Vaginismus: A case presentation

by Dr James Walton

One busy winter afternoon Mrs B, a new patient aged 21 years, presented at my surgery with symp tomatology typical of foregut pathology.

Indigestion and heartburn which often awoke her at 3 am had increased in intensity over recent weeks. "My stomach gets into a knot and throbs", she complained as she clutched her fist tightly at her epigastrium. A friend at work had recently had a duodenal ulcer diagnosed and this had precipitated her visit to the doctor.

Mrs B went on to describe frequent and severe cervico-occipital headaches previously diagnosed as "tension" and for wich she had consumed regularly a variety of analgesics and muscle relaxants. Feeling quite bucked with myself for discovering the aetiology of her epigastric pain so easily I proceeded to order a few routine investigations — Barium Meal, X-Ray cervical spine and FBC. The Barium Meal and FBC came back negative while the cervical X-Rays indicated a disturbance in muscle tone.

Having reassured the patient I prescribed: Metoclopramide 1 tds, Propraholol 40 mg tds, Rubragel D prn, and a course of physiotherapy for her neck (not forgetting of course to prohibit the use of those analgesics irritant to gastric mucosa).

Mrs B went away happy that she did not have an ulcer, and a follow-up visit a few days later proved that she had responded well to medication and her pains had subsided.

The remission was short lived. Within two weeks Mrs B was back once more with severe indigestion, headache and her period was very late. "Everybody thinks I'm neurotic", she exclaimed.

"My husband's mother is in a mental institution and I don't want to turn out like her. She's such a problem to the whole family and my husband has enough worry with his mother to have me being so neurotic too. Oh I get so depressed about everything," she sighed.

I could see that Mrs B was deeply distraught. She was an attractive young woman with a vibrant almost vivacious personality but at the same time she appeared very immature, overtalkative and lacking in self confidence. Her state of anxiety was obvious as she moved restlessly in her chair, spoke with her hands and looked nervously past me as she spoke — hardly ever making eye to eye contact.

"My husband's mother is in an institution and I don't want to turn out like her"

I gently prodded her on in an attempt to discuss the cause of her anguish but could pinpoint nothing very obvious. Mrs B was unhappy in her job, the neighbour's children were always swimming in her pool without permission, her mother-in-law was a strain on her husband and this in turn affected her. There were, however, no financial difficulties; she denied marital conflict and described her husband as quiet, consistent and "not demanding" although of late he had begun to liken her to his mother, a fact which troubled her enormously.

Being primarily concerned with her physical symptoms at this stage I advised that a gastroscopy was indicated — when I explained the procedure to her she recoiled in horror and said "nobody is going to stick anything down me" and no amount of persuasion on my part could change her attitude.

Groping for ideas I suggested an anti-depressant (having concluded that her early morning awakening was possibly depressive rather than gastric in origin "Oh I've had anti-depressants before" she replied "and they just make me worse". (I was only just beginning to see why Mrs B was labelled by her friends and family as neurotic — in fact I felt somewhat irritated by her demanding but uncooperative and negative attitude.)

I suggested that perhaps she should see a psychiatrist to which she immediately reacted by bursting into tears and saying that she did not want to go the same way as her mother-in-law and pleaded with me not to refer her. After a few moments she collected herself, said she would think about it and come back to me.

A week or so went by and I heard nothing more except from her pharmacy who asked if they could repeat the script for Metoclopramide and propranolol. The physiotherapist reported that Mrs B was receiving regular and apparently successful treatment for her neck.

One afternoon she came into the rooms and asked if I would prescribe cimetidine which her friend at work was finding very effective for her ulcer.

Mentally I had already labelled Mrs B as being psychosomatic but couldn't help feeling that she was an unusually young woman and married for such a short time to be frequenting the doctor so regularly with this type of condition. If there was any more to her story of which I was unaware, she concealed it very deliberately and effectively.

"She remembered her mother as being overprotective and somewhat domineering."

I prescribed the cimetidine as requested and was relieved to see her go. A few days later she phoned from work and said she was desperate and insisted on seeing me that day. We were heavily booked but I sensed an urgency in her voice and agreed to see her as my last patient that evening. She was unusually quiet when she came into my office and sat down. "There's something I must tell you about myself. I've wanted to tell you before but couldn't bring myself to do so. I wanted to first see if I could talk to you and trust you but today I feel I can tell you about it." Then the story came out.

At the age of 16 years she had been raped on the way home from school. She had fallen pregnant as a result and was whisked off to the U K by her parents where at two months the pregnancy was terminated. "And now every year towards September I start working myself up into a real state as I am reminded of the ordeal. You see I'll never get over it?" she whimpered.

Having a special interest in both psycho, as well as sex therapy I was able to extract from her that her marriage had in fact never been consumated as any attempt at penetration had not only been impossible physically but extremely traumatic emotionally. Although she had enjoyed clitoral and other foreplay early on in the marriage relationship and in fact had been orgasmic on clitoral stimulation there was now far less physical affection and loveplay between her husband and herself and she feared that her husband was losing his patience and could possibly stray.

Having made a provisional diagnosis of vaginismus — which was confirmed during a subsequent consultation when a vaginal examination was attempted and failed as the patient kept snapping her knees back together and squirming. The introitus was impassable due to the tight contraction of the surrounding vaginal musculature.

I explained to Mrs B that I believed she could be helped but I would need to see her for a series of consultations to work through her fears and the pattern of avoidance she had developed. Somewhat hopelessly she consented to undergo therapy but was completely resistant to involving Mr B in any way.

Initially I agreed to go along with this as I anticipated that a lot of headway could be made by working through her own intrapsychic fears and conflicts on an individual therapy basis. At a later stage I hoped Mr B could be included in order to resolve the marital dysfunction.

Mrs B's reluctance to involve her husband was seen as part of the avoidance pattern pursued by a patient suffering from Vaginismus as any attempt at penetration which is feared and thus avoided. I was confident enough that Mrs B could be brought to a place where she would be agreeable to involving her husband.

The relevant points to be worked on were:

- Her sense of general failure and worthlessness.
- Her anger towards her parents as well as fear of her mother.
- Her guilt regarding the abortion and falling pregnant in the first place.
- Her sense of failure as a wife.

Mrs B herself was an only child, the result of an unplanned pregnancy. Her parents were both very young when she was born. The fact that her parents had never contemplated further children presented many possibilities with regard to her parent's attitude to her as a child. She remembered her mother as always being overprotective and somewhat domineering. It was postulated that her mother had probably been resentful at being thrust into parenthood so unexpectedly and that initially this had been reflected in her attitude to her child. This resentment had subsequently given rise to feelings of guilt and remorse which culminated in a reversal of feelings with overprotection and "smother" love being the consequence.

Mrs B's abortion at the age of 16 years could be seen as her mother's final attempt to protect her daughter from men and the ills of this world.

Mrs B had subconsciously received certain inconsistent and immature injunctions or messages from her mother during childhood and adolescence.

For example:

- DON'T EXIST — I never planned you or wanted you when you were born — you messed up my life so just remain quiet and insignificant so I can get along with my own life.
- DON'T GROW UP — Remain young and immature and Mommy will look after you to make up for all her guilty feelings about rejecting you!
- I'M THE BOSS — You're not allowed to do what you want or have your own feelings — I'm your mother after all and I know what is best for you!
- DON'T ENJOY SEX — It will only get you into trouble like it got me!
- DON'T HAVE CHILDREN — Or they'll mess up your life like you messed up mine!

She was allowing these messages to perpetuate through into her adult life giving her a poor self image with feelings of worthlessness, negativity and resultant emotional immaturity. Guilt regarding her very existance let alone enjoyment of sex and having babies, dominated her psyche.

During therapy it was pointed out to her that as an adult she was no longer bound to parental overtones but was free to make her own decisions and to "feel" the way she chose to.

to page 29

She had never expressed her anger to her mother over her upbringing and the forced abortion and this she was encouraged to do during therapy sessions. She was shown how to express her own feeling to her mother . . . . . "Now look mom — you may have decided how I should feel, think and be — but I'm an adult now and I don't have to stick with your opinions. I'm going to give myself permission to do what I choose to do and not feel guilty about it."

I explained that Vaginismus is a conditioned reflex under voluntary control and that by clamming up vaginally she was in fact acting in accordance with those negative parental injunctions.

As regards the abortion she came to see that there was no need for her to feel guilty as she had never been given any say in the matter. Similarly her being raped and falling pregnant in the first instance had been beyond her control and so why should she be bearing the consequence of the experience?

It was a matter of concern as to whether the Vaginismus was the consequence of anger at being raped with the desire to castrate or frustrate men — the rapist in particular — her husband in effect. This would be in keeping with the psychoanalytic conceptualisation of Vaginismus as being due to penis envy. This concern was unwarranted however, as was discovered during consequent couple therapy.

During therapy Mrs B proved to be very co-operative. She obviously enjoyed the sessions and her sense of relief at her new found emotional freedom was obvious by her spontaneity and keen participation in discussion and role play.

After half a dozen sessions or so Mrs B had freed herself so much from guilt, resentment and shame that she asked if she could bring Mr B along. She had already told him that she was undergoing therapy and they were both keen to try and resolve their sexual problem.

My first impression of Mr B was a favourable one. He was quiet yet solid — concerned and very co-operative. I saw them only as a couple from then on although they were advised that should either of them wish to see me alone I would be agreeable. Mr B confirmed the pattern of avoidance — stating that he had ceased to initiate sexual activity as this invariably led to conflict. He admitted feeling angry and resentful towards his wife and shared her concern over the consequences should the problem not be resolved.

Although he never admitted to extramarital affairs his resentment towards his wife was beginning to mount up and he felt at times the desire to have an affair to deliberately hurt her.

He commended her for seeking help however and had seen such a change in her since she had commenced therapy that he was prepared to forgive her and co-operate in therapy.

The objectives at this stage were: to improve the quality of the marriage relationship; to teach Mrs B to relax, enjoy her own body and develop an awareness of her own sexuality without feeling guilty; to accustom her to an intravaginal foreign body.

Initially the couple were told that they were NOT to attempt penetration but were to indulge in non-genital love play for 30 - 45 minute periods at least five times before the next session a week later.

After this they progressed into phase two where manual and/or oral genital caressing was permitted but penetration, still forbidden. This prohibition of actual intercourse was intended to remove the "threat" to love play in order that the latter be enjoyed for its own merits.

Running concurrently with these assignments Mrs B was instructed in the art of voluntarily contracting and relaxing her pubococcygeus muscles for five to ten minutes at a time at least twice a day. As she became proficient in this she was instructed to insert one of her own fingers, well lubricated with K Y Jelly, into her vagina voluntarily contracting and relaxing the P C muscles around her finger. This she was instructed to do at home when she could practice uninterrupted and at her own pace. She was also instructed in various forms of general body relaxation.

As a result of our earlier consultations Mrs B had already resolved most of her intrapsychic fears, and committed herself to doing whatever was necessary to overcome the Vaginismus. After some initial trepidation she was thus able to participate in these assignments without much difficulty.

When she could satisfactorily retain one finger intravaginally she was encouraged to attempt two fingers. By this time the couple were indulging in quite extensive love play including genital stimulation and so the transition from inserting her fingers to her husband's fingers was easily made.

"Guilt regarding her very existence, let alone enjoyment of sex, dominated her psyche."

By the middle of the third week the couple were permitted to attempt penetration in the female superior position where Mrs B could control the situation. She claimed to be enraptured with the experience. The first real intercourse took place a couple of days after this and Mrs B became orgasmic during the experience.

During a subsequent interview I pointed out to Mrs B that during the whole course of therapy which lasted some ten weeks — she had not once mentioned headaches, epigastric pain or any of her other psychosomatic symptoms. She was somewhat surprised and laughed — agreeing that she had virtually forgotten about them!

I did not see Mr or Mrs B for some weeks after we terminated therapy, except to see Mrs B popping into a beauty salon near my surgery one day. She seemed embarrassed at seeing me and I wondered if they had changed doctors as patients so often do when they realise they have exposed their thoughts and the intimacies of their private lives to a stranger. Not long after this she came to see me with a sore throat.

I enquired as to the situation at home and she happily reported that things were still running well. She had stopped taking her cimetidine and had no recurrence of gastric symptoms. She had not had a headache for weeks. □