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The complexities and challenges of sexual dysfunctions diagnosis in females: A case report

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Abstract

Background: Managing sexual problems requires skill and enough time and precision. The patient's chief complaint and data can alter through treatment processes.
Objectives: This case report is about the complexities and challenges of sexual dysfunctions diagnosis in females.
Methods: The present study reports different diagnoses of a woman referred to a sexual clinic.
***Results*:** A 24 years old woman with a history of 4-year unconsummated marriage due to primary vaginismus referred to a sexologist. Previous visits by gynecologists, psychiatrists, and urologists showed no mental or medical problems in the couple. The woman reported that marriage had been done with the couple's consent, she loved her husbands, and no conflict existed between the couple. After examining history and assessing sexual distress and function by means of FSDS-R and BISF questionnaires, routine treatment of vaginismus such as desensitization was initiated through vaginismus diagnosis. Some sessions later, woman's narratives and examinations led to the diagnosis of sexual aversion (sexual aversion was one of the DSM-IV categories). Next interviews with the couple revealed that the woman did not suffer from any sexual dysfunction. The woman replaced her husband with her dead father and consequently was not able to have any sexual relationship with her, although she loved him.
Conclusion: In the mentioned case, 11 visits and more than 10 hours' interview were done. One session with the husband alone, three sessions with the couple, and seven sessions with the wife were held. Three distinctive diagnoses were considered. Although enough time was devoted to introduction in the first session (60 minutes), correct diagnosis needed more visits. The process of the client's trust to the therapist occurred gradually, and frequent interviews and separated man and woman visits were crucial for precise diagnosis.

Keywords: case report, sexual dysfunction, unconsummated marriage, vaginismus, women health

Introduction

Sexual desires include beliefs, values, and emotions which are affected by individual spiritual, cultural, and ethical aspects [1]. Sexual disorders and complications are common with destructive effects on the individual's health and marital relationship [2]. In visiting sessions of couples, female sexual disorders were classified Based on DSM-IV as desire disorder, arousal disorder, orgasmic disorder, dyspareunia, and vaginismus. Sexual aversion disorder belongs to other dysfunctions category [3]. According to DSM-V, female sexual disorders are classified into three categories: Female Sexual interest/arousal disorder, Orgasmic disorders, and Genito-Pelvic Pain/penetration disorders (GPPPD) [4]. GPPPD is formed by combination of dyspareunia and vaginismus. The current

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classification is associated with several limitations. Some researchers believe that vaginismus is hindered behind dyspareunia, while the vaginismus anxiety is much more prominent for the couples, and these two phenomena are fairly different in terms of causes and treatments [5]. Currently, most studies are conducted based on the old classification in which dyspareunia and vaginismus are separated. Accordingly, vaginismus is defined as repetitive persistent pain or fear of vaginal penetration or gynecologic examination [6], which is the definition used in this study. Vaginismus incidence is reported between 5 to 17 percent though it seems to be more prevalent in Islamic societies [7]. A review article reported prevalence rates of 0.4 to 8% [8]. Adequate information is not available on the prevalence of vaginismus in Iran, and it is often measured as coital pain. A study in 2017 measured the GPPPD (including dyspareunia and vaginismus) in the general population based on the new definition. They reported the prevalence of severe sexual pain to be 10.5% and mildly sexual pain to be 25.8%. As Reissing found that the new definitions hindered vaginismus, and no prevalence was found for vaginismus [9]. Although vaginismus is often caused by fear, anxiety, and lack of sexual knowledge [10,11], cultural-religious causes are involved to some extant; thus, its prevalence may differ in different cultures [12]. Based on the researcher's long years of experience on vaginismus, the current case was a special case in which the vaginismus diagnosis was ruled out finally though the patient's initial diagnosis was vaginismus. This case may elucidate the complex multi-dimensional aspects of sexual disorders and present how completely different diagnosis may emerge during the treatment course with different approaches.

Methods

A 24-year-old woman with BS degree and a 29-year-old spouse who was an MS student and employee with 4 years of working experience with unconsummated marriage referred from psychiatrist with vaginismus diagnosis to a sex therapist. The sex therapist had a reproductive health PhD degree and 11 years of therapeutic, educational, and research experience. The first session was held with the presence of wife and spouse for 60 minutes. In addition to history taking, wife completed the female sexual distress scale (FSDS_R) [13]. This scale consists of 13 questions, and a score above 11 defines sexual distress. In this patient, the score turned to be 17 which determined sexual distress. Besides, Brief index of sexual function (BISF) was used. This scale consisted of 22 questions and was first developed in 1994 to assess the sexual function and satisfaction of women in clinical examinations, which included three main areas including sexual desire, sexual activity, and sexual satisfaction [14]. Then, Mazer et al. [15] scored BISF using a new scoring system which included 7 areas: D1 (sexual desire) including two questions with the score range of 0-12; D2 (sexual arousal) including two questions with the score range of 0-12; D3 (frequency of sexual activities) including one question with the score range of 0-12; D4 (sexual coitus acceptance or initiation) including three questions with the score range of 0-15; D5 (sexual pleasure and orgasm) including two questions with the score range of 0-12; D6 (sexual satisfaction) including three questions with the score range of 0-12; D7 (problems affecting sexual function) including four questions with the score range of 0-16. The lowest normal values for women without sexual disorders were as follows: D1=5.31; D2=6.21; D3=3.90; D4=8.85; D5=4.91; D6=8.90; D7=4.47. Scoring this questionnaire is really difficult since each question consists of some parts with specific scoring method though its clinical advantage accurately defines the problem area. In this case, D1, D2, D5, and D7 areas were normal and included several problems regarding frequency of sexual activities, coitus acceptance, and sexual satisfaction. However, no problem was found in terms of sexual pleasure and orgasm due to emotional intimacy. The wife was able to reach orgasm, and no sexual dysfunction such as erectile dysfunction, premature ejaculation, or delayed ejaculation was observed in the spouse based on the history and urologist reports. There were no reports of sexual pain since no vaginal penetration occurred, and the wife reported that she prevents coitus due to sexual aversion. The marriage occurred with the agreement of the couple and their families, and the couple had a good economic status. They reported no history of physical or mental disorder and were not smokers or opium-addicts. No history of violence or sexual

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abuse in the childhood was reported. The wife has lost her father in the adolescence which has impacted her very badly. She stated that she prevents flirting due to her fear of sexual relationship. She felt positive about her body, and the couple loved each other with no noteworthy conflicts. The wife was highly informed about vaginismus.

In the first session, the wife, in presence of her husband, stated that she hates sexual relations and is afraid and upset that she cannot have sexual relationship. She feared that her husband may leave her. She has referred to a couple of phycologists, a gynecologist, and a midwife. They have purposed hymenectomy, sedatives use, alcohol drinks, and husband seriousness in the relationship, which were not accepted by the couple. Therapist asked whether the aim of referring was to have sexual relationship or foster pregnancy. They replied that they want to have sexual relationship. Weekly visits were set, except for some occasions due to menstruation or other reasons reported by the couple. Therapist did not follow the couple during the week though they called the therapist in case of any problem or question. Moreover, the instructed actions of the previous session were evaluated at the beginning of each session. At the end of the first session, gradual desensitization was taught to the wife, which included daily use of mirror, small size dilator, and vaginal objects every day for 20 minutes.

The second and third sessions were held with presence of the couple and each lasted nearly 45 minutes. Surprisingly, individual exercises were done without any fear or avoidance. The wife states that her husband was very considerate of her worries and just asked for sexual relationship once in a month. Besides, he acted very passionately though she has nausea and vomiting and felt sexual assault and leaves the place while crying. She stated that as soon as the sexual relationship initiates, she becomes very distressed and anxious. Contrary to other patients with vaginismus, she did not experience loss of control and unrealistic exaggerated fear of pain. The patient continuously stated that her problem may not be solved. In this session, a sexual instruction film was shown to the patient. The second step of gradual desensitization and the first step of sensate focus were elaborated. Desensitization with larger dilators with the same duration was recommended. Sensate focus exercises should be done at least 4 times a week, for 20 minutes each time. In this step, with previous consent, the phone number of two previous patients with resolved vaginismus was given to the patient to be assured by her peer group that her problem was treatable. The patient did not permit vaginal examination.

The fourth and fifth session were held with the presence of the wife for 40 minutes. Again, all exercises were done successfully without any fear or avoidance. Surprisingly, vaginal examination by the therapist was done without any avoidance, fear, or pain in terms of touching genital areas. The only compliant of the patient regarded her dreams of having sexual relationships with others, which bothered her a lot. Generally, conflicts were seen in the patient's statements. Relaxation exercises were instructed to reduce her sexual anxiety, which included respiratory, muscular, and mental relaxation. These exercises were recommended to be done at least 3 times a week for at least 20 minutes. In addition, the second step of sensate focus was suggested. Therapist diagnosed the patient with sexual aversion in this step (at the visit time, DSM-IV was the latest DSM edition in which sexual aversion was a category of sexual disorders).

In the sixth session with the presence of wife for 60 minutes, she stated that the (individual) desensitization exercises were done easily. However, the second step of sensate focus should be done with husband cooperation, and touch of sexual organs was not done. Exercises for improvement of sexual desire were implemented. In this session, she stated that she does not hate sexual relationships though she thinks that her husband is not the right person. She stated that she may enjoy sexual relationships with another man. Due to this sudden change in the history, therapist decided to hold a session with the husband. Besides, the wife was suggested to refer to a psychiatrist for anxiety control.

The seventh session was hold with the presence of husband. Before this session, psychiatrist contacted him clarifying that her anxiety was limited to sexual relationship. On the other hand, the treating physician suggested the husband to ignore his wife for a while or go on a business trip to see the possible changes in her behaviors.

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The husband announced some different issues in the seventh session which lasted 60 minutes. He spoke about different issues in her wife such as conflict in the speech, excessive idealism on all issues including sexual issue, excuses and exaggerations, feelings of guilt and anxiety, and finally her fatherly feeling on him. Moreover, he stated that her wife had phone relationships with her neighbor's son though she was ashamed, and he has forgiven her. He asks the therapist to never talk to the wife about this issue. Additionally, he stated that he never thought about divorce despite his sadness. However, he never expressed his feelings, and any time her wife rejected the sexual relationship, he ended it cheerfully. He was highly worried that maybe he was not capable enough and did not know what to do. He said that he had individual consultations in this regard and read many articles. In this session, the therapist asked the husband to express his actual feelings and ignore his wife for a while to evaluate her reaction. Among the abundant information received in this session, the fatherly feeling of wife toward her husband attracted the attention of therapist since she has talked about the death of her father in detail in the first session. And, she stated in many sessions that her problem may not be solved, and she may not have this problem with another man. Up to this session, it was not possible to understand the cause of problem since the wife has chosen her husband and loved him a lot.

In the eighth session, with the presence of wife, the advancement of couple's exercises was very low, and she said that she kept experiencing this problem only with her husband which may not be solved. In this session, which lasted 60 minutes, the therapist asked her to explain how they got to know each other. She answered that her husband was her brother's friend who helped their family a lot and provided her with abundant emotional support. In fact, he has got a father role for her. They got married 2 years after her father's death. From the beginning, she enjoyed being with her husband and going out him though she felt nausea and vomiting at the time of sexual relationship. She first thought that these feelings might disappear in the course of time. She clearly stated that she loved her husband though she hold a fatherly feeling to him; thus, it is clear why she could not have sexual relationship with her father. She tried to convince him to divorce her since she was suffering from vaginismus. She never told him her real feeling; thus, her husband responded that he loved her and will not get divorced due to lack of sexual relationship.

Ninth session was held with the presence of the wife for 50 minutes. She said that she was ashamed of her husband since he is a very kind and honorable man. Despite these feelings, she could not tolerate this situation anymore. Suddenly, she asked the therapist to hold a session with her husband, tell him the problem, and persuade him to get divorced, which was the opposite of her words in the first session.

The tenth and eleventh sessions were held with the presence of the couple for more than 60 minutes. Since they both loved each other, these sessions were really hard and deeply affected both. Firstly, how the husband has entered her life and the the actual feeling of the wife were discussed. Then, the wife was asked to explain the issue herself. She was expressing her actual feelings for the first with great sorrow and tears and asked her husband to get divorced for the benefit of both. Unfortunately, they got divorced in a couple of months.

Discussion

According to the results of this study, the process of diagnosis and treatment of sexual disorders is sometimes complicated and unpredictable. In the first session, the client stated that she intended to have intercourse while she harbored a completely opposite intention and was in fact just looking for someone to understand her so that she could announce her real feeling. Three completely different diagnoses were purposed during this sexual consultation. Firstly, patient used the term vaginismus to describe her problem and received the same diagnosis from her psychiatrist. After some sessions, sexual aversion was purposed, while finally it was clarified that she married him just to forget her father's death since he was very sympathizer. She considered him as her father. Thus, it is obvious that not only coitus but also any intimate relationship was awkward for her, which led to aversion.

We should consider the point that vaginismus may be caused by some rare causes such as fear of pregnancy and willingness to maintain hymen due to the fear of beauty loss after hymen defloration

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[12] as well as other common causes such as fear of pain, anxiety [11], limited sexual knowledge [16], and communication problems [10]. Vaginismus is relatively and successfully treated in the case of doing the exercises, husband cooperation, and multiple visits for appropriate feedback. However, in the case of unsuccessful treatment, a more precise history taking and identification of rare causes might be helpful. Diagnosis and treatment of sexual problems not only requires skill and knowledge but also enough time devotion. Moreover, since the diagnosis of sexual disorders is based on the statements of individuals or couples, and no paraclinical tests are available, firstly, a trusted relationship should be built between the client and therapist. Thus, the history of the first session does not reflect the real problem in many cases due to confidential issues, and history taking is required in each session. More comprehensive studies showed that the main intention of women for marriage and sexual relationship is emotional intimacy [3, 17]. This case may present an unusual example of emotional intimacy. We should consider that sexual disorders are multi-dimensional and rarely occur due to a single reason; thus, the relevant treatments necessitate individualized plans [12, 18].

Conflict of interest

The author declares no conflicts of interest.

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References

1. Ryle R. Questioning gender: A sociological exploration. 1st ed. New York: Sage Publications; 2011.
2. Shifren JL, Monz BU, Russo PA, Segreti A, Johannes CB. Sexual problems and distress in United States women: prevalence and correlates. Obstet. Gynaecol. 2008; 112(5): 970-78.
3. Basson R. Women's sexual dysfunction: revised and expanded definitions. Cmaj. 2005; 172(10): 1327-33.
4. IsHak WW, Tobia G. DSM-5 changes in diagnostic criteria of sexual dysfunctions. Reproductive System & Sexual Disorders. 2013; 2(2): 122.
5. Reissing ED, Borg C, Spoelstra SK, et al. “Throwing the baby out with the bathwater”: the demise of vaginismus in favor of genito-pelvic pain/penetration disorder. Arch Sex Behav. 2014; 43(7): 1209-13.
6. Basson R, Althof S, Davis S, et al. Summary of the recommendations on sexual dysfunctions in women. J Sex Med. 2004; 1(1): 24-34.
7. Yasan A, Gürgen F. Marital satisfaction, sexual problems, and the possible difficulties on sex therapy in traditional Islamic culture. J Sex Marital Ther. 2008; 35(1): 68-75.
8. Sabetghadam Sh, Keramat A, Malary M, Rezaie Chamani S. A Systematic Review of Vaginismus Prevalence Reports. J Ardabil Uni Med Sci. 2019; 19(3): 263-71. [In Persian[
9. Alizadeh A, Farnam F, Raisi F, Parsaeian M. Prevalence of and Risk Factors for Genito-Pelvic Pain/Penetration Disorder: A Population-Based Study of Iranian Women. J Sex Med. 2019; 16(7): 1068-77.
10. Karagüzel EÖ, Arslan FC, Tiryaki A, Osmanağaoğlu MA, Kaygusuz EŞ. Sociodemographic features, depression and anxiety in women with life-long vaginismus. Anadolu Psikiyatri DE. 2016; 17(6).
11. Rosenbaum TY. An integrated mindfulness-based approach to the treatment of women with sexual pain and anxiety: Promoting autonomy and mind/body connection. sex relatsh ther. 2013; 28(1-2): 20-28.
12. Farnam F, Janghorbani M, Merghati-Khoei E, Raisi F. Vaginismus and its correlates in an Iranian clinical sample. Int J Impot Res. 2014; 26(6): 230-34.
13. Derogatis LR, Rosen R, Leiblum S, Burnett A, Heiman J. The Female Sexual Distress Scale (FSDS): Initial validation of a standardized scale for assessment of sexually related personal distress in women. J Sex Marital Ther. 2002; 28(4): 317-30.
14. Taylor JF, Rosen RC, Leiblum SR. Self-report assessment of female sexual function: psychometric evaluation of the Brief Index of

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Sexual Functioning for Women. Arch Sex Behav. 1994; 23(6): 627-43.
15. Mazer NA, Leiblum SR, Rosen RC. The brief index of sexual functioning for women (BISF-W): a new scoring algorithm and comparison of normative and surgically menopausal populations. Menopause. 2000; 7(5): 350-63.
16. Farnam F, Janghorbani M, Merghati-Khoei E, Raisi F. Vaginismus and its correlates in an Iranian clinical sample. Int J Impot Res. 2014; 26(6): 230-34.
17. Farnam F, Raisi F, Janghorbani M, Merghati-Khoei E. How do Iranian women with sexual problems conceptualize sexuality? A qualitative research. Nurs Prac Today. 2016; 3(3): 107-15.
18. McCarthy B, Wald LM. A psychobiosocial approach to sex therapy. The Wiley handbook of sex therapy. 2017; 190.
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