

Sex Therapy in a Case of Unconsummated Marriage

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Abstract

The prevalence of sexual dysfunction is common in both genders. Psychogenic factors are a common cause for unconsummated marriages. We report a couple who had an unconsummated marriage of 5 years due to vaginismus in the wife and erectile dysfunction in the husband. It took 8 sessions of sex therapy with the couple without the use of medication. The sessions included sexual education, behavioural techniques like graded insertion of fingers, homework assignments and cognitive behaviour therapy which resulted in the couple consummating their marriage.

Keywords

Vaginismus, Sex Therapy, Unconsummated Marriage, Erectile Dysfunction

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1. Introduction

The prevalence of sexual dysfunction ranges from 25-63% in women and 10-52% in men.¹⁻³ In unconsummated marriages psychogenic factors, performance anxiety organic causes, vaginismus, premature ejaculation are the common causes.⁴

Vaginismus is known in 5-17% of cases attending the sexual dysfunction clinics⁵ due to anxiety, sexual functioning of partners, quality of marital relationship and lack of knowledge about anatomy and sexuality.^{6,7} We report a couple who had an unconsummated marriage of 5 years, due to vaginismus in the wife and erectile dysfunction in the husband.

2. Case

A young couple in their early thirties with an unconsummated marriage for 5yrs were referred to the psychiatrist by a gynaecologist. Both were highly educated technocrats, working in multinational companies but were unable to talk about sex to each other. The couple consented

for sex therapy by the male and female investigators for 8 weekly sessions. Enquiry revealed that the wife had fears about coitus since her adolescence, as she had heard it was painful and so she did not allow her husband to penetrate and reported having tightness of the vagina. Her husband did not make demands and she would only allow foreplay. The husband would initially self-masturbate and ejaculate to satisfy his urges but soon started having erectile dysfunction and expressed lack of libido.

Their personalities differed with the husband being particular, neat, meticulous and finicky about cleanliness whereas the wife claimed she was lazy and would do things in a relaxed way. She worked from home and watched all late night soap operas whereas her husband would go to work early and come home late and then be busy on his laptop. They hardly spoke to each other or shared any information. But both felt that their marriage was perfect with total understanding of each other. Since 8 months, their foreplay also stopped as the husband felt that his hand would get contaminated if he touched his wife's genitals. He also reported a decrease in libido with impotence though he did not give any symptoms of depression.

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The wife gave fears about pain during penetrative intercourse without any symptoms of depression. She had never masturbated or allowed her husband to masturbate her. In their initial married days, she would have spasms of her vaginal muscles with closing of her thighs after which she would push her husband away and they would both end up feeling hurt and angry. Though the couple did not seem to be bothered about their non-existent sex life, their families were concerned about them not having any children. They consulted a gynaecologist who referred them to the psychiatrist as all their laboratory tests were normal. In the initial sessions both were explained about the anatomy of the genital organs and physiology of the sexual response cycle. The first thing done was to improve communication between them. Both were asked to spend time with each other discussing their activities, have meals together, share their problems and take a walk together after dinner. The wife was told to switch off the T.V. and the husband his laptop. They were asked to hold hands and experience “the feel of each other.” They were asked to express these feelings to the partner, when they would take a walk or be together in the house. Along with communication, they were taught about the sensate focus and asked to know each other’s erogenous zones. They were given home exercises where they would undress self/each other, touch each other in initial non-erogenous areas and later when comfortable to touch the genital areas of the partners. They were explained about using fantasy and masturbation if they got aroused.

Both were taught sex hygiene and asked to take a bath, brush their teeth and then allow themselves to be undressed by the partner. Their inhibitions were discussed and tackled. Information on diet, clothing was additionally given to make them comfortable with each other. As the sex therapy continued, the couple progressed in their communication styles and enjoyed touching with the husband experiencing the desire to have sex and having erections.

Behavioural techniques were used for the wife’s fears where she was first advised to use gloves and do 1 finger penetration by self. She was taught relaxation and deep breathing and made comfortable. She was advised to do it by self when alone for a few days and then to gradually progress to 2 and then 3 fingers insertion. As she could do it in a couple of weeks, she was then advised to do it in her husband’s presence. He was asked to comfort her and indulge in foreplay whilst she inserted her fingers which continued for 1 week after which the wife was absolutely comfortable and did not feel any pain on insertion of her own fingers nor have spasm of the vaginal muscles. They were then asked to have coitus with the wife in the female superior position guiding the penile penetration with the help of lubricating jelly and just experiencing and enjoying the vaginal

containment. She was told to relax and be the active partner while the husband remained passive. This continued for about a week after which the couple went on a holiday to experience their “first night” after more than 5 years. They finally succeeded in consummating their marriage and are now having normal sexual intercourse.

3. Discussion

Sexual dysfunction is a common problem which leads to inter-personal problems and marital discord. Vaginismus is defined as recurrent or persistent involuntary spasm of the musculature of the outer third of the vagina, which interferes with coitus and causes distress and interpersonal difficulty. Physical causes need to be excluded. There is a debate on the inclusion of spasm in the definition as it has not been consistently documented by the women.^{8,9} It has been classified as primary when the woman has never experienced non-painful penetrative sexual intercourse and as secondary when she has experienced non-painful penetrative vaginal intercourse in the past.⁸ Vaginismus is believed to be a psycho-physiologic disorder due to fear from actual or imagined negative experiences with penetration and/or organic pathology. Women with vaginismus have also been noted to have a lack of sex education.¹⁰

It took 8 weekly sessions of sex therapy with the couple to treat the fear of penetrative intercourse and improving communication between the partners to achieve success. Sex hygiene is an essential part of sex education as many couples do not communicate to their partners about body odour or bad breath. This often reduces the arousal as was seen in our case. The sex therapy sessions include education, homework assignments and cognitive behaviour therapy⁶ which resulted in the couple consummating their marriage.

Treatment for vaginismus have included systematic desensitization along with insertion of graded dilators/fingers¹¹, drugs like benzodiazepines, anxiolytics, botulinum toxin injection,¹² and hypnosis.¹³ An eclectic approach involving education, graded insertion of fingers, Kegel’s exercises and usage of anaesthesia with vaginal containment was tried by Harish *et al.*⁷ In the Indian scenario where the talk about sex is taboo and limited among partners it becomes very essential to first improve their communication so as to improve the sex related issues.

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