Dyspareunia: An Integrated Approach to Assessment and Diagnosis

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Dyspareunia, or painful intercourse, is frequently referred to as the most common female sexual dysfunction. It can occur singly or be manifested in combination with other psychosexual disorders. Diagnosis of dyspareunia is appropriate in cases in which the experience of pain is persistent and severe. There has been little agreement concerning the origin of dyspareunia. Organic conditions and psychological variables have alternately been presented as major factors in causality. There is a presumed high incidence of physical disease associated with dyspareunia when compared with other female sexual dysfunctions. In the majority of cases, however, organic factors are thought to be rare in contrast with sexual issues and interpersonal or intrapsychic difficulties as a cause of continuing problems.

The finding of an organic basis for dyspareunia does not rule out emotional or psychogenic causes. Thorough and extensive gynecologic and psychological evaluation is essential in cases of dyspareunia. The etiology of dyspareunia should be viewed on a continuum from primarily physical to primarily psychological with many women falling in the middle area.

A recurrent pattern of genital pain during or immediately after coitus is the basis for the diagnosis of dyspareunia.[1] *The Diagnostic and Statistical Manual of Mental Disorders* (DSM-III)[2] has included dyspareunia under the classification of psychosexual disorders. Dyspareunia is defined as functional when the occurrence of recurrent and persistent genital pain in either the man or woman is associated with coitus. Additionally, diagnostic criteria state that it is not caused exclusively by a physical disorder, is not because of a lack of lubrication (criteria for inhibited sexual excitement), and is not the result of functional vaginismus or another clinical syndrome. Dyspareunia is far more common in the woman than in the man,[3,4] and female dyspareunia is more likely to involve psychological factors than is male dyspareunia.[5] This article will restrict its discussion to dyspareunia in women.

Submitted, revised, August 5, 1986.

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Dyspareunia and vaginismus are undeniably linked, and repeated dyspareunia is likely to result in vaginismus, as vaginismus may be the causative factor in dyspareunia.[6,7] The difference between vaginismus and dyspareunia is that intromission is generally painful in the latter condition but virtually impossible in vaginismic women because of the involuntary muscle contraction of the vaginal sphincter.[8] If vaginismus is present, concurrent dyspareunia is not considered to be a separate entity, as any persistence or success with forced penile entry is invariably painful.[9] If vaginismus is the cause of dyspareunia, the primary diagnosis is vaginismus.[1]

Many women with dyspareunia are anorgasmic as well, and for a significant number the anorgasmia precedes the dyspareunia.[3,10-12] Although there are supportive data, no conclusive evidence is available that confirms anorgasmia necessarily precedes the development of dyspareunia.

Even though precise statistics regarding the incidence of dyspareunia are not available, Brant[13] notes that the complaint of dyspareunia is a common clinical presentation. Kaplan[12] and Masters and Johnson[3] report that next to anorgasmia, dyspareunia is the most frequently occurring sexual dysfunction. Lamont[6] points out that probably every sexually active woman

has had occasional dyspareunia; consequently, the incidence of the isolated symptom may be said to be universal. Fordney and Settlage[11] report that in women of lower socioeconomic class with a higher proportion of non-European white racial background, dyspareunia is the most common sexual dysfunction complaint. Fordney[9] comments, however, that this finding may simply reflect that dyspareunia is a more disabling dysfunction than anorgasmia. Fordney points out that women with fewer resources may live with the absence of orgasm without requesting treatment, but in the presence of pain that seriously alters their ability to engage in sexual behavior, they will seek assistance.

DESCRIPTION AND CLASSIFICATION

Dyspareunic pain has been described and classified in a variety of ways. Claye[14] categorized dyspareunia in two ways: superficial if difficulty or pain occurs during penetration, or deep when pain occurs after penetration. Fink[10] separates pain experienced at the vaginal outlet from pain felt on deep penetration. Similarly, pain experienced during intercourse is described by Abarbanel[5] as ranging from postcoital vaginal irritation to severe pain during penile thrusting. Lazarus[15] reports that dyspareunia pain or discomfort may be described in terms of pressure, aching, tearing, or burning and may have a wide range of individual intensity and duration. Fordney[9] states a coital episode may be slightly painful with intromission, momentarily during the first few thrusts, or minimally painful throughout coitus and not interfering with desire, receptivity, or orgasm; therefore she reserves the syndrome diagnosis for those cases in which pain is usually persistent and severe. Her definition excludes occasional dyspareunia caused by a lack of arousal and resultant lack of lubrication, prolonged coital contact, or transient conditions caused by infections. Several authors hypothesize that women who experience dyspareunic pain without supposed organic involvement are unlikely to be able to localize specifically or to describe the character of their pain, and will report it as diffuse and not typically persisting following termination of coitus.[3,10]

A variety of classification systems have been used to delineate dyspareunia. Worchester[16] utilized the terms primary and secondary to connote physical and psychological etiology, respectively. Hartnell[17] approached the terms quite differently: primary as usually manifest immediately after marriage, and secondary appearing some years later, frequently after the birth of one or more children. Spano and Lamont[7] regard dyspareunia as primary when penetration has always been painful, or secondary when the onset of painful intercourse occurs following previously comfortable intromission. Brant[13] distinguishes superficial type dyspareunia as originating from failure of lubrication, and deep dyspareunia as stemming from failure of vaginal relaxation and ballooning, occurring in an episodic or random fashion.

Given this lack of consistency in term usage, the subclassification of sexual dysfunction types utilized in DSM-III[2] provides a somewhat more comprehensive framework from which to assess and diagnose dyspareunia. The symptom is described as primary or secondary and as complete or situational. A primary condition is defined as existing throughout the sexual lifetime of a woman, whereas a secondary symptom is one that developed after a significant symptom-free period. A complete symptom is one that is present under all circumstances rather than occurring selectively with specific situations, such as one particular partner, a type of stimulation, or other external variables. By definition dyspareunia is restricted to coital activity as a type of stimulation. General current categorization of the term *superficial* is applied to pain perceived at or near the introitus or vaginal barrel, and *deep* as located at the cervix or lower abdominal area.[10,11] As there is frequent occurrence of more than one sexual dysfunction in the same individual,[3,12] the arrangement of these disorders by subclassification and relative time of onset can be extremely useful in determining etiology and implementing appropriate treatment.[9]

ETIOLOGY

The etiology of dyspareunia has traditionally been divided into two classes, organic and psychogenic.[7] Lamont[18] reports that some of the gynecologic literature on dyspareunia has tended to discuss conditions that could be treated medically or surgically, while conversely, behaviorists have expounded on psychogenic causes of the syndrome. Although gynecologists are frequently called upon by referring mental health professionals to rule out organic causes in dyspareunia, Grillo and Grillo[19] state residency programs are woefully inadequate in this area of gynecology, and standard texts rarely devote even minimal attention to the disorder. Fink[10] also comments on the existing gap between gynecologists and the psychological realm, and stresses that an understanding and acceptance of psychological causality in painful intercourse are essential. The literature obviously presents dichotomous viewpoints. Organic pathology and psychological variables are alternately proposed as the major factors in causality of dyspareunia. In illustration, Huffman[20] contends psychogenic dyspareunia is relatively uncommon; alternately, Spano and Lamont[7] state organic factors underlying dyspareunia are usually temporary, easily correctable, and rare as a cause of a continuing problem.

Wabrek and Wabrek[21] stress that although it is dif-

ficult for gynecologists to determine causality of dyspareunia as organic or functional, no woman should be labeled as having dyspareunia of a psychosomatic etiology without a very thorough, extensive gynecologic evaluation. Fordney[9] states that dyspareunia is the only sexual dysfunction in which there is a presumed high incidence of physical disease etiology or association. Among the physical factors commonly cited as cause of dyspareunia are a rigid hymen, painful hymenal tags, endometriosis, pelvic inflammatory diseases, senile atrophy of the vagina, relaxation of the supporting uterine ligaments, pelvic tumors, childbirth pathologies, stenosis of the vagina, urethral carbuncle and hemorrhoids.[12] Imperforate and abnormally fibrous hymen and hymenal rings and remnants have been found to be a physical cause as well.[19] Fink[10] adds to the list episiotomy scars, Bartholin's gland inflammations, clitoral inflammation and adhesions, lesions of the vulva, a variety of vaginal infections, radiation vaginitis, iatrogenic causes, and allergic reactions to contraceptive and douching materials. Spano and Lamont[7] report that many complaints of dyspareunia are caused by sensitivity to self-administered irritants, such as feminine hygiene deodorants or restrictive clothing. They additionally contend feminine hygiene products are unnecessary and may be damaging. Other possible organic causes of dyspareunia include trauma, irradiation tumors, cystitis, constipation, proctitis, and ectopic pregnancy.[22]

Fordney[9] states that dyspareunia is not a constant symptom of any one pelvic disease, as there are well-recorded instances of extensive disease in which dyspareunia was conspicuously absent from the symptom complex. Fordney reports that most women seeking treatment for dyspareunia have experienced chronic pain from two to six years, and that the presence of subtle or missed physical factors is common in women who have longstanding dyspareunia yet have been considered to be gynecologically normal.

Many authors cite insufficient vaginal lubrication as a major causal factor of dyspareunia.[3,13,23] Insufficient lubrication may be a constant phenomenon or more situational in nature, and may be related to lack of interest, fear of pregnancy, pain, fear of loss of control, or anger at the male partner.[21] Anxiety has been implicated in the etiologic origin of dyspareunia as a result of its interfering effect on lubrication, which can lead to pain, burning, itching, and aching during and following intercourse.[3,24] Spano and Lamont[7] cite failure of arousal as a potential cause of dyspareunia. The female sexual response cycle includes vasocongestion and neuromuscular excitation, which produces lubrication of the vagina and erection of the clitoris that results in vaginal expansion and elevation of the uterus.[3,12] They maintain that each of these steps is necessary if penetration is to be accomplished without the experience of pain. DSM-III[2] assigns lack of lubrication as a diagnostic criteria for inhibited sexual excitement, and excludes it in the diagnosis of functional dyspareunia. Fordney[9] states that in 60 to 70 percent of the cases of longstanding dyspareunia, organic factors cannot be identified. If no physical factors can be found after a thorough gynecologic evaluation and the complaint of discomfort persists, dyspareunia is then often regarded solely as a symptom of underlying psychosexual dysfunction, and a diagnosis of psychogenic origin must be made.[15]

Psychological theories in regard to the etiologic origins of dyspareunia include fear-anxiety conflicts, phobic reactions, conversion reaction, and hostility toward sexual partners.[3,10,25] Psychoanalytic theory considers dyspareunia as constituting a hysterical or conversion symptom, conceptualized as the symbolic expression of a specific unconscious intrapsychic conflict.[12] Learning theory relates the development of the dyspareunic response to lack of learning or faulty learning, and hypothesizes that a dysfunctional pattern is reinforced with each succeeding sexual contact.[26] Operant conditioning models theorize that based on prior accidental occurrences with either positive or aversive consequences, the individual woman develops a preconditioned set that is reinforced.[10]

Lazarus[15] contends that dyspareunia is not a unitary disturbance, but involves a broad spectrum of personalistic and idiosyncratic variables. More generally, DSM-III[2] states any negative attitude toward sexuality because of particular experiences, internal conflicts, or adherence to rigid subcultural values predisposes an individual to psychosexual dysfunction. Wabrek and Wabrek[4] report that an anxiety response may be manifested in anticipation of pain during intercourse as a result of ignorance or misinformation. Fear of pain or pregnancy and the resulting aversion to coitus may have their origins in childhood teachings or memories of distressing sexual experiences in childhood or adolescence.[20] Kaplan[27] reports on causes of psychogenic dyspareunia, including guilt about intercourse and erotic pleasure, fear of penetration, and anger at the partner. Masters and Johnson[3] cite the residual aftereffects of associated psychological trauma resulting from rape as a cause of pain during intercourse.

Abarbanel[5] reports that other psychological factors may be feelings of guilt, shame, or tension occasioned by new sexual situations, or inept precoital techniques by the man, which contribute to a lack of arousal in the woman and ultimately result in insufficient lubrication and coital discomfort. Lazarus[15] contends that a major variable in psychogenic dyspareunia involves the fundamental feelings and attitudes between sexual partners. Sexual issues, such as faulty information and intrapsychic problems, appear to be more prominent in primary dyspareunia, whereas in secondary dyspareunia, relationship issues may be more important.[11]

As long ago as 1931, Dickinson[28] proposed an interesting conceptualization of dyspareunia that addressed the reasoning of both organic and psychogenic camps. He argued that physical dyspareunia is likely to be followed by psychic dyspareunia, as well as accom-

panied by it. There is also a basis for suspicion that psychic may precede physical dyspareunia in many cases. Psychic origins may take the form of physical pain, which can mask aversion, while, conversely, physical pain can be joined with psychological dissonance. Dickinson emphasized that while it is clearly apparent that logical development is difficult to establish in these cases, care should be taken to avoid one-way reasoning when reverse reasoning has an equal likelihood of proving to be true. The attitude conveyed in Dickinson's argument is in opposition to an either/or approach to assessment and diagnosis of dyspareunia. Fink[10] further strengthens this point of view by stressing that finding a physical cause for dyspareunic pain does not mean that all psychological matters can be set aside or considered solved.

Dickinson's discussion clearly emphasizes careful evaluation of the emotional and psychological aspects of each case of dyspareunia in addition to the physical aspects. The preceding review of dyspareunia indicates that despite the above conceptualization having been present in the literature for over 50 years, a balanced approach to this sexual dysfunction has been largely lacking in clinical and research reports, with authors aligning themselves with one side of the continuum, paying only minor lip service to alternative etiologic factors. A more genuine consideration of both organic and psychological factors in understanding cases of dyspareunia should be established.

IMPLICATIONS

This review of organic and psychogenic causative factors in the development of dyspareunia suggests a general lack of agreement concerning etiology of the disorder. While authors in both camps present factual and convincing arguments, the singling out of organic or psychological causes is neither warranted nor essential and, in fact, could be counterproductive in many instances.

Implications of this review point to a need for the medical and psychological community to increase their level of awareness and expertise in regard to the complexity of factors involved in this syndrome. Heretofore, rigid assumptions about the strict causality of this disorder appear to be erroneous and misinformed. Approach to diagnosis in a stepwise fashion, emphasizing etiologic factors as they are discovered, would appear to be most beneficial. Viewing causality on a continuum as primarily of a physical or psychogenic nature with the potential for both to be equal contributors to dyspareunic pain is more practical and efficacious. The use of a consistent diagnostic battery is recommended, as is the development of new assessment procedures.

An integrated rather than dichotomous view of dyspareunia, combined with increased knowledge of possible etiologic factors of both organic and psychogenic origin, would appear to enhance the chances for accurate assessment and diagnosis. Rather than medical and psychological professionals working at odds in a unitary fashion, collaborative research efforts incorporating the knowledge and expertise of both disciplines should be employed. Additionally, reciprocal consultation and referral by both physicians and mental health practitioners are essential and in keeping with the advocated approach.

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