SECTION: SEXOLOGY AND GENDER PSYCHOLOGY

РОЗДІЛ: СЕКСОЛОГІЯ ТА ГЕНДЕРНА ПСИХОЛОГІЯ

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DYSPAREUNIA OF NONORGANIC ORIGIN, PHOBIC VARIANT: CASE REPORT

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The article describes a case with a 22-year-old female patient, who had been in a "common-law marriage" with a 29-year-old man during 7 months. When she sought medical advice the patient informed that she remained a virgin. She associated it with tough upbringing and a hard set that one must not live a sex life before marriage. From 6 to 16 years of her life the patient and her mother were members of the international religious organization "Jehovah's Witnesses", where the above set exists. Besides, her mother told the patient that one could engage in sexual intercourses only after registration of marriage, and those girls who allowed themselves to do it before marriage were prostitutes. The patient reported that an attempt to make coitus caused "a spasm of muscles in my vagina" and a severe pain, and for that reason the man could not "enter" her. Before such an attempt the following thoughts appeared: "It is not allowed before marriage, because it will be regarded as adultery. God will be against it". But a strong desire to make coitus existed. She made a point that she was afraid of a severe pain and haemorrhage that might appear in coitus (she saw twice some porn, where defloration was made hard, resulting in fixation of some fear in her). She believed that the above was still producing its effect on her. At first I thought that the patient had vaginismus of non-organic origin caused by psychogenic inhibiting effects and coitophobia. But later, having drawn an analogy with contraction of muscles during orgasm, I concluded that she did not have the above contraction while attempting to make coitus, but an obstacle to perform it was caused by a pain that developed at attempt of introjection and made her squeeze her legs together, thereby imitating the result of contraction of muscles involved in vaginismus. Therefore the diagnosis of "dyspareunia of non-organic origin, the phobic variant" was made. The following treatment was provided: different cognitive techniques, hypnosuggestive therapy (2 sessions). Recommendations for optimizing the performance of coitus were given. An immediate therapeutic result was achieved with complete resolution of the above problem.
Key words: dyspareunia of nonorganic origin, phobic variant, case report, cognitive influences, hypnosuggestive therapy.

Dyspareunia is genital pain felt before, during or after coitus. This can be caused by influence of both psychogenic and somatic factors as well as by their combination. In our opinion, it is also possible to say about dyspareunia when some pain of non-organic origin arises outside coitus (not before it or immediately after it) and is associated with sexual problems as well as when this is in reference not only to pain but also to severe physical discomfort in the genitals felt during coitus (Kocharyan G.S., 2020).

The rate of this pathology is as follows. Dean A. Seehusen et al. (2014) have pointed out that dyspareunia occurs in about 10-20% of women in the USA. After questioning 6,669 sexually active women of Great Britain at the age of 16-74 years K.R. Mitchell et al. (2017) have revealed that 7.5% of the women reported about painful sex, which in a quarter of the cases was very frequent or always during ≥ 6 months, thereby causing distress. Painful sex was closely associated with other sexual problems, particularly vaginal dryness, anxiety over sex and lack of sexual enjoyment. The above was caused by an unequal level of interest in sex as well as by the fact that it was unwanted. Also, an association with indices of mental and physical health, including symptoms of depression, was

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revealed. The proportion of individuals, who reported about painful sex, was the highest among the youngest women (16-24 years) and women aged 55-64.

After assessment of results of their enquiry of 313 women Aaron Glatt et al. (1990) have revealed that 122 of them (39.0%) had never felt pains associated with coitus, i.e. 61% of the women ever felt those pains.

Dyspareunia is reflected in modern medical classifications. The International Classification of Diseases, Tenth Revision (1994) has Code F.52.6 "nonorganic dyspareunia" and Code N94.1 "dyspareunia", which is referred to a disorder of organic origin. But the latest national American classification of sexual disorders, reflected in the *Diagnostic and Statistical Manual of Mental Disorders. Fifth Edition* (2013), uses the term "genito-pelvic pain/penetration disorder" [GPPPD] (Code 302.76). In this case it means complex diagnosis, which combines vaginismus and dyspareunia. The decision about a reasonable use of such a generalized diagnosis was taken in this classification with reference to the fact that the both sexual dysfunctions are highly comorbid and hard to differentiate. To this date, few researches have been conducted for studying the incidence of sexual pain in the context of the new diagnostic concept of GPPPD (Alizadeh A. et al., 2019).

Now we would like to present our clinical observation of psychogenic dyspareunia.

Female patient K, aged 22, was to complete her master's degree programme in architecture half a year later; during 7 months she had been in a "common-law marriage"; she did not work. She received pension in the amount for 1,400 hryvnias per month for her mother, who died from breast cancer. By law, it would continue till she was 23. She was maintained by her "common-law husband". He was 29, had higher printing education and worked as designer in printing office. They lived in a single room apartment rented for his money. She sought our medical advice on September 7, 2018.

Complaints and anamnesis. She informed that she was a virgin and "cannot give myself to a boy". She associated it with tough upbringing and a hard set that one must not live a sex life before marriage. From 6 to 16 years of her life the patient and her mother were members of the international religious organization "Jehovah's Witnesses", where the above set exists. She reported that an attempt to make coitus caused "a spasm of muscles in my vagina" and a severe pain, and for that reason the man could not "enter" her. Before such an attempt the following thoughts appeared: "It is not allowed before marriage, because it will be regarded as adultery. God will be against it". But she felt a strong desire to make coitus, "to present the man energy and receive it from him". She made a point that she was afraid of a severe pain and haemorrhage that could appear in coitus. She also remembered that at the age of 16 she watched some porn, where defloration was made hard, with resultant fixation of fear in her. She watched a similar plot later once more. She believed that the above was still producing its effect on her. About 100 attempts were made to have coitus, but nothing good came of it. After ineffective attempts of introjection her present partner produced a stormy reaction, felt nervous, raised his voice, threw away unused condoms out of spite, and later could lie silently for half an hour. He said that he was not angry with her, but was angry with the situation. Virtually, her partner did not pay attention to the preliminary period, which lasted 2-3 minutes or even could be shorter. After her requests only once the duration of the above period was 5 minutes. The penis of her sexual partner was of medium size. He gave cunnilingus to her, and she received orgasm from it. For the whole period of their life together he made it at her request about 20 times, and orgasm occurred in 70% of the cases. Her "husband" had a large need for sex. Sometimes she stimulated his penis with her hand, sometimes she gave fellatio, and he ejaculated. Her partner always said that he loved her. She believed that it was really so, because he cared of her very much. The patient loved him too. They did not have any disagreements in other spheres. But in connection with the situation that existed, 2 weeks before he told her to pack up and leave. She did not call on anybody with her problem; she did not know who could help her in its solution and whether it was possible at all. Therefore, she developed a fear that if she got pregnant the boy might give her up. I told her that he said it "in a fit of

temper", because later he did not tell her anything like that anymore.

Before she began to live with that man, during 3.5 years she went with a boy of the same age. There were not any vaginal intercourses and attempts to make them with him ("I was not ready for that"). Cunnilingus was performed very often, and every time it produced orgasm. She was in love with that boy but gave him up of her own accord, because she thought that he was characterless (he would give many promises, but failed to fulfill them). Besides, she did not like that he abused alcohol and smoked. Before that time, at the age of 17-19 she went with another boy during 1.5 years, but they had only caresses and kisses.

She did not suffer from rapes and attempts to make them as well as any abusing actions from adults.

Any essential sexual education in her family was not provided. However, her mother told the patient that one could engage in sexual intercourses only after registration of marriage, and those girls who allowed themselves to do it before marriage were prostitutes. She did not discuss that subject with her father. When once she talked on the subject to her grandmother, who had a better attitude to her than other close relatives, including her mother, she (her grandmother) said the following: "When you feel that this man is yours, you won't hesitate over a choice to give herself to him or not, no matter you are married to him or not". Characterizing her mother, the patient informed that she was always dissatisfied with everything, criticized everybody and was always in a bad mood.

She reported that at present she did not have any moral restraints concerning a possibility to make coitus and lose virginity. She stated that even if she married officially nothing would change in this respect.

Platonic (romantic) libido arose at the age of 5, and **erotic** one at 14. She did not realize it by the age of 16. **Sexual libido** arose at 20. She was heterosexual.

Masturbation started from the age of 5 years, and at the same age she experienced her first orgasm. By the age of 11 she masturbated three times or so (by stimulation of the outer part of her clitoris with her finger), but later she forbade her to do it.

Erotic dreams were present from the age of 16. She remembered four or five such dreams for the whole time. She had those dreams mainly during the period when she went with her second partner. She dreamed caresses, kisses and sexual intercourses with him.

When she was 5, an 8-year-old girl lied on her and rubbed against her, but she did not understand what it was and did not remember how it ended.

Her **menses** were regular, every 30 days, during 6-7 days; these were painful on the first day and not later, and resisted towards different unfavourable effects. They appeared at the age of 11; during the first half year their duration was not the same, but later everything went right.

She lived in a couple family, her mother was 22 years older than her (she died a year before), and her father was 26 years older. Her father had a good attitude to her mother, but she was always dissatisfied with him. Her mother exercised strict control over the patient, criticized for her behaviour and took a tough attitude to sexual relations with men.

She denied chronic diseases. She did not smoke. Her consumption of alcohol was occasional and in small doses. She did not use drugs.

Objective data. Body height = 163 cm, body weight = 53 kg; breast cup size: between 1 and 2. Her pubis was shaved, but she said that there was no hair stream from her pubis to her navel. No moustache grew on her face. There was a little hair on her arms and legs.

Diagnosis. At first I thought that the patient had vaginismus of nonorganic origin, caused by psychogenic inhibiting effects and coitophobia. But later I developed some doubts concerning the validity of such a diagnosis. That was caused by the fact that, as it was revealed in the process of her thorough questioning, during an attempt to make coitus the partner inserted his penis by 1/3, then she felt some pain and owing to appearance of an obstacle the penis did not move further. During my second talk to the patient I informed her that achievement of orgasm develops, in particular, contractions of respective muscles, and asked whether those muscles contracted in her at an attempt to insert the penis into her vagina. She answered that

such a contraction was absent, but only the pain appeared at that time. Her partner inserted his penis into her vagina partially, but later an obstacle appeared for its further movement. Though both she and her partner believed that it resulted from contraction of her vaginal muscles, my thorough questioning revealed that when she felt painful sensations she squeezed her legs, it imitating the result of muscular contraction in vaginismus. Therefore, the diagnosis of "dyspareunia of nonorganic origin" was made in her case.

Recommendations and treatment

I. Cognition-oriented influences.

1. I told the patient that some girls engage in prostitution since the age of 12-14 years. Excluding vaginal contacts, they make oral and anal sexual intercourses and get married as "virgins". But in this case it means only preservation of their hymen integrity, and they remain virgins only in the anatomical sense. But in the psychological respect they have ceased being virgins long ago.

2. I told her about one girl whom I treated. She kept away from vaginal intercourses, because she perceived the penis as a foreign object. Nevertheless, she had oral sex (fellatio). I told her that it is the vagina that the penis should be inserted into (in the Russian language the words "vagina" and "to insert" contain the same root), while the mouth is primarily intended for other things.

3. Also we used our technique of "comparison by contrast" (Kocharyan G.S., 1987, 2007, 2016). When this technique is used the talk should be made in the following way. At first the patient is informed about a large capacity of the vagina to enlarge, and this fact is confirmed with an example of delivery. Here it should be pointed that the weight of the normal baby and its body length at delivery achieve large values (their range is indicated). Shortly thereafter it is said that the length and volume of the penis are by far smaller. In such a way a contrast between the size of foetus and that of penis is brightly drawn for the woman. This fact creates favourable conditions for a more successful taking of other therapeutic (mainly psychotherapeutic) measures aimed at elimination of the existing pathology, as it contributes to reduction of the degree of severity of the phobic potential resulting from its invalidation.

4. I attracted the patient's attention to the fact that tenderness and discharge of some blood during defloration are widespread phenomena and should not serve as an obstacle for making a sexual intercourse.

It was recommended for the partner to insert his penis quickly at an attempt of coitus, thereby creating more favourable conditions for a successful realization of the attempt. An analogy with syringe needle pricks was drawn, when attempts to prick carefully were compared with those ones when the patients became aware of their injection after the latter was given. Besides it was recommended for the man to prolong the preliminary period as well as react to unsuccessful attempts of coitus quietly and with understanding.

It should be noted that after the patient's visit to me together with her "husband" on September 11, 2018 it never came in upon her mind that a sexual intercourse before marriage would be sinful and God would be against her defloration before marriage. She associated it with the fact that on that day I told her about some girls who engage in prostitution since their early age and allow oral and anal sexual intercourses (vaginal intercourse are prohibited). Much later they get married as "virgins", but really they are not virgins any more by this time.

II. Hypnosuggestive therapy. This technique is widely and successfully used by us for treating different sexual disorders (Kocharyan G.S., 2007, 2013, 2020).

III. Recommendations for optimization of the process of coitus, including its preliminary period.

September 17, 2018. On my recommendation the patient was examined by a gynaecologist. Conclusion: virgo. No speculum examination was performed. She reported sharp tenderness in her vaginal region, when her hymen was touched upon.

September 18, 2018. The 1st session of hypnosuggestive therapy was given. Suggestions were made for getting rid of fear of pain development during coitus and for filling with confidence in her sexual abilities. A normal course of coitus with an easy insertion of the penis into her vagina was programmed. A made suggestion was focused on relaxation of her vaginal muscles during coitus with an indication concerning a large capacity of the

vagina to enlarge. Relaxation of her femoral muscles, whose contraction prevents insertion of the penis into the vagina, was programmed too.

September 22, 2018. In the evening of September 18, 2018 an attempt to perform coitus was made. Her fear of pain development and fear of failure reduced from 10 to 6 points by a 10-point scale, but nevertheless she squeezed her legs ("I refused with my legs"), and the sexual intercourse failed.

September 22, 2018. The 2nd session of hypnosuggestive therapy was given. This time she was submerged into hypnotic state more deeply. The same suggestions as during the previous session were made. Additionally, a suggestion was made that it is the vagina that the penis should be inserted into (in the Russian language the words "vagina" and "to insert" contain the same root).

After the session the patient said that she thought about complete normalization of her state as early as after the first session of hypnosis. But now, after the second session, she stated that it would come by all means.

September 26, 2018. On September 24, 2018 they managed to make coitus with full insertion of his penis after the third attempt. At first 2 times the partner tried to solve the problem himself: he was over, and it hurt her. He managed to insert his penis by half. There was a break of 15-20 minutes between those two attempts, until the patient became quiet. Some 15-20 minutes after the second attempt she made the running. Having assumed the cowgirl position, the patient was gradually "sliding down" the penis herself. Though the pain was present, but it was not so significant as before, and the sexual intercourse succeeded. She informed that she was highly motivated and that time wanted to bring everything to the end. They had sex about eight minutes, but there was some discomfort. For that reason, they ceased their coitus on her initiative. There were no pains after the coitus, but it resulted in some blood discharge.

As it came to her "common-law husband" that the patient did not place confidence in him, because being over during the sexual intercourse she took initiative from him, I conducted explanatory work with him. I explained that it was caused by her residual fear rather than lack of confidence. After she tried to make coitus in the cowgirl position a couple of times more, they could transfer to using other positions.

Consequently, in this case the therapeutic result with complete resolution of the problem that existed was achieved very rapidly, much more rapidly than we prognosticated.

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ДИСПАРЕУНІЯ НЕОРГАНІЧНОГО ПОХОДЖЕННЯ, ФОБІЧНИЙ ВАРІАНТ: ВИПАДОК ІЗ КЛІНІЧНОЇ ПРАКТИКИ

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У статті наводиться випадок, де мова йде про 22-річну пацієнтку, яка знаходиться в «цивільному шлюбі» з 29-річним чоловіком протягом 7 місяців. При зверненні за лікувальною допомогою вона повідомила, що залишається незайманою. Пов’язує це з суворим вихованням і твердим настановленням, що жити статевим життям до шлюбу не можна. З 6 до 16 років разом з мамою була членом міжнародної релігійної організації «Свідки Єгови», де існує така настанова. Крім того, мати говорила пацієнтці, що статеві акти можна здійснювати тільки після укладення шлюбу, а ті дівчата, які дозволяють собі це до шлюбу, – повії. Зазначає, що при спробі здійснити коїтус виникає «спазм м’язів піхви» і сильний біль, через що партнер не може в неї «увійти». Перед цією спробою з’являються такі думки: «До шлюбу не можна, тому що це буде вважатися перелюбством. Бог буде проти цього». Однак існує сильне бажання здійснити статевий акт. Зазначає, що є боязнь сильного болю і кровотечі, які можуть виникнути при коїтусі (двічі дивилася порно, де позбавлення невинності здійснювалося жорстко, і у неї в зв’язку з цим зафіксувався страх). Вважає, що це досі має на неї вплив. Спочатку я думав, що у пацієнтки має місце вагінізм неорганічного походження, обумовлений психогенними гальмуючими впливами і коітофобією. Однак потім, проводячи аналогію з скороченням м’язів при оргазмі, прийшов до висновку, що такого скорочення при спробі здійснення статевого акту у неї не відбувається, а перешкода до його скоєння обумовлена виникаючим болем при спробі інтроекції, що призводить до стиснення ніг, а це «імітує» результат скорочення м’язів, які залучаються при вагінізмі. Тому був поставлений діагноз «диспареунія неорганічного походження, фобічний варіант». Проведено наступне лікування: когнітивні впливи, гіпносугестивна терапія (2 сеанси). Надані рекомендації щодо оптимізації проведення статевого акту. Досягнуто швидкий терапевтичний результат з повним усуненням існуючої проблеми.

Ключові слова: диспареунія неорганічного походження, фобічний варіант, клінічне спостереження, когнітивні впливи, гіпносугестивна терапія.