Women's Sexual Pain and Its Management

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ABSTRACT

Introduction. Approximately 15% of women have chronic dyspareunia that is poorly understood, infrequently cured, often highly problematic, and distressing. Chronic dyspareunia is an urgent health issue.

Aim. To provide recommendations/guidelines concerning state-of-the-art knowledge for the assessment and management of women's sexual pain disorders.

Methods. An international consultation, in collaboration with the major sexual medicine associations, assembled over 200 multidisciplinary experts from 60 countries into 17 committees. One six-member committee focused on women's sexual pain disorders, developing recommendations over a 2-year period.

Main Outcome Measure. Expert opinion was based on grading of evidence-based medical literature, widespread internal committee discussion, public presentation, and debate.

Results. There is increasing evidence for the role of neuropathic pain mechanisms in the pathophysiology of sexual pain disorders. Empirical literature has demonstrated the comorbid presence of clinical psychopathology. With regard to the pathophysiologic role of the pelvic floor and sexual pain disorders, studies reveal that (i) differentiation between vaginismus and dyspareunia using clinical tools is difficult; (ii) vaginal spasms have not been identified; (iii) physical therapists can differentiate vaginismic women from matched controls based on muscle tone/strength differences; (iv) the traditional treatment of vaginismus with vaginal "dilatation" plus psycho-education, desensitization, and so forth is not evidence-based; (v) pelvic floor muscle tone/strength measures for women suffering from vulvar vestibulitis syndrome are intermediate between those of women with vaginismus and no-pain controls; and (vi) the pelvic floor musculature is indirectly innervated by the limbic system and highly reactive to emotional stimuli and states. Pelvic floor therapies for dyspareunia may be effective.

Conclusion. Recommendations include (i) revising the definitions of vaginismus and dyspareunia; (ii) integration of treatment approaches; (iii) validation of nonspecific treatment effects; (iv) controlled studies to test interventions; and (v) sexuality education to help prevent sexual pain.

Key Words. Female Sexual Pain Disorders; Vulvar Vestibulitis Syndrome; Dyspareunia; Vaginismus

Introduction

Treatment for sexual pain disorders in the healing professions has always been a tricky matter. This is well illustrated by a comment made by Robert Latou Dickinson in 1933:

> The surgeon thinks of difficult coitus in terms of a knife passed through muscles in spasm; the psychiatrist thinks of dyspareunia as a mental knot to be disentangled by analysis; the gynecologist who is weary of patching—poor and late patching—begins to think in terms of prevention through routine premarital examination and instruction [1].

This article will review pathophysiology, psychopathology, treatments, and prognostic factors in sexual pain disorders, but interestingly there are no studies on prevention. Everyone who regularly encounters the complaint of dyspareunia knows that women are inclined to continue with coitus, if necessary, with their teeth tightly clenched. The repercussions on the woman—sexually and emotionally—plus the distancing and misunderstanding between the partners can make the treatment of sexual pain disorders difficult and frustrating for patients and clinicians.

Characteristics of Women's Sexual Pain at Variance with the ICD-10 and the DSM-IV-TR

This review highlights the clinical presentation of two categories of sexual pain disorders, dyspareunia and vaginismus. The ICD-10 and the DSM-IV-TR view sexual dysfunction as involving either psychological or somatic components or a combination of both, suggesting these are separate entities and that etiologies are usually known [2,3]. However, sexual function is a supreme example of the mandatory blending of mind and body. Moreover, the precise etiology of dysfunction is often unclear. Frequently, sexual pain is or becomes associated with lack of subjective arousal (and orgasm) and lack of desire or interest. Reduced genital congestion is frequently reported but is as yet not scientifically documented [4]. Whereas a lack of sexual arousal is one certain etiologic factor, other factors are currently extremely unclear. Therefore, we do not recommend the specification of a biologic or psychological etiology.

Current diagnostic systems also rely heavily on the sexual response cycle. However, the categories of pain disorders, vaginismus and dyspareunia, are not part of the sexual response cycle. Also, the assumption that dyspareunia and vaginismus are distinct types of sexual pain disorders has recently been challenged [5–8].

Recommended Definitions of Women's Sexual Pain

Despite the foregoing, in this review the independent existence of dyspareunia, vulvar vestibulitis syndrome (VVS), and vaginismus is *a priori* accepted to allow the use of the existent scientific literature based on this nosological distinction. For the present review on the etiology of sexual pain disorders, dyspareunia is defined as recurrent or persistent genital pain associated with sexual intercourse. It can be subdivided into deep and superficial pain. In the case of superficial (introital) pain, dyspareunia may or may not be identified as VVS. Vaginismus has been defined as recurrent or persistent involuntary spasm of the musculature of the outer third of the vagina that interferes with vaginal penetration, causing personal distress.

As knowledge of etiology and treatment of sexual pain disorders advances, these definitions are being modified. An international consensus committee recently recommended the following definition for vaginismus [9]: persistent or recurrent difficulties of the woman to allow vaginal entry of the penis, a finger, and/or any object, despite her expressed wish to do so. There is variable (phobic) avoidance, involuntary pelvic muscle contraction, and anticipation/fear/experience of pain. Structural or other physical abnormalities must be ruled out or addressed. As for dyspareunia, the recommended definition is persistent or recurrent pain with attempted or complete vaginal entry and/or penile vaginal intercourse.

Prevalence of Sexual Pain

Prevalence estimates for dyspareunia range from 3% to 43% and varies not only with culture (the lower estimates are from Northern European countries, whereas the higher ones are from the United States), but also with the setting (3–18% in the general population, 3–46% in the general practice, 0–30% in sexuality clinic settings, and 10–20% in gynecologic clinics) and the gynecologist's initiative to bring up the matter. Several authors found a major difference in the incidence of sexual complaints between self-reported data by the patients and data obtained during a discussion about sexuality initiated by the gynecologist [10–12]. Therefore, in order to detect sexual problems and sexual dysfunctions, explicit questions will have to be asked.

Prevalence rates for vaginismus are scant, without the benefit of multiple studies on specific populations. Prevalence estimates for vaginismus range from 1% to 6% [13].