg/m ²	< 8 years	3	Vaginal	Multiparous	No	No	27:23
16	41	Married	White Background	< 25 Kg/m ²	> 9 years	2	C-section	Multiparous	No	No	15:59

Age: Years; BMI: Body Mass Index. Education: Years

Theme 1. The long and lonely pathway: from the identification of symptoms of VL to diagnosis		
From the invisibility of VL to the perception of their symptoms	“Everything will fall out!”: shame, guilt and stigma as diagnosis barriers	“But I had no idea of looking for a treatment.” Women's strategies to begin a help-seeking process
<ul style="list-style-type: none"> VL is an unknown and little-spoken topic. Talking about the topic is difficult and embarrassing. Other symptoms are added to their perception of VL. 	<ul style="list-style-type: none"> Concern when identifying the symptoms. Fear, stigma and shame prevent seeking help. Guilt for behaviors in the past. 	<ul style="list-style-type: none"> Home treatments and exercises to relieve symptoms. Surgeries as an alternative treatment. The demand for specialized treatments.
Theme 2. “The label of vaginal laxity is a heavy burden to bear” meanings associated with VL complaints		
<ul style="list-style-type: none"> Women's perceptions on the main causes of VL. 	<ul style="list-style-type: none"> The term “vaginal laxity” causes embarrassment. 	<ul style="list-style-type: none"> Blame themselves and healthcare professionals for VL symptoms.
Theme 3: Self-relationship: “I don't feel like a complete woman”.		
<ul style="list-style-type: none"> Difficulty looking at themselves. 	<ul style="list-style-type: none"> Refer to themselves as less feminine. 	<ul style="list-style-type: none"> The need to generate pleasure for their partners.
Theme 4: Effect of VL on sexual intercourse		
<ul style="list-style-type: none"> Decreased sexual desire, decreased lubrication and anorgasmia during sexual intercourse. 	<ul style="list-style-type: none"> Adaptations for sexual activities. 	<ul style="list-style-type: none"> Perception that narrowing the vagina is directly associated with pleasure.
Theme 5: “I know it changed everything!”: Relationship with the partner		
<ul style="list-style-type: none"> Communication about symptoms is a reason for shame and embarrassment. 	<ul style="list-style-type: none"> VL symptoms interfere with the dimensions of intimate partner relationships. 	<ul style="list-style-type: none"> Recurrent concerns with the partner's pleasure nullifying their pleasure.

Fig. 1 The five major themes

Subtheme 1.1: from the invisibility of VL to the perception of their symptoms

VL is an unknown and little-spoken topic, which demonstrates the low visibility and discussion of this topic either among patients or among health professionals. In this sense, they highlight the importance of addressing this issue and the need for greater dissemination.

Is it a bit of a myth that is said? It's a little veiled ... it's a little talked about... it's unknown.(Participant 1).

Women reported that talking about VL with a person who does not complain about it is difficult and embarrassing.

I was always kind of withdrawn in that sense... sexually, because I thought... oh, who am I going to talk to? ... Sometimes colleagues don't know much ... and there's the issue of prejudice too ... you can't go around saying that to others ... right? ... And so, gynaecologists, professionals ... did not have this knowledge ... I had no one to talk to ... and so I had the opportunity to meet C. (nurse).(Participant 4).

Moreover, the difficulty in naming the complaint also becomes a barrier to seeking specialized help. Thus, diagnosis of VL can be delayed, and consequently, access to treatment options. In this process, denial of the symptoms or thinking that “it's all in my head” is a mechanism that women use to deal with the symptoms.

Ah, I don't know... I think that, as always, we always let it go, ... saying, “no, ... it will pass!” ... this is something that will pass ... it's something in my head ... it's something that I have in my head because the other person is not complaining about anything, so ... then we leave it as it is, and it stays as it is... right? Because, sometimes you don't talk to the gynaecologist, you don't talk... and... you just let it go... right?(Participant 5).

On the other hand, the identification of other pelvic floor symptoms such as stress urinary incontinence, flatus vaginalis, dyspareunia and anorgasmia made the diagnosis of VL difficult. These symptoms are commonly present in other conditions and their overlap contributed to complicating the diagnosis process.

Subtheme 1.2: “Everything will fall out!”: shame, guilt and stigma as diagnosis barriers

Women experienced fear, fright, sadness, tension, shame, frustration, and concern when identifying VL symptoms. “Everything will fall out” would be interpreted as a metaphor for all the intense feelings that women have to deal with for a long time and that affect them and impact their perspectives for the future.

We observed that when these symptoms occur on a daily basis, the suffering seems to be enhanced and persist for a long time.

I got frustrated! ... (pause) ... and the frustration has been coming for a long time! ... Because ... I have



Fig. 2 Word frequency based on NVivo (NVivo 11 – QSR International MA, USA) analysis

a 26-year-old son ... do the math ... more than 25 years with this frustration! ... like ... it's ... for me, it's frustrating, because ... my husband, he enjoys it! Sure! (emphatic) ... any man has pleasure! ... but I ... I'm missing something! (Participant 3).

Fear, stigma and shame usually prevent women from seeking immediate help. Moreover, it is possible to observe a certain guilt for having this complaint, as women consider that they may have had some responsibility in the past as they might have “damaged” their vagina during vaginal delivery, thus confronting its consequences today.

It wasn't like that, from one day to the next... we always put the blame on ourselves, right... always on the woman, right... (smiled)... something with us is wrong, but we I don't know why... but (pause)... I don't know ... I already had two children.(Participant 5).

**Subtheme 1.3: “But I had no idea of looking for a treatment.”
Women's strategies to begin a help-seeking process**

Finally, in this subtheme, as part of the women's journeys, we point out that, as a continuation of the interviewees' moments of encounter with the symptoms of VL and the feelings that emerged, there is a behavioural mobilization to seek help or information, either through professional help and especially through other less reliable sources, in an attempt to continue to understand what is happening to them and how to alleviate these symptoms.

Some women reported seeking information about home treatments and exercises as alternatives to relieve symptoms.

I researched a lot on the internet... so the internet helped me a lot! ... it helped a lot ... with information ... and reading about ... more like that.(Participant 9).

The possibility of performing surgeries as an alternative treatment was a recurring theme among the various interviewees. Another way used by the women was to seek friends with the same symptom, as of having the need to build a network support.

I talked to a friend who spoke... about vaginal looseness... because I didn't even know what it was... I imagined... I don't know... that I had to do some plastic surgery... surgery or something.(Participant 11).

Regarding the contact with health professionals, women reported that the first contact to address the topic was mediated by the gynaecologist; however, they recognize that this is a topic that is still little addressed in the consultations and feel that there is poor knowledge from physicians to deal with their complaints.

A doctor even told me that this was a prolapsed bladder, she didn't tell me that I was wide! She said: "you can't lift weight because of your bladder"... but the bladder goes down, but not so much! ... I thought she was already here at the door! ... Each one said something, you know? ... One said that I wasn't wide... he treated the hormones and said that I needed surgery... so I was kind of lost! ... I only found myself here (at the university) when I was called to participate in the research ... Because then I knew exactly what I had. Because each one said the same thing!(Participant 7).

The demand for specialized help intensifies when they observe that the symptoms worsen, especially those that interfere with sexual intercourse and the bond with the partner.

During sex, I realized, oddly enough, after I got to know the program (research project). Because then I started to pay more attention to it... if I was... I saw Vaginal Laxity on the internet, on the Research Program profile and... I said "wow! " It's about vaginal laxity then! And then I started to pay more attention to it and then I came up with this idea. I observed more like this... then I noticed this feeling of looseness during sex. It was just after signing up.(Participant 1).

The expectations around the cure and the gradual improvement of the symptoms were seen with a positive perspective, and a moment of personal overcoming.

My expectations are that I will get better... that everything will be perfect... and that from the

treatment I will get to know myself much better... and that I will... ah that it will be 100%... wonderful!(Participant 9).

Theme 2. "The label of vaginal laxity is a heavy burden to bear" meanings associated with VL complaints

VL allows the surge of several meanings associated with the looseness of the vagina and weakness of the vaginal musculature. Thus, perceptions and explanations that women elaborate on the main causes of VL are reinforced, and these actions result in negative qualifiers that are linked to their own experiences.

The term itself causes embarrassment in the interviewees. Participants identify it as a shocking term that generates shame and results in stigmas that emerge in interaction with others. Some of the qualifiers reveal VL as "weakness in the vagina muscles" ;"flabbiness or flaccid underneath", "open", "vacuum", "withering", "as if it were hollow inside" and "laxity". The interviewees generally associate the complaint with the terms "loose thing", "loose" or "wide", "enlargement" of the vagina. Others describe having identified it as "something strange", different or missing compared to other women, as well as changes in the appearance of the external genitalia.

Who wants to be recognized as a vaginal laxity? Imagine if this is diagnosed as a disease! And what is the name of your problem? ... It's vaginal laxity... it doesn't work!(Participant 13).

Women reported that VL could have been caused because their vagina had been excessively used or that they had badly behaved in the past that could have interfered with their current condition, blaming themselves for this. Others blamed health professionals and practices during childbirth with procedures such as episiotomy. They also reported that pregnancy and childbirth, genital prolapse, age and the ageing process would also be explanations.

A wide thing! ... (pause) ... a wide thing that ... can't be filled ... you know ... it's been used! ... and ... it widened ... as if we had ... it's ... like, for example ... stuck something in there for a long time ... and it took that shape ... understand?(Participant 3).

Theme 3: Self-relationship: "I don't feel like a complete woman"

Women reported difficulties looking at themselves and identifying the signs and symptoms associated with VL. Feeling uncomfortable or not liking their vaginas

or vulvas, insecurity, incapability, powerlessness, guilt, or anger are the emotions women reported during the interview.

... I can't even look anymore... I can't even look at myself in front of the mirror... because then I cry!(Participant 7).

For some of them, self-care practices are not so frequent, and women may refer themselves as less feminine, with statements that denote the perception of feeling “less of a woman” or incomplete. Some of them reinforce the expectation of wanting to “be normal” and mention that these transformations make them feel that they are not the same person.

(...)I look in the mirror and say “it's not me! (emphatic) ... I feel less of a woman!(Participant 10).

Moreover, for another group of women, they feel the need to generate pleasure for their partners in sexual intercourse and VL impacted their self-esteem and their femininity.

...my self-esteem is down there in that part (floor) ... I don't feel like a complete woman! (emphatic) ... right... I don't feel pleasure, right... it's like I'm hollow inside! (emphatic) ... that's not what I wanted to feel! ... I wish I could feel pleasure! ... I wanted to (emphatic) give pleasure, you know? ... and currently I'm not feeling anything anymore in this relationship between me and him ... I look in the mirror and say “it's not me! (emphatic) ... I feel less of a woman!(Participant 10).

Theme 4: Effect of VL on sexual intercourse

Decreased sexual desire, decreased lubrication and anorgasmia during sexual intercourse were recurrent reports, qualifying sexual intercourse as an “absence of sensation”, “an empty thing” or “empty”. One of the interviewees described the sensation during penetration as “a finger floating in space”. We observed the use of some terms that denote dissatisfaction regarding their own pleasure and sexual experience. As well as an objectification of themselves.

I noticed in these leaks (urine) and in sexual relations in which I could not feel my partner ... my partner's penis ... (pause) ...and in the vaginal area.(Participant 6).

I don't feel the penis... I don't feel like I have the strength to grab it... even when I try to force it

to work the muscles... even when I try hard I can't!(Participant 13).

It's like I... have nothing, doctor (emphatic)... like I'm a huge hole, and... (she thought)... and without any sensation!(Participant 6).

Women reported that the duration and frequency of sexual penetration became shorter and with longer intervals between one and other. They have also mentioned the use of pillows and supports as an attempt to contract the vaginal musculature during penetration, as well as changes in the sexual position and simulation of orgasm to satisfy the partner.

Sexual practice without penetration (foreplay activities to longer periods), reduction of the duration of sexual penetration and maintaining relations with the lights off in the bedroom were used as strategies to deal with uncomfortable situations VL would cause.

In reality (pause) ... the foreplay was the best part, because ... penetration was the worst part for me ... (pause) ... a lot of times I even avoided it ... I accepted the foreplay but the penetration, no! ... Uncomfortable.(Participant 2).

Women have the perception that narrowing the vagina is directly associated with pleasure. The feeling that it is not tight, the “lack of fit in the intercourse”, being “tight” or “loose” have a direct impact on sexual pleasure and satisfaction, especially with the partners, being the object of constant concern by them. More interestingly, some women even think about having pain during sexual penetration as means of having achieved a narrower vagina as part of some expectations.

You have no desire to do it... and when you try it's horrible! (emphatic) ... because you feel lax, loose! It's the same thing as having nothing inside you!(Participant 7).

Theme 5: “I know it changed everything!”: relationship with the partner

Communicating about symptoms, especially those that interfere with sex-erotic relationships, is a reason for shame and embarrassment, which is why it is often an issue that is avoided. Evading this theme also intends to avoid any possibility of offending, hurting the partner or receiving any kind of questioning.

It's because I think I end up pulling away... I think I'm not enough... that I'm not pleasing... and then he ends up pulling away... and there's no conversation, right... because you don't want to be exposed. Then

when I expose myself, he says it's all in my head... that everything is normal for him. Then I think... "is it really true?" Is it okay for him? ... here come the doubts ... come the questions.(Participant 11).

VL symptoms also interfere with some dimensions of intimate partner relationships, such as communication, impacting their perceptions regarding the affective bond or even influencing some relevant decisions such as the possibility of getting divorced.

I didn't like that he didn't even come near me! ... I don't know if it's in my head or what it was ... I know it changed everything! I even thought about getting divorced! (...) I didn't want any more contact with my husband... I distanced myself from him... so, it affected a lot my relationship with my husband ... so, I cooled down!(Participant 7).

Women reported that they are recurrently concerned with the partner's pleasure during sexual intercourse, thus nullifying their own pleasure. Having sexual activities with the partner becomes an obligation even when some practices may cause discomfort, shame, and insecurities. Interestingly, they report situations where partners may avoid them and causes for that are elaborated such as possible betrayal, lack of affection or not feeling desired. All these points make their own sexual pleasure to not be their main priority.

. man always complains! ... thinks the woman doesn't want to! ... that the woman has a headache ... because of this or that! ... and sometimes we don't talk ... the real thing ... and even if we tell them ... it always has to be the way they want it ... right? ... then ... it changed! (emphatic) ... it changed ... even if I didn't say it, even if I didn't talk ... it changed ... I didn't say it at all ... I kept it to myself...(Participant 5).

Discussion

Our study reveals how women deal with VL throughout their lives and the impact it causes on intrapersonal and interpersonal relationships, as well as the barriers they face in accessing early diagnosis and treatment. Obtaining a diagnosis of VL is a long and difficult process. Several factors collaborate to reinforce these barriers, among them: the delay in recognizing the problem; waiting for the condition to improve spontaneously; if the partner doesn't complain, it's not so bad; links to other nonspecific symptoms (for example, urinary leakage) considered to be related to VL. The lack of knowledge about the body and its physiology becomes evident, as well as the

subordinate and passive women's position in the affective-sexual relationship. Feelings of shame and embarrassment by women reinforces the barriers for treatment and subsequent notification.

The invisibility of VL reinforces the need for discussion and research on the topic. A survey carried out among physicians of the International Urogynaecological Association (IUGA) revealed that 83% of respondents consider VL to be an underreported condition [13].

The scarcity of evidence on the pathophysiology of VL and the lack of objective diagnostic tools contribute to this underreported condition. Diagnosis of VL is based on women's self-report. The lack of clarity in the exposition of the theme by health professionals was some of the problems pointed out by the study participants. These findings support previous studies that identified that health professionals do not routinely address questions about sexuality with their patients; reasons would be lack of time, resources, health policies and training [14].

Given that, the Internet becomes one of the main alternatives for women to seek information. However, it does not guarantee reliable information. This source is used by them to build their opinions about VL and their expectations about treatment, bringing reflection about the role of social media on educating lay people. About treatment options for VL, for some participants, surgery appears as an alternative for immediate resolution of the symptom. Interestingly, surgical treatment of VL was perceived by IUGA member physicians as the most effective intervention when compared with Kegel exercises or physiotherapy [13].

As reasons for developing VL, blaming themselves for attitudes of the past, and attributing the aetiology of VL to it, are some of the behaviours observed in the interviewees. The ageing process, pregnancy and childbirth are understood as elements that impact in the current condition. In this sense, although the aetiology of VL has not yet been clearly identified, studies point out to hypotheses that pregnancy and vaginal delivery affect the sensation of VL [2, 15].

In the construction of the female identity, women identify the ability to give pleasure to their partner as a central condition, which affects their self-image. We noticed that, for women, the improvements in the symptoms associated with VL are understood as to recover their femininity. Studies suggest that negative changes in female sexual function are common, the main reasons for which are biological, psychological, interpersonal and socio-cultural changes [16, 17]. In this context, many women experience changes in their bodies [17, 18], with potential changes in their sexual organs [19]. All these changes impact the way these women perceive themselves and, consequently, their body image. Body image is defined as the perception of the aesthetics or attractiveness of one's

own body [20] and, thus, of sexual function and satisfaction [21]. Similar to our study, Thomas et al. [21] found that feeling attractive was an important aspect of women's sexual activity and the way in which they responded to perceived changes in their bodies also affected their sexual activities and sexual satisfaction.

A previous study revealed that couple communication was considered a priority for the women surveyed. The highest rates of emotional and partner relationship satisfaction were reported by women who rated their sexual relationships as active and satisfying [22]. In our study, symptoms such as decreased lubrication, anorgasmia, and the VL affect their perception of their partner's sexual satisfaction. Sexual relations are perceived as an obligation in their role as wives, and therefore, submitting to practices that they attribute as uncomfortable is a way of maintaining the bond with the partner. For Hinchliff et al., placing the sexual needs of partners above their own needs implies the passivity of female sexuality. The feeling of duty, the uncertainty of not knowing what else to do, the attempt to prevent the partners from seeking sex with another woman and the collapsed marriage were some of the reasons that made women engage in sexual relations when they had no desire [23].

Heterosexual women are less likely to endorse communication with their partners on topics other than sex as relevant to their sexual satisfaction than bisexual women [24]. According to the participants' reports, reporting VL interferes with intimacy with the partner, generating a distance between the couple. By avoiding contact and communication with the partner, the interviewees experience feelings of worthlessness and the need not to be exposed. Lack of communication is also seen as the possibility of extramarital sexual activities. When there is an attempt at communication, dissatisfaction with the dialogue with the partners is notorious when the interviewees reveal that the partners do not understand the complaint, stating to them that it is "things in your head".

VL symptoms are perceived as a barrier to having pleasurable penetrative sex. The study by Holt et al. [24], found that heterosexual women valued orgasm frequency more than other groups of women. Vaginal intercourse is avoided or postponed until the final moments of sexual activity. Frustrated attempts to keep the vagina tighter are revealed during the participants' speech. According to the interviewees, a tight vagina is considered ideal for both female and male orgasms. In this context, as they are unable to offer a tight vagina to their partners, anal intercourse is allowed to guarantee pleasure for the partner.

The present study has limitations that need to be elucidated. Our findings need to be interpreted considering that the study was carried out in a single centre, in a tertiary hospital, which reflects the perceptions of

women who attend a specialized service. Future studies could include a population that comprehensively assesses aspects of VL from the LGBTQIAP+ group, such as homo and/or bisexual women. On the other hand, to the best of our knowledge, this is the first study that qualitatively assesses the perception of women with VL. Based on our findings, new hypotheses can be developed for a better understanding of the pathophysiology of VL, as well as the need to develop specific assessment instruments for such complaints.

Supplementary Information

The online version contains supplementary material available at <https://doi.org/10.1186/s12905-024-03366-8>.

Additional file 1: Interview Form

Additional file 2: Participants' experiences assessed by themes and sub-themes related to vaginal laxity

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Author contributions

GMVP: conception and design of the study, acquisition of data, analysis and interpretation of data, drafting and revising the article, final version approval. ODRS: acquisition of data, analysis and interpretation of data, drafting and revising the article, final version approval. FGS: analysis and interpretation of data, drafting and revising the article, final version approval. LASL: drafting and revising the article, final version approval. CRTJ: conception and design of the study, drafting and revising the article, final version approval. LGOB: conception and design of the study, acquisition of data, analysis and interpretation of data, drafting and revising the article, final version approval.

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Data availability

The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate

Local Institutional Review Board has approved the study (CAAE number 12919119.9.0000.5404). Participants who agreed to participate in the study signed an informed consent form.

Consent for publication

Not applicable.

Competing interests

The authors declare that they have no competing interests.

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