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USE OF COGNITIVE HYPNOTHERAPY AND COUPLES THERAPY FOR FEMALE PATIENTS WITH PSYCHOGENIC VAGINISMUS

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ABSTRACT

This clinical case study illustrates the two month long use of cognitive hypnotherapy treatment (CHT) and couples therapy (CT) for female patients suffering from psychogenic secondary vaginismus (PSV). CHT with CT was focused on patient and couples training to identify and modify maladaptive cognitions, imaginal desensitization with relaxation to learn effective vaginal sphincter muscle control, and positive self-hypnosis. Thirty-one female patients were divided into an 'A group' of women (19 patients) who after having received two months of CHT and CT treatment reported improved sexual well-being and sexual relationship satisfaction in comparison with 'B group' patients (12 patients), who received only CHT (without CT). The effectiveness of CHT was monitored by patient examination, subjective pain-test manifestation, and a clinical examination using stress monitoring.

Key words: vaginismus, mental reaction, cognitive hypnotherapy, couples therapy, desensitization, sexual well-being

THEORETICAL AND RESEARCH BASIS

During the last two years 20% of all female patients having sexual pain disorders in our practice were patients with psychogenic secondary vaginismus (PSV). Vaginismus is a condition or reflex response where the muscles around the entrance to the vagina contract involuntarily: the vagina is unable to relax, making sexual intercourse or medical examination painful or even impossible (ICD-10, 1992). Secondary vaginismus is psychogenically triggered by fear and/or disgust; it is a mental reaction to psychotraumatic events and for these women posttraumatic stress develops (Plaut et al., 2004).

Modern cognitive science research carried out during the last two decades shows the important role played by cognitive distraction, automatic thoughts and emotions, negative cognitive schemas of sexual dysfunction, negative self-body image, and depressed mood in subjects with dysfunctional beliefs who interpret unsuccessful events as a sign of failure or personal incompetence (Nobre, 2007). Cognitive hypnotherapy allows cognitive and emotional regression and cognitive and emotional progression to occur in parallel. The patient may return to earlier years and imagine the events and experiences of that time, including memories of a traumatic experience repressed in the unconscious mind, or to imagine events that have not yet happened (Kirsch, 1993).

In Latvia cognitive hypnotherapy treatment (CHT) and couples therapy (CT) are used in the treatment of female patients with PSV—a framework using several different scenarios: a woman meets herself in psychotraumatic situations and in positive situations without having the vaginismus reflex and depressed mood. CHT consists of several phases: an introductory phase, a trance phase, a hypnodrama phase, and an exit-from-trance phase. Before entering CHT, hypnotic susceptibility is recorded and pain, depression, or stress scales are applied.

In this therapeutic work cognitive and emotional processes from the patient's consciousness and unconsciousness are involved and modelled and a personality paradigm is developed. In cases of PSV the CT allows the therapist to improve the husband–wife relationship: both members of the couple are able to find a positive solution to problem situations (Roja, 2007).

CASE PRESENTATION

This case illustrates the use of cognitive hypnotherapy as an adjunct to therapy in the treatment of vaginismus. Our aim was to investigate the benefits of CHT and CT in a two month treatment course for female patients with PSV.

PRESENTING COMPLAINT AND HISTORY

Thirty-one female patients, aged between 24 to 37 years (M=30.5) had suffered from PSV for three to five years with psychogenically triggered fear. The women complained about involuntary vaginal contractions with pain before intercourse and associated with sexual intercourse, a phobic attitude towards penetration, anxiety, negative self-body image, and their partners were often very frustrated. PSV was diagnosed only after a complete sexual examination. Twelve females had experienced sexual abuse in their childhood, in seven females sexual dysfunction occurred after sexual harassment and violence at the workplace, and in 12 females vaginismus was caused by negative and painful sexual experiences. Nineteen females expressed fear of being abandoned by their partner, and 11 couples showed common anxiety.

ASSESSMENT

Nineteen females were willing to receive CHT and CT and were included in group A—they received a two month CHT course, involving a 60 minute session twice a week combined with CT and a 60 minute session once a week. Twelve females wished to receive only CHT and they were included in group B—they received two months of CHT in a 60 minute session twice a week.

Before starting the CHT course, assessment of hypnotic susceptibility was performed for each individual patient using the Clarke and Jackson test (1983). This test enables the therapist to determine the kinds of suggestion and imagery to which the patient is responsive. Intensity of the pain and anxiety were measured using patient self-monitoring with a Visual Analogue Scale (Robinson et al., 2001) at the beginning and at the conclusion of the therapy course with valuation from 0–10 points (0 – no pain, no anxiety; 10 – maximum negative bodily sensations and neurotic disorders).

Stress monitoring during the CHT sessions was carried out using the 'Biofeedback' GSR2 device-sensor (Boucsein, 1992) at the beginning and at the conclusion of the therapy course. Physiological changes of the body in stress situations were measured by electrodermal changes in sweat glands under sympathetic autonomic control (Forbes & Pekala, 1993). Patients were asked to monitor their feelings in a pain diary. Treatment efficacy was re-evaluated in a follow-up visit after five months. In the statistical processing of the stress monitoring results the reliability of the data were assessed using the Pearson Correlation Coefficient (Landis, 1977).

COURSE OF TREATMENT AND ASSESSMENT OF PROGRESS

During the CHT session different scenarios were induced—first positive, then negative, until during subsequent sessions a simultaneous experience of positive, negative, and desirable scenarios was possible. The patient tries on different roles to solve the problem and gives signals to the hypnotherapist when she visualizes a definite event or emotion. The hypnotherapist reacts verbally to this signal and approves it verbally (ratification).

The patient is introduced to scenario-bound developments according to her goals and problems. The patient imagines (on an imaginary screen or stage) experiences or events during different periods of her life. She can also experience developments that have yet to take place but which could happen through age regression and progression. The patient can meet the event to observe it, to change, to ignore it, and so on. The patient's unrealized goals and dreams can be realized and she can then construct positive acceptable scenarios by herself.

The human genitalia are innervated by the autonomic nervous system (ANS): very important is the sympathetic solar plexus and the sympathetic celiac plexus from the pectoral and abdominal part of the spinal cord. Ancient anatomists used to call the solar plexus 'the abdominal brain'. It is possible to work with this idea successfully during cognitive hypnotherapy sessions, creating a feeling of warmth in the pubis, the lower part of the abdomen, and in this way accustoming the patient to relaxing her muscles like 'the bud, which dehisces in the warm rays of the sun'.

During CHT some women experience nonstandard, humorous, and surprising solutions to their old, distressing problems. The patient in CHT may act simultaneously as a director, actor, spectator, and assessor. In this way, the patient can create a positive and effective self-image.

During the CHT and CT sessions women with vaginismus, a barren marriage due to the condition, pain and fear, may experience the joy of painless sexual intercourse, the possibility of conceiving, a healthy pregnancy, and being delivered of a child. Time distortion has been helpful for women who have periods in their life when the pain flares up. This utilizes relaxation until a gradual desensitization of the psychotraumatic event occurs.

During CT sessions each couple was focused on the present with an eye to the future. For two partners it was painful to recognize the depth of an adulterous relationship the other person was having: during CHT sessions these couples were taught to look for new emotional and cognitive behavioural alternatives. For one couple, the woman had an inwardly contradictory attitude towards sex; for another couple, the woman had a psychotrauma—a rape in her anamnesis. During three sessions we worked with such couples using music which created an erotic transference between the lovers.

Sexual reactivity is influenced by depression, low self-esteem, sexual illiteracy, and poor contact between partners. Spasms of the vagina may also represent an unconscious wish to keep the male partner back from coitus or it may represent a neurotic fear of sexuality. In one case at the beginning of the CT course the husband considered himself to be guilty for the 'coldness' of his wife; in another the husband suspected his wife of having a lover and that she was doing this on purpose. However, in both cases husband and wife loved each other and wanted to have a child. During the hypnotherapeutic session each member of the couple learned that sex is not only about vaginal intercourse, but is also a creative experience between affectionate partners. Hypnotherapy helped them: both couples now have children.

An unpleasant sexual experience may also be caused by psychosocial factors. In one case a mother punished her daughter because she had caught her while stimulating the clitoris, and said: 'Shame on you!' In another case a stepfather was having sexual relationships with young girls or teenagers. This led to the jealous mother treating her daughter as a rival. One woman was afraid of pregnancy, venereal disease, and failure, and was dispirited because of feelings of inferiority. Through age regression she discovered that in her childhood she had had a domineering mother, and for the next two sessions this woman experienced a 'different' kind of mother. The mother was affectionate and the daughter could trust her and tell her about her intimate feelings. During CHT this woman, who subconsciously wanted to have children, experienced in her imagination sexual intimacy with her husband and the birth of a son. After just two sessions the couple's relationship had changed. The woman had experienced physiological and psychological orgasm—she wrote in her diary that 'it is the feeling of delight, the feeling of the nirvana'.

During hypnotherapeutic suggestion we emphasised that 'it is the woman's own wish to end intimacy with penetration, that she won't resist but will contribute to this'. We encouraged the woman to imagine the penis, to imagine how she spreads her legs so that the orifice of the vagina automatically widens. The mental images during CHT sessions included not only visual images, but also images of the other senses. One woman, a sexual assault victim, during her hypnotherapy session was a beautiful, sweet-scented rose blossom, to which a butterfly flies and immerses its proboscis in the middle of the blossom to suck honey-dew. During this metaphorical change the patient got rid of her 'human fear' of sexual intercourse; during the session she was a queen rose who was not afraid of the butterfly, but on the contrary tried to attract it. The proboscis of the butterfly symbolized the penis; the butterfly enjoyed the honey-dew of the rose; and both partners had a sweet experience. Another metaphor was used where the woman was the sea in which swims a swan—both enjoy the contact. In the next session the patient became a joyful dog-girl, having sex with a joyful dog-boy. A hypnotherapist, like a poet, has to tailor special scenarios, without speaking directly of the penis and sex.

During suggestion the level of the libido always goes up, tense muscles maximally relax, and the woman has an orgasm and experiences a sexual intercourse of full value with their beloved partner. During CHT and CT an intense orgasm and a strong psycho-erotic transference developed for one A group female. The work with this woman helped the hypnotherapist to overcome counter-transference. During the session one female had a psychotic manifestation: it was a dramatic reaction of the woman's mind–body vital activity. In this case a psychiatric consultation was necessary. Due to the CHT sessions on

desensitisation and cognitive restructuring she freed herself with the influence of new sensory experiences and her 'ego' and self-image were strengthened.

In another case the couple did not want to continue therapy: the woman had faced aggressive behaviour from her partner while deflowering. Music during the CHT and CT sessions helped to affect a cure. At the conclusion of the therapy course this woman gave way to her sexual fantasies more fearlessly.

During hypnotherapy sessions 17 group A patients and 4 group B patients learned self-hypnosis. The women noted in their pain diaries that depressive music during the first hypnotherapeutic sessions helped them to recall psychotraumatic memories and events. Techniques of behavioural change were used together with the development of emotional self-expression and self-control.

Seventeen (90%) of A group females and one (8%) B group female disclosed after two months of therapy that now they experienced a good and pleasurable sexual life without pain, anxiety, and disengagement thoughts.

Figure 1 shows the changes of sound frequency, corresponding with electrical resistance of the skin on the patient's fingers, characterizing the stress level of one A group patient during different phases of the psychotraumatic event CHT session, with an opportunity for the woman to develop her personal, desirable scenarios at the conclusion of the session.

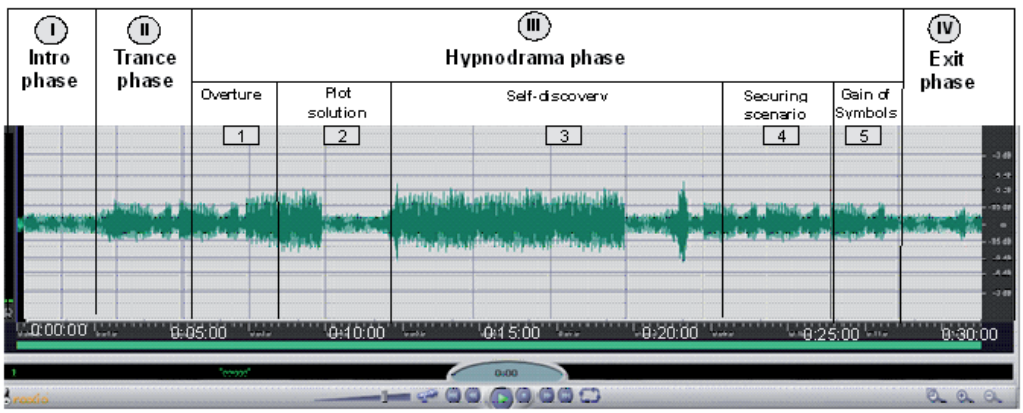

Figure 1: Stress level monitoring of an A group female during CHT session phases with psychotraumatic event and opportunity for the patient to develop personal, desirable scenarios at the conclusion of the session.

Stress level monitoring data for 23 A and B group patients with PSV showed a connection between the increase of stress levels and negative emotional experiences at the beginning of the CHT course and a corresponding decrease at the conclusion of the CHT course.

Using the Visual Analogue Scale the following data were acquired: at the beginning of therapy both A and B group patients used maximum points (10) of evaluation. At the end of CHT there were evaluation scores of 0 points for 18 A group (94.7%) and 6 B group females (54.5%). Patients noted in their pain diaries that relaxation training helped them to identify their own bodily sensations associated with tension, and to change obsessive behaviour. The summary of the results using the hypnotic susceptibility test, the pain diary, and the Visual Analogue Scale is shown in Table 1.

Table 1. Hypnotic susceptibility test, pain diary and visual analogue scale during CHT

METHODS	AT THE BEGINNING OF THE TREATMENT COURSE	AT THE CONCLUSION OF THE TREATMENT COURSE
1. Clark and Jackson Hypnotic Susceptibility Test	A and B group: in 17 females, good creative imagination; in 8 females, good dissociative capacity and cognitive flexibility.	
2. Pain Diary	A and B group: women suffered from involuntary vaginal contractions with pain before intercourse and associated with sexual intercourse, phobic attitude towards penetration, anxiety, marital distress.	17 A group females and 4 B group females noted in their diaries that when self-hypnosis was acquired in CHT and CT, they obtained mental and physical relaxation. 17 A group females and 1 B group female reported successful intercourse and improved body image. Music during CHT and CT helped find a way out of the sexual impasse.
3. Visual Analogue Scale (VAS)	A and B group females: 10–9 points	A group: 18 females – 0 points, 1 female – 1 point. B group: 6 females – 0 points, 1 female – 3 points, 5 females – 7 points.

FOLLOW-UP

In a follow-up visit after five months 15 A group patients and 3 B group patients reported improvement in their psycho-emotional and somatic state, as well as improvement in their quality of life. They had regularly practised self-hypnosis. After her treatment one A group patient even wrote a book about women suffering from vaginismus.

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