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Sex and vulval pain

There is now almost universal agreement among experts that vulval pain syndrome impacts on sexual functioning, affecting both the quality and quantity of sexual activities. Women suffering from conditions resulting in vulval pain are typically aged between 20-45 years, *i.e.* when they might be at their most active and (re)productive sexually, although women outside this age-range can also be affected.

Previous Research into Sexual Dysfunction and Vulval Vestibulitis

A study of 45 women with localised vulvodynia carried out in 1992 (Schover *et al.*) found the following sexual problems: 60 per cent of women complained of vaginismus (involuntary spasm of the pelvic floor muscles surrounding the vagina, effectively making penetration impossible), 57 per cent were unable to achieve orgasm in certain situations, 57 per cent had problems with vaginal lubrication or expansion during sex (the normal changes which usually take place during arousal), 51 per cent had low sexual desire, and 49 per cent also complained of poor sexual communication. Furthermore, 6 per cent had a complete aversion to sex.* In terms of the frequency of sexual activity, at the time of diagnosis the women with VVS reported sex as taking place between once a day (3 per cent) to not at all (25 per cent), with an average frequency of once a month.

Another study carried out by Meana and colleagues (1997) compared 105 women with dyspareunia (pain during sexual intercourse), including 54 with vulvodynia, to 105 pain-free controls. The vulvodynia sub-group were less sexually active, had less frequent sexual intercourse, lower levels of sexual desire and arousal, and less likelihood of achieving orgasm, either through oral sex or intercourse, compared to the pain-free controls.

A similar finding was obtained in another study (Jantos and White, 1997) of 50 women with vulvodynia, where 95 per cent experienced a decrease in libido, desire, arousability and sexual activity.

It is clear, therefore, that many women with vulval pain are significantly affected across the whole spectrum of sexual activity and enjoyment.

**Percentages based on the number of women who provided relevant information*

The Cycle of Pain and Sexual Avoidance

The cycle of pain caused by vulval conditions which may ultimately lead to avoidance of sexual activities, is illustrated below.

- Vulval pain
- Fear of pain and anticipation of pain during sex

- Partial avoidance of sexual intimacy and activity (seen as protection again pain)
- Sexual arousal disorder (insufficient or no vaginal expansion and lubrication)
- Loss of sexual desire
- Problems with orgasm
- Total avoidance of sexual activity
- Relationship difficulties

Unfortunately, many women may only present with a complaint, or be accurately diagnosed, when they are already experiencing significant sexual avoidance or relationship problems.

What is also important when assessing sexual dysfunction, are psychological factors which might in some way be associated with the physical symptoms experienced. Much of the early research in the 1980s tried to establish whether any particular "personality types" or psychological characteristics might be implicated in the development of vulval pain/symptoms. However, there is no evidence to support this idea, and later research established that women with vulval pain report normal levels of relationship satisfaction and psychological adjustment, as assessed on standardised questionnaires. On the contrary, the study by Meana and colleagues actually found that the women with the most psychological symptoms had the least sexual problems, whereas there was no difference between the vulvodynia subtype and normal controls in terms of psychological symptoms.

Treatment Approaches to Sexual Problems

A review of medical/surgical treatment approaches is without the scope of this article, and the information below therefore concentrates more on biofeedback, behaviour therapy and psychosexual therapy.

A very small study conducted by Abramov and colleagues in 1994, using vaginal dilators, resulted in 3 out of 7 women experiencing an improvement in vaginismus, but not in their vulvodynia symptoms. A further 3 women obtained complete relief, and the remaining one woman did not improve at all.

A larger study carried out by Glazer and colleagues in 1995 investigated the effects of biofeedback training in 33 women with vulvodynia, in order to reduce the presumed spasm or tension of the pelvic floor muscles. After an average of 16 weeks of practice, 22 out of 28 women had resumed sexual intercourse, having abstained at the beginning of the study, and 17 out of the 33 reported painfree sexual intercourse. Biofeedback equipment can now be purchased by mail-order for practice at home, although ideally this should be with access to support, guidance and advice from a suitably experienced healthcare professional.

Research by Schover and colleagues (1992) investigated the effects of surgery and other approaches in 38 women with vulvodynia. Those women who consented to a

psychological evaluation pre-operatively did significantly better than those who refused and only had surgery (excision) — *i.e.* 91 per cent in the former category were rated "some better" or "much better", as opposed to 84 per cent in the latter category. Women who had at least one session of post-operative sex-therapy also had a significantly better outcome, which was not related to the number of sessions they had (100 per cent were some/much better, no-one failed to improve). Sex-therapy included counselling, specific pelvic floor exercises, vaginal dilation, and couple therapy.

Finally, a well-known group of researchers in Holland (Weijmar-Schultz *et al.*, 1996) found that in a group of 14 women, a combination of surgery and behaviour therapy was not significantly more effective than behaviour therapy alone. When the women and their partners were subsequently given a choice of treatments, 82 per cent chose a behavioural approach alone — perhaps not surprisingly! — without this resulting in any significant difference in treatment outcome. The conclusion to draw from this is that a non-invasive (behavioural) approach should therefore be the treatment of choice, with surgery only being regarded as an addition.

Standard psychosexual couple-therapy known as "sensate focus", pioneered by Masters & Johnson (1970) is very useful in the treatment of a range of sexual problems. In essence, the couple are instructed to set "protected" time aside on a regular basis during which they are encouraged to explore and touch each other in a mutually pleasurable way. Initially, this starts off with touching only the non-sexual parts of the body, and as the couple progress, the sexual parts are included gradually. Throughout all this time, there is a "ban" on sexual intercourse, in order to allow the woman to relax and enjoy "safe" touching without tensing up (physically and/or emotionally) at the thought of "what might follow" (i.e. penetrative intercourse and pain). It is also important for the couple to alternate between being the "active" and "passive" partner during each pleasuring session, and to take it in turns to initiate (who goes first as the "active" one, *i.e.* the one to start touching/stroking/massaging their partner). Gradually, over a number of weeks, the woman can hopefully move from safe, physical, non-sexual closeness to sexual/erotic intimacy and ultimately to sexual intercourse, whilst experiencing an increase in libido, arousal, vaginal expansion and lubrication.

For women with vulval pain during penetration, "sensate focus" psychosexual therapy with her partner is best combined with pelvic floor exercises, biofeedback, and the use of graded vaginal dilators to use during additional solo practice. Women who experience painful sex are likely to suffer from impaired libido and arousal, as described earlier. Therefore, concentrating more on foreplay and non-penetrative forms of sexual pleasuring should help to increase enjoyment and reduce pain. "Sensate focus" is a good way of "re-educating" partners in the art of sensuous pleasuring without merely perceiving this to be a "means to an end"! However, where penetrative intercourse does occur, it is important to use also plenty of additional vaginal lubrication (*e.g.* Senselle, Astroglide).

Where to Get Help

Sexual therapy is available privately and on the NHS. In terms of finding psycho-sexual therapists with expertise in vulvodynia, these may well be linked to NHS Departments

where specialist vulval clinics are being offered (*e.g.* Departments of Genito-urinary Medicine, gynaecology/women's health care departments, dermatology clinics), in which case the responsible medical consultant should know whom to refer on to. A number of chartered clinical psychologists who specialise in sexual health do provide expert input to NHS clinics (primarily in England), where women with vulval pain are being seen.

A list of accredited and registered sexual and relationship therapists is available from BASRT (British Association of Sexual and Relationship Therapy), PO Box 13686, London SW20 9ZH, T 020 8543 2707). BASRT-listed practitioners work in the NHS, privately, in other appropriate services, or in a combination of such settings.

Approximately 10 per cent of Relate (formerly Marriage Guidance) counsellors have also got additional training in psychosexual therapy. Their number can be found in the telephone directory, and self-referrals are accepted. As a registered charity, the service relies on donations from clients (approx. £20-30 per session), although this can be negotiated (and reduced) depending on individual circumstances.

Further help for sexual and/or relationship difficulties, or help with acute and chronic pain, can be obtained from your local Department of Clinical Psychology. Referral to a qualified clinical psychologist is usually necessary via the patient's GP or hospital consultant.

Conclusion

Sexual dysfunction in women with vulval pain is common, but not inevitable. When it occurs, it is important for the woman (and her partner, if she is in a relationship) to be aware that sexual problems can be treated, and that help is available. When sexual problems are ignored, the woman may find herself in a position where (months or years later) her vulval condition has improved, with or without treatment, but in the meantime she has lost her sexual desire, and may even be experiencing more general relationship difficulties as a result of long-term sexual avoidance. In essence, "competent medical diagnosis, attention to associated sexual and emotional symptoms and an integrated treatment will help an increasing number of women whose vulvodynia deserves to be clinically defined and cured". (Graziottin, 1998).

Gundi Kiemle, Consultant Clinical Psychologist, Bolton Centre for Sexual Health, Royal Bolton Hospital

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