“Common Sense” Approach to the Management of Vaginismus: A Case Series

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Introduction

Vaginismus is the contraction of muscles leading to vaginal muscular spasms making vaginal penetration painful or impossible.1,2 It usually coexists with dyspareunia. Poor interpersonal relationships can also lead to the onset of this condition, or its persistence, due to the mechanism of either intrapsychic conflict or reinforcement.3,4 Vaginismus accounts for 1% to 7% of unconsummated marriages worldwide.5,6 The etiology of Vaginismus needs to be explored and understood before initiating its treatment. Various treatment approaches have been recommended and proven to be useful,4,7 a few producing success rates greater than 90%.8 However, whether such approaches can be applied and successfully implemented in the Indian setting is a moot issue, as there is lack of available literature regarding the same. In our opinion, a different sociocultural milieu and related pragmatic issues necessitate modification of the “Western” approaches and techniques so advocated.

In the following case illustrations, we highlight the need for a detailed assessment in treatment planning, followed by the use of innovative methods for managing this difficult clinical condition of Vaginismus.

Case 1

A 35-year-old female, married for 6 years, working as a government employee, and living in a joint family, came for consultation in January 2018 to Marital Sexual Clinic (MSC) run by the Department of Psychiatry as her spouse was diagnosed with low sexual desire and obsessive-compulsive personality disorder which was interfering with their marital harmony. The couple had failed to conceive in spite of indulging in completed acts of sexual intercourse on a few occasions. She reported that her husband never initiated sexual intimacy during the first 1 year of marriage. She initially approached him few times (3 to 4 times in a week) due to her desire for sex. But her request was rejected by him as he thought they should allow time to know each other before getting sexually involved. Subsequently, the marriage was consummated. Afterwards, over the next 1 to 2 years she often approached him for sexual intimacy, but he would avoid by making different excuses (eg, specifying that he was feeling fatigued, it caused interruption in his routine, his need for proper sleep, etc.). His avoidance pattern led to gradual reduction of sexual desire in her too. The frequency of sexual intercourse decreased from once per month to once every 3 to 4 months. She started remaining irritable but maintained adequate socio-occupational functioning. Due to infrequent sexual contact and fear in her interpersonal relationship, she gradually lost interest in sexual intimacy with subsequent development of pain during sexual intercourse. Sexual contact became rare between the couple. During the fourth year of marriage, she developed symptoms of Vaginismus manifested by complete rejection of penile penetration. This was reinforced by her pain coupled with the ongoing behavior of low desire and avoidance of sex by her husband. She was diagnosed with nonorganic Vaginismus (F52.5) and nonorganic dyspareunia (F52.6). During this period, her husband had been experiencing interpersonal issues at home and workplace and was taking therapy for the same.

The treatment plan so developed focused on individual problems of the couple as well as their sexual issues. Hence, sensate focus (SF) aiming at managing both low sexual desire and erectile dysfunction8 in the husband along with graded exposure (GE)4 using “finger approach” in lieu of “dilators”7 for the patient was utilized. Hence, the overall management plan comprised of an initial comprehensive assessment,

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followed by sex education, environmental modifications, SF clubbed with GE to insertion/penetration.

SF helped in return of the sexual desire between the couple. GE was introduced during the third stage of SF. The third and fourth stages of SF were prolonged as they included exposure to insertion. A finger and, later, penis of the husband. This continuous process of insertion to penetration to thrusting was thereafter conducted in a graded manner. A total of 20, inclusive of both “termination” and “booster,” sessions were taken. This resulted in improved sexual relationship between the couple.8,9 Thereafter, she reported herself to be remaining sexually active, experiencing pleasure and deriving satisfaction even 1 year after termination of therapy when last contacted in November 2019.

Case 2

A 27-year-old female, housewife, got married in 2012 after being in a long-term relationship with her boyfriend since 2003. Sexual activity between the couple was initiated only in 2014. They had started dating at a very young age and by the time they matured in age, her partner had been out of country for job prospects. She presented to MSC in August 2014 with complaints of tightness in her vaginal musculature and pain during intercourse. There was history of first failed sexual attempt where patient felt excruciating pain during insertion of penis, and this induced persistent fear for vaginal intercourse. The couple was compatible in sexual desire and often indulged in anal or oral sex to satisfy their sexual needs. On one occasion, during physical examination by the doctor, she felt pain and thereafter decided not to seek any consultation. She presented to MSC through a referral from a gynecologist and was diagnosed with nonorganic Vaginismus (F52.5) and nonorganic dyspareunia (F52.6).

The assessment revealed phobic reaction to penetration; hence, systematic desensitization (SD)4 was planned as the mainstay of the treatment plan. The overall management plan included sex education, relaxation exercises, SF, and SD. A total of 22 sessions inclusive of both “termination” and “booster,” sessions were taken. Initial sessions were on sex education with special emphasis on the physiology and anatomy of male and female reproductive organs.8 In addition, the couple was advised to use a mirror in order to properly explore their genitals, and advised to refrain from oral or anal sex as part of SF.8 Subsequently, as part of SD, Jacobson’s progressive muscle relaxation2 was introduced for the patient, with a special emphasis on pelvic muscle relaxation to be practiced regularly at home. A hierarchy was developed in conjunction with the couple regarding exposure to insertion initially using finger, and later penis, of the husband. It was started with the patient’s own finger, followed by her 2 fingers, and then shifted to the husband’s fingers: initially 1 and then 2. Thereafter, penile insertion was initiated: tip of the penis, one-third of penis, half penis, and full penis. Also, the hierarchy simultaneously combined insertion in a graded manner as follows: without movement, with movement inside, with in-out repetitive movements. In keeping with the basic premise of behavior therapy, a subsequent step was not initiated till complete mastery over and pleasure in a previous step was achieved. The couple was called on alternate days for a session. Progress was regularly charted and monitored to the next level as per the drawn-up hierarchy. Whenever discomfort was experienced, the patient was advised to stop and relax herself using deep breathing; each sexual behavior therapy session of 30 to 40 minutes was practiced at home. Deep penetration and thrusting was achieved by the twelfth session of SD. She maintained well in follow-up (booster) sessions after 6 months and 1 year. After successful sexual contact (ie, vaginal intercourse), therapy was terminated. She reported to be maintaining well after 3 years of termination, and had a child at time of last contact in February 2017.

Discussion

Vaginismus is one of the most common female psychosexual dysfunctions; although the exact prevalence rate among the Indian population is not known.10 Case 1 had a cordial relationship with her husband but reported feeling both frustrated with him (due to her sexual need not being fulfilled) and fearful of him (as she had witnessed his anger outbursts at home). Both factors perpetuated her suppression of sexual desire, coupled with acceptance of refusal by the husband in any form of sexual relationship. On the other hand, case 2 was a sexually active female with her spouse using oral and anal forms of sex to fulfill her sexual needs. However, this sexual behavior was maladaptive and became a barrier for her in seeking professional help for Vaginismus. It was only social pressure of conception that made the couple seek professional consultation, and the therapy process made them shift from this pattern of “maladaptive behavior of deriving sexual satisfaction” to trying out vaginal intercourse.

The treatment protocol of Vaginismus emphasizes the need for a detailed assessment.2 This is essential as the etiology for Vaginismus, its pathogenesis, and subsequent management protocol can have different trajectories. As mentioned earlier, case 1 had low sexual desire (accentuated by personality traits of the spouse who himself suffered with low sexual desire), dyspareunia, and later Vaginismus, whereas case 2 had normal sexual desire but Vaginismus as a phobic reaction to coitus.

Additionally, both cases of Vaginismus so presented reveal a difference in the approach to formulation and development of an appropriate management plan.7 The Western literature supports the use of dilators in such cases, but in these cases, “finger approach” was used due to reasons of feasibility,7 because availability, procurement, and hygiene management of dilators were practical issues which were not easy to deal with in a busy outpatient low and middle income
group countries (LAMIC)-based general hospital setting like ours. Also, previous studies have shown successful treatment of Vaginismus using SD. SF along with GE and SD (in case 1 and case 2, respectively) in Vaginismus was tailor-made as per patient needs; hence, it may be termed as being “innovative” and “common sense.”

SF was utilized in both cases. However, it is a treatment which is widely used and recommended in male sexual disorders, with or without their spouses. Its viability in female sexual disorder has not been well established. The successful management of Vaginismus in both our cases makes us wonder and put forth the proposition that SF can also be successfully employed in female sexual disorders like Vaginismus (with the proviso that they are properly assessed and preselected for management).

Couples in both cases were motivated, participative, and compliant to the therapeutic work. Both cases were able to indulge in completed sexual intercourse while the therapy sessions were ongoing. This is contrary to what is advised in the traditional Western treatment model, where it is not permitted to have sexual intercourse during the course of therapy and sexual intimacy must progress stage-wise. In our professional opinion, however, occurrence of sexual intercourse was taken as part of the overall therapy process and considered as achieving a therapy end point, ie, clinical success.

Clinical outcome was rated based on a few measures using the “visual analog scale” (Table 1). Table 1 shows average prerating and postrating scores on various clinical parameters using the visual analog scale.

Hence, to summarize, the 2 cases so presented here highlight the need for a comprehensive and detailed assessment of the different stages of sexual response cycle (MJ) in order to determine the exact etiopathogenesis of Vaginismus and also to determine the management protocol and type of therapy. Modifications/innovations carried out, and common to both cases, were: use of “finger technique” instead of dilators, introduction of SF as an integral component of overall therapy, and indulging in actual proper sexual intercourse whilst the therapy was ongoing.

| Measures                  | Case # 1 | Case # 2 |
|---------------------------|----------|----------|
|                           | Pre     | Post     | Pre     | Post     |
| Desire                    | 2       | 10       | 7       | 9        |
| Lubrication               | 2       | 10       | 4       | 9        |
| Pleasure                  | 2       | 10       | 8       | 9        |
| Satisfaction              | 0       | 10       | 7       | 9        |
| Urge for intercourse      | 3       | 10       | 6       | 9        |
| Spouse’s quality of erection | 1     | 10       | 8       | 10       |

Notes: Minimum score = 0; maximum score = 10.

*All parameters for female except.

This case series, in essence, puts forth a proposition that modifications to the routinely advocated Western methods of managing Vaginismus may be needed in the Indian setting. Other authors have also previously propounded the need for innovative techniques to achieve results in a starkly different and sensitive sociocultural setting like India. As literature from India is lacking, there is a need not only for further sharing of experiences on this subject matter but also for our “common sense” approach to be tested for its internal strengths and fallacies. We hope that these 2 cases shall help in generating appropriate interest amongst the concerned readers.

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