Successful management of vaginismus: An eclectic approach

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ABSTRACT

Vaginismus is defined as recurrent or persistent involuntary spasm of the musculature of the outer third of the vagina, which interferes with coitus and causes distress and interpersonal difficulty. In this report, we describe the successful treatment of vaginismus in a 25-year-old lady based on a model proposed by Keith Hawton. The eclectic approach involved education, graded insertion of fingers, Kegel’s exercises and usage of local anesthesia with vaginal containment along with the prescription of Escitalopram.

Key words: Management, sexual dysfunction, vaginismus

INTRODUCTION

Vaginismus is defined according to DSM IV-TR[1] as recurrent or persistent involuntary spasm of the musculature of the outer third of the vagina, which interferes with coitus and causes distress and interpersonal difficulty. Physical causes and other axis I disorders need to be excluded. The inclusion of spasm in the definition has been questioned as it has not been consistently documented.[2] It has been classified as primary when the woman has never experienced non-painful penetrative sexual intercourse and as secondary when she has experienced non-painful penetrative vaginal intercourse in the past.[3] Vaginismus is comorbid with dyspareunia; sensitivity and specificity of the distinction between the two, however, has been doubtful.[4] Pain due to inflammation, infections, trauma, radiotherapy, muscular and neurological causes may contribute to psychological causes. Urge incontinence and anorectal problems need to be excluded.

Classical psychoanalytic theory conceptualized vaginismus as a conversion disorder caused by unresolved psychosexual conflicts in early childhood. Vaginismic women have been characterized as fixated or regressed to the pre-oedipal or oedipal stages.[5] Vaginismus is believed to be a psychophysiologic disorder due to fear from actual or imagined negative experiences with penetration and/or organic pathology. Women with vaginismus have also been noted to have a lack of sex education.[6]

CASE REPORT

A 25-year-old lady sought consultation with the psychiatry outpatient services for sexual dysfunction. She reported of tightness of vagina and introital pain while attempting sex with her husband. She had also become fearful about having sexual intercourse. These symptoms were present for 3 months following marriage. Patient’s husband disclosed that few months back when they got engaged, she had expressed apprehensions about having painful sexual intercourse. After the wedding, patient had postponed attempts at penetrative intercourse for 10 days. Whenever penetration was attempted, she would not part her legs and...
The patient reported of sadness, ideas of worthlessness and depressive symptoms over the past 5–6 weeks. She was noted to be clinically depressed. She had no contributory past history. Except for hypertension in her mother, family history was negative. She was described to be shy and sensitive by nature. There was no history of sexual abuse or earlier penetrative intercourse. The family of origin was religious; sex was not openly discussed in keeping with local cultural norms. However, the environment was not excessively strict or restrictive. She had normal menstrual history. Physical examination was unremarkable and she did not permit a local examination. She had in the past also not permitted vaginal examination by gynecologists. Her mental status examination revealed depressed affect, ideas of hopelessness and worries about non-consummation of marriage. She was diagnosed to have vaginismus with secondary moderate depressive episode without somatic syndrome. She was advised behavior therapy and marital work. She was also prescribed tab Escitalopram 10 mg HS.

The patient underwent five sessions (weekly) of sex therapy with the first author being the primary therapist. The sessions were based on the model provided by Keith Hawton.[6] The sessions included the husband and the couple initially participated jointly in educative sessions with the primary therapist. The exercises were carried out at home by the patient and her husband. In the first session, normal reproductive anatomy and physiology of the sexual act were explained. The patient was made comfortable with her genitals by asking her to look at the area in the mirror. She was taught Kegel’s exercises. Kegel’s exercises help control the pubococcygeus muscle which surrounds the entrance to the vagina. In the next couple of sessions, she was advised to insert her fingers into her vagina and move them around, initially one finger, later two fingers. Penetrative sexual intercourse was prohibited during the period. Only after the patient became comfortable with these over three sessions, vaginal containment with lubrication and local anesthesia provided by 5% lignocaine jelly was advised. Vaginal containment involved the patient in female superior position, guiding penile penetration with her hands and the couple remaining still, concentrating on the pleasant sensations they experience. After a month of initiating therapy, the patient was able to indulge in normal sexual intercourse without the need for local anesthesia. Her depression also improved. In subsequent follow-ups, her antidepressant dose was tapered and stopped over the next 9 months.

**DISCUSSION**

James Marion Sims first coined the term “vaginismus” in 1862 at an address to the Obstetrical Society of London.[3] Vaginismus is thought to be one of the most common female psychosexual dysfunctions but the exact prevalence rate among the general population is not known. However, in sexual dysfunction clinics, the rates vary from 5 to 17%.[6] This condition can result in significant interpersonal problems and marital discord.[3] Treatments have included systematic desensitization along with insertion of graded dilators/fingers.[8] The sex therapy sessions include education, homework assignments and cognitive therapy. Relaxation therapy and flooding are also used. Pharmacotherapeutic approaches have included using benzodiazepines and anxiolytics. Botulinum toxin injection[9] and hypnosis[10] are the other approaches that have been tried. There are no randomized controlled trials available to garner evidence for treatment of vaginismus.[8] Limited evidence is available from case series alone.

In the case discussed here, an eclectic approach was used involving education, graded insertion of fingers, Kegel’s exercises and usage of anesthesia with vaginal containment. The use of SSRI Escitalopram may also have aided the therapy by providing anxiolysis and relief from depression. The report demonstrates a successful approach toward managing vaginismus in a clinical setting. There is a need for randomized controlled trials to establish efficacy and bolster these approaches.

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