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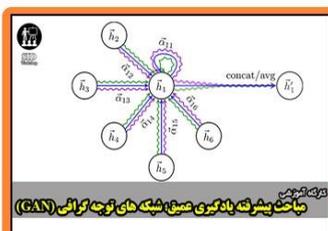


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کارگاه های آموزشی مرکز اطلاعات علمی جهاد دانشگاهی



کارگاه آنلاین آشنایی با پایگاه های اطلاعات علمی بین المللی و ترند های جستجو



مباحث پیشرفته یادگیری عمیق؛ شبکه های توجه گرافی (Graph Attention Networks)



کارگاه آنلاین مقاله نویسی IEEE و ISI ویژه فنی و مهندسی

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.

Iran J Med Sci 2003; 28(2):

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

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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

exclusively due to the direct physiological effect of a general medical condition.² Some researchers believe that vaginismus with its negative outcomes is a medical emergency and should be treated as such.^{3,4} Vaginismus could lead to marital disharmony, disruption of marital relationship, faulty sexual intercourse, guilt feeling, depression and secondary impotence in male partner. Traumatic sexual experiences, religious orthodoxy, dyspareunia and wrong sexual information are known to play a crucial role in the etiology of this disorder.^{5,6,7} Clark, et al believe that in the majority of cases, there is no clear reason why such spasms are so readily elicited. It remains a possibility that some women are constitutionally prone to such perivaginal spasm.⁸ During the last three decades with introduction of cognitive-behavioral models for desensitization of phobic disorders several psychiatric approaches have replaced surgical interventions in vaginismus. In most of these therapeutic modalities in addition to relaxation techniques, hypnosis instruments such as dilators or vaginal molds are being used.⁹⁻¹¹ The aim of this study was to determine the efficacy of self-finger approach instead of dilators in management of vaginismus.

Material and Method

Seventy patients with the diagnosis of primary vaginismus according to DSM-IV criteria¹² 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 together. All the patients were examined by gynecologists and had no major physical causes for vaginismus. Five patients had undergone hymenectomy, with no improvement of vaginismus. Once the couple agreed on the method of therapy then they were referred to the second author (female clinical psychologist with special training in cognitive-behavior treatment of vaginismus). In the second visit, a general idea about the method of therapy and normal sexual intercourse was explained to the couple emphasizing that management 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 particularly anxiety and phobic disorders, causes, development, and therapy of vaginismus were discussed. 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. Duration 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 psychiatric disorders, 2 (2.85%) had depression, 1 (1.42%) schizophrenia, 13 (18.57%) anxiety disorder, 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 responders.

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 anxiety disorder (5 patients), and major depressive disorder (2 patients), were the three most common psychiatric co-morbidities, which were treated before 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.¹³ The success rate of using graded dilators, as reported by Masters and Johnson is 98.8% hence the highest rate among sexual disorders compared to combined totals of sexual dysfunctions which is 81.8%.¹⁴ Despite the fact that Masters and Johnson 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 Beck¹⁵, 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 al¹⁶, 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.

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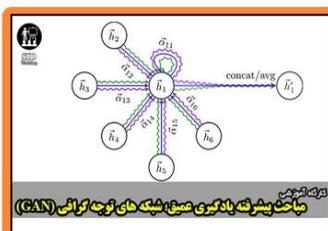


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