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Are Sexual Pain Disorders Linked to Trauma?

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Female sexual pain disorders are complex with its etiology being multifactorial. The most effective treatments are utilizing a multi-disciplinary approach (Fugl-Meyer et al., 2013;Al-Abbadey, Liossi, Curran, Schoth, & Graham, 2016). Sexual Pain Disorders present with complaints of penetrative discomfort with concerns and/or anxiety in anticipation of vulvovaginal penetration. Genito-pelvic pain/penetration disorder is characterized as marked difficulty having intercourse and may be caused by various changes within the body such as vestibulitis, interstitial cystitis, atrophic changes with dryness and thinning of the vaginal tissues. These conditions can be accompanied with tensing of the pelvic floor muscles which makes any penetrative sex more difficult and painful. Sexual pain disorders are commonly reported in 10-28% of females in the USA (Diagnostic and Statistical Manual of Mental disorders Fifth Edition, DSM-5-TR TM, American Psychiatric Association,2022). Research on the psychological and sexual functioning aspects of women with sexual pain disorders report higher levels of psychological distress with higher anxiety, lower levels of sexual satisfaction, sexual desire, arousal, genital self-image (Desrochers, Bergeron, Landry & Jodoin, 2008; Pazmany, Bergeron, Van Oudenhove, Vergaeghe & Enzlin, 2013; Al-Abbadey et al. 2016) and hypervigilant to possible discomfort with penetration (Payne, Binik, Amsel & Khalife, 2005; Al-Abbadey et al.2016).

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A common experience of women with a history of sexual pain is to experience feelings of a lack of worthiness, shame, guilt, avoidance of interactive penetrative experiences and report negative effect on quality of life (Xie et al., 2012; Al-Abbadey et al., 2016). In general, there are limitations on the current research done in this area. Research is needed on LBTQI+ individuals and pain disorders. There needs to be clear definitions of the type of vaginal pain being treated, a need for control groups in treatment outcome studies, description of the questionnaires used as outcome measurements, establishment of what criteria meets clinical significance and ample sample sizes to test the hypothesis in question.

Avoidance of sexual interactions is common and are associated with fear and anxiety (Brauer, Lakeman, Rik van lunsen, Laan 2014). In addition, posttraumatic stress disorder can occur with sexual difficulties (Bird, Piccirillo, Garcia, Blais, Campbell 2021). Trauma may be related to the experience of sexual or emotional abuse related to intimate and sexual encounters and result in either complete avoidance, disconnection during sexual encounter and/or painful sexual penetrative encounters. It is not uncommon for sexual desire; arousal and orgasmic functioning to be compromised if a pain disorder is existing.

The good news is that with gynecological, urological, and psychotherapeutic treatments these conditions can be treated. An integration of different treatment modalities is supported in the research (Bergeron et al., 2015). Use of physical therapy, use of dilators, electrical stimulation, EMG biofeedback and psychological therapies support the biopsychosocial approach to treating sexual pain disorders and improving sexual functioning psychological well-being and sexual satisfaction. (Bergeron et al., 2001;Danielsson et al., 2006; Bergeron et al., 2008; Goldfinger et al., 2009). Some invite yoga or acupuncture into the treatment as well. (Brotto, Krychman, & Jacobson, 2008; Khamba et al., 2013). For women with pelvic floor pathologies, physical therapy maybe recommended (Goldstein & Komisaruk, 2017; Fontaine et al., 2018). A meta-analysis on pelvic floor training on women with sexual disorders concluded effectiveness of this strategy (Tennfjord, Engh, & Bø, 2017).

There are several comprehensive treatment approaches of sexual pain, all include working with specialists in sexual health:

- Psychological therapies such as cognitive behavioral therapy (CBT), and hypnotherapy and eye-movement (EMDR)
- Consultation with a physical therapist with a specialty in sexual health
- Medical evaluation and possible pharmacological treatments
- Consideration of surgical interventions

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Things that you can engage in:

- Dialogue with your clinician about your sexual functioning and intimate relationships
- Acknowledge and embrace your concerns and goals
- Consider possible etiologies: hormonal/endocrine; urological; history of trauma and its relation to intimacy and sexuality; psychological status; medications and medical difficulties that may impact sexual and emotional intimacy
- Consider treatment options by consulting with clinicians that work with sexual health, specifically with sexual penetrative difficulties
- Bring in balance and wellness into your life experience by sharing your experiences with others; developing a meditative practice to bring calmness into yourself and into your interactions with others; create a group of clinicians that support your situation and lean into your friends and family for comfort

The Interface of the Sexualities and Gender Variations

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The sexualities, sexual orientation, range from heterosexual, bisexual, pansexual, same-sex (lesbian, gay) and asexual. Gender may be binary (male, female), agender or outside the binary i.e. transgender, non-binary or genderqueer. The notion that one's sexual attraction to another individual extends across all diverse genders is not a new concept. There exists an inseparable interface between sexual orientation and gender variations.

Historically, sexual orientation and gender identities were considered separate domains until 2015 when there was a paradigm shift reflecting the intersectional nature and overlap of these domains (APA published letter in NIH:https://www.apa.org/science/about/psa/2015/12/sexual-gender-minorities.pdf.

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One's sexual and gender identity is intersected by a number of factors such as racial, ethnic, sociocultural, linguistic, educational, psychological and psychiatric history, one's familial differences and need to be accounted for within any interaction (Hymel, Lasky, Crowell, et al., 2018; Okoro, Hillman, & Cernasev, 2020). When all these aspects of the individual are not considered, disruptions and potential negative effects on accessing healthcare influences outcomes of care (Cyrus, 2017; Shangani, Gamarel, & Ogunbajo, 2020). Healthcare disparities and inequities among sexual and gender minorities may result.

Within the patient-provider dynamic we strive for clinical partnerships, where shared decision-making result and lead to potentially positive outcomes (Tervalon & Garcia (1998; Bukstein, Guerra, Huwe et. Al, 2020). This type of approach will produce quality patient-provider interactions and ultimately result in less health disparities and inequities. Ongoing training and education in sexual and gender health while incorporating intersectional identities is vital in promoting best practices (Foronda et al., 2018; White & Stubblefield-Tave, 2017). Training needs to include the acquisition and internalization of skills and strategies that shape provider knowledge and behavior (Thomas & Booth-McCoy, 2020) and incorporate aspects of humility, self-reflection, and partnering (Gonzalez et al., 2021) can result in increased sensitivities within sexual and gender health.