Non-Pharmacological Management of Idiopathic/Persistent Dyspareunia

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ABSTRACT

Painful sexual intercourse, or dyspareunia, is a condition numerous women experience. An unknown, but still important, number of those affected find no relief with medication or surgery. Yet, it can be difficult for patients to discuss concerns with their provider. In addition, many providers do not have an adequate comfort level to discuss such topics. This research aims to equip providers with non-pharmacological treatment options which include pelvic floor physical therapy, sex therapy and lifestyle changes. With the cultural shifts and changing ideas of sexuality in today's age, it is important that clinicians remain versed in sexual health and patient education.

INTRODUCTION:

Dyspareunia can be defined as pain induced in the genital region preceding, during, or shortly after sexual intercourse. It can be divided into superficial and deep subtypes which are based upon the anatomy that is afflicted by insertion. Up to 20% of women in the US experience this.[1] Chronic pelvic pain is correlated with increased levels of depression, anxiety, and impaired quality of life.[2] There are a multitude of risk factors, conditions, and substances that can elicit dyspareunia. The basis of which can be physiological, psychological, or idiopathic. Unfortunately, antibiotics, hormone replacement, antidepressants and surgery do not sufficiently address every patient's needs.

INTERVENTIONS:

At Home Care

- Vaginal lubrication can increase with regular sex or masturbation.
- Artificial lubricant may be necessary. Silicone-based is preferred, but water-based lubricants are non-staining and dry faster than silicones.[3]
- Oil or petroleum-based lubricants should not be used with condoms as they can degrade the latex.
- Menopausal women experiencing vaginal dryness should use vaginal moisturizers daily.
- Sexual devices can be used to help increase sexual arousal, activity, or stimulation.[4] Also an adjunct to, or an alternative means of, providing pleasure for those who have painful intercourse. (See figures 2 and 4)
- Categories of devices: collision aids, dilators, vibrators, penetrators (dildos), anal-specifics, and air-pulsaters.[4]
- Non-penetrative devices can be useful for patients with pelvic floor dysfunction.[4]
- Devices should be of a soft, nonporous material that is easy to disinfect; silicone is preferred.[4]
- Silicone lubricants should not be used with silicone devices because it will cause the material of the device to degrade.[4]
- Devices should be cleaned with mild soap and warm water.[4]
- If sharing a device with a partner, a condom or use of another barrier is encouraged.
- Patients should be encouraged to buy from reputable sources, preferably with certified professional sex counselors and/or educators in prominent roles.[4]

Pelvic Floor Physical Therapy

- Dyspareunia is a hypertonic pelvic floor disorder. The pelvic floor muscles (PFMs) are weakened, yet simultaneously overactive.[5]
- Physical therapists work to strengthen PFMs and maintain proper tone.
- Manual Muscle Testing involves examining the pelvic floor externally and internally for points of tenderness and abnormal tone and elasticity.[5] (See figures 1 and 3)
- "Releasing" of tightened fascia with pressure and stretching is another method used to better isolate PFMs and improve contraction. Myofascial release is effective because it improves circulation in the muscles and breaks the cycle of genito-pelvic pain and over-contraction.[5]
- Digital biofeedback is utilized to teach patients to control the activity of their pelvic floor during intercourse.[5] A pressure sensor is placed in the vagina or rectum to ascertain the strength of contraction of the muscle.[6]
- Similarly, electrical stimulation (TENS) uses low current to contract individual muscles in order to assist a patient in learning to isolate particular PFMs and relax them at will.

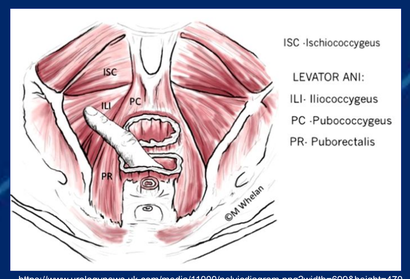

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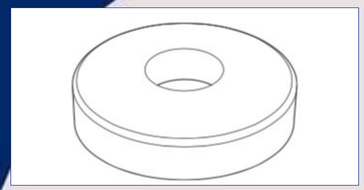
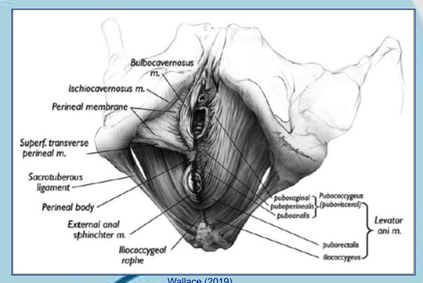
Figure 1. Manual Muscle Testing of the levator ani. The levator ani is one of the most common muscles attributed to dyspareunia.[8]



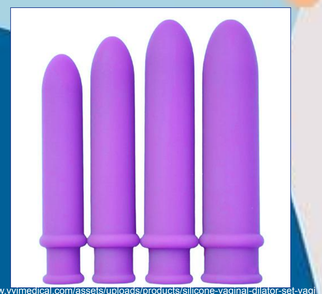
Rubin (2019)

Figure 2. Collision dyspareunia aids may be particularly helpful for those with deep dyspareunia. These aids are tire-shaped buffers that, when placed at the base of a penis or dildo, decrease penetration depth.[4]



Wallace (2019)

Figure 3. Superficial and deep muscles of the pelvic floor



https://www.vvrmedical.com/assets/uploads/products/silicone-vaginal-dilator-set-vaginal-dilation-therapy-44e362eddb0a27e147aba3069fe8a507.jpg

Figure 4. Gradual stretching of the vagina through dilator therapy is another method used to treat dyspareunia. It prepares the person physically and psychologically for penetration.[9] Vaginal narrowing may occur from involuntary contraction or from scarring. [9]

background image: iStock
https://static.independent.co.uk/s3fs-public/thumbnails/image/2019/11/14/11/woman-illustration-141119.jpg?quality=75&width=1368&auto=webp

Sexual Counseling and Therapy

- Clinicians, sex counselors, therapists, educators and product retailors/specialists work as a team to promote sexual wellness.[7]
- It takes a lot of vulnerability for a patient to discuss intimate difficulties with sex.
- It's important to lead culturally competent, age-appropriate conversations with patients. Clinicians must remain open-minded and versed on various aspects of sexuality.
- The National Coalition for Sexual Health notes tips for discussing sexual topics with patients. (table 1)
- The American Association of Sexuality Educators, Counselors, and Therapists list 17 knowledge areas in which to be versed in terms of sex education. (table 2)

NCSH Sexual Health Conversation Recommendations

- If you are uncomfortable talking about sex, so will your patient. Pay attention to your body language, facial expression, and tone of voice.
- Establish rapport before asking sensitive questions
- Use non-judgemental, neutral and inclusive terms (e.g., "partner")
- Don't make assumptions person's sexual orientation, behaviors, or gender identity. Identify your biases
- Use those pronouns and support that patient's current gender identity, even if their anatomy does not match that identity.
- Rephrase your question or briefly explain why you are asking a question if a patient seems offended or reluctant to answer.
- Use ubiquity statements to normalize the topics so patients understand that sexual concerns are common.
- Use terms patients understand. Ask a patient for clarification if they use a word you don't know

AASECT Core Knowledge Areas

- Ethics and ethical behavior.
- Developmental sexuality from a bio-psycho-social perspective across the life course.
- Socio-cultural, familial factors (e.g., ethnicity, culture, religion, spirituality, socioeconomic status, family values) in relation to sexual values and behaviors.
- Issues related to sexual orientation and/or gender identity: heterosexuality; issues and themes impacting lesbian, gay, bisexual, pansexual, asexual people; gender identity and expression.
- Intimacy skills (e.g., social, emotional, sexual), intimate relationships, interpersonal relationships and family dynamics.
- Diversities in sexual expression and lifestyles including, but not limited to, polyamory, swinging, BDSM and tantra.
- Sexual and reproductive anatomy/physiology.
- Health/medical factors that may influence sexuality including, but not limited to,illness, disability, drugs, mental health, conception, pregnancy, childbirth, pregnancy termination, contraception, fertility, HIV/AIDS, sexually transmitted infection, other infections, sexual trauma, injury and safer sex practices.
- Range of sexual functioning and behavior, from optimal to problematic including, but not limited to, common issues such as: desire discrepancy, lack of desire, difficulty achieving or maintaining arousal, sexual pain, penetration problems and difficulty with orgasm.
- Sexual exploitation including sexual abuse, sexual harassment and sexual assault.
- Cyber sexuality and social media.
- Substance use/abuse and sexuality.
- Pleasure enhancement skills.
- Learning theory and its application.
- Professional communication and personal reflection skills.
- History of the discipline of sex research, theory, education, counseling and therapy.
- Principles of sexuality research and research methods.

CONCLUSIONS:

Nonpharmacological management of dyspareunia is a viable option for patients who have exhausted (or want to avoid) surgical and pharmacological treatment. Clinicians must approach idiopathic or persistent dyspareunia in a multifaceted manner, promoting sexual wellness by addressing the physiological and psychological. Sexual devices and lubrication are tools used to take control of sexual pleasure. Those affected can also undergo pelvic floor physical therapy or sex therapy. Patients may feel uncomfortable initially discussing their sexual pain. Provider comfort with the topic will enable patients to be open to discussion and better educated on the resources that are available to them.

REFERENCES:

1. Hill DA, Taylor CA. Dyspareunia in Women. Am Fam Physician. 2021;103(10):597-604
2. Brooks T, Sharp R, Evans S, Baranoff J, & Esterman A. Predictors of depression, anxiety and stress indicators in a cohort of women with chronic pelvic pain. Journal of Pain Research. 2020;13:527.
3. Edwards D, Panay N. Treating vulvovaginal atrophy/genitourinary syndrome of menopause:how important is vaginal lubricant and moisturizer composition?. Climacteric. 2016;19(2):151-161. doi:10.3109/13697137.2015.1124259
4. Rubin ES, Deshpande NA, Vasquez PJ, Spadt SK. A clinical reference guide on sexual devices for obstetrician–gynecologists. Obstetrics & Gynecology. 2019 Jun 1;133(6):1259-68
5. Ghaderi F, Bastani P, Hajebrahimi S, Jafarabadi MA, Berghmans B. Pelvic floor rehabilitation in the treatment of women with dyspareunia: a randomized controlled clinical trial. International Urogynecology Journal. 2019 Nov;30(11):1849-55.
6. Wallace SL, Miller LD, Mishra K. Pelvic floor physical therapy in the treatment of pelvic floor dysfunction in women. Current Opinion in Obstetrics and Gynecology. 2019 Dec1;31(6):485-93.
7. Litam SA, & Speciale M. Deconstructing Sexual Shame: Implications for Clinical Counselors and Counselor Educators. Journal of Counseling Sexology & Sexual Wellness: Research, Practice, and Education, 2021;3 (1):14-24. https://doi.org/10.34296/03011045
Other references available upon request.