MSSVD SPECIALIST INTEREST GROUP ON SEXUAL DYSFUNCTION

Guidelines for the management of vaginismus

Definition
Vaginismus is an involuntary reflex spasm of the muscles surrounding the entrance to the vaginal that may be severe enough to effectively prevent penetration of the vagina. The Diagnostic and Statistical Manual of Mental Disorders (DSM)\(^1\) defines vaginismus as occurring when there is recurrent or persistent involuntary spasm of the musculature of the outer third of the vagina that interferes with coitus and is not caused exclusively by a physical disorder.

Vaginismus usually occurs when a woman anticipates intercourse but may also occur in anticipation of any object being placed inside or even near the vagina.

Historical background
The condition was first described in 1834 by D K Huguier. However, it was an American gynaecologist, J Marion Sims who coined the term “vaginismus” in 1862 when addressing the Obstetrical Society of London. He recommended excision of the hymen and the use of a glass bougie as treatment.\(^2\)

Aetiology
Vaginismus may arise as part of a conditioning response that is acquired secondary to physical and/or psychological stimuli. In other words, following an adverse stimulus a cycle evolves in which subsequent fear and anticipation of pain increases the likelihood that future attempts at penetration will produce such a sensation of pain. This results in avoidance (by means of muscle spasm) and the accompanying relief reinforces the avoidance.\(^3,4\) In many instances there is a specific phobia or fantasy surrounding vaginal penetration, for example, that the vagina is too small to accommodate a penis or that the vagina will be damaged by the act of penile penetration.\(^5\)

Physical
Vaginismus may develop secondary to painful sexual experiences. Physical causes of pain include of the genital tract infections (such as herpes, recurrent candida and pelvic infection.), vestibulitis\(^6\), atrophic vaginitis due to post-menopausal oestrogen deficiency\(^4\), trauma associated with genital surgery (such as episiotomy) and radiotherapy. Sexual dysfunction is commoner in women with a physical disability.\(^7\)

Furthermore, problems with arousal can result in poor lubrication and painful intercourse. Arousal dysfunction is commoner in diabetic women\(^8\), multiple sclerosis and spinal cord injury\(^9\). However, many women with this condition are very capable of sexual desire, arousal and orgasm and can maintain long term stable sexual relationships.

Psychological
Reported psychological associations are a history of sexual abuse or sexual assault, familial, religious and cultural taboos.\(^2,3\) Some women describe traumatising gynaecological examinations by unsympathetic doctors. It has been suggested that some women who have a tendency to somatise negative emotions may be more
susceptible to developing vaginismus. A dysfunctional relationship may also occasionally present as vaginismus.

It can be classified as:
1. Primary (The woman has never experienced non painful penetrative intercourse).
2. Secondary (The woman has previously experienced non-painful penetrative vaginal sexual intercourse).
3. Consistent (It occurs each time any form of penetration is attempted).
4. Global (It occurs independent of the partner or the circumstances).
5. Situational (It occurs only with certain partners or circumstances).

Prevalence
Sexual dysfunction has been reported in over 20% of men and 9% of women attending a London GUM clinic, of whom 25% had vaginismus. In another study, 22% of women attending a GUM clinic with a sexual problem had vaginismus. Figures from sexual dysfunction clinic populations vary from 12% to 17%.

Presentation
Vaginismus affects heterosexual and lesbian women and is commoner in younger women. The presentation may be overt or covert. A woman may present requesting help for non-consummation and being aware that she cannot tolerate a penis or other object inside her vagina. On the other hand, a woman may present covertly, for a check up, smear or complaining of genital symptoms or painful intercourse. In either case, she may have severe adductor spasm and be unable to tolerate even one finger per vagina. The less obvious case may only seem unable to relax during the speculum examination or appear to find the experience distressing. A simple acknowledgement of this finding by the doctor, for example, “I notice that the examination was difficult for you, I wonder if it is painful when you have sex?” may enable the women to begin a discussion about the problem with the doctor if she wants to.

Management
Therapy is tailored to the needs of the woman and her partner, if she is in a relationship. Involvement of the partner in the treatment of her vaginismus should be the decision of the woman.

The first step is to take a detailed medical history including contraceptive, gynaecological, obstetric and genito-urinary details. Ability to use tampons should be elicited. A careful sexual history should ascertain whether the problem is primary, secondary, situational or global. An exploration of the woman’s social circumstances and relationship history as well as any current relationship and identification of areas of conflict should be undertaken. The woman’s attitude to her own genitals and whether or not she can self examine or tolerate touching herself is also important.

Examination of the external genitalia, to exclude any organic pathology as discussed above, is mandatory. This should be followed by a gentle pelvic examination. It is very important to give the woman control over this examination by describing what you are going to do. For example, show her the speculum if you intend to use it and give her permission to change her mind at any point in the proceedings even if this
means no examination is done on that day. Some women choose to hold the speculum or the doctor’s wrist in order to feel that they are in control of the process. You should proceed very slowly and inform her of exactly what you are about to do e.g. “I am now going to put my finger just on the outside of your vagina.” Ask her to tell you when she is ready for you to insert your finger. Use only one finger. It is during this examination that you should be able to establish that she does have vaginismus. Sometimes at the first visit the woman might not be able to even tolerate the finger just inside the introitus or even externally. If she can accept one finger you can teach her how to contract and relax her pelvic floor. This should demonstrate to her how much more uncomfortable she feels when her pelvic floor muscles, which control the entrance to her vagina, are contracted. Establishing the connection between her need to be in control and the “involuntary” contraction of pelvic floor muscles can be therapeutic and helps to introduce the concept of exercises to gain conscious control of her vaginal opening through self-examination and pelvic floor exercises. 

Encouraging the woman to insert her own finger is the next step. This may be done by the patient or partner at home or with supervision by the doctor. Over a number of sessions the patient learns to insert one and then two fingers. Use of lubrication may be helpful. Whether she uses her own, the partner’s fingers or graduated dilators does not matter. It is important that on her follow up visits her reactions to this process are discussed and any resistance explored. It may be at this point that she is able to disclose any fantasy or phobia about penetration that she harbours. In addition to the repeated practice of vaginal exploration using fingers or vaginal dilators, some therapists recommend concurrent pelvic floor exercises. The patient may also be taught relaxation exercises. In some instances, the vaginal “homework exercises” are carried out within a sensate focus programme involving a graded series of massage exercises for a couple in which there is an initial ban on intercourse.

**Outcome**

There are no controlled or treatment comparison studies of vaginismus. However, there is evidence that therapy involving insertion training appears to be very effective, with an unusually clear outcome measure, that is, the ability to have penetrative vaginal intercourse. Success rates from 72-100% have been reported.

Most cases that present are amenable to short term treatment varying from 2 to 15 sessions. However some women are particularly resistant to treatment and may require either skilful couple therapy or long term individual therapy. In such cases, the vaginismus is often the presenting symptom of a more complex sexual or relationship problem.
References
1 Diagnostic and statistical manual of mental disorders


4 Human sexuality and its problems (second edition) 1994 J. Bancroft; Churchill Livingston


6 White G Jantos m, Sexual behaviour changes with vulvar vestibulitis syndrome. J Repro Med 1998;43, 783-9


11 Crowley T. Sexual dysfunction as presented in a routine GUM clinic compared with that within a specialist psychosexual clinic. Sexual Dysfunction 1998; 1: 25-29


14 Dean J. Examination of patients with sexual problems. ABC of sexual health. BMJ 1998; 317:1641-1643


**Further reading**


The ABC of sexual health is edited by John Tomlinson, physician at the Men's Health Clinic, Winchester and London Bridge Hospital,


A list of therapists can be obtained from the British Association for Sexual and Marital Therapy (PO Box 13686, London SW20 9HZ) or the Institute of Psychosexual Medicine (12 Chandos Street, London W1M 9DE, web site: www.ipm.org.uk) and Relate-Marriage Guidance (a list of local centres can be obtained from its office at Herbert Gray College, Little Church Street, Rugby CV21 3AP).