

# **Sexual Pain, Sexual Fears: When Women Find Sex Impossible**

by Stephanie Buehler, MPW, PsyD, CST

Probably the most heart-breaking cases we see at The Buehler Institute are women who have sexual pain disorders. The story we often hear is that the woman has gone from one physician to another, getting very little in the way of diagnosis or treatment. Meanwhile, as she searches for a solution her partner grows frustrated, and her relationship is often threatened.

*Dyspareunia* (dis-pear-ee-oo-nee-ah) and *vaginismus* (va-gin-is-mus) are two of the most commonly diagnosed problems. This article is a brief summary of what each is and how they are treated. For more information, go to The Buehler Institute website, click on the "Our Services" page and scroll down to

## ***Dyspareunia***

Dyspareunia is recurrent genital pain associated with sexual activity. If the pain has always occurred with sexual activity, it is called "primary" dyspareunia. If, on the other hand, there has been a period of pain-free sex prior to its development, it is called "secondary" dyspareunia. Dyspareunia usually is thought to occur when there is pain with penetration, but it can also occur during genital stimulation. The site of the pain determines which type of dyspareunia a woman may have.

One of the things that makes diagnosing dyspareunia difficult is that there is not always a visible sign, something that physicians are taught to look for. This is why the problem is often thought to be only psychological, but generally this is not true. That being said, like other chronic pain problems, dyspareunia has a psychological component to it. Dyspareunia is distressing and causes disruptions in the sexual relationship.

One of the things that can also happen with dyspareunia is that a cycle of pain can occur. Fear of pain with intercourse can lead to avoidance of sexual activity. A woman may also fail to become aroused or to achieve orgasm, so that sex is no longer exciting. Thus, her sex drive may also begin to flag. Eventually there can be total avoidance of sex, and it isn't unusual for us to hear a couple going a year--or longer--without attempting intercourse.

Dyspareunia can be from superficial vulval pain, vaginal pain, or deep pain. Superficial pain can occur in several places around the entrance to the vagina. Women with vulval pain may experience burning, itching, or stinging. The pain may be present at times other than when sexual activity is taking place.

Vaginal pain is the least common type of dyspareunia because only the lower third of the vagina has nerve endings. Common causes are lack of lubrication, infection, irritants like latex, urethral problems, and sexual trauma. Deep dyspareunia usually occurs with the thrusting that takes place during intercourse. Causes include pelvic inflammatory disease (PID), surgeries; tumors, including fibroids, irritable bowel syndrome, urinary tract infections, and ovarian cysts. Different positions can also cause problems, such as when a man can thrust deeply enough to hit an ovary.

## **Treatment**

Cognitive behavioral therapy has been shown to be helpful in relieving this problem. In cognitive behavioral therapy, negative thoughts and fears about sex are dealt with directly and corrected. Relaxation techniques can also help. Gaining a partner's cooperation is key. Sometimes pelvic floor biofeedback or massage, performed by a trained physical therapist, can provide relief for tight pelvic floor muscles. The techniques used for resolving vaginismus, described later in this article, are also used. Again, for more information, see Dr. Buehler's article on Sex Therapy in the Treatment of Vulvodynia.

## ***Vaginismus***

This is considered to be a conditioned response that comes from associating sexual activity with pain and fear, although it can be caused or aggravated from physical problems such as repeated yeast infections. In general, though, it is a phobia of penetration of the vagina and involuntary spasm of the pubococcygeal ("PC") and associated muscles surrounding the lower third of the vagina.

Primary vaginismus is diagnosed when a woman has never experienced vaginal penetration, and secondary vaginismus is diagnosed when a woman has been able to have penetration without a problem in the past. Sometimes the symptoms are so severe that the woman experiences sexual aversion, or avoidance of sexual contact of any kind. Some women, though, find that they are able to enjoy all kinds of sexual activity with their partner--just not intercourse. Eventually this becomes frustrating, as most couples desire this type of very intimate contact. Or, sometimes, the couple comes to a place where they would like to have children, but fear they cannot because of the vaginismus.

Some women also are unable to have a gynecological exam or to use tampons, while others can. If a woman can have penetration in one instance and not another, the vaginismus is said to be situational.

Vaginismus can be thought of as an involuntary muscle spasm. Why it occurs is a bit mysterious, because not all women who have sexual fears or aversion experience it. Sometimes the cause is obvious, as when a woman has had an invasive medical exam, surgery, painful first intercourse, past sexual abuse, or a deep fear of pregnancy.

Religious orthodoxy, lack of sexual knowledge, fear of intimacy, and the belief that the vagina is too small to accommodate a penis are other contributing factors.

## **Treatment**

As with dyspareunia, cognitive behavioral treatment plus relaxation are essential. The cognitive therapy explores underlying fears and helps the woman learn to counter them with more positive and realistic thoughts about sex. The woman also learns to work with her PC muscles, relaxing and tensing them in preparation for using dilators comfortably. A referral to a physical therapist may be appropriate for help in this regard. The woman also learns to desensitize her vagina to penetration as she works with increasingly larger dilators. (Dilators are generally made of plastic. They look a bit like candles without wicks and are graduated from about finger size to about penis size.)

Once she is comfortable using the largest dilator on her own, she begins to work with the dilators in the presence of her partner. Eventually, she will attempt intercourse, usually in the "woman on top" position so that she has maximum control of the experience. Sex education for the woman, and very often the partner, is an important part of the treatment. Happily, vaginismus has a very good rate of being resolved.

At The Buehler Institute, we have treated many women with these concerns. Many physicians in the area refer to us when they have a patient that needs help, and if you don't have a physician who understands the problem, we can refer you to someone who does. If you would like to set up a consultation, please call. If you do not live in the area, please visit AASECT at [www.aasect.org](http://www.aasect.org) to find a sex therapist near you.

*Dr. Stephanie Buehler is a licensed psychologist, AASECT-certified sex therapist, and Director of The Buehler Institute. Visit [www.thebuehlerinstitute.com](http://www.thebuehlerinstitute.com) to sign up for the newsletter and read about services and staff at the Institute.*