

T H E V I R G I N W I V E S

(APAREUNIA DUE TO VAGINISMUS or
THE UNCONSUMMATED MARRIAGE)

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It is a rare man these days who seeks or indeed can find a virgin for a wife. The ones who do, however, occasionally end up with rather more virginity than they bargained for. Sometimes the cherry remains unplucked for weeks, months or even years after the honeymoon, despite valiant efforts to deflower her.

So you can't be too sure that a woman "comes across" just because she is married. The virgin bride is quite unable to have intercourse no matter how much she desires her husband or wishes to satisfy him.

Even a child or a number of children doesn't rule out the possibility that the woman is still technically a virgin. I have now delivered several women of their children or have treated many women who previously have given birth but where vaginal intercourse has not taken place. A form of intercourse has taken place called coitus interfemora where the penis is rubbed along the outside of the female genitals or vulva and sperm has been able to swim all the way inside and produce impregnation!

Other couples have been reported in the scientific literature who for years had anal or urethral intercourse, blissfully unaware that they were somewhat misdirected.

The majority of our virgin wives are, however, trying desperately to have intercourse but each time their husbands seemingly come up against a brick wall. The brick wall is what is known as vaginismus - an incredibly effective tensing up of the vaginal and thigh muscles. This tensing is a purely reflex reaction to a sexual fear, similar to an eye blinking in response to an approaching finger. The virgin wife has vaginismus in its severest form but any woman who is tense will tend to freeze to some extent, making penetration more difficult and thus more painful. Vaginismus can also be noted during a medical examination of the vagina.

An interesting variant of vaginismus occurs when the woman tenses up after penetration. If her legs are encircling her partner, he can literally become caught in the act (coitus captivus) - hence the stories about couples stuck together at drive-ins and on beaches.

How does this situation develop, and how can it be cured? The answers can be found in cases I have seen and treated, mainly successfully over the past decade or more. I have had over 160 cases comprising some 4% of patients seen for sexual problems. This gives you an idea of how uncommon it is, yet more common than most people realise. The majority of women think they are the only one, that they are some kind of freak. The ages of women range from just under 20 to over 45. The overwhelming majority are married, very few are single or in a de facto relationship. By the time the women come to see me, the problem has been in existence from between 1 month and 15 years. Several have previously been to psychiatrists for 1-2 years, psychologists for from 1 visit to 1 year, and several have also been to other gynaecologists who have surgically enlarged the vaginal entrance to no avail. As already mentioned, several have previously borne children. Apareunia is very rarely due purely to a tough hymen which doesn't permit penetration. The condition exists, however, and in my series of 160 cases, only in 4 or 2.5%.

CAUSES

Let me say from the outset that vaginismus is caused in most cases by an overwhelming penetration anxiety or fear. Vaginismus appears when the woman's coping mechanisms fail. There is usually no one specific cause. You will see, however, that in all of the cases many common factors are present which tend to generate fear. Let me also say from the outset that the great majority of women with vaginismus know long before the wedding night that intercourse is going to prove impossible. Since many of these factors commenced in the woman's childhood, this article should be of more than passing interest to parents who read it. Furthermore, let me emphasise that in general as a woman's personality develops into adulthood, she learns the ability to cope with most problems which beset her.

These women obviously weren't able to cope. Others can, and rape is a good example. As horrifying and terrible as rape can be, some girls and women make marvellous adjustments and subsequently cope with sex quite normally.

As a result of my research, the most frequent common factors were as follows in this personal series:-

1. Religion:

52.8% of my cases came from families who were adherents of a strict, orthodox religion, and most still followed that religion. I am not against religion, far from it, but I am against what it can do to people. Dogmatic principles which are blindly accepted can result in disabling guilt complexes in marriage, when sex is supposed to no longer be dirty, wrong or a mortal sin. After so many years of saving themselves through religious guilt, these women become totally disillusioned from the wedding night onwards.

2. Parental Attitudes:

54.7% of women had their attitudes adversely coloured towards men, sex and the fear of pregnancy. In almost half of the cases, the verbal earbashing was

reinforced by beatings when caught masturbating or petting. One mother went as far as to shove a broom handle into her daughter's vagina, pants and all! This woman has not responded to therapy yet, nor is she likely to.

3. Sex Education:

73.6% of women were not told anything by the parents. One girl was told repeatedly by her mother that soon she would be "told all". Each time her mother would come in to tell a bedtime story, she cringed in fear that this would be the night.

Several other girls were revolted by what they learned from friends and others again had read or heard that sex hurt. Some were put off by girlfriends who described tampon "horror stories" such as the incredible pain they experienced or the "severe" haemorrhage they produced when trying to insert them. Other women were affected by descriptions friends recounted of sexual acts regarding either how much it hurt with the boyfriend the first time ("like he was cutting me with a knife") or vivid descriptions of how they were molested by other men.

4. Relatives:

18.9% of cases had negative experiences with male relatives. When I first started treating vaginismus, incest was almost as taboo a subject to discuss as were sex and death. We now realise how much more common unfortunate experiences with relatives really are. The abuse may be verbal, not only physical. I had one patient whose uncle delighted in making frequent comments about her "small tits" - giving her a hangup about her body image which carried forward into her marriage. Another's grandfather used to repeatedly fondle her breasts. This type of experience seems more common in cases of vaginismus in which the woman is also unable to achieve orgasm.

5. Unfortunate experiences with men:

50.9% of women had been involved in various incidents with men, either being forced to touch or kiss a penis, attempted or actual rape, indecent exposure or being beaten up for non-submission. We can all appreciate how this factor could be so significant in later life.

6. Unfortunate experiences with doctors:

50.9% of women fell into this category, which hadn't been previously realised in the scientific literature. It is a most illuminating finding. Just over half the women I have seen, and notice it is the identical frequency to molesters and rapists (Factor 5.), either had painful examinations by general practitioners, gynaecologists or both, and often by more than one of each, or the doctors concerned had made what to these women were highly significant remarks. "You are very small and will have trouble with a husband one day", "Gosh you're tight, you're going to have trouble getting pregnant one day."

Another negative experience with doctors is when women have had a surgical widening of the entrance and this has failed to permit intercourse. The skilled

vaginal examination is an art and the women believe that if a family doctor or gynaecologist hurts them, it is little wonder that they have experienced pain with their partners because they don't know nearly as much about the female anatomy as doctors. Women often give up hope after a painful medical examination or two believing nothing can help them.

7. Husband's experience:

41.5% of the married women had husbands with little or no previous experience. They consequently desisted at the slightest hint of inflicting pain and either stopped trying altogether or tried at increasingly sporadic intervals. With a virgin couple, it must be rather like two people walking hand in hand through a maze whilst blindfolded. Most women now expressed a wish to me that their husbands had been rather more assertive on the wedding night.

Unfortunately many women do attempt penetration with painful results many times before seeking help. This is sad because their possible previously healthy attitudes towards sex are then severely undermined by these negative experiences. Unfortunately many doctors see the entire problem as simply due to the physical barrier and completely ignore the fear that has developed.

In passing I feel I should record a few observations about these women. Half of the women seen were on their own admission "prick teasers". They were often deliberately flirtatious in dress or behaviour in front of men - enticing them to the point of intercourse and then backing out. Their "come-ons" were "put-ons". Also, most of them were fairly uninhibited in one way or another. Few were hung up about being naked, having lights on, etc., and many were happy to fellate their partners and to accept cunnilingus. Oral sex is a "no no" for many married couples with otherwise normal sex lives. It may surprise readers to learn that these women were happy to perform and receive oral sex. The motivation is in fact obvious - they were so intent on avoiding the sexual confrontation by satisfying their partners before there was any attempt at penetration.

TREATMENT

Patients who go right through therapy have been cured after intervals as short as half a day or up to a few weeks after first being seen, the average time from first visit to cure being 42 days. The success rate is in the vicinity of 83%. There are those in the other 17% category who drop out, but who resurface often years later at an infertility clinic or psychiatrist's office. Many within this group never wish to be cured and merely attend clinics in order to appease parents and in-laws who make comments about the couple's lack of children, and attending clinics gives an external appearance of "doing something about it". Even in this group, one can at least make some progress in that whereas these women still can't have intercourse, some at least can now use tampons each month or insert vaginal creams and foams when necessary. There are some women who when they present to me directly from GP's need preliminary preparation before they can cope with the treatment I'm about to outline. For example, some women have a strong penis or sperm aversion, and psychotherapy is

required to reduce these fears prior to commencing my programme. I refer these women to clinical psychologists or psychiatrists specializing in sexual problems.

Whereas vaginismus can be spectacularly easy to treat, an important point is that I don't wish to minimise the work of psychotherapists who may have treated the women before me. Psychotherapy can be an essential prerequisite in preparation for mine. The woman can be much more relaxed and have more insight into the causative problems and issues for having had this therapy. Some women have vaginismus as a result of hangups or their problems with vaginismus have in turn led to hangups. In medicine one cannot make a patient do anything, one can only advise, suggest or recommend. One may even urge, but never force.

The principles of my therapy are based upon the following:-

1. Patient Ignorance:

The couples invariably have a lack of knowledge total or partial, pertaining to sexual anatomy and physiology (function). This leads to poor technique and the husband's misinterpretation of his wife's eye/body language, i.e. wincing and tensing, making him believe he is hurting his loved one, which makes him stop immediately. Thus they have to be fully educated, even showing them both the clitoris and external genitals for the first time.

If the woman can be taught to increase her arousal, sex need no longer be a negative experience and thus she will be much more receptive to the idea of intercourse. In this situation, the therapist stands in and does the job parents, teachers and society at large should have performed. Specific literature, models and diagrams of male and female anatomy are an integral part of this educative process.

2. Penetration Anxiety:

These women have never inserted tampons, vaginal applicators and the like, let alone a finger or penis. They have often tried to insert all of these, found a problem and been put right off. They think they are too small, and as mentioned previously, many of these women have had other gynaecologists who listened to them but didn't examine them critically. What one has to do is show them what their vaginas are capable of accepting.

The woman conducts the speed of her own therapy in terms of how quickly she permits one to take her through the stages. Most often, this can be done at the first or second session and even the longest case took only five sessions.

Starting with the fingers, I insert one and then two, slowly, never hurting. With the aid of a mirror, the woman is then shown the fingers being withdrawn. By watching the process, the woman is not only seeing herself quite often for the first time, but is actively participating in what is going on, giving her a sense of control previously lacking. Also, two fingers side by side are very close to the size of most penises.

The woman is taught to do likewise with her own fingers, and if she accepts these more readily than the therapist's, the next step is to get her to hold the therapist's hand and insert his fingers under her control. The woman is encouraged to use her pelvic floor muscles simultaneously at this and subsequent stages to show her how much more easily things go in and out when these muscles are used.

Next, a graded series of gynaecological instruments is inserted called speculums. The series approximates the erect penis in size, and the final one exceeds it. The woman watches with the mirror as these instruments are withdrawn and sees that she can accept a penis. This is the first breakthrough. At the end of each session, the instruments inserted are shown to the woman, to both her amazement and delight.

3. Organ Displacement Anxiety:

Once the vagina has been entered, a new hurdle has to be overcome. The woman must become accustomed to the unfamiliar sensations which follow penetration. What exactly are these sensations?

The vagina is a collapsed tube in the resting (normal) state. Its walls only separate when something is inserted, or something (such as a baby) comes out. The vagina is designed and constructed to be very expandable. Clearly, when something is inserted so that the walls are separated, structures deep to the walls must be displaced or pushed to one side.

This causes sensations which are normal but for obvious reasons, alien, weird or strange to these women. Displacement of the uterus upwards or to the sides is the main cause. These women have accepted the sensations of a full bladder or rectum for what they are - normal, ever since they were "toilet trained", but a full vagina, the other pelvic organ, is unfamiliar to them and causes unusual sensations perceived by them as unpleasant. These sensations once triggered can also lead to a vaginismic response. Therapy conditions the woman into accepting these feelings for what they really are - normal.

Thus the next step is to deliberately displace these organs by hand or with the use of applicators. One then instructs the woman how to insert a vaginal applicator (such as those used for inserting vaginal creams), and how to then displace the uterus and get used to the sensations produced. At this stage one simultaneously uses a model of the pelvis and an identical applicator to demonstrate what the woman is doing to herself. The women all volunteer that they are not feeling what they once imagined was pain, but just a sensation to which they were not accustomed.

Having done this, one then teaches them how to insert tampons, which most have never done before. This is the next breakthrough. Most women I find accept that tampons are more desirable than pads if only they could insert them like any normal woman and are upset that girls half their age can use them freely. Once they learn they can do it, it is a real ego trip for such women at the next visit after a period, when they announce they have used their first tampons, and survived! They feel much more like normal women.

The woman is also asked to practise at home all the progress made during this and every subsequent session. She is encouraged to do this in front of her husband which allows him to participate and further encourage and support her.

This therapy programme lends itself to treatment by remote control - women distant from therapeutic centres can easily adapt the steps I have outlined to a self-help programme. To substitute for the graded speculums, it is possible to purchase from most medical suppliers a series of graded dilators - perspex or glass rods which increase in size from very small (like a pencil) to exceeding normal penis size. What I really prefer women to use are natural things, especially the woman's own fingers.

Remember to start off by gradually trying to insert your own finger. If you wish, you could then switch to the dilators, gradually learning to insert each dilator in turn. (You can lubricate the dilator with oil or lotion and warm it slightly to make it more comfortable). As I said, this is for women who cannot see a therapist. In my own practice, I have never ever used a dilator nor got my patients to use any.

I also ask all women to perform at home what I call "five finger exercises", inserting one, then two, perhaps even three fingers repetitively until this no longer causes any anxiety or worries to the woman, because she has become so accustomed to these normal feelings. This is my preferred alternative to the dilators. (A woman rang me in a mad panic one day. She said she was doing her five finger exercises but she couldn't get all five in, only three! I told her to re-read my instructions.)

The woman is now very close to achieving intercourse. There are a few important finishing touches. The insertion of tampons and applicators is first performed whilst the woman is lying on the couch. It is then demonstrated in the crouching position as shown in instruction leaflets with tampons. Most often, she finds that things go in more easily in this position. This is the next breakthrough.

At this stage, the husband is brought in. The steps performed so far are repeated in front of him. He thus sees what his wife is now capable of doing, contrary to what he has been led to believe from past experience. At each step, if there is any tensing of muscles, grimacing or eyelid flicker, I stop, I ask, "Am I hurting you?" The answer invariably is "No. I only thought you were going to." I then turn to the husband who is watching and point out how hitherto he has misinterpreted these signals as his wife being in actual pain, and I proceed.

The husband is then invited to insert the fingers of his gloved hand, first one, then two. This is supervised by me as often this is the first time it has happened, and he is unfamiliar with the vaginal anatomy. Once deeply inside, he is then asked to produce displacement sensations to reinforce the fact they aren't painful.

Once again the couple is asked to do "homework". Now the husband attempts the five finger exercises, carefully following his wife's instructions. If this

causes distress, she is counselled to control the situation by holding his hand and inserting his fingers as an intermediate step.

The woman now knows she can accommodate her husband's penis without pain; she has learned sexual anatomy and physiology; the importance of sexual stimulation, love play and the production of natural lubrication; and she has learned that the best angle for penetration is when she is in a crouching position. It follows from this that when intercourse takes place, it should be in the astride (female superior) position, with the man lying flat on his back, with his legs together. She straddles him (so that her legs can't crash together) and faces him, but apart from his kisses and caresses, he remains still - above all, he must not thrust, for she must be in total control.

This has been one of her problems up until now in that intercourse was invariably tried in the "missionary" (male superior) position and she hasn't been in control. The man has done all of the thrusting. In the astride position, however, it is the woman who is in control and the bending of her knees determines the depth and speed of penetration. (She just will not hurt herself - after all, I mentioned at the beginning how vaginismus was like the involuntary blinking of the eye. Just try and poke one of your own eyes out. You can't do it!) By now the woman has been conditioned in such a way that this position is a very attractive proposition. The woman is then left alone to her own devices, to go home and make the final breakthrough. The results speak for themselves.

CONCLUSIONS

How can we summarise vaginismus? It is the involuntary spasm of the muscles surrounding the vaginal entrance plus those which bring the thighs together (the "guardians of virginity") which thereby make intercourse either impossible (apareunia) as well as vaginal examinations, or makes them difficult and downright painful. In its extreme form, the muscles of the back arch and the woman's hands come down in a protective manner to push the offending object (penis or doctor's hand) away. It is the classical example of a psychosomatic condition in which the person's "head" (psyche) wants to make love, but the person's body (soma) says, "NO!!" It is caused by an overwhelming penetration anxiety which in turn is caused by some or a number of factors long before the consummation of marriage is contemplated. Vaginismus appears when the woman's coping mechanisms fail. Although the therapy outlined is not devised by a psychotherapist, the therapy itself is psychotherapeutic, and over the years many different psychotherapeutic techniques have been suggested to describe in a nutshell what I do. These include systematic desensitization, implosion, flooding, self hypnosis and reinforcement. The one I like best is a relatively recent psychological term, controlled exposure, because that is exactly what I do.

From a therapist's point of view, the end point or "cure" of this condition is not purely the ability to have sexual intercourse. The woman must be given permission to be comfortable with her own body and sexuality in general. She must be helped in familiarizing herself with that which is rightfully hers and no one else's - her own body. She must be prepared for life itself, the

necessary vaginal examinations for her own health, for pregnancy and childbirth and for applying or inserting treatment which may be required, including vaginal methods of birth control. A new concept I like is that rather than thinking in terms of penile penetration of the vagina, it is nicer and friendlier to talk of penile envelopment by the vagina. The whole issue of her own arousal and pleasure culminating possibly in her own orgasm is another issue which has to be addressed in approximately 50% of cases since these women have never become aroused and climaxed.

This group of women form a nucleus from which come one's most grateful patients. The problem is so devastating for the couple, many are on the brink of divorce, some have even had a trial separation already, that when it's all over, it's wonderful to see the positive change in their personalities. Therapy occasionally has to be intensive, 1 -1 1/2 hours a day for 2-5 days. This is a short space of time in terms of the duration of the problem.

I remember well one woman, who after 5 years of trying, 3 psychiatrists, 1 gynaecological operation to widen the entrance, 1 psychologist and then 5 days of therapy parted company with me one afternoon at the end of the course. She had been an extremely hungup woman. I received a call from her the very next morning, "Doctor,.....I got laid last night."