# sexual pain disorders

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دانشیار بهداشت باروری از علوم پزشکی اراک

- The sexual pain disorders, dyspareunia and vaginismus—now classified in the DSM-5 as a single entity termed genito-pelvic pain/penetration disorder persistent or recurrent difficulties with one or more of the following for at least 6 months and resulting in clinically significant distress:

are thought to affect 14 to 34 % of younger women and 6.5 to 45 % of older women

33% of Iranian women expressed their experience of pain or fear during intercourse

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persistent or recurrent difficulties with one or more of the following for at least 6 months and resulting in clinically significant distress:

(1) vaginal penetration during intercourse;

(2) marked vulvovaginal or pelvic pain during vaginal intercourse or penetration attempts;

(3) marked fear or anxiety about vulvovaginal or pelvic pain in anticipation of, during, or as a result of vaginal penetration;

and (4) marked tensing or tightening of the pelvic floor muscles during attempted vaginal penetration

# Consequences and Associated Difficulties

- Women with a sexual pain disorder report disruptions to every aspect of their sexuality compared to women without
- these conditions, including :
- lower desire,
- arousal,
- sexual satisfaction,
- and frequency of orgasm and intercourse
- They also report more sexual anxiety, a greater tendency to perceive sexual cues as negative ,
- more negative and less positive cognitions about penetration, poorer sexual communication, and lower sexual self-esteem compared to pain free controls

- In qualitative studies, women report feelings of guilt, shame, and inadequacy as a sexual partner, as well as fears of losing or disappointing their partner because of the pain

- women with sexual pain are more likely than women without sexual pain to have insecure romantic attachments and couples affected by sexual pain report lower sexual communication than pain-free couples

- In turn, lower sexual communication and insecure romantic attachments are associated with women's greater sexual distress and couples' lower sexual function, sexual satisfaction, and relationship satisfaction

- In one of the first studies to examine the impact of women's sexual pain on male partners, the partners reported more depressive symptoms when compared to a control group of healthy men
- male partners have reported decreased sexual satisfaction and an increased prevalence of sexual difficulties (e.g., erectile dysfunction) compared to male partners of women without sexual pain

- vulvodynia may be associated with some degree of pelvic floor muscle dysfunction. Using electromyography recordings, several increased resting muscle tone, impaired voluntary relaxation and decreased voluntary muscle contractile ability in women with vulvodynia compared to asymptomatic women

# Vaginismus

- Working with physical therapists, Reissing et al. found that women with vaginismus demonstrated significantly higher vaginal/pelvic muscle tone and lower muscle strength than women or controls.

# Etiology

1. **Biomedical Factors**
2. **Psychological Factors**
3. **Relationship Factors**

# Etiology

- Biomedical Factors Most sexual pain problems of the genital skin and mucus membranes are transient and are caused by inflammation from acute genital infections, such as candidiasis, trichomoniasis, and genital herpes, or an infection of the greater vestibular glands.

# Psychological Factors

In a large-scale cross-sectional study, female adolescents experiencing pain during sexual intercourse were more likely to report a history of sexual abuse, fear of physical abuse, trait anxiety,

- Higher levels of catastrophizing, fear of pain, and lower levels of self-efficacy correlate with increased pain in women with control,

# Relationship Factors

- Given the sexual context in which female sexual pain is most often triggered, research has increasingly focused on the role of relationship factors in sexual pain.
- Partner responses, the most studied of the relationship factors, can be negative (e.g., hostility), solicitous (e.g., sympathy), and facilitative (e.g., affection and encouragement of adaptive coping).

- Role of partner is important. greater facilitative partner
- responses were associated with women's lower intercourse
- pain [67] and better sexual functioning [68], as well as couples' greater relationship and sexual satisfaction
- hostility partner responses are associated with greater pain and more depressive symptoms in women [72], as well as lower sexual functioning [68] and relationship and sexual satisfaction in couples

# Treatment

- Medical Treatments- treatment of vaginal infection
- The most commonly prescribed topical medication is lidocaine 5 %. 30 min before sexual intercourse.

- application of estradiol 0.03 % and testosterone 0.1 % is effective in women who have developed vestibulodynia while taking oral contraceptives

- A common oral treatment is the use of antidepressants, such as tricyclic antidepressants (TCAs), selective serotonin reuptake inhibitors (SSRIs), and selective norepinephrine reuptake inhibitors (SNRIs) [93]. Descriptive studies regarding the use of antidepressants to treat vulvodynia report success rates of 27 to 100 %

- anticonvulsants (e.g., gabapentin and carbamazepine) have been used to treat vulvodynia

- Additionally, interferon α and injection of botulinum toxin A have been successfully used for the treatment of vulvodynia.

# Physical Therapy Treatments

- Improvements in pain, pelvic floor contractility, and muscle relaxation using electrical stimulation.

- Electrical stimulation resulted in a reduction in muscle tension and pain. Finally, in a randomized controlled trial in 40 women with vulvodynia , Murina et al. found a reduction in pain and an improvement in sexual function following transcutaneous electrical nerve stimulation (TENS) treatment

# Psychosocial Treatments

- CBT
- Surgery

Vestibulectomy

# Vaginismus

- Vaginismus consists of involuntary spasms of the pelvic muscles, which have no external effects of the vagina associated with fear and/or pain

- Among FSD, vaginismus is classified as a painful sexual disorder, with a prevalence of 5to 17% of the female population with an active sex life

# Etiology

- Factors that cause biopsychosocial that can be affected in this condition, such as sexual abuse,
- strict sex,
- education,
- physical or emotional trauma,
- low quality sexual,
- religious beliefs, or even fear of sexual intercourse for the first time
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# classified vaginismus

- vaginismus can be classified as primary, when the woman has never had sexual intercourse without pain
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- secondary, when the woman has had any previous pain-free experience. It can also be classified as global, when contractions occur regardless of partner and/or circumstances, and situational, when contractions occur only with certain partners and/or specific circumstances

# Classification

**Grade 1** It is the mildest form. These patients can control the contraction of their vaginal muscles with the suggestions given during the examination.

**Grade 2** Despite the suggestions given to the patient, they continue to contract the pelvic floor muscles throughout the examination.

**Grade 3** Throughout the examination, the patient raises or pulls her hip to the side, thus trying to prevent the gynecological examination.

**Grade 4** During the examination, the patient lifts her hips, pulls herself back, closes her legs, and thus prevents the examination.

# Treatment

1) couples were given detailed information about the female sexual cycle, arousal, plateau, orgasm, and resolution phases. The anatomy and function of the hymen, pelvic floor, clitoris, and vagina were explained using models and anatomical drawings.
2) Kegel exercises (KE) and breathing-relaxation exercises (BRE) were taught and written
3) Water-soluble vaginal lubricant gel was applied to the vaginal area and the gynecologist's fingers or oneself finger.

5. Water-soluble vaginal lubricant gel was applied to the vaginal area and the husband's fingers.
6. choosing one of the cowboy (active female) or missionary (active male) positions for coitus.

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