she still felt pain and asked him to stop when the glans of his penis was in her introitus. The couple also followed advice to increase the frequency of their noncoital lovemaking and, again, to incorporate vaginal caressing by the husband by inserting first one finger, then two. The couple was given explicit instructions for the husband to insert each dilator in turn into his wife's vagina, first with her manual guidance and then with her verbal permission. They were given instructions to try intercourse slowly and gradually with the wife in the female superior position, sitting down onto her husband's penis while he stayed motionless.

The couple cancelled several appointments but returned after 7 weeks. By that time they had had several successful episodes of penetration and full-scale intercourse. Mrs. Jones had no pain and had adequate vaginal lubrication without using a supplemental lubricant. The couple was experimenting with different positions for intercourse. They continued to use basal body temperature testing as a method of avoiding conception, but both were hoping to start trying for a pregnancy within the next year. Ways to enhance Mrs. Jones' pleasure with intercourse (by her husband providing extra breast or clitoral caressing) were discussed. She was able to experience pleasure during intercourse but had not yet reached orgasm from coital stimulation. Both partners felt improved self-esteem and affection for each other. In addition, they said that they no longer felt they had a "shameful secret," and that they felt like a "normal" couple.

DISCUSSION

Most cases of unconsummated marriage seen by sexual dysfunction practitioners are caused by vaginismus, an involuntary contraction of the muscles surrounding the outer third of the vagina. Vaginismus is a psychophysiological problem, usually related to fear that intercourse would be painful. The most common etiologic factor is a background of strong religious orthodoxy with guilt and inhibition about sexual activity.[1,2] Because vaginismus is relatively common, it is easy for physicians and other health professionals to overlook organic factors that can interfere with penetration for intercourse. In most clinical settings, vaginismus is diagnosed by either a gynecologist or a mental health professional. In such a setting, interdisciplinary collaboration in treating unconsummated marriage would be unusual.

Although this case had a successful outcome, treatment was drawn out over 18 months and required collaboration between three professionals in different aspects of sexual dysfunction. Ambivalence on the part of both patients about becoming sexually active can be seen in the repeated delays between phases of treatment. Both were consciously eager to experience intercourse together, but each was also quite perfectionistic and self-punitive. Each new assignment stimulated fears of insurmountable failure.

The case illustrates the utility of our interdisciplinary clinic, in which staff can discuss difficult cases from the perspectives of both psychological and medical knowledge of sexual dysfunction. When one element of the treatment plan did not succeed, cross-referrals identified previously unsuspected impediments which were then eliminated in turn.

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Commentary

This report of the successful resolution of complex, persisting sexual dysfunction in an otherwise compatible marriage by means of a varied clinical approach has an almost "fairy tale" ending. The moral of the story is that one should not give up and assume that residual sexual dysfunction is situational or emotional until all physical possibilities have been thoroughly explored and excluded. This philosophy should be applied in all other aspects of clinical medicine.

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