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CASE REPORT

Primary Vaginismus and Associated Phobia: Successful Treatment with Behavior Therapy

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ABSTRACT

Objectives: To report two cases of primary vaginismus with associated phobia, successfully treated with behavior therapy.

Results: In our two reports, we describe the successful treatment of vaginismus with associated phobias using behavioral therapy. The behavioral approach involved psycho education, graded exposure, relaxation therapy and systematic desensitization.

Conclusion: The report demonstrates a successful approach toward managing vaginismus and associated phobias in a clinical setting.

Keywords: Vaginismus, Phobia, Behavior therapy, Systematic desensitization.

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INTRODUCTION

Diagnostic and statistical manual of mental disorders, fifth edition (DSM-V)[1] defines vaginismus as a recurrent or persistent involuntary spasm of the musculature of the outer third of the vagina that interferes with sexual intercourse. And, it is specified that the disturbance is not better accounted for by another axis I disorder like somatization disorder/any general medical condition. Vaginismus can lead to marital disharmony, disruption of marital relationship; faulty sexual intercourse, guilt feeling and depression in either partner; and secondary impotence in the male counterpart. Though the treatment of vaginismus is primarily by nonpharmacological means, only limited evidence from uncontrolled trials is available to recommend the use of systematic desensitization.[2] An earlier work reported that 44 out of 49 (89.7%) women were successfully treated with systematic desensitization compared to six out of six (100%) with hypnotherapy.[3] The role of fear of pain in vaginismus has been stressed by several authors; indeed most of the patients report 'fear of pain' as the primary reason underlying the condition. Similarly, 'mutilation fear' may be one of the psychological hypothesis for blood injury injection phobia. Therefore, it may not be illogical to hypothesize that both disorders may share a similar fear, that is the fear of penetration into the body either by penis or by injection.[4]

In this report, we discuss the successful treatment, of vaginismus with associated injection phobias, by systematic desensitization and exposure therapy.

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CASE REPORTS

Case 1

Mrs X is a 25-year-old graduate, married since 4 years, visited gynecology outpatient department for evaluation and management of primary infertility. Routine investigations, hormonal profile and necessary detailed infertility work-up of Mrs X and her husband by the gynecologist and urologist revealed no abnormality. Vaginal examination was not possible because of the spasm of lower third of vagina, and was not associated with any demonstrable local pathology. Subsequent psychiatric assessment revealed her marriage was not consummated because of her fear of and pain on penile penetration which was the sole reason for infertility; had tried penetration with alcohol, xylocaine jelly, drugs; undergone a minor surgery to widen her vaginal introitus without any benefit. Detailed exploration, however, revealed stable interpersonal relationship with husband though both were worried about to have a child. There was no history of depressive symptoms, lack of libido, extramarital affair, other psychosocial problems, substance abuse or any other psychiatric symptoms. She was diagnosed with primary vaginismus and associated specific phobias. She was educated about her problem and the treatment modality; was reassured; relaxation therapy in form of Jacobson's progressive muscular

relaxation was instituted; sex education was given. Other specific phobias identified were: excessive and unreasonable fear of painful touch like threading, fear for pin prick, fear of trickle, fear of intramuscular and intravenous injections; and detailed behavioral analysis was done. Hierarchy of different phobias was made according to subjective unit of distress (SUD). For treatment of vaginismus, the hierarchy made was: imaginal exposure to penile penetration, graded *in vivo* exposure to penetration of progressively increasing size Hegar dilators and husband's finger. The exposure therapy was carried out under the cover of relaxation therapy, supervised by therapist and co-therapist (husband). Initially, regular daily exposure sessions (lasting for 30-45 minutes) in the hospital continued; subsequently, Mrs X practiced the behavior therapy sessions at home under supervision of her husband and followed up with the therapist for carrying out session with next level of SUD, once she attained zero anxiety/distress. It took 4 months to complete all the hierarchy. At end of behavior therapy, she was comfortable in all phobic situations including vaginal examination in gynecology OPD, marriage got consummated, she conceived naturally and is currently under regular antenatal check up with the gynecologist.

Case 2

Mrs Y was 24 years old graduate from middle socioeconomic class presented to psychiatry OPD with marital discord and depressive disorder. She married (love marriage) 3 years back, but her marriage was not consummated. Nonconsummation of marriage was because of painful spasm of vagina during sexual intercourse which in turn was the important reason for marital disharmony leading to impending divorce. She had visited many gynecologists and was not cooperative for vaginal examinations with jelly. Diagnosis of primary vaginismus, depression and injection phobia was made after detail psychiatric evaluation. She was put on Tab Escitalopram 10 mg/day for depression; given sex education and psycho education followed latter by systematic desensitization (exposure therapy plus relaxation therapy). Similar to first case hierarchy of different phobias was made according to SUD, with vaginal intercourse being at the highest level of SUD in the hierarchy. Behavioral therapy was carried out as described in first case. After 3 months of regular behavior therapy, patient allowed for vaginal examination and had successful vaginal intercourse.

DISCUSSION

Vaginismus is thought to be one of the most common female psychosexual dysfunction but the exact prevalence in the general population is unknown. However, in sexual dysfunction clinics, the rates vary from 5 to 17%.[5,6] Vaginismus can result in significant interpersonal problems, marital discords and depression.[7] Treatments over a period of time have included systematic desensitization along with insertion of graded dilators/fingers. The sex therapy sessions include education, homework assignments and cognitive therapy. Relaxation therapy and flooding are also used.[8] Pharmacotherapeutic approaches have included using benzodiazepines and anxiolytics. Botulinum toxin injection[9] and hypnosis[3] are the other approaches that have been tried.

Nonetheless, association of vaginismus with other phobias and its treatment with behavior therapy has not been discussed much in literature. But with the emergence of new theories of psychopathology, a variety of different points of view concerning the etiology of vaginismus have emerged. However, what actually interferes with penetration is never specified, is it the physical barrier posed by a severe muscle spasm, or the expectancy and/or experience of pain.[10] This seems true for some women with vaginismus, but it is not clear whether fear of penetration is cause or effect.[5]

In the cases discussed here, a behavioral approach was used involving educating the patient in detail about the normal anatomy and physiology of genital system; principles and process of behavior therapy; graded exposure phobic situations; relaxation and systematic desensitization. Simultaneously cognitive approach was also adopted to identify the irrational beliefs and correcting them. The presence of associated specific phobias helped the patient in better participation in graded exposure, better understand and prepare to overcome the actual fear of sexual intercourse and finally. Moreover, addressing faulty cognitions, perhaps, acted as 'catalyst' for successful outcome.

CONCLUSION

The report demonstrates a successful approach toward managing vaginismus and associated phobias in a clinical setting. For the psychological treatment of vaginismus it is advisable to explore for other specific phobias. Incorporating behavioral procedure and cognitive restructuring from the outset as demonstrated in both the cases need to be replicated in randomized controlled trials to establish efficacy and bolster these approaches.

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