

Placing foreign bodies in the vagina to avoid sex

Sexual aversion disorder (SAD) is defined as the active avoidance of and aversion to genital sexual contact with a partner; the disturbance must cause extreme interpersonal difficulty or marked distress.¹ Persons with SAD experience anxiety, fear, or disgust when confronted by a sexual opportunity with a partner. The intensity of the reaction may range from moderate anxiety and lack of pleasure to extreme psychological distress. Some patients with SAD experience generalized revulsion to all sexual stimuli, including kissing or touching, even when intercourse is not involved. The disorder can be generalized or situational (prompted by a specific sexual event or partner), lifelong or acquired, and it may have multiple etiologic components, including psychological factors

and a history of sexual abuse. When a history of sexual abuse is associated with SAD, as appears to be the case in our patient, the physician must develop a treatment plan that addresses both situations.

SAD is often difficult to distinguish from hypoactive sexual desire.^{2,3} Patients often use avoidant behaviors that enable them to limit or circumvent sexual contact. Avoidant strategies that have been linked to SAD include traveling, going to sleep early or late, neglecting personal appearance, substance abuse, and over-involvement with work, social, or family activities.¹ Extreme efforts to avoid sexual contact are evident in some patients and include self-mutilation, self-cutting, and purposeful gross distortions of bodily image.⁴

Case Report

F.C. is a 31-year-old African American woman who presented to the gynecology clinic inebriated and complaining of severe, sharp abdominopelvic pain on the morning after two shot glasses shattered while she maneuvered them within her vagina as a part of her act as an exotic dancer. She declined clinical examination but consented to examination under anesthesia for the removal of these foreign bodies. Surgical and urologic consultations were on standby in the operating room out of concern for bowel and bladder perforation. Two double-shot glasses and several glass fragments were removed from her vaginal vault, and its mucosa was slightly erythematous but intact. In addition, a travel-size perfume bottle was removed from her rectum, without complications. Upon recovery from anesthesia, F.C. refused further medical or psychiatric evaluation and was discharged. A follow-up visit was scheduled for a week later, but she did not keep the appointment.

F.C. was next seen several months later, when she was brought to our clinic from a local prison. While incarcerated, she had placed multiple objects within her vagina and rectum, which inadvertently became lodged and could not be removed without surgery. Surgical removal under anesthesia revealed fragments of plastic forks and knives and a toothbrush cap.

A prison records review showed she had undergone numerous medical and evaluations while incarcerated. Her medical history revealed similar episodes of placing foreign objects in her genitals. Surgical history was significant for cesarean sections, knee surgery, and a diverting colostomy with subsequent re-anastomosis secondary to bowel perforation caused by foreign objects placed in her vagina.

Also while incarcerated, the patient often made threats to place objects in her vagina and was classified by medical personnel as being at risk for self-mutilation. Extensive psychiatric evaluation revealed that she had no suicidal ideation and no evidence of psychotic thinking, depression, or mania, and she was deemed competent to make decisions regarding her treatment.

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Case Report

During evaluation, F.C. revealed a prolonged history of violent physical and sexual abuse beginning at age 14, by her alcoholic father and other men. At age 15 she began drinking alcohol daily and daily use of marijuana. She admitted that her behavior would often become violent and aggressive when she was extremely intoxicated. F.C. described her unusual behavior as a coping mechanism for the sexual abuse: habitual use of drugs enabled

her to cope with the physical trauma, and the object placement provided a physical barrier intended to avoid sexual contact and prevent penetration.

F.C. was ultimately diagnosed with a borderline personality disorder and alcohol dependence, associated with her severe childhood abuse, and the concurrent diagnosis of SAD was strongly considered. The patient declined any further intervention, and upon release from prison, was lost to follow up.

Clinical implications

Although the etiology may not always be clear, this case highlights the connection between early sexual abuse and later extreme sexual problems, which may also alter the individual's body image, self-image, and sexual activity.⁵

Behaviors such as exploration of fetishes, sexual fantasies, or the use of sexual toys for sexual enhancement and satisfaction may also account for deliberate insertion of foreign bodies within

the vagina or rectum. However, a history of sexual abuse combined with deliberate placing of unusual objects in the genitals may suggest a diagnosis of SAD. Foreign body placement in the vagina may be a deliberate behavior to avoid sexual activity, a coping mechanism for dealing with severe childhood trauma.

Little is written about the management of SAD. In one recent report, a 30-year-old woman with SAD, depression, and a 5-year's

References

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unconsummated marriage was successfully treated with behavioral desensitization leading to increased sexual intimacy, while also increasing the antidepressant dosage.⁶ Two methods were used, one addressing the patient's increased comfort with exploration of her own body and the other dealing with partner relations. A positive spousal relationship, high motivation, and lack of a history of sexual abuse contributed to a favorable outcome in this case.⁶