Case Report

Successful Management of Penetration Disorder: A Holistic Approach to an Age-Old Problem

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Abstract

Penetration disorder, formerly referred to as vaginismus, is the recurrent or persistent involuntary spasm of the musculature of the outer third of the vagina that interferes with vaginal penetration. It is a common female psychosexual problem and is a cause of significant personal and relationship distress. In this report, we describe the successful treatment of vaginismus in a 28-year-old woman by using a combination of different interventions. This involved providing sexual education, psychotherapy, serial dilation using graded plastic dilators, sensate-focused therapy, and anti-anxiety medication.

Keywords: *Sensate therapy, sexual abuse, sexual dysfunction*

Introduction

In the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5), genito-pelvic pain/penetration disorder (GPPPD) is defined as persistent or recurrent difficulties with one or more of the following: (1) vaginal penetration during intercourse; (2) vulvo-vaginal or pelvic pain during vaginal intercourse or attempts at penetration; (3) fear or anxiety about vulvo-vaginal or pelvic pain in anticipation of, during, or as a result of vaginal penetration; and (4) tightening or tensing of the pelvic floor muscles during attempted vaginal penetration. To meet diagnostic criteria, at least one of these symptoms must have persisted for at least six months and must cause significant distress. The disorder can be specified by severity and as either lifetime or acquired.

Risk factors of sexual pain in women include a number of psychiatric conditions like anxiety disorders, poor knowledge of sexual practices due to cultural and religious factors in this environment, and a previous history of traumatic sexual encounters. When sex is painful, research suggests that women may develop anxiety related to sexuality that subsequently maintains the vicious cycle of pain in patients with GPPPD.

In this case report, we discuss the successful treatment of a couple who were unable to achieve penetration using a combination of anxiety medication, graded dilation, and sensate-focused therapy. A holistic approach is characterized by the treatment of the whole person, taking into account biological, mental, and social factors rather than just the symptoms of a disease.

Case Report

A 28-year-old lady presented to the general out-patient clinic with her husband on account of her inability to achieve penetration during sexual intercourse for the past four months of their marriage. She reported tightness of her vagina and pain upon an attempt at penetration and as such coitus was impossible. She had become fearful of sexual intercourse. Her husband admitted that they had never had intercourse prior to marriage due to religious reasons. After marriage, attempts at penetrative sexual intercourse proved abortive. The first time the couple tried, he was unable to penetrate as the vagina was "too tight" and she cried that it was

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painful. At subsequent attempts, she would close her thighs and weep. Her whole body would shake and she would not be able to sleep much. Foreplay was said to be enjoyable and adequate. Both the husband and wife had poor knowledge of the sexual process.

The patient also experienced periods of excessive fear and palpitations and poor sleep three months prior to presentation. She also had sad and guilty feelings. However, there was no history of lack of energy or loss of interest in previously pleasurable activities.

There was a positive history of a traumatic sexual encounter in childhood: this, she admitted after repeated reassurance of confidentiality and when her husband was not in the consulting room. She had been raped at the age of 12 by an older cousin who lived with them. The event happened once and for a long time after the episode, she would have nightmares and flashbacks. She had not had any sexual encounter since the rape. She had no previous relationships before her current husband. This was her first order of marriage. Her husband was a 30-year-old driver.

There was no significant past medical or surgical history in the patient. Her father was diagnosed with diabetes two years prior. She had normal menstrual history. She had no prior psychiatric visits and there was no history of mental disorders in her family. Her family was religious and conservative; therefore, sex was not openly discussed. The patient did not smoke or drink alcohol.

Physical examination was unremarkable. Her mental examination revealed an apprehensive woman who was fearful and sad about the non-consummation of her marriage. Vaginal examination was not done as she was too afraid. A diagnosis of genito-pelvic pain/penetration disorder (formerly called vaginismus) secondary to sexual trauma in a young woman with anxiety disorder was made. A management plan was outlined: (1) anxiolytics (tab. fluoxetine 20 mg daily for three months and tab. diazepam 10 mg nocte for five days), (2) sexual education, (3) sensate-focused exercises, (4) serial dilation.

The patient visited eight in three months. At the first visit, the first author, who was the primary therapist, commenced her on medication and educated the couple on the various methods of treatment. A combination of sensate-focused therapy and serial dilation was employed due to their poor sexual knowledge and the advantage the sensate-focused exercises would have in improving their communication and relationship. Subsequent visits followed steps 1 to 5 of the sensate-focused therapy, which included (1) communication about the couple's sexual desires and non-genital touching, (2) genital and breast touching, (3) mutual touching, (4) using lubricants, and (5) sexual intercourse/penetration. Additionally, on the second visit, the author started dilation with the smallest dilator which was 0.6 inches in diameter. Once the patient was comfortable with the size, she was encouraged to practice at home with her husband. The patient was taught to wash the dilator in soapy water before and after each use. The dilator size was increased only when the patient was comfortable with the previous size. By the sixth visit, she was using the last dilator (1.5 inches in diameter) and was at stage 5 of the sensate-focused therapy (penetration). Her prescription of fluoxetine was renewed for another three months, after which it was discontinued.

Discussion

Previously, the DSM-4 included two sexual pain disorders: dyspareunia and vaginismus. However, in the DSM-5, sexual dysfunction combined these two disorders into genito-pelvic pain/penetration disorder (GPPPD). In DSM-4-TR, dyspareunia was defined as genital and/or pelvic pain, while vaginismus referred to an involuntary spasm or tightening of the pelvic muscles. The merging of dyspareunia and vaginismus emphasizes the multidimensional nature of genital pain, particularly in women.

As GPPPD is new to DSM-5, prevalence estimates are limited. An Iranian study yielded a prevalence rate of 10.5% among married women living in Tehran.[1] Different prevalent rates exist for dyspareunia and vaginismus across various countries.

Notably, higher rates of painful sexual intercourse have been in countries where arranged marriages, polygamy, and/or widow inheritance are common.[2] Additional risk factors for GPPPD include poor health, lower education, low family income, high stress, more frequent emotional problems, and the presence of urinary tract symptoms.[2,3] GPPPD is also far more likely in women with histories of abuse.[4,5] Additionally, women who experience vaginal spasms report high levels of anxiety symptoms. It is, however, unclear whether anxiety is a cause or consequence of such spasms.[6,7]

This couple was managed using both pharmaceutical and non-pharmaceutical methods. Serial dilation has been used in gynecology practice, with much success. However, combining dilation with sensate-focused therapy in this couple produced faster and more effective results.[8,9] Sensate focus is a combination of exposure therapy (teaching you to associate good, relaxing experiences with touch, sex, and your partner), mindfulness (focusing the mind away from distracting thoughts), and sensate touch (mindfully touching the

body while thinking only about the texture, temperature, and pressure you feel). In a previous study on the effectiveness of sensate focus as a treatment for a variety of sexual difficulties, therapists found it to be 83% effective.[10]

Women with vaginismus can also do Kegel exercises at home to learn to control and relax the muscles around their vagina. This is called progressive desensitization and the idea is to get comfortable with insertion. The patient is encouraged to start with a single finger insertion and gradually move up to three fingers. This method was, however, not employed as the index patient was apprehensive and had poor knowledge of the sexual process.

This case report demonstrates a successful holistic approach toward managing GPPPD in a clinical out-patient setting. There is a need for randomized controlled trials to establish efficacy and bolster these approaches.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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Nil.

Conflicts of interest

There are no conflicts of interest.

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