Genito-Pelvic Pain/Penetration Disorder: A Practical Case from Ghana

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Abstract

Effective health care rests on strong collaboration among different specialties. One of these collaborations is one between the physician and the clinical psychologist. This paper presents a collaborative treatment of genito-pelvic pain/penetration disorder (formally called vaginismus) suffered by a couple for two whole years after their marriage in Ghana. The collaboration involved a gynecologist and clinical psychologist. Data on such cases are rarely presented in this part of the world. It is therefore important to present such cases in order to inform future treatment options and procedures.

INTRODUCTION

According to the Diagnosis and Statistical Manual (DSM-V) genito-pelvic pain/penetration disorder (GPPPD) is a female sexual disorder characterized by six months of one of the following four symptoms; difficulty with vaginal penetration, marked genital or pelvic pain during attempted or actual intercourse, significant fear of pain as a result of vaginal penetration, and tensing or tightening of the pelvic floor muscles during attempted vaginal penetration [1]. In the former edition (DSM-IV, TR) the condition was called vaginismus [2].

To many people, it is baffling to suffer a condition such as this. At best, people attribute the condition to biological factors such as large penis size of the partner, smaller vagina cavity, or some other form of disease. Even though this view may pull some technical points, penetration disorder is very much caused by the state of the vaginal muscles associated with psychological past traumatic experiences especially with sex. What is interesting however is that despite the fact that this disorder exists, its sufferers have poor insight about the condition and thus find it difficult to explain and embarrassing to disclose. For this reason, persons who suffer from the condition have been described as a hidden population [3]. Unfortunately, this leads to delays in treatment or at least, disrupts treatment procedures [4]. Regardless of this delay, patients of this condition do eventually seek help from a wide range of specialists including the gynecologist, general practitioners and psychologists [5].

The effect of GPPPD is varied. It ranges from physical pain to psychological/emotional disturbances such as anxiety, fear, depression and poor intimate relationship [6], feeling of inferiority, death wishes, self-blame, guilt feeling, anger and stress. Of course, one of the obvious effects is reduced chances of pregnancy [7]. Also, reported that painful, unsuccessful attempts at intercourse increase degree of marital distress in couples and this situation has negative effect on physical and emotional satisfaction of each spouse [8].

The justification for this paper is that, some couples in our part of the world are suffering from this and related conditions, a situation that makes GPPPD a global issue (thus, it is not limited to any specific geographical location). However, in Africa and Ghana for that matter, the case is rarely reported, both within the community of practitioners and researchers. As such, the reports on indigenous attempts in handling such cases are not readily available to practitioners in this part of the world. This paper aims at setting the pace for the reportage of such sensitive cases.

CAUSES OF GPPPD

As indicated in the introduction of this paper, the cause of GPPPD is not readily known [9]. There is however a considerable body of knowledge indicating that gynecological and psychological factors underlie the condition. For example, vaginal muscle inflammation or vulva injury could result in the condition where severe pain will be experienced in an attempt at vaginal penetration during sexual intercourse [10]. This more likely will result in a psychological stimulus response where the thought of sexual intercourse will trigger fear/anxiety and stress. Also, a woman who experienced painful or traumatic sexual intercourse could develop the condition [11]. Even the fear of
getting pregnant could trigger the condition as well as being told in childhood that ‘sexual desire is wrong’ or ‘sex is painful’ [12]. Religious ideations, poor or wrong sex education have also been noted to play a role in the etiology of the condition [11,13].

THE CASE

This is the case of a couple (man-28, woman-26) who have been married for two (2) years without penetrative sexual intercourse. They were not able to achieve vaginal penetration for two years even though they were married and were legally and religiously licensed to do so. Over the two years all attempts to have penetration was unsuccessful. The woman experienced severe pain during any attempt. As a result the man always withdrew in order to avoid causing further pain to his wife. The woman reported to have constantly avoided any attempt by her husband to initiate sex since she had come to dread the act. For that reason, she slept dressed up in order to avoid arousing her husband. On their own they tried to address the situation. They tried with the man’s finger and only a one third (1/3) could penetrate amidst severe pain. After a year into the situation, the couple reported to a first gynecologist who examined the woman and conducted an examination under anesthesia in order to ‘open up’ the vaginal opening. This was believed to help with penetration since it was highly thought that the cavity was small. One year on, the couple was still unable to achieve penetration. The female partner had adequate desire and arousal. They were able to achieve orgasm in both the female and the male partner via partner masturbation. Despite all these attempts, penetration remained impossible and this brought them to our hospital.

Prelude to the condition

Before marriage, the woman reported that while in the university, she heard her friends discuss that sex was a very painful experience especially the first time. Following this conversation, she watched a movie where a young lady was having sexual intercourse for the first time with severe pain, screaming and crying. This confirmed the story her friends had told her. From that time on, she always dreaded sex especially for the fear that she was a virgin. The man recounted that when they were courting, there was a time when they both got carried away and got to the point of initiating sexual intercourse, this incident triggered a significant panic for the woman and he was not able to penetrate as the woman cried out in pain. ‘Well, we are not married yet so let me not worry’ were the words he used. From that time on, they always had to put up a front before friends and family.

Effects of the problem

For the woman, this meant disappointing her husband. She felt guilty for bringing this problem into her marriage. She cried several times and refused to eat whenever she remembered the situation. She lost weight, lost interest in activities and gave up on trying seeking help longer. She had constant headache, sleeplessness, and withdrew from social activities. Her responses to a psychological screen for depression, anxiety and stress showed borderline for stress, moderate for depression and severe for anxiety. On other intake screens, she reported difficulties at work, lack of confidence, sexual problems just to mention a few.

The man was equally severely affected by the situation. He reported being sad, stressed and disappointed. He was easily angered and found it hard to appreciate his wife. At a point, he confessed wanting to quit the marriage. He narrated that, he wanted to run away from the woman to another city. He wanted to die. Practically, every aspect of his life was affected. He equally lost weight, lost appetite and lacked interest in social activities.

They recounted that they felt a lot of pressure from society, friends, parents and other relations to have children. They could not discuss their situation with anyone. They lacked satisfaction in the marriage. They were becoming antagonistic towards each other since the man felt the woman was not trying hard enough and the woman felt her husband was not being understanding. In fact, they both reported that they felt their marriage life was miserable but they always had to put up a front before friends and family.

Treatment method(ology)

The treatment approach was both medical (gynecological) and psychological. The gynecological intervention consisted of vaginal examination and the introduction of vaginal dilators. Cognitive Restructuring, Progressive Muscle Relaxation, Systematic Desensitization, Sensate Focus and behavioural modification were the main psychological interventions utilized. Each approach is described in turns below.

The gynecological method: On examination the client was found to be of normal stature and her sexual development was normal. Her breast and pubic hair development were tanner stage was V. Visual inspection of the vulva confirmed that there were normal female genitalia. Any attempt at clinical vaginal examination was met with reflex spasm of the thigh muscles making digital examination impossible. The woman was given a single Plastic Pratt Dilator size 7-8 for use over the subsequent two weeks. The diameter of one end was 7mm and the other end was 8mm and both ends were well rounded and smooth. The goal was to be able to insert about 5cm of the length of the dilator into the vagina without pain.

She was instructed to insert the smaller end into the vagina gradually as she felt comfortable. She was also advised to use a small amount of lubricant like KY gel. She was to pause if pain was felt and retry until the required length of the dilator was able to enter without pain. She was then to progress to the larger diameter side of the dilator and repeat the process. She was asked to master this stage with confidence and without pain also using the relaxation methods taught by the clinical psychologist. The plan was to give her progressively larger diameter dilators over time until she was able to comfortably pass the largest which had a diameter of 14mm.

Four different sizes of dilators were to be used (7/8mm, 9/10mm, 11/12mm and 13/14mm sizes). However, each dilator was given for one to two weeks and replaced on the next visit to the facility. Water based gel was recommended for any form of penetration to avoid friction. After all the dilators were successfully inserted, the fore finger of the client was to be inserted.

The psychological method: The psychological approach involved the use of clinical psychological strategies. The main
therapeutic intervention adopted was the Cognitive-Behavioural Therapy (CBT). Cognitively, a comprehensive psycho-education and Cognitive Restructuring were the main approaches adopted. The couple was educated extensively on the etiology of the condition, its effects and possible interventions. Furthermore, negative thinking and certain patterns of distorted thoughts were identified and challenged. Reference was made to the diagnosis of GPPPT (and vaginismus which might have been heard by some people) with all the associated characteristics. This was meant to demystify the condition especially in our part of the world where it is easy to attribute conditions to spirituality. This gave the couple a better insight and appreciation of the turmoil they had endured all this while. Effort was also made to link the past experiences of the woman to the condition in the process of explaining the causes of the condition. This broadened their scope of understanding and imparted on the perception of the pain she has had over the time as well as inspired the man towards dealing differently with their sexual issues. From the education, they both learnt to appreciate the fact that the condition was real and could be treated. Efforts were made to help the woman recondition her body, especially her genital area is within reach to the man. She was taught to do this exercise before insertion of fingers or dilator. Relaxation was again practiced. They must set time aside to deal with the issues such as spending the weekend together on the trials, trying the dilator every morning and at night. She was further encouraged to join the man in activities he enjoys, watch movies together, play together and go to bed together. She was also taught to fantasize about the sexual act with her husband and relate it to her calming/exciting moments. She was also taught simple relaxation exercises such as breathing in and out and imagery.

Thirdly, the couple was taught Progressive muscle relaxation. This is a relaxation exercise which consists of alternately tensing and relaxing groups of muscles in a prescribed sequence; for example, starting from the feet and moving upwards. The woman was taught to do this exercise before insertion of fingers or dilators. She was also to continuously breathe in and out and to imagine how exciting the sexual encounter will be.

Fourthly, Systematic Desensitization, a behavioural therapy used to treat phobias and other behavioural problems that involve anxiety was also used. In this approach patients are exposed to anxiety provoking situations in a gradually more threatening sequence. In this case, vaginal trainers that are gradually bigger in size were used with the approach of systematic desensitization until she was able to tolerate the situation comfortably [14].

**Treatment outcome**

This was a collaborative treatment for a condition that rarely comes up in the Ghanaian general medical setting. All stakeholders worked toward the same result from this treatment i.e. the ability to have pain-free sex.

After week one, the couple returned with negative feedback. The woman was still feeling pain in the attempt to insert the smallest sized dilator as well as finger. She reported that she imagined the dilator was “too pointed” and could “injure” her. They were unable to carry out almost all the behavioural instructions they were given. However, the hopeful cue for success was that the couple reported that for the first time they were able to live together with less antagonism. They purposefully discussed their problem and encouraged each other to comply with the treatment.

The second phase was week two of the treatment. The perception that the dilator was pointed and the fear that it could injure were cognitively challenged. She was made to compare the dilator with her finger. The dilator was noted to be as small as her finger. It had no nail that could scratch or hurt. She got the impression that the dilator was probably modeled after her finger. The couple was also made to understand that the treatment process required their active and conscious effort.

They must set time aside to deal with the issues such as spending the weekend together on the trials, trying the dilator every morning and at night. The woman was asked to go the extra mile by trying her finger regularly//more frequently as well as the dilator. Relaxation was again practiced.

This couple appeared more serious, determined and willing the second week. Three days into the week, they were successful with first the dilator, then fore finger, and finally two fingers both of the woman and the man. By the close of the fifth day of the second week they had achieved full penetrative sexual intercourse. It must be noted that the first sex was painful but with less anxiety. They repeated penile penetration for three consecutive days. At this point they could not wait for their appointment. They called to break the news. Three months after this result, the couple achieved pregnancy.

Clearly, the pain must have diminished well enough over the time taking into account the role of the man in penetrating gradually, helping the woman to relax and discussing sex related topics with the woman as well as doing house chores together. There was joy, healthy relationship communication and peace of mind.

**CONCLUSION/DISCUSSION**

Health care across the world has taken a trend that promotes collaboration in order to achieve efficient results. Holistic health care brings many different specialists on board. This is the approach utilized in this case treatment. It is clear from that the first gynaecologist who attempted the case did not apply due diligence in terms of collaboration. He conducted surgery without proper indication. He failed to collaborate with other specialists who might have given him better insight and results.
The outcome in this case was rapidly achieved mainly due to effective collaboration. Drawing from this outcome, it is clear that psychology in medicine is very important. It is also very important for team work between the physician and the psychologist for better results. Usually, because some medical procedures are dependent on the activities of other specialists especially those in diagnostics, the collaboration between them becomes unavoidable. Little effort is often made to collaborate with the psychologist in the health setting especially in Ghana. To this point it is obvious that our clients/patients need our collaboration for their healing.

The effects of this collaboration were not only success in sexual penetration and satisfaction but also achievement of pregnancy, restoration of the marital relationship and restoration of social confidence and status for the couple.

COMPLIANCE WITH ETHICAL STANDARDS

Names of patients and possible identifying information were withheld. The name of the hospital is also withheld. The paper reports the professional techniques employed in a collaborative procedure in managing a clinical case. All sources used were duly acknowledged.

REFERENCES
