Austin Journal of Women's Health

Open Access

Austin Publishing Group

Case Report

Interdisciplinary Approach for Treatment of Vaginismus

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Received: November 28, 2016; **Accepted:** February 22, 2017; **Published:** February 24, 2017

Abstract

The study describes a multi professional treatment for a case of vaginismus performed at the Sexuality Outpatient Clinic of a Brazilian state. The treatment was performed by a team of physicians, physiotherapists and psychologists for five months, consisting of outpatient medical monitoring, weekly physical therapy with seven 40-minute sessions and 12 biweekly psychological therapy sessions with duration of one hour each. The sessions were held separately, however, with joint interdisciplinary discussions to define the therapeutic plan. In this study a multiprofessional intervention plan was structured, focused on reducing anxiety associated with sexual contact and eliminating muscle contraction, with the aim of resolving vaginismus of patient. Considering the multiple factors involved in human sexuality, this report suggests possible contributions of the interdisciplinary practice for promoting integrality in care of sexual health, as well as indicating interdisciplinarity as a resource for approaching sexual experience, going beyond pathology and promoting health so that sexuality is experienced more fully and satisfactorily.

Keywords: Vaginismus; Multiprofessional team; Sexuality; Interdisciplinarity; Cognitive behavioral therapy

Case Presentation

Vaginismus is a condition characterized by contraction of perivaginal muscles when attempting vaginal penetration with penis, finger, tampon or speculum; this spasm can occur due to the anticipation of introduction of a penis into the vagina [1]. Vaginismus may entail important consequences to sexual function in general, such as decreased sexual interest, avoidance of sexual interaction and reduction of involvement and pleasure, stress factors that may interfere in interpersonal relations with impairments in affective interaction [2]. It is often underdiagnosed and not appropriately treated [3]. Considering the biopsychosocial and cultural complexity of sexual function [4] and the multiplicity of etiology involved in vaginismus, the clinical evaluation of this condition, therapeutic monitoring and treatment require the involvement of different specialities for the construction of a multiprofessional approach model.

From these assumptions, a multiprofessional intervention plan was structured in this study, focused on reduction of anxiety associated with sexual contact and elimination of involuntary muscle contraction of a Brazilian patient with vaginismus. The aim was to enable an active attitude towards the sexual response itself for an optimization of the subjective quality related to sexuality.

The clinical case definition was carried out through an initial medical and psychological evaluation and the Visual Analogue Scale (VAS) was applied in the beginning and at the end of intervention to evaluate pain intensity [5]. Treatment consisted of multi professional outpatient monitoring and weekly physiotherapy monitoring with seven 40-minute sessions. There was also biweekly psychological monitoring, with 12 sessions of one hour using cognitive-behavioral techniques, such as sensory focus, relaxation training, and sex therapy techniques, such as education and sexual guidance [6-9].

Patient characterization

A 32 years old, single, graduated, living with parents. P. was referred to the Human Sexuality Outpatient Clinic due to the impossibility of performing a gynecological examination and difficulties with sexual intercourse, which, according to patient, had negative repercussions on her quality of life. P. reported impossibility of penile penetration since the start of sexual activity at age of 22 years. The first experience with penetration was described as anxiogenic, involving pain and bleeding. In subsequent experiments with other partners, consecutive penetration attempts occurred without success, with muscular contractions and anticipatory thoughts of pain. Before intervention, sexual relationship was characterized as a significantly aversive experience, with feelings of violation and disrespect.

During the performance of gynecological exam, P. also presented anticipation of pain and discomfort that the examination could produce. She reported a feeling of invasion of her body with consequent contraction of levator ani muscles and thigh adductor muscles, which impeded the entry of the speculum, preventing the gynecological evaluation.

Interdisciplinary evaluation

Gynecologist performed a first evaluation to identify the initial complaint, with a survey of clinical history and previous sexual history, to identify possible organic and psychosocial causes related to complaint. From the outlining of initial complaint, a multiprofessional evaluation was carried out by team to define the therapeutic plan. The physical evaluation by physiotherapist showed bilateral tension and shortening of the thigh adductor muscles. P. said that as a child she felt fatigue in the thigh muscles and, for this, she was advised to take ballet classes.

In the presence of palpation of vaginal opening, P. scored 08 according to the VAS. During the evaluation, P. assumed a defensive

Citation: Ramos LCB, Lara LAS, Pandochi HAS, Gorayeb R, Romao GS and Romao APMS. Interdisciplinary Approach for Treatment of Vaginismus. Austin J Womens Health. 2017; 4(1): 1023.

posture, with adduction of thigh, demonstrating great anxiety. At this moment, P. did not allow access to muscles of pelvic floor. This evaluation was possible in the second physiotherapeutic consultation, producing the following findings: superficial muscles of perineum (superficial transverse and spongy urethra) normotonic; levator ani muscles presented a strong spasm with hyperactivity after passive stretching. P. had a good perception of the contraction of these muscles after verbal command, however, relaxation was absent. She presented no trigger points, scar tissue or adhesions.

At psychological evaluation, possible risk factors were observed: repressive education with punishments for childhood sexual discovery experiences, rigidity of parental practices, previous traumatic sexual relations, maternal model, deficient information about sexual response and sexuality in general, including myths/beliefs and values that conferred a promiscuous connotation on the sexual act [4,10-11]. Faced with repeated penetration impossibilities, feelings of powerlessness and frustration were identified, with repercussions on the self-esteem and self-concept, which, added to the painful sensation involved, generated avoidance behaviors related to sexual activity with consequences in affective interactions.

Intervention

Intervention involved therapeutic resources such as: a) health education, with information about the anatomy of sexual organs, sexual response and sexuality in general, b) information and guidance on practice of erotic self-stimulation and sensory focusing to expand body consciousness and awareness of sensations, c) relaxation training for control of physical sensations triggered by anxiety and stress, d) rehabilitation of pelvic floor muscles, e) cognitive-behavioral techniques to produce changes in dysfunctional thinking patterns associated with negative emotions, and f) erotic reading for stimulation of sexual fantasy.

Regarding sex education, P. demonstrated having knowledge about genital anatomy, however, presented a deficient repertoire of information related to sexual functioning, with mystification of sexuality. Accordingly, gynecologist offered explanations about function of the vagina as an organ capable of holding a penis and allowing the passage of a fetal head with 10 cm diameter, and worked with the demystification of notions that consider sexuality as restricted to intercourse, emphasizing the need for affective interaction with partner in order to promote satisfaction, relaxation and involvement. The complexity and the biopsychosocial comprehension of human sexual experience were discussed. Additionally, an active attitude of patient towards gaining body knowledge was stimulated.

For stimulation of body awareness, muscle exercises were proposed [12]. A hard plastic model of the female pelvis and a figure illustrating the layout of pelvic floor muscles were used, in order to facilitate perception of the contraction and relaxation of vaginal muscles with emphasis on voluntary relaxation for future control of penile penetration. P. was encouraged to identify and touch vaginal region as home exercises, reporting team about her perceptions and difficulties during the performance of exercises. After intervention, P. came to consultation referring many difficulties and a lot of pain when introducing the finger into the vagina, as well as difficulties in obtaining muscle relaxation, signaling frustration and anxiety.

Based on these data, a psycho-educational intervention was initiated by a psychologist, demonstrating the relationship between cognitions, feelings and physiological changes resulting from anxiety. Self-monitoring was used as a technical resource for identification of variables associated with the complaint [13], which consisted of systematically recording behaviors, cognitions, and feelings related to sexuality.

Cognitive schemes were observed that considered the sexual experience as a practice strictly directed toward satisfaction of the partner. Standards of moral restraint were identified faced with contact with her own sexual organ including an attitude of aversion to self-stimulation. This difficulty interfered with performance of the proposed muscle exercises, restricting patient's adherence to the program.

Psychologist intervened with an analysis of logical inconsistencies and verification of alternative interpretation of sexuality. As a strategy to eliminate clinical signs of anxiety and stress, P. was guided to perform diaphragmatic breathing exercises. P. resumed exercises, gradually managing to accomplish the introduction of the finger as directed and allowing the physical therapist to perform a functional evaluation of pelvic floor muscles, with initiation of rehabilitation of PFMs with intravaginal massage, described by Thiele in 1937 and performed as proposed by Oyama [14].

P. referred to initial discomfort when performing the massage, however, the levator ani muscles presented a moderate spasm and responded with hyperactivity during the passive stretching. The adductor muscles of the hip remained shortened, however, did not cause more discomfort, according to patient.

Throughout treatment, P. presented strategies for dealing with signs of stress and anxiety, with elimination of painful sensations during digit insertion by the physiotherapist and during the massage. She presented adequate muscle tone, good muscle response for relaxation, without hyperactivity after the passive stretching. Ease in performing home exercises was observed and, considering clinical advances, a gynecological examination was proposed by the physician. P. managed to complete the entire examination without any complaints of pain or discomfort.

P. received positioning guidance for when starting sexual life, since she had no partner at that time, using positions in which the control of penetration depended on her, using knowledge previously acquired to promote muscle relaxation and manage emotions that could interfere negatively during intercourse. By virtue of having no partner, P. received a hard plastic vaginal dilator and hygiene instructions, aiming to maintain proper muscle tone, discontinuing its use when sexual activity was resumed.

In a subsequent experience, P. reported success with penetration, having used cognitive and relaxation strategies to facilitate penetration and enhance sexual experience. With this step achieved, the treatment plan was directed toward the development of autonomy, rediscovering sensations and pleasure, stimulating proximity and empowerment of body. As a facilitating strategy to approach body, activity facing a mirror was suggested to identify positive and negative aspects related to body perception. In addition, activity during bathing [15] was proposed, in which the bath, associated with essences, tones and

colors, was used as a resource for focusing attention on the body and stimulating perception of bodily sensations.

After this, P. reported a previously unknown perception of sensations of bodily pleasure. At that moment, the treatment involved an intense process of expressing feelings, which highlighted discovery of body and feelings associated. Body recognition and self-acceptance were observed, involving the perception of body as something with the possibility of providing pleasure. Regarding pleasure, initially the attribution of feelings of guilt was observed, indicated through self-reports performed during the erotic reading activity, a strategy employed to promote the enhancement of the sexual desire.

Results

Throughout treatment, important therapeutic results were observed, with regard to the expansion of the strategies for coping with anxiety, reducing the discomfort and pain associated with the exercises and the sexual contact. After treatment, when performing invasive examinations and penetration, P. presented expansion of perception of self-efficacy with positive effects on self-concept and self-esteem.

Expansion of perception of sexuality as transcending coital and biological limits was observed, which added to the perception of the erotic experience with legitimization of body and pleasure.

At the end of physiotherapy intervention, it was observed that P. no longer presented defensive behavior when assuming the gynecological position and reported pain as 0 according to the VAS during the digit insertion and massage. Regarding the tone of levator ani muscles, these were found to be normotonic and an improvement in proprioception was evidenced, i.e., the voluntary control of these muscles in terms of ability of contraction and relaxation, which is essential to facilitate penetration of penis into the vagina.

Discussion and Conclusion

This study refers to a multiprofessional intervention in sexuality seeking, beyond focusing on the dysfunction, to promote health so that sexuality can be experienced in a fuller and more satisfying way. The challenge of the study refers to the monitoring of a participant that was single, with no steady partner, an aspect little explored in the literature, which mostly focuses on addressing couples. The current redimensioning of the concept of affective interaction has important ramifications in the area of sexuality, which promoted, in this study, a therapeutic process aimed at improving the individual sexual response as a strategy to improve quality of shared erotic experience.

Considering the biopsychosocial dimension involved in sexual health, interdisciplinarity is highlighted as a fundamental resource for the complexity involved in human sexuality to be contemplated. The dialogue between different specialties for construction of a multiprofessional therapeutic process enriches the care provided, contributing to the effectiveness of care integrality.

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Austin J Womens Health - Volume 4 Issue 1 - 2017
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