ABC of sexual health

Female sexual problems II: sexual pain and sexual fears

Josie Butcher

Dyspareunia and vaginismus are two common and extremely frustrating sexual dysfunctions for women. The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) lists them as two separate disorders in the subcategory of sexual dysfunctions.

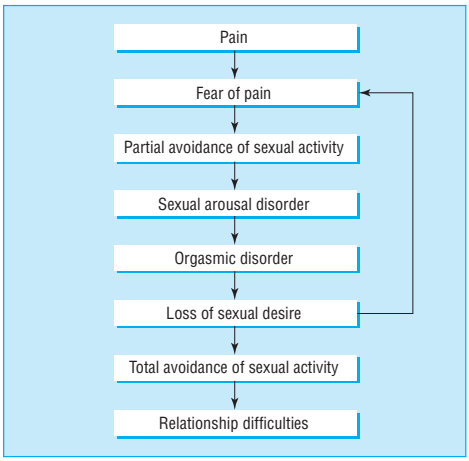
Dyspareunia

Dyspareunia is recurrent genital pain associated with sexual activity and can be classified as primary, when pain has always occurred during sexual activity, or secondary, when it occurs after a period of pain free lovemaking. The term is usually used to describe pain on penetration, but it can occur during genital stimulation. It is best described according to the site of the pain.

Traditionally, it was thought that superficial dyspareunia (at or around the vaginal entrance) is likely to have a psychogenic origin, whereas deep dyspareunia is likely to have an organic cause. These explanations are no longer considered helpful. It is important to try to identify the history of the pain, its site, sort, severity, onset, duration, and any other associated factors. Look for any physical abnormalities and discuss their effects on the sexual relationship. It must be remembered that physical signs are not always visible, and vulval histology is sometimes required. It is never enough to suggest that dyspareunia is simply psychological, and it should be looked at medically before any psychological components are considered.

Repeated sexual pain can set up a cycle of pain, in which fear of pain leads to avoidance of the sexual activity that produces it, in turn leading to lack of arousal, failure to achieve orgasm, and loss of sexual desire. This can progress to total avoidance of sexual activity and difficulties in the relationship.

Belief that her vagina is too small may be one of the reasons for a woman's fear of vaginal penetration. (*Cinesias entreating Myrrhina to coition*, 1896, by Aubrey Beardsley)

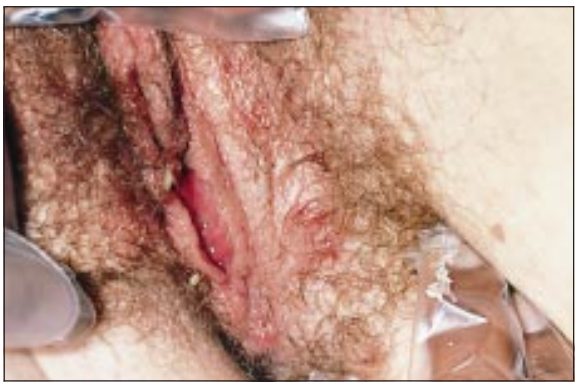


Cycle of sexual pain and avoidance of sexual activity

Superficial vulval pain

Superficial vulval pain is common and has many causes. Identifying the cause is difficult, however, and patients often see treatments as frustrating and inadequate. There is a great risk of a patient focusing on the discomfort and repeatedly trying to find answers. She may consider herself misunderstood, and her doctor may become frustrated through failure to find a cure. Although patients are anxious and may be introspective about their symptoms, they seem psychologically "healthy."

Vulval pain can be relapsing and remitting. Experiences of burning, itching, and stinging—with patients describing feeling "inflamed"—are common, and any area of the perineum may be affected. Pain may be felt not only on sexual stimulation but can be present all the time and triggered by non-sexual activities such as walking. The main causes are vulvitis, vulvovaginitis, vulvovestibulitis, genital herpes, urethritis, and atrophic vulvitis, as well as inadequate lubrication and topical irritants such as spermicides or latex.



Small sores on vulva caused by herpes simplex II virus. Genital herpes is a major cause of superficial dyspareunia

Vaginal pain

This is the least common category of dyspareunia, partly because sensory nerve endings are present only in the lower third of the vagina. Pain is mainly experienced at the entrance to the vagina. Common causes are lack of lubrication, vaginal infection, irritants (spermicides and latex), urethral problems, gynaecological and obstetric interventions (episiotomy), radiotherapy (radiation vaginitis), and sexual traumas.

Deep dyspareunia

Deep dyspareunia, often described as pain resulting from pelvic thrusting during sexual intercourse, is also common and has many causes. Major causes include pelvic inflammatory disease; gynaecological, pelvic, or abdominal surgery; postoperative adhesions; endometriosis; genital or pelvic tumours (including fibroids); irritable bowel syndrome; urinary tract infections; and ovarian cysts. A common cause is positional, with deep thrusting by the woman's partner hitting an ovary (equivalent to hitting or squeezing a man's testicle).

Treatment

When considering treatments for dyspareunia, all physical causes should be treated as far as possible. However, cognitive behavioural programmes can be useful and are similar to the approach used for vaginismus (see below). Many women, once they understand their sexual problem, can adapt and can achieve good quality sexual activity leading to penetration even though they have a painful physical condition. Successful treatment is in large measure due to the patient feeling that she owns her vagina and controls her sexual activity.

Vaginismus

This is a conditioned response that results from associating sexual activity with pain and fear. It is a severe problem for many women, who may experience not only extreme physical pain on attempted penetration but also severe psychological pain. It consists of a phobia of penetration of the vagina and involuntary spasm of the pubococcygeal and associated muscles surrounding the lower third of the vagina.

Primary vaginismus is diagnosed when a women has never experienced vaginal penetration, and secondary vaginismus is diagnosed when a woman has had vaginal penetration without a problem in the past.

The severity of the symptoms can lead to a general sexual inhibition with avoidance of any sexual touching, and in most severe cases to avoidance of any affectionate touching. The spasm can occur not only on attempted penetration but on anticipated penetration or foreplay. At the other end of the spectrum some women are sexually responsive and have good quality sexual experiences, with imaginative "foreplay" continuing to orgasm but avoiding penetration.

Attempted penetration leads to pain, fear, humiliation, and frustration, often resulting in feelings of inadequacy and abandonment. The discomfort from repeated attempts at penetration or speculum examination can produce a tightening of muscles in the pelvis, thighs, abdomen, and legs. As well as unsuccessful intercourse, women will have experienced failed gynaecological examinations, difficulty using tampons, and defaulting from attendance for cytology of cervical smears, all of which are almost impossible.

Causes

The immediate cause of vaginismus, whether primary or secondary, is the involuntary muscle spasm. Why some women develop vaginismus and others do not is uncertain. The initial response may be secondary to any type of vaginal pain, including all causes of dyspareunia. Experience of physical or sexual abuse can induce phobia of vaginal penetration, as can frightening medical procedures experienced during childhood, painful first sexual intercourse, problems with a relationship, and fear of pregnancy.

Masters and Johnson suggested that important factors may include religious orthodoxy, poor sexual education, sexual inhibition, sexual abuse, rape, and anger in relationships. Other

By taking complete control of vaginal penetration, women can learn to overcome their fear of sexual activity. (*Angelique et Medor* from *Aretino or The Loves of the Gods*, circa 1602, by Agostino Carracci)

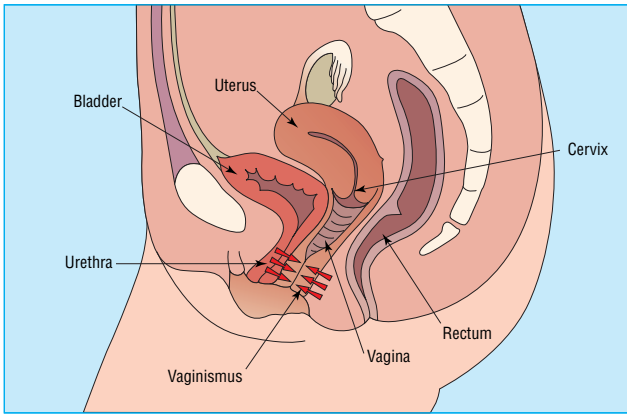
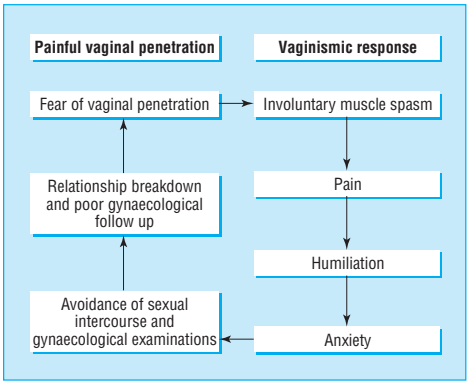


Diagram of vaginismus. (Redrawn from Masters WH, Johnson VE, Kolodny RC. *Human sexuality*. 5th ed. New York: Harper Collins, 1995)



Cycle of vaginismus

suggested factors include fear of intimacy, pregnancy, or aggression and belief that one's vagina is too small. There is a suggestion that psychological conflict can be implicated, in which a woman indirectly expresses anger towards her partner by closing off her vagina.

Treatment

Cognitive behavioural treatment programmes for vaginismus comprise a programme of relaxation with specific exercises for relaxing the muscles around the vagina and a systematic desensitisation of the vagina.

The woman learns to control her vaginal muscle spasm while gently introducing trainers of gradually increasing size into the vagina. Trainers can be fingers, tampons, or specifically designed specula such as Simms or Amielle. Throughout, the woman is in total control, and this gives her great confidence. The programme progresses to a point where she is able to share the introduction of the trainers with her partner. This stage is followed by insertion of the penis into the vagina with the woman in control.

The phobic element of the problem also needs to be addressed and is often the most difficult part of the treatment. Although women may dread the prospect of the treatment programme, the success rate is nearly 100% if the woman persists with the programme. The aim of the treatment is to achieve a situation where the woman feels that she owns her own vagina and can share it for sexual activity should she wish.

Anorgasmia (female orgasmic disorder)

The role of orgasm for women is not well defined. For some it is extremely important and sought at every sexual encounter. However, for others it seems less important and sometimes of little relevance; many women can be quite content without it. An important issue is the male partner's understanding of the female orgasm. He often feels that, like him, his partner cannot fully enjoy sexual activity without orgasm, and this can put enormous pressure on the woman to achieve orgasm.

A working definition of anorgasmia would be an involuntary inhibition of the orgasmic reflex. A woman may have a strong sexual desire with good arousal and enjoy the sensation of the penis in the vagina, but she then holds back even though the stimulation should be sufficient for orgasm. These women often have a strong fear of losing control over feelings and behaviour. The fear can be conscious or unconscious, but resolution of the conflict is an important aim of treatment. An example of a situational anorgasmia is a woman who can achieve orgasm by masturbation but not in coupled sexual activity.

Historically, orgasm has been equated with loss of control leading to death and has been described as the "mini-death." Most women coming for help feel that having an orgasm will dramatically change their lives. Education and rational discussion is important in disassociating orgasm from symbolic qualities.

Treatment

Work with both the individual and the couple is aimed at treating the "holding back"—the fear or phobia of orgasm or losing control. Resolution of conflicts (decreasing inhibitions) combined with increasing stimulation is very successful.

A considerable amount of couple work is helpful, during which sexual education, sexual myths, and a greater understanding of a partner's needs can be discussed. The question, "Who is this orgasm for?" can be addressed. The idea of difference can be achieved, and the concept of benign variation of sexual need accepted.

Treating vaginismus

1—Sexual education
2—Control of vaginal muscles
3—Self exploration of sexual anatomy
4—Insertion of a trainer under controlled relaxation
5—Sharing of control with partner
6—Insertion of penis, with the woman in control
7—Transfer control of insertion of penis to partner
8—Exploration of phobia

Amielle trainers, which can be used to help overcome fear of vaginal penetration

Classification of anorgasmia

Primary—Orgasm has never been achieved
Secondary—Orgasm has been achieved in the past
Absolute—Orgasm impossible in all situations
Situational—Orgasm impossible only in certain situations

Treating anorgasmia

1—Self exploration
2—Sensate focus
3—Masturbation
4—Use of adjuncts (vibrators)
5—Resolution of unconscious fears of orgasm
6—Distraction
7—Exercises to heighten sexual arousal
8—Transfer to heterosexual situation
9—Orgasm on sexual intercourse

Objectives of treatment

- Heightening sexual arousal so that woman is close to orgasm before penetration
- Enhancing awareness of pleasure and vaginal sensation with tactile stimulation in outer third of the vagina
- Maximising clitoral stimulation with active thrusting by woman, woman in superior position, direct clitoral stimulation, use of a vibrator, and use of external clitoral stimulation by woman

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The picture of genital herpes, by Dr P Marazzi, is reproduced with permission of Science Photo Library.

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