Management of Vaginismus with Cognitive – Behavioral Therapy, Self-Finger Approach: A Study of 70 Cases

M. Mousavi Nasab, Z. Farnoosh

Abstract

Background: Vaginismus is an involuntary spasm of the muscles of the outer third of the vagina caused by real or anticipated attempt of vaginal penetration. It could lead to marital disharmony, guilt feeling and depression. Cognitive behavioral models for therapy of this disorder have gained considerable attention during last three decades.

Objective: To determine the efficacy of self-finger approach in the management of vaginismus.

Methods: Seventy patients with the diagnosis of primary vaginismus based on DSM-IV criteria were enrolled in the study. The data were gathered by a semi-structured interview. After consent, the patients were referred to a female clinical psychologist for weekly sessions of cognitive behavioral therapy, i.e. desensitization using a self-finger approach. Those who had psychiatric co-morbidity were treated for the co-morbid disorders.

Results: Sixty four patients (91.42%) of the total 70 completed the course of therapy and all of them responded well to the therapy.

Conclusion: Non-instrumental cognitive-behavioral therapy, self-finger approach, was an effective method for treatment of vaginismus.

Keywords • Sexual dysfunctions, psychological • cognitive therapy • behavior therapy

Introduction

Vaginismus, an involuntary spasm of the muscles of the outer third of the vagina, brought about by real, imagined or anticipated attempt at vaginal penetration, often leads to non-consumption of marriage.¹ The latest edition of diagnostic and statistical manual (DSM-IV) in criteria A defines vaginismus as a recurrent or persistent involuntary spasm of the musculature of the outer third of the vagina. It interferes with sexual intercourse and in criteria C it is specified that the disturbance is not better accounted for by another axis I disorder (e.g. somatization disorder) and is not
In the second session, after relaxation one finger
patients had to practice 2-3 times a day at home.
several times to make sure it is done appropriately.
provided with the opportunity to practice relaxation

cussion. Then general body relaxation and vaginal
development, and therapy of vaginismus were dis-
larly anxiety and phobic disorders, causes, devel-
therapy after searching for co morbidities particu-
private sessions with observation of cultural and
plained to the couple emphasizing that manage-

cial approach is as effective as methods

M. Mousavi Nasab, Z. Farnoosh

Material and Method

Seventy patients with the diagnosis of primary
vaginismus according to DSM-IV criteria and their
husbands, mainly referred by gynecologists and
psychiatrists, were evaluated in a semi-structured
interview for demographic data, past and current
psychiatric disorders and sexual knowledge to-
gether. All the patients were examined by gynec-
ologists and had no major physical causes for
vaginismus. Five patients had undergone hyme-
nectomy, with no improvement of vaginismus.
Once the couple agreed on the method of therapy
then they were referred to the second author (fe-
male clinical psychologist with special training in
cognitive-behavioral treatment of vaginismus). In
the second visit, a general idea about the method of
therapy and normal sexual intercourse was ex-
plained to the couple emphasizing that manage-
ment would be done by a female sex therapist in
private sessions with observation of cultural and
religious factors. In the first session of individual
therapy after searching for co morbidities particu-
larly anxiety and phobic disorders, causes, devel-
opment, and therapy of vaginismus were dis-
cussed. Then general body relaxation and vaginal
muscle training (V.M.T) were taught. Patients were
provided with the opportunity to practice relaxation
several times to make sure it is done appropriately.
Patients had to practice 2-3 times a day at home.
In the second session, after relaxation one finger
approach with lubrication was instructed. During
the next weekly sessions, desensitization continued
to the point that 2-finger approach could be done
successfully. Patients were reevaluated for organic
causes of dyspareunia and whether there was pain
during finger insertion. Intercourse was permitted
when the therapist was fairly confident that it could
be performed with no fear.
No dilators or hypnotic suggestion were used. The
number of therapeutic sessions were adjusted to
the need and progress of the patient. Those who
had psychiatric co-morbidity with sufficient severity
to interfere with sex therapy were treated for the
co-morbid disorders.

Results

The patients were 17 to 36 years old (mean =
23.37). Three (4.28%) of the patients were illiterate,
6 (8.57%) had taken elementary school, 12
(17.14%) high school, and 49 (70%) had high
school diploma or a higher level of education. Dura-
tion of marriage was 2 to 132 months (mean =
27.42). Four patients had positive family history of
vaginismus (5.71%). None of the patients had past
history of sexual trauma. Regarding history of psy-
chiatric disorders, 2 (2.85%) had depression, 1
(1.42%) schizophrenia, 13 (18.57%) anxiety disor-
der, and 8 (11.42%) phobia. Sexual knowledge of
34 patients (48.57%) was inadequate or wrong.
Number of therapeutic sessions were 3 to 8 (mean
= 4.5). Sixty-four (91.42%) patients were respond-
ers.
Six patients (8.57%) did not continue the treatment
program after a few sessions of treatment, so, it is
not known whether they improved or not. Anxiolytic
medications were used for 4 patients who suffered
from intense anxiety during self finger approach.
Blood-injury phobia (8 patients), generalized anx-
xiety disorder (5 patients), and major depressive dis-
order (2 patients), were the three most common
psychiatric co-morbidities, which were treated be-
fore providing the cognitive behavioral therapy of
vaginismus.

Discussion

Our results show that non-instrumental cognitive
behavioral approach is as effective as methods
using hypnotic suggestion or dilators. The suc-
cess rate of using graded dilators, as reported by
Masters and Johnson is 98.8% hence the highest
rate among sexual disorders compared to com-
bined totals of sexual dysfunctions which is
81.8%. Despite the fact that Masters and John-
son suggested two weeks of intensive therapy, we
found the weekly sessions more suitable, and the
patients have more time to practice relaxation, with
no disruption in their routine activities. It seems if
Management of Vaginismus Cognitive behavioral, self- finger approach Study of 70 cases

DSM-IV criteria for vaginismus which are basically psychological are applied, significant results could be obtained. A trained female clinical psychologist has the key role in dealing with cultural and religious concerns, developing therapeutic alliance and helping the patients to perform pelvic relaxation. Our experience revealed that the number and duration of therapeutic sessions should be tailored according to the needs of patients. We found that educating and encouraging of the spouse for cooperation, as mentioned by Beck 15, crucially increased the success rate.

Thirteen of our patients were suffering from anxiety disorders with severe accentuation during sexual intercourse. As recommended by Plaut et al 16, anxiolytic medications, started in addition to psychotherapy for these patients, proved to be very effective.

Almost half of our patients had inadequate or wrong sexual information indicating that sex education should be an integral part of therapy. As the majority of our patients had high school or higher education, inadequacy of sexual information could be due to lack of formal sex education particularly during adolescence. None of our patients reported sexual assault or rape. This information should be elicited cautiously as the patients may deny such experiences due to the socio-cultural factors.

References