

CASE REPORT

Addressing Vaginismus in Muslim Women: A Case Report on Integrating Cultural Sensitivity Into Sexual Health Care

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ABSTRACT

Vaginismus is common among women in Muslim-majority societies, where cultural and religious factors shape views on sexuality. This case report examines a Muslim woman with vaginismus, whose condition was worsened by societal taboos and limited communication with her spouse. The case reveals how cultural norms and a lack of open discussions on sexual health led to misunderstandings about sexual function. A culturally sensitive treatment approach, combining psychotherapy, physical therapy, and sexual education, was used. This approach highlights the value of integrating cultural and religious perspectives in treating sexual dysfunction to improve patient outcomes. *Malaysian Journal of Medicine and Health Sciences* (2026) 22(SUPP4):160-163.doi:10.47836/mjmhs.22.s4.23

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INTRODUCTION

Sexual pain disorders are complex conditions affecting women globally (1). In the Malaysian context, female sexual dysfunction (FSD) is reported to affect approximately 25.8% to 30% of women in the general population. Among breast cancer survivors, however, the prevalence rises markedly, with rates reported as high as 90% (2). These disorders can significantly impact the stability of marriages, as the associated impairments may lead to marital dissolution (3). Despite the potential severity for couples, vaginismus remains poorly understood (4).

This case report explores the experience of a Malay Muslim woman in Malaysia diagnosed with vaginismus,

whose condition was compounded by sociocultural taboos and limited spousal communication. The case was managed at a tertiary care hospital, involving both gynaecology and psychiatry services.

A qualitative study highlighted key themes, including the perception of sex as a taboo subject and its classification as culturally inappropriate. These findings suggest the influence of cultural practices on societal attitudes toward sexuality (2). Sexual life is also one of the most affected areas by religious beliefs, which are often shrouded in taboos (5). It is essential to differentiate between Islamic teachings (which generally promote marital intimacy and mutual satisfaction) and cultural norms which often frame sex as taboo. This conflation may lead to misinterpretations, particularly among women who internalise these messages from a young age. Thus, Muslim women experiencing vaginismus represent a unique patient population, necessitating healthcare professionals to understand their religious and cultural context in order to provide culturally competent care (1).

CASE REPORT

28-year-old Malay female, referred from the gynaecology clinic for primary subfertility for five years secondary to vaginismus. She has been married to her husband for six years. She presented to the gynaecology clinic, complaining of fear and pain during sexual intercourse. Thus, she was referred to the psychiatry clinic for further assessment.

Psychosexual assessment done during the first appointment at the psychiatry clinic mainly to assess aetiology, predisposing factors, the patient's and spouse's understanding regarding physiology and sexual response cycle. Both spouses generally have a good understanding of psychosexual knowledge. However, the patient perceived sexual intercourse as inherently "painful and disgusting," a belief rooted in her strict cultural upbringing, where discussions about sex were considered shameful and inappropriate. From a young age, she was taught that sex was a taboo subject, associated with sin and moral impurity, particularly for women. These internalised messages created deep-seated negative cognitions about sexual intimacy. Although she possessed basic psychosexual knowledge, her emotional and cognitive schemas about sex remained dominated by fear, shame, and guilt. She expressed feeling spiritually unclean whenever sexual intimacy was initiated, often believing that experiencing sexual pleasure would compromise her religious piety. These distorted beliefs led to intense anticipatory anxiety, involuntary muscle tightening, and avoidance of penetration.

These symptoms started early in their marriage. She is also having a long-distance relationship with her husband. They meet once every two weeks. The lack of open and effective communication between the patient and her spouse further exacerbated the condition. The couple initially sought treatment during their third year of marriage but discontinued follow-up due to logistical challenges. Treatment was resumed two years later when both partners began to experience increased psychological distress related to subfertility.

Gynaecological examination in the gynaecology clinic prior to referring to psychiatry ruled out structural abnormalities, supporting the functional nature of the patient's pain and penetration difficulties. The patient was diagnosed with vaginismus, aligning with the DSM-5 criteria for Genito-Pelvic Pain Disorder, due to ongoing difficulties with vaginal penetration accompanied by significant anticipatory anxiety and involuntary pelvic muscle contraction.

Initial barriers to treatment included the patient's hesitancy to discuss sexual issues and the husband's emotional withdrawal due to repeated failed attempts at intercourse. Psychotherapy sessions focused on cognitive restructuring of negative beliefs regarding

sexuality, relaxation techniques, and gradual exposure through sensate focus exercises. Psychoeducation also addressed misconceptions by highlighting Islamic teachings on marital intimacy as a source of mutual satisfaction rather than guilt. The patient and her spouse were provided with psychosexual education emphasising the importance of a healthy sexual life. This included explanations regarding the physiology and anatomy of sexual organs, and the patient was advised regarding sensate focus exercises to reduce anxiety associated with sexual intercourse. The couple was encouraged to engage in non-penetrative intimacy to reduce anxiety and build confidence before attempting penetrative intercourse.

To address misconceptions about sexuality from a religious perspective, it was clarified that in Islam, sexual relations with one's husband are not only permissible but also considered virtuous. Engaging in marital intimacy can be a source of blessings (barakah) for women, as it is an act encouraged within marriage. Additionally, this practice is highly valued as it contributes to procreation and strengthens the marital bond. Although the couple initially expressed discomfort discussing sexual issues, they later reported that the incorporation of Islamic perspectives into therapy helped them feel respected and understood. This approach improved their trust in the therapeutic process and their willingness to continue treatment. As therapy progressed, they reported improved marital communication and greater emotional closeness.

The patient was also referred to the occupational therapist for systematic desensitisation, gradual dilator insertion, and pelvic floor muscle training. She successfully used the dilator up to a size of four cm with minimal discomfort. During subsequent follow-ups, the husband disclosed experiencing erectile dysfunction for the past year, which he attributed to repeated failures in achieving penetrative sexual intercourse. This condition required further evaluation to rule out organic causes and was referred to the surgical department. However, it was also noted that the wife's condition might have predisposed his psychological distress, as the couple sought to share the burden of subfertility.

DISCUSSION

The multifactorial aetiology of vaginismus includes psychosocial, cultural, religious, and interpersonal elements. In this case, the patient's beliefs that sex was painful and shameful (despite otherwise adequate psychosexual knowledge) point to deeply internalised cultural taboos. This reflects how, for Muslim women, experiences of sexuality and sexual dysfunction are closely intertwined with religious and cultural frameworks (1). In Muslim-majority countries, the prevalence of such conditions is notably high, likely due to traditional social backgrounds (4). In Middle Eastern

countries and Turkey, vaginismus is the most common female sexual dysfunction, despite Turkey's status as a secular, developing country with a predominantly Muslim population (5). This pattern is also evident in Southeast Asia; among Malay women (such as in this case), the prevalence of female sexual dysfunction remains high, reflecting various cultural influences that shape their sexual experiences within marriage (2).

While Islamic teachings affirm the permissibility and spiritual value of sexual intimacy in marriage, this patient's beliefs were shaped more by cultural influences than by religious texts. Sexual disorders within marriage can compromise one of its primary goals (procreation and the preservation of offspring) (3). Therefore, understanding the intersection of vaginismus, religion, and culture among Muslim women is crucial for healthcare providers to deliver culturally competent care and reduce biases that may influence care quality (1).

The aetiology of vaginismus is multifactorial, encompassing psychosocial, cultural, biological, and sexual factors (5). Among Muslim women, vaginismus is often associated with cultural taboos, a lack of sex education, an absence of open discussion about sex, negative sexual cognitions, expectations to tolerate a male partner's inconsiderate sexual behaviour, and familial interference (1). Furthermore, the lack of knowledge and failure to adhere to the positive values and teachings regarding sexual satisfaction, as outlined in Islamic teachings, have further compounded women's sexual dysfunction and relationship challenges (2). Many couples, despite being well-educated, had poor sexual education and often consulted traditional healers, general practitioners, or gynaecologists before being referred to sexologists (4). Moreover, a long-distance relationship, such as in this case, and shame in seeking care, further delayed help-seeking and complicated intervention.

Couples experiencing sexual dysfunction should seek appropriate treatment from qualified medical specialists rather than opting for silence or considering divorce as an easy solution (3). Culturally sensitive care (integrating medical treatment with faith-affirming education) proved beneficial in building rapport and facilitating engagement. A culturally sensitive and comprehensive sexual education program that integrates both medical and Islamic knowledge could effectively reduce female sexual dysfunction (2). Providing sexual education, alongside treatments such as psychotherapy and physical therapy, appears to be beneficial in addressing female sexual pain. We advocate for sexual education and a cultural shift that supports women's sexual autonomy as critical strategies to reduce and prevent sexual pain (1). With proper treatment, most individuals are able to achieve vaginal penetration relatively quickly (4).

Multidisciplinary care is essential in the management of vaginismus, as it also involves both physical and psychological components. In this case, collaboration between gynaecology, psychiatry, and occupational therapy ensured a comprehensive evaluation and treatment strategy. The gynaecology team excluded organic causes, psychiatry addressed cognitive and emotional factors through psychosexual therapy, and occupational therapy provided practical interventions such as systematic desensitisation and pelvic floor training. This highlights the importance of equipping healthcare providers across specialities with the skills and cultural sensitivity necessary to support women with this condition.

CONCLUSION

In conclusion, this case of vaginismus highlights the impact of cultural, religious, and educational factors on a patient's understanding of sexuality and sexual dysfunction. The patient's misconceptions, shaped by societal taboos, limited sexual education, and poor spousal communication, highlight the need for culturally sensitive care. Effective treatment for vaginismus goes beyond medical intervention to include psychotherapy, physical therapy, and comprehensive sexual education. For Muslim women, integrating medical and religious perspectives in care can improve outcomes. Culturally competent care and open discussions on sexual health are crucial to empowering patients and enhancing sexual health and marital satisfaction. Moreover, healthcare providers, especially those in multicultural or religiously conservative contexts, should be trained in delivering culturally sensitive sexual health care. Incorporating Islamic perspectives into sexual education may enhance treatment engagement and outcomes for Muslim women with vaginismus.

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