

Psychological impact and health-related quality-of-life outcomes of Mayer–Rokitansky–Küster–Hauser syndrome: A systematic review and narrative synthesis

Journal of Health Psychology
1–14

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DOI: 10.1177/1359105319901308

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Abstract

Mayer–Rokitansky–Küster–Hauser syndrome causes absence or underdevelopment of uterus and vagina, but women’s subjective experience remains understudied. This systematic review was conducted to examine the psychological and health-related quality-of-life outcomes of Mayer–Rokitansky–Küster–Hauser syndrome. In total, 22 articles identified through electronic search matched the inclusion criteria and were included in our review. Mayer–Rokitansky–Küster–Hauser syndrome may be associated with psychological symptoms and impaired quality of life, but especially with poor sexual esteem and genital image. Women may experience difficulties managing intimacy and disclosing to partners. Mothers may be perceived as overinvolved, with consequent negative emotions in women with the disease.

Keywords

health-related quality of life, Mayer–Rokitansky–Küster–Hauser syndrome, psychological health, systematic review, vaginal agenesis

Introduction

Mayer–Rokitansky–Küster–Hauser (MRKH) syndrome, or Müllerian aplasia, is an important cause of vaginal agenesis, a congenital condition that affects one in every 5000 female births (Herlin et al., 2016) and is characterized by the underdevelopment or complete absence of uterus and vagina, despite the presence of normal secondary sexual characteristics and external genitalia, a 46,XX karyotype, and functioning ovaries and fallopian tubes (Dabaghi et al., 2019; Fedele et al., 2010; Fliegner et al., 2014).

The disease usually manifests itself during adolescence with primary amenorrhea and is subsequently diagnosed by ultrasound and magnetic

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resonance imaging in most cases (Bombard and Mousa, 2014).

Medical treatment of MRKH syndrome involves the creation of a neovagina using non-surgical and surgical procedures. Non-surgical approaches entail vaginal enlargement with dilators, using gradual simple pressure with increasingly larger devices (Frank method; Dabaghi et al., 2019). When non-surgical methods do not enable sexual intercourse, a variety of surgical interventions with different techniques can be performed to create a neovagina (Watanabe et al., 2017). All these procedures may have complications such as, for example, dyspareunia and urinary tract obstruction (Dabaghi et al., 2019). Overall, women seem more likely to prefer surgical procedures because these interventions are experienced as faster and less frustrating than non-surgical methods, which can be difficult to practice also due to cultural and social limitations, with consequent feelings of embarrassment (Dabaghi et al., 2019).

In a 2009 literature review examining the psychological impact and quality-of-life (QoL) outcomes of MRKH syndrome (the latest published review on this topic, at least to our knowledge), Bean et al. (2009) reported that women may be able to physically engage in penetrative sex after the creation of a neovagina, but having an anatomically intact vagina does not necessarily lead to optimum sexual function, which also requires good psychological conditions. The literature examined in the Bean et al. (2009) study provided evidence regarding the disruptive impact of the disease on women's sense of themselves, with poor self-esteem and body disturbance. In this context, the inability to carry a pregnancy due to uterine absence or abnormality (a condition referred to as absolute uterine factor infertility; Ejzenberg et al., 2019) represents an important risk factor associated with feelings of inadequacy deriving from comparisons with healthy women (Bean et al., 2009; Heller-Boersma et al., 2007).

Given this background, we reviewed the research evidence published in the last decade, after the Bean et al. (2009) study, to describe the psychological impact of MRKH syndrome, as

well as the effects of the disease on women's health-related QoL (HRQoL, a multidimensional concept focused on the specific impact of health—including medical conditions and their treatment—on people's lives, in terms of physical, mental, and social functioning; Bourdel et al., 2019).

Materials and methods

This review was designed to provide a comprehensive picture of the psychological and HRQoL conditions of women with MRKH syndrome. Thus, we included quantitative and qualitative studies reporting original research evidence on this topic. As far as possible for this review, we followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA; Moher et al., 2010).

Electronic search

From June to August 2019, we conducted a systematic electronic search of two databases (PubMed and PsycINFO). The search process is displayed in Supplemental Figure 1. After preliminary examination of title, abstract, and keywords of a sample of articles focused on the topic of interest, we identified the following set of search terms that were combined using appropriate Boolean operators (AND/OR): "Mayer-Rokitansky-Küster-Hauser syndrome," "vaginal agenesis," Rokitansky, psychological, anxiety, depression, coping, personality, "lived experience," neuroticism, "quality of life," distress, vaginoplasty, sigmoid, dilator, Vecchiotti, Davydov, McIndoe, Frank. The reference lists of the studies included in this review were also examined to identify other eligible studies.

Article selection

We included articles written in English and reporting psychological and HRQoL outcomes of the disease and/or its treatment. Given that Bean et al. (2009) considered studies published between 1955 and 2007, we included articles published from January 2008 to August 2019.

We excluded literature reviews, commentaries, case reports, doctoral theses, and opinion papers. Due to the psychological focus of our research question, we did not include studies reporting exclusively sexological outcomes (i.e. vaginal length, sexual function, sexual distress, and sexual satisfaction) of MRKH treatments (a systematic review of this body of literature was recently conducted by Dabaghi et al., 2019). However, we included studies that explored the association between sexological outcomes and psychological factors, such as, for instance, women's feelings and emotions, self-esteem, and body image. We excluded studies that reported psychological and HRQoL outcomes of MRKH and other genital anomalies without discriminating between malformation types. After duplicates elimination, articles were screened independently by the first three authors, starting with titles and abstracts, and subsequently retrieving full texts.

Data extraction and quality assessment

Data extraction involved the creation of an Excel recording spreadsheet to summarize information of interest (i.e. authors, date and country of publication, research aims, sample description, study design and methods, main results). The first three authors independently assessed and subsequently discussed the quality of all eligible studies following seven criteria applicable to both quantitative and qualitative studies (Culley et al., 2013; Shepherd et al., 2006): (1) presence of a comprehensive theoretical framework, (2) clear explanation of research aims, (3) appropriate description of factors important for result interpretation, (4) precise sample description, (5) detailed presentation of materials and methods, (6) data analysis performed by more than one researcher, and (7) rigorous (vs. speculative) interpretation of results based on the original research evidence provided in the study. The included studies had to meet at least four of these seven criteria (Canzi et al., 2019). All discrepancies among authors were discussed until consensus was reached.

Analysis and narrative synthesis

The analytic process entailed a three-step thematic analysis (Dixon-Woods et al., 2005) that involved (1) reading all articles to identify relevant issues, (2) categorizing these issues to define the prominent themes, and (3) providing a narrative synthesis of the findings. A narrative approach—rather than standard systematic review methodology—is particularly appropriate to summarize findings from very different types of studies, such as those included in this review (Culley et al., 2013).

Results

Selection and characteristics of the studies

A total of 185 articles were initially retrieved from electronic search (Supplemental Figure 1). At the end of the selection process, 22 research articles were included in our review. No further material was identified after reference list examination. Characteristics and main findings of the included articles are summarized in Table 1. Of these 22 studies, 16 (73%) were quantitative, 2 (9%) were qualitative, and 4 (18%) used a mixed-methods design. Six studies (27%) focused on the outcomes of specific treatments, mainly surgical procedures (Carrard et al., 2012; Cheikhelard et al., 2018; Gatti et al., 2010; Labus et al., 2011; Leithner et al., 2015; Sabatucci et al., 2019). Most of these studies examined not only sexual function but also women's body image and genital perception, sense of femininity, self-esteem, as well as psychological symptoms and QoL. The other 16 studies (73%) were primarily focused on women's subjective reaction to the disease, including coping styles, psychological and sexual health, impact of diagnosis, infertility, and attitudes toward motherhood.

Almost all studies (86%) originated in Europe, especially in the United Kingdom, Germany, and Poland. Two studies were conducted out of Europe, specifically in North America (Ernst et al., 2016) and Australia

Table 1. Characteristics of the studies included in the systematic review.

Authors, year of publication, country of analysis	Study aim/research question	MRKH (n)	Non-MRKH (n)	Evaluation of psychological and HRQoL outcomes	MRKH Treatment	Relevant findings
Bargiel-Matusiewicz et al. (2013) (Poland)	To examine the associations between neuroticism, coping styles, and positive/negative emotions, and the underlying mechanisms, in women with MRKH syndrome	46	—	Quantitative. NEO-FFI, CISS, Emotional State Survey	—	Emotional coping style mediated the relation between neuroticism and affects. Time of awareness of MRKH moderated the association between neuroticism and negative affects
Bargiel-Matusiewicz and Kroemeke (2015) (Poland)	To compare personality traits and coping styles in women with MRKH versus healthy controls	46	44 healthy	Quantitative. NEO-FFI, CISS	—	Higher neuroticism, greater emotion-focused coping, and lower problem-focused coping in the MRKH group
Beisert et al. (2015) (Poland)	To examine sexual activity in MRKH patients versus healthy controls	31	31 healthy	Quantitative. Psychosexual biography	Surgery (n = 21)	No significant differences regarding age at initiation of autoerotic and anal activity, and level of sexual arousal. In MRKH participants, less frequent vaginal and oral intercourse, later initiation of dyadic sexual activity, less frequent orgasm during intercourse
Brunner et al. (2016) (Germany)	To examine gender self-perception in women with CAIS versus subfertile or infertile women with MRKH and PCOS	49	11 with CAIS, 55 with PCOS	Mixed methods. Multidimensional questionnaire	—	The majority of MRKH participants did not report decreased female identity or doubts about female role
Carrard et al. (2012) (France)	To evaluate functional and psychosexual outcomes of sigmoid vaginoplasty	59	—	Quantitative. Questions assessing depression, body image, desire of motherhood	Sigmoid vaginoplasty (n = 48), Frank's method (n = 11)	Overall, 28% of women reported signs of depression, despite increased sexual function after treatment. No significant group differences in psychological outcomes
Cheikhelard et al. (2018) (France)	To compare dilation and surgery as regards QoL outcomes, anatomical results, and complications	131	—	Quantitative. WHOQoL-BREF	Dilation only (n = 26), surgery (sigmoid vaginoplasty, Davydov, Dupuytren, Vecchietti, McIndoe) (n = 84)	No significant differences in global QoL across the two groups. Overall, lower psychosocial health and social relationship scores compared with the general population
Dear et al. (2019) (The United Kingdom)	To examine pre-treatment sexual experience in women with vaginal agenesis	115	22 with CAIS	Quantitative. Sexual Experiences Questionnaire, MSQ, Vaginal Self-Perceptions	—	The majority of women with MRKH syndrome reported sexual activity before treatment (mostly non-penetrative sex). Most women perceived their vagina as too small. No significant group differences
Ernst et al. (2016) (The United States)	To investigate the process and the emotional impact of disclosing MRKH diagnosis to peers during adolescence and young adulthood	9	—	Qualitative. Semistructured telephone interviews	—	Motivations for disclosing were trust and closeness, honesty, and responsibility toward partner. Deterrents were fear of rejection, or being misunderstood or considered a "freak," lack of trust and comfort, and infertility

(Continued)

Table 1. (Continued)

Authors, year of publication, country of analysis	Study aim/research question	MRKH (n)	Non-MRKH (n)	Evaluation of psychological and HRQoL outcomes	MRKH Treatment	Relevant findings
Flegner et al. (2014) (Germany)	To examine psychological and sexual well-being in women with CAIS versus MRKH and the association between psychological factors and sexual function	49	11 with CAIS	Mixed methods. FUS, RSES, BSI (only Depression subscale), open question	Dilation only (n = 2), surgery (n = 42)	In MRKH patients, feelings of inadequacy in sexual situations affected sexual function. High rates of depression (as for CAIS). Overall satisfaction with sexual life. Sexual problems related to issues regarding vaginal functioning. Worse psychological outcomes in non-sexually active patients In MRKH women, moderate wish for a child, with greater distress, thoughts, and sadness regarding infertility; 29% showed clinically significant depression; positive attitudes toward motherhood associated with depression
Flegner et al. (2018) (Germany)	To explore the role of infertility and attitudes toward motherhood in women with CAIS and MRKH syndrome	49	12 with CAIS	Quantitative. Self-developed questionnaire, FEMu, BSI	—	No significant differences in psychological function between MRKH patients and controls
Gatti et al. (2010) (Italy and Bangladesh)	To investigate the psychological and psychosexual experience of MRKH patients who underwent total sigmoid vaginal replacement	43	30 healthy	Quantitative. RSES, BDI, CTLMA	Total sigmoid vaginal replacement	In MRKH patients, higher phobic anxiety and psychoticism, lower self-esteem, and greater eating disorder symptoms. No significant correlation with time from diagnosis
Heller-Boersma et al. (2009) (The United Kingdom)	To compare the psychological conditions of women with MRKH versus healthy women; to examine whether the psychological impact of MRKH decreases over time	66	31 healthy	Quantitative. SCL-90-R, RSES, IIP-32, EDI	—	No significant differences in overall QoL relative to Australian general population; negative feelings after diagnosis, mostly related to infertility
Kimberley et al. (2011) (Australia)	To evaluate long-term QoL and sexual function outcomes in women treated for vaginal agenesis	28	—	Quantitative. WHOQOL-BREF, Questionnaire assessing reactions to diagnosis	Sheares or McIndoe procedure (n = 4), dilators (n = 16)	Among MRKH patients, 62% had contacts with other affected women; of these, 90% considered contact beneficial; 53% wished to have such contact. High levels of distress in 54% of MRKH women
Krupp et al. (2012) (Germany)	To investigate how women with CAIS, MRKH, or PCOS experience contact with other affected individuals	49	11 with CAIS, 55 with PCOS	Mixed methods. Questionnaire developed to examine different aspects of the contact experience, BSI	—	79% of patients did not report depression. Most participants were satisfied with surgery, considered as the best treatment option; 94% reported satisfactory femininity with heterosexual orientation. Family was the main source of support
Labus et al. (2011) (Serbia)	To evaluate sexual and psychosocial adjustment after rectosigmoid vaginoplasty	36	—	Quantitative. BDI, Questionnaire assessing postoperative satisfaction, social and sexual adjustment	Rectosigmoid vaginoplasty	40% of MRKH patients reported clinical depression and were more likely to report anxiety and depression than healthy women
Laggari et al. (2009) (Greece)	To investigate anxiety and depression in women with MRKH and PCOS	5	22 with PCOS, 22 healthy	Quantitative. BDI, STAI, Stressful Life Events Schedule	—	

(Continued)

Table 1. (Continued)

Authors, year of publication, country of analysis	Study aim/research question	MRKH (n)	Non-MRKH (n)	Evaluation of psychological and HRQoL outcomes	MRKH Treatment	Relevant findings
Leithner et al. (2015) (Austria)	To examine sexual and psychosocial functioning in women with MRKH after surgical creation of a neovagina	10	20 healthy	Quantitative. PHQ, BSI, WHOQoL-BREF, FBek, PBI	Wharton-Sheaars-George technique	No significant group differences in depressive symptomatology, psychosocial burden, QoL, and body image. Less psychological impairment in MRKH patients. Closer mother-daughter relationship
Liao et al. (2011) (The United Kingdom)	To explore QoL, psychological health, and sexuality in MRKH patients	56	—	Quantitative. SF-12, HADS, MSQ	Dilator only (n = 36), surgery (n = 8)	Compared with a standardization sample, MRKH patients reported greater physical QoL, but poorer scores on the mental QoL component and greater anxiety. No differences for depression. Poor sexuality (especially sexual esteem)
Pastor et al. (2017) (Czech Republic)	To investigate sexual well-being and partners' perspective among MRKH patients with a neovagina	42	45 healthy; patients' sexual partners	Mixed methods. FGSIS, semistructured and structured interviews	Laparoscopic Vecchietti vaginoplasty	MRKH patients reported poorer genital image than healthy controls; 97% of men at first did not recognize the artificial vagina. Infertility was not considered a reason for relationship breakup by 83% of men
Patterson et al. (2016) (The United Kingdom)	To investigate young women's subjective experience of MRKH syndrome	5	—	Qualitative. Semistructured interview	—	Although the diagnosis was considered as a private experience, mothers were heavily involved. Women reported sensitivity to difference and intimacy problems. Female identity and self-esteem were compromised by the disease
Sabatucci et al. (2019) (Italy)	To evaluate long-term sexual function and QoL after vaginoplasty	39	—	Quantitative. PGWBI	Modified Abbé-McIndoe technique using autologous in vitro cultured vaginal tissue	Patients reported greater QoL compared with their pre-intervention condition as well as with the median standardized profile of the general population
Weijenborg et al. (2019) (The Netherlands)	To examine sexual and psychological well-being in MRKH patients	54	79 healthy	Quantitative. SES, FGSIS, SCL-90, HADS, RSES, MMQ (subscale Relationship Satisfaction), Sexual and Physical Abuse Questionnaire (three questions)	Vecchietti (n = 1), Davydov (n = 5), McIndoe (n = 5), Williams (n = 1), cutaneous groin flaps (n = 1), unspecified (n = 2)	MRKH patients reported longer relationships, less frequent abuse experiences, and poorer sexual esteem and genital image, but similar psychological health condition compared with controls. Psychological factors (especially sexual esteem) predicted sexual dysfunction

MRKH: Mayer-Rokitansky-Küster-Hauser; HRQoL: health-related quality of life; NEO-FFI: NEO Five Factor Inventory; CISS: Coping Inventory for Stressful Situations; CAIS: Complete Androgen Insensitivity Syndrome; PCOS: Polycystic Ovary Syndrome; QoL: quality of life; WHOQoL-BREF: World Health Organization Quality of Life-Brief Version; MSQ: Multidimensional Sexual Questionnaire; FUS: Fragebogen Unsicherheit in Soziosexuellen Situationen (Feelings of Inadequacy in Social and Sexual Situations); RSES: Rosenberg Self-Esteem Scale; BSI: Brief Symptom Inventory; FEMu: Fragebogen Einstellungen zur Mutterschaft (Questionnaire on Attitudes toward Motherhood); BDI: Beck Depression Inventory; CTLMa: Cohen Test for Life Management Ability; SCL-90-T: Symptom Checklist-90-Revised; IIP-32: short 32-item version of the Inventory of Interpersonal Problems; EDI: Eating Disorder Inventory; STAI: State-Trait Anxiety Inventory; PHQ: Patient Health Questionnaire; FBek: Fragebogen zur Beurteilung des eigenen Körpers (Body Perception Questionnaire); PBI: Parental Bonding Instrument; SF-12: Short Form-12 Health Survey; HADS: Hospital Anxiety and Depression Scale; FGSIS: Female Genital Self-Image Scale; PGWBI: Psychological General Well-Being Index; SES: Sexual Esteem Subscale of the MSQ; MMQ: Maudsley Marital Questionnaire.

(Kimberley et al., 2011), and one study involved both Italy and Bangladesh (Gatti et al., 2010). Only one study reported longitudinal findings (Sabatucci et al., 2019). Two articles (Ernst et al., 2016; Patterson et al., 2016) described findings from qualitative studies providing an in-depth exploration of women's lived experience of MRKH syndrome, while the remaining 19 articles (86%) reported cross-sectional results.

The number of MRKH patients included in the studies ranged from 5 to 131 (total $N=1017$), and the median number was 46. Age at diagnosis ranged from 13 to 21 years and time since diagnosis ranged from 1 to 39 years. In seven studies (32%), women with MRKH were exclusively compared with healthy controls (Bargiel-Matusiewicz and Kroemeke, 2015; Beisert et al., 2015; Gatti et al., 2010; Heller-Boersma et al., 2009; Leithner et al., 2015; Pastor et al., 2017; Weijenborg et al., 2019). In six studies (27%), comparisons were made with women with Complete Androgen Insensitivity Syndrome (CAIS) and/or polycystic ovarian syndrome (PCOS) (Brunner et al., 2016; Dear et al., 2019; Fliegner et al., 2014, 2018; Krupp et al., 2012; Laggari et al., 2009). In four studies (18%), MRKH patients were exclusively compared with general or standardization population (Cheikhelard et al., 2018; Kimberley et al., 2011; Liao et al., 2011; Sabatucci et al., 2019).

Various questionnaires (either standardized or non-standardized and researcher-made) were used to measure MRKH psychological and HRQoL outcomes. The Beck Depression Inventory (BDI) and the Brief Symptom Inventory (BSI) were the most used scales to assess psychological symptoms (Fliegner et al., 2014, 2018; Gatti et al., 2010; Krupp et al., 2012; Labus et al., 2011; Laggari et al., 2009), while HRQoL was mostly evaluated using the World Health Organization Quality of Life–Brief Version (WHOQoL-BREF; Cheikhelard et al., 2018; Kimberley et al., 2011; Leithner et al., 2015).

Narrative synthesis

The thematic analysis conducted led to the identification of eight prominent themes: (1)

reactions to diagnosis and coping styles, (2) psychological symptoms, (3) body image, (4) self-esteem and female identity, (5) infertility and attitudes toward motherhood, (6) sexuality and intimate relationships, (7) family and social relationships, and (8) HRQoL.

Reactions to diagnosis and coping styles. Four studies (18%) reported information regarding women's reactions to diagnosis and coping styles (Bargiel-Matusiewicz et al., 2013; Bargiel-Matusiewicz and Kroemeke, 2015; Kimberley et al., 2011; Patterson et al., 2016). Women's reactions to diagnosis are commonly characterized by negative emotions or even suicidal thoughts in a minority of cases (Kimberley et al., 2011). Being diagnosed with MRKH syndrome entails dealing with increased sense of difference compared with peers (Patterson et al., 2016). Therefore, young women with the disease may try to minimize or even avoid exposure to stressful situations that involve social comparisons (e.g. being around pregnant women; Patterson et al., 2016). In the study by Patterson et al. (2016), women also tried to avoid thinking about MRKH by focusing, for instance, on their careers and plans for the future. As demonstrated by Bargiel-Matusiewicz and colleagues (Bargiel-Matusiewicz et al., 2013; Bargiel-Matusiewicz and Kroemeke, 2015), women's emotional state may also be influenced by their personality, especially by neuroticism, which enhances negative emotions such as uncertainty, disappointment, anger, and depression. The authors also showed that women who had been aware of their condition for more than 6 years reported higher levels of neuroticism and lower problem-focused strategies compared with healthy controls (Bargiel-Matusiewicz and Kroemeke, 2015). Women with MRKH seemed more likely to use emotion-focused strategies that led them, combined with neuroticism, to be excessively focused on negative emotions (Bargiel-Matusiewicz et al., 2013; Bargiel-Matusiewicz and Kroemeke, 2015).

Psychological symptoms. Evidence regarding the presence of psychological symptoms (such as, for instance, anxiety, depression, eating disorders,

psychoticism) was provided by 11 studies (50%), of which 7 reported information about the psychological health of MRKH patients regardless of medical treatment (Fliegner et al., 2014, 2018; Heller-Boersma et al., 2009; Krupp et al., 2012; Laggari et al., 2009; Liao et al., 2011; Weijenborg et al., 2019), whereas the other 4 focused on the outcomes of specific types of surgical interventions (Carrard et al., 2012; Gatti et al., 2010; Labus et al., 2011; Leithner et al., 2015). The first subgroup of articles reported conflicting findings. Three studies indicated that MRKH patients may display high rates of depression (Fliegner et al., 2014, 2018; Laggari et al., 2009). In the study by Fliegner et al. (2014), the rates of depression were three times higher than expected, and clinically significant depression was reported by 29 percent of patients (Fliegner et al., 2018) and 40 percent of patients (Laggari et al., 2009), respectively. There is also evidence that MRKH patients may be more likely to be affected by anxiety, psychoticism, and eating disorder symptoms than healthy women (Heller-Boersma et al., 2009; Laggari et al., 2009), with 54 percent of patients displaying high psychological distress (Krupp et al., 2012). However, in a recent study (Weijenborg et al., 2019), the presence of psychological symptoms in 54 MRKH patients and 79 healthy controls was assessed using the Symptom Checklist-90 (SCL-90) and the Hospital Anxiety and Depression Scale (HADS), with no significant differences between groups. The findings reported by the second subgroup of studies focused on treatment outcomes indicated that overall women showed good psychological health after surgery, with no remarkable difference, compared to women who used dilators (Carrard et al., 2012). In two of these studies, women who underwent surgical creation of a neovagina did not report higher rates of psychological symptoms (including depression) than healthy controls (Gatti et al., 2010; Leithner et al., 2015). Labus et al. (2011) observed that 78 percent of patients who underwent rectosigmoid vaginoplasty did not have depressive symptoms. In the Carrard et al. (2012) study, 28 percent of women reported signs of depression, despite increased sexual function.

Body image. Evidence regarding body image, including subjective genital perception, was reported in five studies (23%; Carrard et al., 2012; Dear et al., 2019; Leithner et al., 2015; Pastor et al., 2017; Weijenborg et al., 2019). The worst outcomes were found when body image was assessed in terms of vaginal image and perceptions, for instance, using the Female Genital Self-Image Scale (FGSIS; Pastor et al., 2017; Weijenborg et al., 2019). It was observed that MRKH patients tend to negatively perceive their vagina (e.g. too small or needing an increase in size) before (Dear et al., 2019) and after treatment, with poor satisfaction (Pastor et al., 2017). In the Leithner et al. (2015) study, body image was assessed from a broader perspective, that is, not specifically focused on female genitals, with no significant differences between the MRKH group and healthy controls. In the Carrard et al. (2012) study, body image was generally assessed in terms of “body image perception” (positive, neither positive nor negative, negative) by means of a questionnaire developed by the researchers, and changes in body image since treatment were evaluated. In both studies, MRKH women reported positive outcomes, without differences related to treatment (sigmoid vaginoplasty vs. Frank method; Carrard et al., 2012) and compared with healthy controls (Leithner et al., 2015).

Self-esteem and female identity. In four studies (18%; Fliegner et al., 2014; Gatti et al., 2010; Heller-Boersma et al., 2009; Weijenborg et al., 2019), self-esteem was assessed using the Rosenberg Self-Esteem Scale (RSES). In three of these studies (Fliegner et al., 2014; Gatti et al., 2010; Weijenborg et al., 2019), women with the disease did not report impaired self-esteem. However, Heller-Boersma et al. (2009) found poorer self-esteem in the MRKH group compared with healthy controls. Four studies (Brunner et al., 2016; Carrard et al., 2012; Labus et al., 2011; Patterson et al., 2016) provided information regarding female identity and sense of femininity. Gender self-perception was investigated by Brunner et al. (2016), who observed that the majority of MRKH participants reported

having a female gender with heterosexual orientation. Two studies (Carrard et al., 2012; Labus et al., 2011) reported satisfactory femininity in women who underwent rectosigmoid vaginoplasty (Labus et al., 2011) and sigmoid vaginoplasty or dilation (Carrard et al., 2012). On the contrary, in a qualitative study by Patterson et al. (2016), women described MRKH as a threat to their femininity, describing feelings of inadequacy, an overall loss of self-confidence after diagnosis, and worries about the fact that others may detect their condition without being told.

Infertility and attitudes toward motherhood. Four studies (Brunner et al., 2016; Fliegner et al., 2018; Kimberley et al., 2011; Patterson et al., 2016) examined the role of infertility in women with MRKH. In the Kimberley et al. (2011) study, 79 percent of participants reported that the reason for their distress was infertility. Fliegner et al. (2018) observed that MRKH patients showed greater distress regarding infertility, as well as thoughts and feelings of sadness compared with CAIS participants. In another study by Brunner et al. (2016), infertility seemed to play an ambiguous role: for some women, it represented the major source of distress, whereas other women contradicted this. Attitudes toward motherhood were systematically explored by Fliegner et al. (2018), who reported that the more positively women saw children, the greater their depression.

As regards reproductive options, the percentage of women who were interested in surrogacy ranged from 36 percent (Pastor et al., 2017) to 82 percent (Carrard et al., 2012). In the Pastor et al. (2017) study, 91 percent of women would consider uterus transplantation.

Sexuality and intimate relationships. The percentage of MRKH participants who had a partner ranged from 37 percent (Bargiel et al., 2015) to 76 percent (Brunner et al., 2016). These percentages are consistent with findings from other studies included in this review, indicating that women tend to have sex before any treatment, although mostly non-penetrative sex (Dear et al., 2019). As reported by Beisert et al.

(2015), although the age of initiation of autoerotic activity can be similar in women with MRKH compared with healthy women, attempted vaginal intercourse is less frequent and dyadic sexual activity tends to start later among women with the disease. In a study by Fliegner et al. (2014), the MRKH group reported pronounced feelings of inadequacy in sexual situations compared with controls, which were strongly associated with impaired sexual function. Moreover, women who were not sexually active had higher feelings of inadequacy in social and sexual situations, and poorer self-esteem. Poor sexual esteem was also observed by Liao et al. (2011) and Weijenborg et al. (2019), although in the latter and most recent study, this psychological factor was strongly associated with sexual dysfunction and sexual distress, while Liao et al. (2011) did not find significant correlations between these factors. In the Weijenborg et al. (2019) study, impaired sexual function was also associated with anxiety and global self-esteem. Managing intimacy represented an important difficulty for the women interviewed by Patterson et al. (2016). Indeed, disclosure was an important issue, as also underlined by Ernst et al. (2016). Trust and closeness were described as an important motivation for disclosing the diagnosis, but at the same time, women may prefer to wait for being more invested in the relationship before discussing their condition (Ernst et al., 2016; Patterson et al., 2016). Fear of rejection (especially due to inability to conceive) was identified as an important deterrent to disclosure in both qualitative studies. The fact that the partner may find out their condition represents a source of stress for women (Patterson et al., 2016). However, Pastor et al. (2017), who examined partners' perspective using structured interviews, reported that 97 percent of men at first did not recognize the artificial vagina and 83 percent of male partners stated that they did not consider infertility as a reason for relationship breakup.

Family and social relationships. Information regarding women's relationship with their mother was

reported in two articles (Leithner et al., 2015; Patterson et al., 2016). In both studies, mothers were described as particularly caring or even overinvolved. As reported in the qualitative study by Patterson et al. (2016), women experience their diagnosis as personal and hindering independence may be an issue when mothers are too intrusive (for instance, they take the lead in consultations with professionals) or overprotective. In another study by Labus et al. (2011), family was described as the main source of support by women who underwent rectosigmoid vaginoplasty. Disclosure to friends occurs when women feel comfortable in a relationship based on trust and sharing secrets, and negative feelings and outcomes related to disclosing the diagnosis are less frequent with friends than with partners (Ernst et al., 2016). In a study by Krupp et al. (2012), 90percent of MRKH participants who had contacts with other affected persons considered it beneficial, and 53 percent of those who did not report any contact wished for such an experience. MRKH participants who did not want any contact were afraid of experiencing distress due to an excessive focus on negative topics during the discussion.

HRQoL. HRQoL was systematically evaluated in five studies (23%) using well-known standardized measures, and specifically the WHOQoL-BREF (Cheikhelard et al., 2018; Kimberley et al., 2011; Leithner et al., 2015), the Short Form-12 Health Survey (SF-12; Liao et al., 2011), and the Psychological General Well-Being Index (PGWBI; Sabatucci et al., 2019). Except for the Liao et al. (2011) study, the other articles mostly reported treatment outcomes. Overall, women showed improved HRQoL after treatment as compared with their pre-treatment situation (Sabatucci et al., 2019), healthy controls (Leithner et al., 2015), and the general population (Kimberley et al., 2011). In the Cheikhelard et al. (2018) study, there were no significant differences in HRQoL between the surgery group and the dilation only group, although women reported poorer psychosocial functioning compared with the general

population. In another study (Liao et al., 2011), women showed good physical QoL, but lower scores on the mental component of the SF-12 compared with a standardization population.

Discussion

This systematic review aimed at providing a comprehensive description of the psychological impact and HRQoL outcomes of MRKH syndrome by summarizing the research evidence published in the last decade. Through systematic electronic search, we identified 22 articles that matched our inclusion criteria and were included in this review. Thematic analysis was conducted, and a narrative synthesis of the findings was provided.

The studies included in our review confirmed that MRKH diagnosis represents a stressful event, with negative emotional reactions characterized by increased sensitivity to difference and impaired sense of femininity, especially due to infertility (Kimberley et al., 2011; Patterson et al., 2016). The psychological burden of the disease was highlighted in several studies (e.g. Heller-Boersma et al., 2009), with women affected by MRKH displaying anxiety and depression, psychoticism, and even eating disorder symptoms and poor self-esteem, but more recent articles reported contradicting findings (Weijenborg et al., 2019) and showed overall good HRQoL, especially after treatment (Sabatucci et al., 2019). Such discrepancies may be partly explained by the fact that women's psychological reactions to the disease may be shaped by individual characteristics such as personality traits (Bargiel-Matusiewicz et al., 2013; Bargiel-Matusiewicz and Kroemeke, 2015), as well as by psychological adjustment before the diagnosis (Bean et al., 2009).

Besides confirming the findings of previous studies (Bean et al., 2009), our review adds to the extant literature by identifying other sources of psychological vulnerability in women with MRKH syndrome. First, women's genital image (rather than general body image) is often negative, indicating that women are not satisfied with

their vagina, to the point of feeling embarrassed and uncomfortable during sexual contacts, with concerns about their genital function (Pastor et al., 2017). These beliefs may have a negative impact on women's sexual esteem, which tends to be poor in women with MRKH and thus leads to sexual dysfunction (Weijenborg et al., 2019), as well as to feelings of inadequacy and fear of being rejected or considered "a freak" (Patterson et al., 2016). Second, women are worried that their partner may detect their condition without being told, but this belief is not supported by research evidence, which suggests that most men are not able to distinguish the neo-created from the natural vagina (Pastor et al., 2017). Third, the quality of mother–daughter relationship also deserves attention, because mothers may be perceived as excessively involved and intrusive, for instance, during treatment (Patterson et al., 2016).

Limitations

Due to the broad nature of our research question, as well as to the paucity of psychological articles in the context of MRKH syndrome, we included studies with different objectives and methodologies. The methodological variability across studies, in terms of research designs, measures (i.e. standardized scales and researcher-made questionnaires), and assessment times (time since diagnosis ranged from 1 to 39 years), may account for some of the discrepancies in the findings, especially as regards psychological symptoms. Because systematic comparisons between studies were not possible, we could not describe women's psychological health trajectories during the years following diagnosis and treatment (e.g. short- vs. long-term effects).

Suggestions for future research and clinical practice

Future studies should investigate women's pathways through MRKH syndrome in a more systematic fashion, for instance, by exploring

the association between time since diagnosis and onset of psychological symptoms. This would allow timely implementation and personalization of multidisciplinary treatment. Longitudinal research is encouraged, considering that only one of the included studies had an actual longitudinal design (Sabatucci et al., 2019).

Patients' subjective experience of dilators requires further exploration, and qualitative research may be particularly useful to explore sociocultural and psychological implications of this type of treatment, as well as the role of family. In this regard, MRKH patients are often adolescents and come to the visits with their parents, who also experience emotional distress. Psychological counseling may help parents and especially mothers, who are sometimes perceived by patients as intrusive and overinvolved (Patterson et al., 2016), improve the quality of the support provided to their daughter.

MRKH syndrome is complex, and a biopsychosocial perspective should always guide research and multidisciplinary treatment. The creation of a neovagina, either with or without surgery, may contribute to decrease women's concerns about their vagina and thus reduce feelings of difference, especially when properly managed by a multidisciplinary team (Leithner et al., 2015). However, the creation of the neovagina itself, although not associated with negative psychological and HRQoL outcomes, is not able to provide a definitive relief to women with MRKH syndrome, who experience multiple sources of distress. Therefore, psychological counseling should be routinely offered to these patients, with assessment of women's beliefs regarding their genitals and partner's perceptions. The issue of disclosure, especially to intimate partners, should also be addressed and discussed. Reproductive options should be clearly explained to patients, as well as the specific type of infertility related to MRKH syndrome. In fact, these women are not able to carry a pregnancy due to uterine absence or abnormality, but they may have normally functioning ovaries.

The language used by professionals is fundamental in the context of MRKH syndrome (Bean et al., 2009), as well as good doctor–patient communication, especially when working with young adolescents who are building their identity. Psychologists may help physicians manage the complexity of the disease and improve the quality of their relationship with patients and their families.

Declaration of conflicting interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

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Supplemental material

Supplemental material for this article is available online.

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