IJCRT.ORG ISSN : 2320-2882

INTERNATIONAL JOURNAL OF CREATIVE RESEARCH THOUGHTS (IJCRT)

An International Open Access, Peer-reviewed, Refereed Journal

Managements Of Vaginismus- A Review Literature

*Dr. Syed Tajvar Usman [1], Dr. Rafi Ahmad Chaudhary [2],

Dr. Asma Rafi Chaudhary [3], Dr. Farhat Afreen [4],

* [1] PG scholar, Dept. of Obstetrics & Gynecology, ZVM Unani Medical College & Hospital, Pune.

[2] Professor & HOD, Dept. of Obstetrics & Gynecology, ZVM Unani Medical College & Hospital, Pune.

[3] Professor, Dept. of Obstetrics & Gynecology, ZVM Unani Medical College & Hospital, Pune.

[4] PG Scholar, Dept. of Obstetrics & Gynecology, ZVM Unani Medical College & Hospital, Pune.

Abstract: Vaginismus is a common sexual disorder among women effects on approximately 1– 7% of females worldwide. There is variety in aetiology and diagnosis. Vaginismus currently classified as Genito Pelvic Pain / Penetration Disorder also known as vaginal penetration disorder. 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 have described various treatment option such as counselling, Kegel's exercises etc.

Keywords: Management, sexual dysfunction, vaginismus

I. Introduction of Vaginismus.

Vaginismus is described as an involuntaryvaginal muscle spasm interfering with sexualintercourse [1]. Since the term was first coined inthe 19th Century, Vaginismus has been conceptualized as a relatively infrequent but well understood and easily treatable female sexual dysfunction. In 1859, Sims wrote that 'frompersonal experience, I can confidently assert that I know of no disease capable of producing so much unhappiness to both parties of the marriage contract, and I am happy to state that I know of noserious trouble that can be cured so easily, so safelyand so certainly' [2]. This conceptualization was perpetuated by Masters and Johnson who reported a treatment outcome success rate of 100% [3]. It seems likely that this presumed high cure rate and lack of diagnostic controversy deterred new research. In fact, Beck described vaginismus as 'an interesting illustration of scientific neglect' [4]. Since Reissing et al.'s review of the vaginismus literature, a few important empirical studies on the diagnosis and treatment of vaginismus have beenpublished [5]. Interestingly, their results challenge the validity of the current definition of vaginismus as well as the notion that it is an easily diagnosable and treatable condition. The current article will examine the literature on the classification, diagnosis, etiology and treatment of vaginismus with a focus on the latest empirical findings, require a stressful gynecological examination that sufferers might often prefer to avoid. As aresult, there have been dramatically varying estimates regarding the prevalence of this

problem. It is one of the most common female psychosexual dysfunctions [7–10]. Although the population prevalence remains unknown, the prevalence rates in clinical settings have been reported to range between 5–17% [11]. In a British study, Ogden and Ward examined the help-seeking behaviors of women suffering from vaginismus and found that the professional most frequently consulted was the general practitioner [12]. Unfortunately, their respondents reported that general practitioners were the least helpful health professional they consulted. Overall, there was general dissatisfaction with available help, which may reinforce many vaginismic women's pre-existing avoidance in seeking help. This is consistent with Shifren et al.'s findings in the USA that only a third of women with 'any distressing sexual problem' consults [13]. According to their sample, the barriers for receiving professional help were poor self-perceived health and embarrassment in discussing sexual problems.

II. Classification & diagnosis

A. Vaginal muscle spasm

In 1547 treatise on 'The Diseases of Women' Trotula of Salerno is thought to have provided the earliest description of what we today call vaginismus: 'a tightening of the vulva so that even a woman who has been seduced may appear a virgin' [14]. Much later, Huguier gave the first medical description of the syndrome; however, it appears that Sims first coined the term 'Vaginismus' in 1862 while addressing the Obstetrical Society of London [15]. Sims described vaginismus as 'an involuntary spasmodic closure of the mouth of the vagina, attended with such excessive super sensitiveness as to form a complete barrier to coition' [2]. To date, the involuntary muscle spasm remains the core element of the definition of vaginismus suggested by the American College of Obstetrics and Gynecology (ACOG) and by the Diagnostic and Statistical Manual of Mental Disorders- IV-TR (DSM-IV-TR) [1, 16]. The International Classification of Diseases (ICD)-10 categorizes vaginismus either as a 'pain disorder' or as a 'sexual dysfunction comprised of a spasm of the pelvic floor muscles that surround the vagina, causing the occlusion of the vaginal opening with penile entry being either impossible or painful' [17].

In addition to the lack of agreement regarding the term muscle spasm and the muscles involved in vaginismus, there is no empirically standardized diagnostic protocol for vaginal muscle spasm. Although Masters and Johnson claimed that a pelvic exam was necessary to diagnose vaginismus, researchers and clinicians have frequently relied on self-report of difficulties with vaginal penetration [2, 32]. The lack of a standardized diagnostic protocol is not a trivial problem since studies concerning vaginismus may well include highly diverse samples. The fact that studies using the vaginal muscle spasm DSM-IV-TR definition of vaginismus failed to find a vaginal spasm suggests that vaginal muscle spasm is not a reliable diagnosis and as a result diverse patient populations might have been included [21–24].

B. Pain in Vaginismus

Even though vaginismus is classified as a sexual pain disorder in the DSM-IV-TR, pain is not mentioned in the diagnostic criteria. Other definitions of vaginismus such as those published by the ACOG [16], the International Association for the Study of Pain (IASP), the WHO and Lamont do mention pain in their definitions [17]. However, no description of the pain characteristics, such as location, quality, intensity and duration are provided. There is also a lack of information regarding whether the pain is a cause or consequence of the vaginal muscle spasm. While most clinical reports and research concerning vaginismus do not make

reference to the pain element in vaginismus [35], some authors believe that pain is one of its core components [10, 18]. In fact, several studies have found that a large percentage of women suffering from vaginismus experience pain withattempted vaginal penetration [18]. The pain experienced by women with vaginismus has been found to be very similar to the pain reported by women with PVD (provoked vestibulodynia) [18].

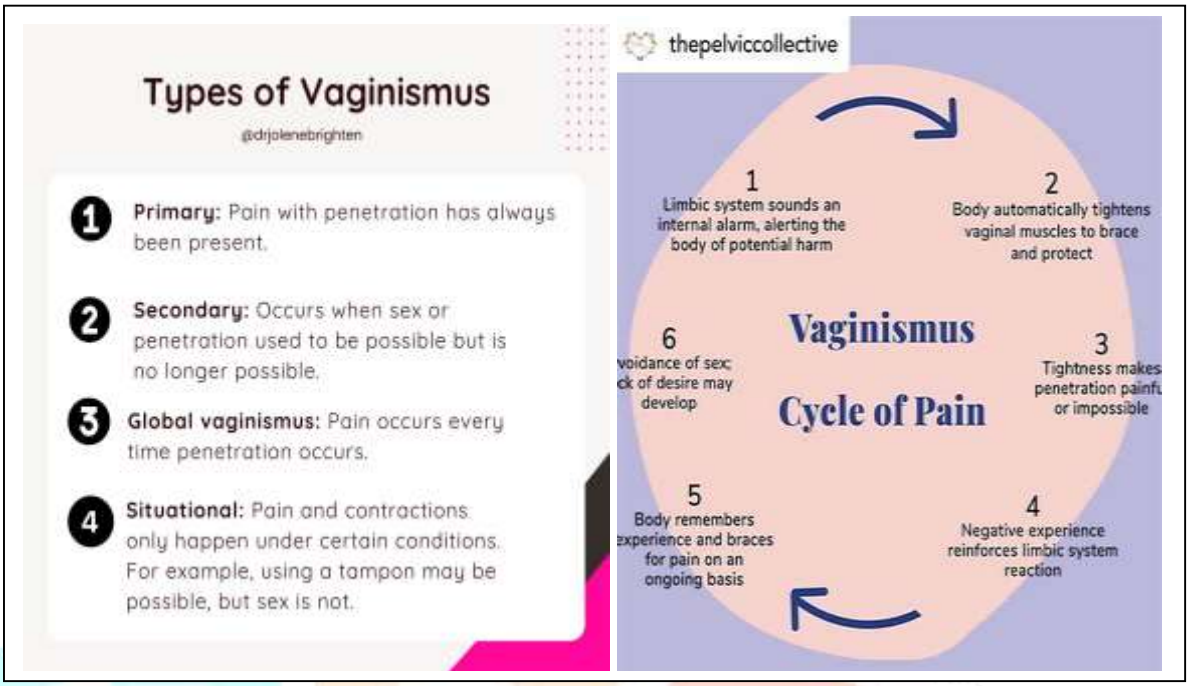

Fig. 01 vaginismus-Types and cycle of pain in female

According to the DSM-IV-TR, vaginismus can be classified as either lifelong (primary) or acquired (secondary). It has often been suggested that provoked vestibulodynia (PVD), may result in acquired vaginismus. Although lifelong and acquired vaginismus is generally consideredto differ in their etiology and response to treatment there are no empirical data validating these claims.

III. Types of vaginismus

Vaginismus is classified into two types:

- Primary vaginismus: when vaginal penetration has never been achieved
- Secondary vaginismus: when vaginal penetration was once achieved, but is no longer possible, potentially due to factors such as gynecologic surgery, trauma, or radiation

Some women develop vaginismus after menopause. When estrogen levels drop, a lack of vaginal lubrication and elasticity makes intercourse painful, stressful, or impossible. This can lead to vaginismus in some women. Dyspareunia is the medical term for painful sexual intercourse. It's often confused with vaginismus. However, dyspareunia could be due to:

- Cysts
- pelvic inflammatory disease
- Vaginal atrophy

V. Causes of vaginismus

There's not always a reason for vaginismus. The condition has been linked to:

- Past sexual abuse or trauma
- Past painful intercourse
- Emotional factors

In some cases, no direct cause can be found. To make a diagnosis, your doctor will do a physical exam and ask about your medical and sexual history. These histories can help give clues to the underlying cause of the contractions.

VI. Symptoms of vaginismus

Involuntary tightening of the vaginal muscles is the primary symptom of vaginismus, but the severity of the condition varies between women. In all cases, constriction of the vagina makes penetration difficult or impossible. If you have vaginismus, you can't manage or stop the contractions of your vaginal muscles. Vaginismus can have additional symptoms, including fear of vaginal penetration and decreased sexual desire related to penetration. Women with vaginismus often report a burning or stinging pain when anything is inserted into the vagina. If Patient have vaginismus, it doesn't mean that stop enjoying sexual activities altogether. Women who have the condition can still feel and crave sexual pleasure and have orgasms. Many sexual activities don't involve penetration, including:

- Oral sex
- Massage
- Masturbation

VII. Diagnosis of vaginismus

Diagnosis of vaginismus usually begins with describing your symptoms. Doctor will likely ask:

- When you first noticed a problem
- How often it occurs
- What seems to trigger it

Typically doctor will also ask about your sexual history, which may include questions about whether you've ever experienced sexual trauma or abuse. In general, diagnosis and treatment of vaginismus require a pelvic exam. It's common for women with vaginismus to be nervous or fearful about pelvic exams. Some women prefer not to use stirrups and to try different physical positions for the exam. When a doctor suspects vaginismus, they'll generally perform the exam as gently as they can. They may suggest that you help guide their hand or medical instruments into your vagina to make penetration easier. During the exam, your doctor will look for any sign of infection or scarring. In vaginismus, there's no physical reason for the vaginal muscles to contract. That means, if you have vaginismus, your doctor won't find another cause for your symptoms.

According to the DSM-IV-TR, there are two mutually exclusive sexual pain disorders: vaginismus and dyspareunia. Dyspareunia is defined as 'recurrent genital pain associated with sexual intercourse' [1]. PVD (provoked vestibulodynia) is reported to be the most frequent subtype of dyspareunia in premenopausal women with a prevalence of 7% in the general population. Women with PVD (provoked vestibulodynia) typically experience a severe, sharp, burning pain upon vestibular touch or attempted vaginal entry. It is diagnosed

through the cotton-swab test, which consists of the application of a cotton swab to various areas of the vulvar vestibule and surrounding tissue. Despite the fact that vaginismus and dyspareunia associated with PVD (provoked vestibulodynia) have been portrayed as two distinct clinical entities, they have many overlapping characteristics, such as the elevated vulvar pain and vaginal/pelvic muscle tone [18].

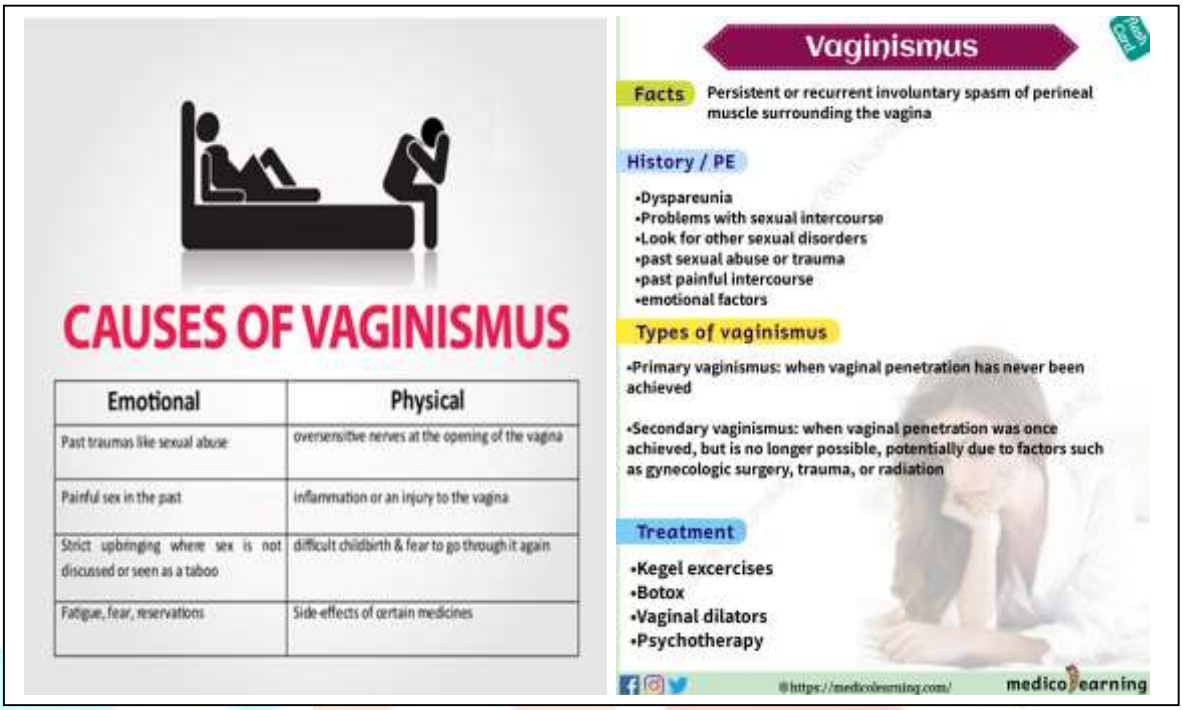

Fig. 02 vaginismus- Causes and managements

In fact, a number of studies have demonstrated that a large percentage (range between 42 and 100%) of women with vaginismus also meet the criteria for PVD [18]. This may explain, in part, why health practitioners (i.e. gynecologists, physical therapists and psychologists) show significant difficulties reliably differentiating vaginismus from PVD (provoked vestibulodynia) [18]. It should be noted, however, that PVD (provoked vestibulodynia) is characterized superficial dyspareunia. The pain of deeper dyspareunia is usually easily differentiable from that associated with vaginismus. Women with vaginismus, however, were found to display significantly higher levels of emotional distress while undergoing a gynecological examination and to avoid significantly more sexual and nonsexual vaginal penetration attempts as compared with women with PVD [18].

IX. Fear-A Responsible factor of vaginismus

Clinical reports have long suggested that fear plays an important role in vaginismus [3, 16]. Only a few studies have investigated this further. For example, fear of pain was the primary reason reported by women with vaginismus for their abstinence as well as the core motive underlying their avoidance of sexual intercourse [18]. Moreover, a large percentage (range between 74 and 88%) of women with vaginismus report significant fear of pain during coitus. Women suffering from vaginismus share a number of characteristics with individuals suffering from a 'specific phobia'. Specific phobias are defined as 'marked and persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation' [1]. Individuals with a specific phobia will experience feelings of anxiety, fear or panic upon encountering the feared object or situation. As a result, they will tend to actively avoid direct contact with the phobic stimulus.

[1] Women with vaginismus report fear of vaginal penetration and associated pain and display high levels of emotional distress during vaginal penetration situations, such as during gynecological examinations [18]. Women with vaginismus also tend to avoid situations involving vaginal penetration (i.e., gynecological examination, tampon insertion and sexual intercourse) [18].

It still remains unknown, however, whether Vaginismic women avoid these particular situations in order to diminish their anxiety level similar to individuals suffering from a specific phobia, or in response to their pain experience, or both. Nonetheless, the avoidance of vaginal penetration cannot be solely explained by the experience of pain since women with dyspareunia, who also experience severe pain during vaginal penetration, have not been shown to avoid vaginal penetration situations as much as women suffering from vaginismus [18].

Although fear appears to be a promising factor that characterizes women with vaginismus, the existing empirical studies lack appropriate control groups, standardized instruments to measure fear and appropriate statistical analysis.

X. Sexual or physical abuse

Although the experience of sexual and/or physical abuse is generally considered an important etiological factor in vaginismus, the empirical evidence is less conclusive [1]. Five out of six studies found no evidence of a higher prevalence of sexual and physical abuse. The sixth study found only weak evidence since women with vaginismus were twice as likely to report a history of childhood sexual interference (attempts at sexual abuse and sexual abuse involving touching) as compared with a 'no pain' group. Larger studies with matched control groups and well-validated definitions of abuse are required to resolve this issue.

XI. Pelvic floor dysfunction

Pelvic floor muscle dysfunction (e.g., hypertonicity and reduced muscle control) has been suggested as a predisposing factor in the development of vaginismus. Barnes et al.'s uncontrolled study argued that vaginismic women had difficulty evaluating vaginal muscle tone and as a result experienced problems distinguishing between a relaxed state and a spasm. It remains unclear, however, whether and Johnson greatly influenced the treatment of sexual dysfunction, in general, and reported that vaginismus could be easily treated with behaviorally oriented sex therapy, which included vaginal dilatation [2]. The success rates for the various treatments, ranging from vaginal dilatation to psychoanalysis to behaviorally oriented sex therapy were always reported to be excellent. Current treatments for vaginismus can be divided into four main categories: pelvic floor physiotherapy, pharmacological treatments, general psychotherapy and sex / cognitive behavioral therapy

XII. General psychotherapy

A variety of psychological treatments for vaginismus have been investigated, including marital, interactional, existential–experiential, relation- ship enhancement and hypnosis. The psychological treatments are often based on the notion that vaginismus results from marital problems, negative sexual experiences in child- hood or a lack of sexual education. The therapy can be conducted in an individual or couple format. Generally, in individual therapy, the treatment is to identify and resolve underlying psychological problems that could be causing the disorder. In couple's therapy, vaginismus is conceptualized as a problem for the couple and

the treatment tends to focus on the couple's sexual history and any other problems that may be occurring in the relationship. Although the reported success rates are high (78–100%), all except two are case studies with poorly designed and described treatment interventions as well as a lack of information on how vaginismus was diagnosed. The two reports that are not case studies lack appropriate control groups and have no follow-up data.

XIII. Sex cognitive behavioral therapy

In the 1970s, Masters and Johnson reported that vaginismus could be easily treated with behaviorally oriented sex therapy that included vaginal dilatation [3]. The first step of their treatment consists of the physical demonstration of the vaginal muscle spasm to the patient (and her partner) during a gynecological examination. The couple is then instructed to insert a series of dilators of graduated sizes at home guided by both the patient and her partner with the aim of desensitizing the patient to vaginal penetration. Masters and Johnson's treatment regimen also emphasized the importance of education regarding sexual function and the development and maintenance of vaginismus in order to relieve the psychological impact of the condition. As a result of the influence of Masters and Johnson, several studies were conducted on the efficacy of sex therapy in the treatment of vaginismus with excellent success rates reported resulting in continued utilization of this treatment that successful outcome was mediated by changes in fear of coitus and avoidance behavior. Van Lankveld's group reformulated their conceptualization of vaginismus from a sexual disorder to a vaginal penetration phobia. A recent study carried out by the same group investigated a treatment for vaginismus focusing more explicitly and systematically on the fear of coitus through the use of prolonged, therapist-aided exposure therapy.

XIV. Treatment options for vaginismus

Vaginismus is a treatable disorder. Treatment usually includes education, counseling, and exercises.

A. Sex therapy and counseling

Education typically involves learning about your anatomy and what happens during sexual arousal and intercourse. Get information about the muscles involved in vaginismus, too. This can help you understand how the parts of the body work and how your body is responding. Working with a counselor who specializes in sexual disorders may be helpful. Relaxation techniques and hypnosis may also promote relaxation and help you feel more comfortable with intercourse.

B. Vaginal dilators

Doctor or counselor may recommend learning to use vaginal dilators under the supervision of a professional. Place the cone-shaped dilators in vagina. The dilators will get progressively bigger. This helps the vaginal muscles stretch and become flexible. After completing the course of treatment with a set of dilators, Patient can try to have intercourse again.

Fig. 03 Applicator in managements of vaginismus

C. Physical therapy

A referral to a physical therapist who specializes in the pelvic floor.

D. Surgery for Vaginismus

The word surgery always sounds grave, but in the case of vaginismus, it is a very short procedure requiring no incisions, sutures, or bandages. Instead, muscle-freezing botox injections are administered directly into the vaginal muscles to prevent them from tightening. The effects generally last for 2-3 months, during which time vaginismus patients are advised to practice daily with a vaginal dilator. After vaginismus surgery and the post-surgery use of vaginal dilators, most women experience pain-free penetration and return to an enjoyable sex life.

E. Home Relaxation Techniques

Deep conscious belly breathing, in contrast to breathing into the chest, is an effective relaxation technique that can be practiced at home to treat vaginismus. This type of breathing relaxes the abdominal muscles, which are directly connected to the pelvic floor muscles. Consciously breathing in and out of the belly is also highly effective to engage the parasympathetic nervous system, which reduces the stress hormones released into the body when it is tense. Instructions for deep belly breathing are as follows:

- Lie down on your back with your hands resting gently on your belly
- Inhale and feel your belly rising against your hands
- As you exhale feel your belly (and hands) falling toward your lower spine
- Repeat at least ten times, 2-3 times per day

F. Pelvic Exercises

Another home remedy for vaginismus is the regular practice of pelvic exercises to retrain the pelvic and vaginal muscles once they have relaxed. The most effective pelvic exercises for treating vaginismus include child's pose, happy baby, deep squats, pelvic floor drops, and piriformis stretches. You can find detailed

instructions for performing each of these exercises here. Performing them daily can help women to regain control of the pelvic & vaginal muscles and prevent any unintentional tightening of the muscles during future penetration.

Conclusion

Although most research concerning vaginismus presents significant methodological limitations, certain conclusions can be made from the few well-controlled studies. First vaginismus as an easily treatable sexual dysfunction has not been supported by empirical research. Unfortunately, it is very difficult to conduct research when inherent problems exist with the definition of vaginismus. Muscle spasm is not a valid or reliable diagnostic criterion for vaginismus. Second, vulvar pain is an important characteristic of most women suffering from vaginismus and should be always evaluated. Third, although vaginismus and dyspareunia are presently considered two mutually exclusive disorders, they share many characteristics and are very difficult to differentiate using our current clinical tools. Fourth, fear and avoidance of vaginal penetration situations have been mentioned to be an integral part of vaginismus; interestingly, there are no controlled published studies examining its role.

Bibliography

1. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders. First MB (Ed.). American Psychiatric Association, Washington, DC, USA (2000).
2. Sims MJ: On vaginismus. Trans. Obstet. Soc. London 3, 356–367 (1861).
3. Masters WH, Johnson VE: Human Sexual Inadequacy. Little, Brown, Boston, USA (1970).
4. Beck JG: Vaginismus. Handbook of Sexual Dysfunctions: Assessment and Treatment. O'Donohue W, Greer JH (Eds). Allyn and Bacon Inc, Boston, USA, 381–397 (1993).
5. Reissing ED, Binik YM, Khalife S: Does vaginismus exist? A critical review of the literature. J. Nerv. Ment. Dis. 187(5), 261–274 (1999).
6. Schmidt G, Arentewicz G: Symptoms. In: The Treatment of Sexual Disorders: Concepts and Techniques of Couple Therapy. Schmidt G, Arentewicz G (Eds). Basic Books Inc., NY, USA, 123–146 (1982).
7. Simons JS, Carey MP: Prevalence of sexual dysfunctions: results from a decade of research. Arch. Sex. Behav. 30, 177–219 (2001).
8. Crowley T, Richardson D, Goldmeier D: Recommendations for the management of vaginismus: BASHH special interest group for sexual dysfunction. Int. J. STD AIDS 17, 14–18 (2006).
9. Kabakçi E, Batur S: Who benefits from cognitive behavioural therapy for vaginismus? J. Sex Marital Ther. 29, 277–88 (2003).
10. McGuire H, Hawton KKE: Interventions for vaginismus. Cochrane Database Syst. Rev. 2, CD001760 (2001).
11. Spector I, Carey M: Incidence and prevalence of the sexual dysfunctions: a critical review of the empirical literature. Arch. Sex. Behav. 19, 389–396 (1990).
12. Ogden J, Ward E: Help-seeking behaviour in sufferers of vaginismus. Sex Marital Ther. 10(1), 23–30 (1995). Shifren JL, Johannes CB, Monz BU,

13. Russo PA, Bennett L, Rosen R: Help-seeking behavior of women with self-reported distressing sexual problems. J. Womens Health 18 (4), 461–468 (2009).

14. Trotula of Salerno: The Diseases of Women. Mason-Hohl Trans. W (Ed.). The Ward Ritchie Press, Los Angeles, CA, USA (1940).

15. Huguier PC: Dissertation sur quelques points d'anatomie, de physiologie et de pathologie. Medical thesis, Paris, France (1834).

16. American College of Obstetricians and Gynecologists: Sexual dysfunction. Int. J. Gynaecol. Obstet. 51, 265–277 (1995).

17. WHO: Manual of the International Statistical Classification of Diseases, Injuries, and Causes of DEATH (10th Edition). Geneva, Switzerland (1992).

18. Reissing ED, Binik YM, Khalifé S, Cohen D, Amsel R: Vaginal spasm, pain, and behavior: an empirical investigation of the diagnosis of vaginismus. Arch. Sex. Beh. 33, 5–17 (2004).

19. Reissing ED, Brown C, Lord MJ, Binik YM, Khalife S: Pelvic floor muscle functioning in women with vulvar vestibulitis syndrome.J. Psychosom. Obstet. Gynaecol. 26, 107–113 (2005).

20. Shafik A, El-Sibai O: Study of the pelvic floor muscles in vaginismus: a concept of pathogenesis. Eur. J. Obstet. Gynecol. Reprod. Biol. 105, 67–70 (2002).

21. Frasson E, Grazziotin A, Priori A et al.: Central nervous system abnormalities in vaginismus. Clin. Neurophysiol. 120, 117–122 (2009).

22. Van der Velde J, Everaerd W: The relationship between involuntary pelvic floor muscle activity, muscle awareness and experienced threat in women with and without vaginismus. Behav. Res. Ther. 39, 395–408 (2001).

23. Van der Velde J, Laan E, Everaerd W: Vaginismus, a component of a general defensive reaction. An investigation of pelvic floor muscle activity during exposure to emotion-inducing film excerpts in women with and without vaginismus. Int. Urogynecol. J. Pelvic Floor Dysfunct. 12, 328–331 (2001).

24. Engman M, Lindehammar H, Wijma B: Surface electromyography diagnostics in women with partial vaginismus with or without vulvar vestibulitis and in asymptomatic women. J. Psychosom. Obstet. Gynaecol. 25, 281–294 (2004).

25. Abrahams AM: Treatment of vaginismus. NZ. Med. J. 86(599), 445 (1977).

26. Van Lankveld JJ, Brewaeys AM,Ter Kuile MM, Weijenborg PT: Difficulties in the differential diagnosis of vaginismus, dyspareunia and mixed sexual pain disorder.J. Psychosom. Obstet. Gynaecol. 16, 201–209 (1995).

27. Fertel NS: Vaginismus: a review. J. Sex Marital Ther. 2, 113–22 (1977).

28. Van de Wiel HB: Treatment of vaginismus:a review of concept and treatment modalities.J. Psychosom. Obstet. Gynecol. 11, 1–18 (1990).

29. Poinsard PJ: Psychophysiologic disorders of the vulvo-vaginal tract. Psychosom. 8, 338–342 (1968).