CASE REPORT

AN UNCONSUMMATED MARRIAGE: A CASE REPORT

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ABSTRACT

Vaginismus is described as “recurrent or persistent involuntary contraction of the perineal muscles surrounding the outer third of the vagina when vaginal penetration is attempted with penis, finger, tampon, or speculum. The purpose of this case report is to investigate the treatment model of a patient with vaginismus who benefited from Cognitive Behavioral Therapy (CBT) in a couple (woman 21, man 23 years old) admitting to family practice for treatment of vaginismus. The duration of marriage was 19 months. The marriage was unconsummated. The diagnosis was made using DSM-IV criteria. They were assessed initially and after treatment by Golombok-Rust Inventory of Sexual Satisfaction (GRISS) index. The initial scores of communication, sensuality, erectile dysfunction and premature ejaculation and the total scores of the GRISS indicated accompanying sexual dysfunction in the man. Sensate focus and gradual desensitization (vaginal self-dilatation) methods with cognitive restructuring techniques were used. The overall sexual functioning of the woman showed improvement.

Keywords: Vaginismus, Primary care, Cognitive behavioral therapy

OLGU SUNUMU: TAMAMLANMAMIŞ BİR EVLİLİK

ÖZET

Vajinismus, penis, parmak, tampon veya spekulum penetrasyon girişimi halinde vajenin dış 1/3’ünü çevreleyen perineal kasların tekrarlayıcı veya persistan istemsiz kontraksiyonu olarak tanımlanır. Bu olgu sunumu, aile hekimliği polikliniğine başvuran ve Bilişsel Davranış Terapisi’nden (BDT) yarar gören vajinismuslu bir hastanın tedavi modelini ele almaktadır. Çift 19 aydır evliydi ancak cinsel birleşme sağlanamamıştı. Tanı DSM-IV kriterlerine göre kondu. Tedavi öncesi ve sonrasında çifte Golombok-Rust Inventory of Sexual Satisfaction (GRISS) endeksi uygulandı. İletişim, cinsel istek, erektil disfonksiyon, prematür ejekülasyon puanları ve toplam puan, erkekte de cinsel disfonksiyon olduğunu gösterdi. Tedavide, bilişsel yeniden yapılandırma teknikleri ile birlikte sensate focus ve kademeli duyarsızlaştırma (kendi kendine vajinal dilatasyon) yöntemleri kullanıldı. Kadının cinsel fonksiyonları iyileşme gösterdi.

Anahtar Kelimeler: Vajinismus, Birinci basamak, Bilişsel davranışsal terapi

INTRODUCTION

Sexual dysfunction (SD) in women is a multifactor condition with anatomical, physiological, medical, psychological and social components. Data reveal that up to 76% of women have some type of SD.[1,2] Women’s SD includes disorders of sexual desire, arousal, orgasm and/or sexual pain, which result in significant personal distress and may compromise women’s health and quality of life. Vaginismus was categorized as “a sexual pain disorder” in Diagnostic and Statistical Manual of mental disorders (DSM)-III-R[3], DSM-IV[4], and the report of the

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International Consensus Development Conference on Female Sexual Dysfunction[5] and in other nosologies such as the American College of Obstetricians and Gynecologists-1995, American Psychiatric Association-1994, World Health Organization-1992. The sexual pain disorders are the only pain problems in the DSM-IV[4] other than "pain disorder" and this appears to reflect the idea that sexual pain disorders are of a special type associated with sexual activity. Vaginismus is defined as an involuntary contraction of the muscles of the outer third of the vagina. The contraction interferes with coitus and occurs during attempts at penetration with, for example, a penis, finger, speculum or menstrual tampon[6]. The pelvic floor muscles involved in these contractions, surround the urethra, vagina and anus and are under voluntary control. However, the pelvic floor muscles can also contract involuntarily, as seen during orgasm[5].These contractions are spastic, as opposed to the rhythmic contractions during orgasm[6]. Vaginistic reactions are often associated with a defense mechanism emerging with experience[7]. Vaginismus leads couples to seek treatment in primary care clinics. The purpose of this case report is to investigate the treatment model of a vaginismus patient who benefited from Cognitive Behavioral Therapy (CBT). The couple was assessed using Golombok-Rust Inventory of Sexual Satisfaction (GRISS) index. GRISS is a 28-item questionnaire for the assessment of sexual dysfunction. The female version produces subscale scores of anorgasmia, vaginismus, non-communication, infrequency, avoidance, non-sensuality and dissatisfaction as well as a total score. The male version produces subscale scores of impotence, premature ejaculation, non-communication, infrequency, avoidance, non-sensuality and dissatisfaction as well as a total score. The GRISS is used by sexual dsyfunction clinics and relationship counsellors to monitor the state and improvement of their patients and clients. It has also been used in clinical trials of pharmacological products that are designed for the treatment of sexual dysfunction.

CASE REPORT

A couple who suffered from nonconsummation of marriage admitted to family practice clinic of Cukurova University and was assessed using GRISS index (Table I)[8,9]. The woman was 21 and the man was 23 years old. The duration of the marriage was 19 months. The marriage was unconsummated. We diagnosed vaginismus using DSM-IV criteria. After the initial assessment, brief information about sexual anatomy and sexual physiology was given to the couple using pictures, and printed material. The couple was asked to refrain from direct sexual interaction in the beginning of the therapy in order to avoid performance anxiety. Sensate focus to increase sensual awareness and gradual desensitization (vaginal self-dilatation) methods to desensitize the woman with cognitive restructuring techniques were used. In sensate focus exercises, the couple was told to touch each other's body to increase sensual awareness. A cognitive restructuring technique was used to change the dysfunctional thoughts interfering with sexual functioning. After the anxiety level decreased, the couple was told to perform gradual vaginal self-dilatation technique to desensitize the woman. At the last stage of CBT, the couple gradually attempted sexual intercourse. The importance of communication was emphasized during sessions. After five sessions (once a week lasting 35 minutes) the couple was assessed again using GRISS (Table I). Treatment was continued until the symptoms were improved. The overall sexual functioning of the woman improved at the end of the therapy. There was significant improvement in avoidance, impotence and premature ejaculation scores of man.

Table I: Golombok-Rust Inventory of Sexual Satisfaction (GRISS) scores of the couple

Scores of GRISS	Female		Male	
	Pretreat.	Posttreat.	Pretreat.	Posttreat.
Communication	3.81	2.21	3.93	4.02
Satisfaction	7.50	3.06	6.44	4.98
Avoidance	6.21	2.87	1.81	1.14
Sensuality	3.45	1.12	6.19	5.85
Vaginismus/Erectile Dysfunction	8.94	2.43	5.75	4.20
Anorgasmia/Premature Ejaculation	8.42	3.98	6.40	3.75

Pretreat: Pre-treatment
Posttreat: Post-treatment

DISCUSSION

The couple satisfactorily consummated their marriage after the sixth session. The woman seemed to benefit from the therapy more than the man. The results showed significant improvement in all GRISS subscale scores (vaginismus, anorgasmia, frequency, communication, satisfaction, avoidance, and sensuality). Our results indicating the efficacy of cognitive behavioral interventions for vaginismus are in accordance with studies by Biswas and Schnyder et al.[10,11]. The initial scores of communication, sensuality, impotence, and premature ejaculation and the total scores of the GRISS indicated accompanying sexual dysfunction of the man. It was not a surprise as some items of GRISS were related to consummation. Those items might have increased the scores, especially on the premature ejaculation and impotence subscales. Studies also indicate a high frequency of male sexual dysfunction among partners of women with vaginismus[12,13]. Vaginismus was also found to be common in partners of men with nonorganic erectile dysfunction[14,15].

We directed CBT strategies toward not only the woman but the couple, and the man also seemed to benefit. There was significant improvement in avoidance, impotence and premature ejaculation scores. Nevertheless, the man was satisfied with his sexual relationships both before and after the therapy. Surprisingly, neither the man nor the woman reported any problem related to impotence or premature ejaculation during the sessions[11-15].

In more conservative subcultures the bride is expected to be a virgin. A bride has to verify her virginity to her husband and his family in the first night of the marriage. This tradition may increase the anxiety during the first sexual interaction especially for couples who do not have sufficient information and experience about sex. As a common tradition, before the wedding feast, one of the elder female family members shares with the bride her sexual experience about the first night. Our clinical observation shows that the shared information may sometimes contain unrealistic and catastrophic information such as claims that consummation for women causes unendurable pain and sickness for several days. This kind of information may lead to sexual dysfunction and may complicate the sexual problem. In our case, we used GRISS which does not include parameters related to traditional myths. Further studies should include other parameters such as personality characteristics, comorbid psychopathology, and so forth, to identify the characteristics of vaginismus.[16,17]

Sexual dysfunction cannot be considered as one generic problem. Dyspareunia, vaginismus, reduced arousal, and aversion to sexual contact were uncommon problems and were associated with other psychological and physical difficulties. Women with these ICD-10 diagnoses were also much more likely to have consulted their general practitioners about sexual matters than women who received a single diagnosis of lack or loss of sexual desire. This suggests that many people do not regard lack or loss of sexual desire as a

serious difficulty. Setting aside this diagnosis reduces the prevalence of any sexual problem to 27% for women and 16% for men[18,19]. Thus we need further evidence that the relatively common complaint of lack or loss of sexual desire is an obstacle to satisfactory sexual relations or that a medical solution is indicated; for many people, reduced sexual interest or response may be a normal adaptation to stress or an unsatisfactory relationship. Women's high consultation rate, as well as their willingness to seek help for such problems, makes it possible for family doctors to become involved. However, general practitioners need to be alert to the possibility of a sexual problem and may need training on how to manage this at a primary care level.

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