Multidisciplinary treatment of an unconsummated marriage with organic factors in both spouses

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■ Successful treatment of a case of unconsummated marriage involved the expertise of a urologist, gynecologist, and psychologist working together in an interdisciplinary clinic to treat sexual dysfunction. Total duration of treatment was 18 months, and components included surgical correction of congenital chordee, surgical excision of a hymenal remnant blocking the vaginal introitus, laser treatment of endometriosis, and sex therapy evaluation and follow-up totalling five sessions for both partners. At the end of treatment the couple was having pleasurable sexual intercourse.

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WE DESCRIBE A COUPLE with an unconsummated marriage of 4 months. Successful treatment required separate interventions by three clinicians—a urologist, a gynecologist, and a psychologist—from the multidisciplinary Center for Sexual Function at the Cleveland Clinic. Both spouses had rare organic genital malformations that interfered with penile-vaginal intercourse and that needed surgical correction; however, even after successful surgery, behavioral sex therapy was needed to overcome residual vaginismus. This case illustrates the importance of collaboration between specialists in evaluating and treating sexual dysfunction.

CASE HISTORY

Urologic evaluation and treatment

Mr. Jones, a 27-year-old accountant, referred himself to our urology clinic because of penile curvature with erection. He had first noted that his erections were abnormal when he saw erotic films at around age 18. He was worried about whether he would be able to have intercourse but was too shy to disclose his problem to anyone. Due to his religious convictions he did not believe in having intercourse before marriage. He met his future wife when both were age 24. She was a marketing trainee, also sexually inexperienced, who grew up in a family that stressed religious orthodoxy. During their 3 years of dating, they experimented with genital caressing, but neither was very concerned about the unusual curve in his erection. A premarital gynecologic examination of Mrs. Jones did not reveal any abnormality. On their honeymoon, several attempts at penetration for intercourse ended in failure because of Mrs. Jones's severe pain when the tip of the penis was inserted into her vagina.

As part of the urologic evaluation, Mr. Jones provided a polaroid picture of his erection. A clearly abnormal ventral curvature was seen in the proximal third of the penis, typical of congenital penile chordee. Surgical correction was performed, using a Nesbit procedure.[3] An artificial erection was induced by saline infusion into the corpora cavernosa, and the site of maximal chordee was identified. A wedge of tunica

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albuginea was then excised. The postsurgical result was excellent: Mr. Jones was able to achieve firm erections that were almost without any curvature.

Sex therapy evaluation and treatment

At 6 months following the chordee repair, a call from the patient's wife and a subsequent visit by the couple revealed that they were still unable to have intercourse because of the wife's dyspareunia on attempted penetration. The couple was referred to the psychologist in the program for sex therapy for presumed vaginismus.

Both Mr. and Mrs. Jones were present for the initial interview with the psychologist. At that point, they had been married for 16 months without being able to have intercourse. Both partners agreed that they got along well on a day-to-day basis, with open expression of affection and good ability to resolve conflict. They had continued to engage in noncoital sexual stimulation two or three times a week. Each partner was able to reach orgasm with the other's manual stimulation. Mrs. Jones did not feel comfortable with the idea of oral sex, so oral stimulation was not a part of their routine. Mrs. Jones had good vaginal lubrication and no pain with caressing of her clitoris or vulva; however, if her husband attempted penile penetration, she felt sharp, strong pain at the vaginal introitus. She was able to use a tampon, and her husband could insert a finger into her vagina, albeit with some difficulty. Because of their religious beliefs, they used birth control based on the menstrual cycle and basal body temperature to avoid intercourse attempts during fertile periods.

The couple viewed a videotape about vaginismus and its treatment with sex therapy.[4] Mrs. Jones was given detailed instructions on using Kegel exercises to contract and relax the circumvaginal muscles. Mr. Jones was assigned to try inserting first one, then two fingers comfortably in his wife's vagina before attempting penetration with the penis. They agreed to return in 2 to 3 weeks but did not make an appointment to come back until 3 months later. They reported that they had achieved insertion of two fingers, but only with pain for Mrs. Jones. She had gone to see her gynecologist, and although the speculum insertion had also been quite painful, he found no abnormality on pelvic examination.

The psychologist suggested that Mrs. Jones consult the gynecologist in the Center for Sexual Function. If that examination was also normal, a set of vaginal dilators of graduated sizes could be prescribed, and sex therapy would continue with dilator training. It seemed important, however, to verify that there was no physical problem, given the persistent introital pain.

Gynecologic evaluation and treatment

On pelvic examination, Mrs. Jones had a subtle and unusual finding. A persistent band of hymenal tissue was noted, beginning just below the urethra and extending to the posterior fourchette. It would be possible to insert a speculum, finger, or tampon without noticing the band of tissue, but if the entrance to the vagina were stretched laterally, the band expanded in a "hammock" effect to block the introitus. No areas of discrete tenderness or lesions were noted around the vaginal introitus. On vaginal examination, the cervix and uterus were unremarkable and the adnexa were supple and benign. There was slight tenderness in the cul-de-sac.

Mrs. Jones was first given the option of trying dilation with her fingers to stretch the band of hymenal tissue. She tried this for 2 weeks but made little progress. Surgery was then performed to excise the hymenal remnant, which consisted of mucosa and rather thick, fibrous tissue. Because Mrs. Jones also complained of intermittent pelvic pain and had tenderness in the cul-de-sac, a diagnostic laparoscopy was included. The finding was stage II endometriosis involving the right ovary, both uterosacral ligaments, and the left posterior broad ligament. Laser fulguration of the endometriosis was performed. At 1-month follow-up, Mrs. Jones had healed well and was told that she could attempt intercourse.

Postsurgical sex therapy

Two months after her last gynecology follow-up, Mrs. Jones contacted the psychologist because she and her spouse were still unable to have intercourse. Mr. Jones had been able to penetrate an inch or two, but his wife felt intense pain at the introitus and pushed him away from her. Discouraged about their inability to have intercourse, the frequency of noncoital sex had also dropped. Mrs. Jones discussed her difficulty in seeing herself as a sexual person, and her sense that she had taken childhood religious prohibitions against premarital sex so seriously that she was having trouble "changing gears to think like a married woman."

At this session, Mrs. Jones was given a series of four graduated vaginal dilators (Milex, Inc.), with a repeat of earlier instructions on relaxing the circumvaginal muscles. She and her husband returned 3 weeks later. In one evening she had been able to progressively use all four dilators in turn without discomfort. Two days later she and her husband again tried penetration, but

she still felt pain and asked him to stop when the glans of his penis was in her introitus. The couple also followed advice to increase the frequency of their noncoital lovemaking and, again, to incorporate vaginal caressing by the husband by inserting first one finger, then two. The couple was given explicit instructions for the husband to insert each dilator in turn into his wife's vagina, first with her manual guidance and then with her verbal permission. They were given instructions to try intercourse slowly and gradually with the wife in the female superior position, sitting down onto her husband's penis while he stayed motionless.

The couple cancelled several appointments but returned after 7 weeks. By that time they had had several successful episodes of penetration and full-scale intercourse. Mrs. Jones had no pain and had adequate vaginal lubrication without using a supplemental lubricant. The couple was experimenting with different positions for intercourse. They continued to use basal body temperature testing as a method of avoiding conception, but both were hoping to start trying for a pregnancy within the next year. Ways to enhance Mrs. Jones' pleasure with intercourse (by her husband providing extra breast or clitoral caressing) were discussed. She was able to experience pleasure during intercourse but had not yet reached orgasm from coital stimulation. Both partners felt improved self-esteem and affection for each other. In addition, they said that they no longer felt they had a "shameful secret," and that they felt like a "normal" couple.

DISCUSSION

Most cases of unconsummated marriage seen by sexual dysfunction practitioners are caused by vaginismus, an involuntary contraction of the muscles surrounding the outer third of the vagina. Vaginismus is a psychophysiological problem, usually related to fear that intercourse would be painful. The most common etiologic factor is a background of strong religious orthodoxy with guilt and inhibition about sexual activity.[1,2] Because vaginismus is relatively common, it is easy for physicians and other health professionals to overlook organic factors that can interfere with penetration for intercourse. In most clinical settings, vaginismus is diagnosed by either a gynecologist or a mental health professional. In such a setting, interdisciplinary collaboration in treating unconsummated marriage would be unusual.

Although this case had a successful outcome, treatment was drawn out over 18 months and required collaboration between three professionals in different aspects of sexual dysfunction. Ambivalence on the part of both patients about becoming sexually active can be seen in the repeated delays between phases of treatment. Both were consciously eager to experience intercourse together, but each was also quite perfectionistic and self-punitive. Each new assignment stimulated fears of insurmountable failure.

The case illustrates the utility of our interdisciplinary clinic, in which staff can discuss difficult cases from the perspectives of both psychological and medical knowledge of sexual dysfunction. When one element of the treatment plan did not succeed, cross-referrals identified previously unsuspected impediments which were then eliminated in turn.

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Commentary

This report of the successful resolution of complex, persisting sexual dysfunction in an otherwise compatible marriage by means of a varied clinical approach has an almost "fairy tale" ending. The moral of the story is that one should not give up and assume that residual sexual dysfunction is situational or emotional until all physical possibilities have been thoroughly explored and excluded. This philosophy should be applied in all other aspects of clinical medicine.

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