OLGU SUNUMU / CASE REPORT

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Psikosomatik Açıdan Sürekli Genital Uyarılma Bozukluğu: Üç Kızkardeşin Olgu Derlemesi

Persistent Genital Arousal Disorder From Psychosomatic Perspective: Brief Reports of Three Sisters

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ÖZ

Giriş: Sürekli genital uyarılma bozukluğu (SGUB), öncelikle kadınları etkileyen ve önemli sıkıntıya neden olan nadir bir durumdur. Patofizyolojisi tam olarak anlaşılamamıştır ve tedavi yaklaşımları farklılık göstermektedir. Bu çalışmanın amacı, SGUB ile literatürde nadiren bahsedilen travmatik çocukluk yaşam deneyimleri arasındaki olası bağlantı hakkında farkındalık yaratmaktır.

Yöntem: 41 yaşında SGUB tanılı kadın hasta Giresun Bulancak Devlet Hastanesi Psikiyatri Polikliniğinde klomipramin, psikoeğitim ve destekleyici görüşmeler ile tedavi edildi. Hasta travmatik çocukluk yaşam deneyimleri öyküsü sunduktan sonra kardeşleriyle telefon aracılığıyla görüşmeler yapıldı ve tedavi için hastanın kardeşleri, farklı şehirlerde yaşamalarından ötürü bulundukları şehirlerde psikiyatri kliniklerine takip ve tedavilerinin sürdürülmesi amaçlı sevk edildi. Hasta daha önce farklı antidepresan, antipsikotik ve antiepileptik ilaçlara karşı direnç geliştirmişti.

Bulgular: Takip sürecinde klomipramin ve destekleyici müdahaleler ile hastada belirgin semptomatik düzelme görüldü. Farklı şehirlerde yaşadıkları için aynı semptomlara ve muhtemelen aynı etiyolojiye sahip kardeşlerle görüşülerek kişiler psikiyatrik takip ve tedavi amaçlı yönlendirildi.

Sonuç: Bu olgu serileri, hastaların sıklıkla açıklamayı ihmal ettikleri SGUB semptomlarının klinisyen tarafından tanınmasının yanı sıra çocukluk öyküsü de dahil olmak üzere ayrıntılı anamnez almanın önemini vurgulamaktadır. Semptom sorgulama ve anamnez alırken aile üyeleri de sürece dahil edilmelidir.

Anahtar Kelimeler: sürekli genital uyarılma bozukluğu (sgub), klomipramin, çocukluk çağı travması

ABSTRACT

Objective: Persistent genital arousal disorder (PGAD) is a rare condition that primarily affects women and causes significant distress. The pathophysiology is not well understood, and treatment approaches differ. The goal of this study is to raise awareness about the possible link between PGAD and traumatic childhood life experiences, which is rarely mentioned in the literature.

Method: A 41-year-old woman with PGAD was treated at Giresun Bulancak State Hospital's Psychiatry Outpatient Clinic with clomipramine, psychoeducation and supportive interviews. After the patient provided a history of traumatic childhood life experiences, her siblings who were living in different cities, were interviewed by phone and referred for psychiatric treatment. Patient had previously developed resistance to other antidepressants, antipsychotics, and antiepileptic medications.

Results: During the follow-up period, the patient experienced significant symptomatic improvement with clomipramine, psychoeducation and supportive interviews. Because of living in different cities, siblings with the same symptoms and possibly the same etiology were interviewed and referred to psychiatric treatment.

Conclusion: These case report series emphasize the significance of clinician recognition of PGAD symptoms, which patients frequently neglect to explain, as well as the importance of obtaining detailed anamnesis, including childhood history. Family members should be included in the symptom inquiry and anamnesis.

Keywords: persistent genital arousal disorder (pgad), clomipramine, childhood trauma

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INTRODUCTION

Persistent genital arousal disorder (PGAD) is a rare condition first described in the scientific literature in 1989 by Modell and defined in 2001 by Leiblum and Nathan (1,2). It is distinguished by genital arousal sensations that are unrelated to any subjective sense of sexual desire. These sensations are, by definition, intrusive, unwanted, and distressing and do not usually go away with orgasm. These symptoms, which primarily affect women, are described as intrusive, painful, and associated with feelings of shame, and they frequently lead to severe anxiety disorders, depression, self-harm, suicidal ideation, and even suicide. There are theories about the etiology, triggers, pathophysiology, and prevalence of PGAD, but current knowledge is very limited (3-5). One theory is that it's a post-traumatic dissociative symptom. PGAD is frequently associated with a history of sexual abuse: 53% in childhood, 35% in adult sexual abuse, and even 46.7% (6). People who have been traumatized by a difficult childhood maintain anxiety and hypervigilance in adulthood, which is characterized by sympathetic hyperactivation: these symptoms are also very common in people suffering from PGAD, and often precede them. Dissociative symptoms have been linked to early childhood traumas (7). These childhood traumas most likely explain the anxiety, depressive syndromes, and more structured psychiatric disorders seen in people with PGAD, vulvodynia, and other general "functional" disorders (8). Despite being in good physical health, women with PGAD reported high levels of distress about their condition, according to one study. Invasive and unwanted feelings of genital arousal; continuous symptoms; feelings of unhappiness, shame, and worry; and decreased sexual satisfaction were the strongest predictors of distress. They also revealed that many women with PGAD had high levels of anxiety (61.8%), stress (67.7%), and depression (42.7%) (9). Whatever the underlying issue, the patient's difficulty expressing symptoms, shame, and guilt makes it difficult for somatic physicians, psychologists, and psychiatrists to diagnose PGAD. There is no data on familial clustering of this disorder, despite various hypotheses based on biological and psychosocial assumptions. Three sisters' case reports are described in this current study. We would like to draw attention to the stories of a female patient who was exposed to early sexual experiences as a child and complained of PGAD symptoms, as well as her two sisters, who were noticed to have similar symptoms. All patients provided written informed consent in accordance with the Helsinki Declaration's ethical guidelines.

CASE REPORT

CASE 1.

A 41-years-old female, second of three siblings, married, heterosexual, secondary school graduate, non-worker, belonging to middle-upper socioeconomic status, having four children and living with her family applied to the psychiatry outpatient clinic due to worry, unhappiness, anhedonia, lack of motivation, distractibility, poor concentration, ruminations and suicidal ideations. She stated that she had been receiving treatment for about 6 years with similar symptoms, but she did not benefit from any medication at all.In the initial evaluation of her, no psychopathology related to childhood history, developmental periods, family history was described and she had attributed her symptoms to stressors related to life events.

Mixed anxiety and depressive disorder was considered as the preliminary diagnosis and Hamilton-D and Beck Anxiety Scale were administered.

Blood tests were applied. The Hamilton-D Scale score was 25/53, indicating moderate depression, and the Beck Anxiety Inventory Scale score was 30/63, indicating severe anxiety. Blood test examination results revealed no pathology. She was consulted to neurology with the symptoms of of poor concentration and distractibility. Imaging results, Mini-Mental State Examination Score and EEG were resulted as normal. In the third of the interviews to investigate the possible etiology; she disclosed complaints of unbidden intrusive orgasm-like genital arousal and genital sensations constantly throughout the daytime. She had arousals several times a day that lasted 20-30 minutes each, resulting in orgasm, which was frequently achieved through masturbation in an attempt to be relieved. Despite the fact that masturbation provided relief, the aggravation of genital symptoms resulted in despair, emotional lability, catastrophizing, ruminations, and suicidal thoughts. According to her definition, genital arousals were triggered in particular by vaginal rubbing while sitting, feeling worried or angry.

She described burning and irritation in the genital area due to frequent masturbation and was referred to gynecologist. Physical examination and hormone tests were reported as normal.

Concurrently, thoughts of masturbation predominated. These physiological arousal signs were perceived to be unrelated to any subjective sense of sexual excitement or desire. Problems arose between her and her husband as a result of her not experiencing orgasm during her sexual intercourse with her husband and relaxing by masturbating after intercourse. The patient stated that she was embarrassed to tell these complaints, so she did not express them during the initial interviews, and she frequently felt guilty.

She was around eight years old when the symptoms began, and in the early stages, she was having orgasms while dreaming on a nightly basis. She recalled masturbating for the first time at this age, imagining sexual fantasies. She stated that she felt guilty after being punished by her mother for masturbating once. As her mother's punitive and guilty attitude continued and from time to time, she could masturbate between classes at school those days. Along with all this, she stated that she and her two sisters had witnessed their parents' sexual relationships being as they slept in the same room with their parents. She reported that she remembered sleeping in the same room with her parents until she was seven years old. She and her siblings described this witnessing as the factor that caused their increased arousal.

Considering the patient's current complaints and negative childhood life experiences, persistant genital arousal and accompanying anxiety and depressive disorder were diagnosed. Since the patient was previously resistant to other antidepressants, antipsychotics, antiepileptics and obsessive character of ruminations for genital stimulation and masturbation, clomipramine was considered as first choice. While she was on clomipramine pharmacotherapy, she also started to receive psychoeducation and supportive interventions targeting anxiety and depressive symptoms were maintained continuously.

Clomipramine and interventions provided significant decrease in the patient's complaints in the first month of treatment. The recovery period started from the first to second week with a significant reduction in the frequency of genital arousal and the need for masturbation. At the end of one month, the Hamilton-D Scale and Beck Inventory Scale scores were 15/53 and 24/63, respectively.

Interviews were also held with the her two sisters, who had similar complaints with the patient, but did not receive treatment at all. Since these two patients lived in different provinces, they were sent to different outpatient clinics for psychiatric treatment, but interviews were made with them on the phone.

CASE 2.

The patient who is 47-years-old female, first of three siblings, married, heterosexual, high school graduate, having three children and living with her family was interviewed. She stated the complaints of persistent genital arousal for about 30 years. She had arousals 3-4 times a day for 15-20 minutes each, resulting in orgasm, which was frequently achieved through masturbation in an attempt to relieve herself. She lacked sexual desire and orgasm during sexual intercourse, as well as hipersexuality outside of it. The patient, whose sexual relationship problems have intensified for the last fifteen years, masturbated by herself after intercourse to relax the whole time. She suffered from major depressive disorder and obsessive compulsive disorder mainly characterized with cleaning and contamination. Hence there was a suicide attempt by taking medication once. She felt intense guilt and shame because of her sexual problems and masturbation; for this reason, she did not express the complaints about PGAD to psychiatrists any of whom she applied for. For all these reasons, she did not benefit from the different treatments that she used and stopped taking.

She said that her first complaints started with the feeling of hiperarousal in the first grade of primary school and at that time, she was trying to relax herself by masturbating. She stated that this was due to the arousal and curiosity started after she witnessed her parents' sexual intercourse experiences, as her sister in case 1 mentioned.

CASE 3.

The patient who is 32-years-old female, third of three siblings, married, heterosexual, high school graduate, having two children and living with her family was interviewed. She mentioned the complaints of about 10 spontaneous orgasms per day and episodic vaginal vibration and fullness sensation without hypersexuality for the past ten years. Although she did not feel sexual desire, she was able to have orgasm during sexual intercourse at times, but she could not feel fully relieved. At first, she attributed the problems of vaginal vibration and fullness to gynaecologic and applied to a gynecologist, but she refused to apply psychiatry because of the shame she felt when she was told that her complaints were of a psychiatric nature. She stated that she was trying to make through the problems such as distress, depressive thoughts and mental preoccupations with sexual problems that she was experiencing due to PGAD by herself, and by taking herbal support treatments from time to time. She stated that vaginal stimulation and masturbation with sexual fantasies first started at the age of 9.

She said she thought it was probably related to sleeping in the same room with her parents and seeing them having sex, as described in her siblings cases 1 and 2. She stated that at that time she felt intense fear and arousal due to witnessing sexual intercourse, and after a while this turned into resentment and anger towards her parents which negatively affecting the current parent relationship.

DISCUSSION

In the literature, many neurological, psychological and physiological organic or non-organic possibilities related to the etiology of PGAD are mentioned (10). In this paper, especially the past histories of our cases prompted us to think in line with psychodynamic approaches. As we know, parental attitudes, negative life events and early sexual experiences in childhood appear with different mental appearances in adulthood and are important for stages of spiritual development. According to Mahler, separation-individuation is one of the important steps in the transition from childhood to adulthood (11). When the time comes, every child should be able to leave their parent's safe haven in peace, and the parents should be willing to allow it. In all our cases, the child who could not be safely separated from her parents and who was already trying to resolve the oedipal conflict suddenly finds herself in the middle of the "primal scene", further complicating the current confusion (12). Was she present in that scene as a main actor or as a spectator? Freud said that, having sexual experience before reaching sexual maturity causes the sexual response to be higher than normal. One theory explain this with sympathetic activation. Perhaps the premature onset of intense sexual sensations establishes a powerful link between the sympathetic nervous system and sensory experiences of sexual stimulation in the poorly myelinated brain of the young child (10). From another perspective, maybe we can think that it is an unconscious mechanism that prevents a person from enjoying sexual activities because of the guilt of mixed and "wrong" feelings they felt in childhood.

Complex stimuli and emotions create restlessness. Restlessness is a precursor for anxiety. Disturbing negative or ambivalent emotions are often manifested by psychosomatic symptoms. PGAD is included in "Disorders with Somatic Symptoms" and is frequently seen together with various disorders such as anxiety, depression, and obsesssive compulsive disorder (10). Unless detected, it gradually continues with isolation, embarrassment and suicidal thoughts (8, 13). In support of this, our second case had a past suicide attempt. The education levels of our cases are close to each other, no difference has been found in the studies related to the education status of the individuals and the course of PGAD, as well (14).

The appearance of the same symptoms in all three siblings proves how important the upbringing and parental attitudes are in the spiritual development of the person. It is difficult for patients to talk about their sexual lives or express their complaints about it at the first stage of the interview. This condition may result from conscious or unconscious resistance. We should always keep in mind that, when there are treatment resistant psychiatric complaints, anamnesis should be deepened and the underlying traumatic experiences of childhood or adulthood should be meticulously questioned.

Pychotherapeutic colloboration is really important. As a result of that, in the first case, the use of not only medical treatment but also

psychotherapeutic collaboration was very beneficial. Another important point is that as a result of the carefully deepened story of a sibling, it was possible to reach other siblings who had similar complaints but were reluctant to apply.

CONCLUSION

In summary, there are many views on the etiology of PGAD, and no standard cause has been mentioned yet. It is worrisome to the person and is often hidden behind other psychiatric symptoms. It should be kept in mind that it is an important disorder that can negatively affect the functionality and sociability of the person and cause disability.

Informed Consent: Consent was obtained from all participants in this study.

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