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ABSTRACT

Pain-related sexual disorders in women are included in three classifications, i.e. 1. International Statistical Classification of Diseases and Related Problems (ICD–10) by the World Health Organization, 2. American Foundation of Urologic Disease (AFUD) by the American Urological Association, and 3. The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR and prior thereto) [1]. Pain-related sexual disorders in women have not been associated with gynecology and obstetrics up to modern times.

At present, the situation seems to undergo a fundamental change due to the DSM-V Classification published in 2013. Dyspareunia and vaginismus are classified jointly there and described as genito-pelvic pain disorders / penetration disorders.

KEYWORDS: vaginismus, dyspareunia, genito-pelvic pain disorders / penetration disorders, DSM – V.

Introduction
The history of observations of sexual pain in women is four thousand years long. 'On Vaginismus', the first ever lecture on sexual pain was read by an American physician Marion Sims before the Obstetrical Society of London in 1861.

Sims distinguished two types of painful sexual intercourse: vestibulitis and involuntary contraction of muscles around the vagina opening (vaginismus). However, he described the two conditions with one term, i.e. vaginismus.

In his times, Sim's theory did not find soil favorable for its development. In fact, it was entirely ousted when Sigmund Freud (1856 – 1939) introduced his psychoanalytical theories into the medical environment. It was the latter that were better accepted by physicians in defining sexual problems as neuroses and hysteria, i.e. exclusively psychiatric issues. All through the 20th century physicians kept perceiving women's sexuality in the light of psychiatry.

The first classification of women's sexual disorders which stood in opposition to psychiatry was compiled by American Foundation for Urologic Disease (AFUD) in 1998. The classification created a new diagnostic and therapeutic attitude towards women's sexual disorders which takes into consideration the organic aspect, in the origin of pain-related sexual disorders in particular. This calls for the necessity to begin diagnostics of the painful sexual intercourse with a gynecological examination [2,3,4].

Sexual pain is not only a matter of psychiatry
The aspect of pain of the surface of the vestibule of the vagina, as thoroughly described by Sims, was ignored until the late 20th century. Women were referred to psychotherapist whose procedures did not include a physical gynecological examination. And without such examination, it was impossible to detect and properly diagnose the ailment.

In all its versions, including the penultimate one, i.e. DSM - IV - TR, the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM ) limited the definition of sexual dysfunctions to mental diseases. It was assumed that distinguishing an "organic cause from inorganic one" was impossible. This resulted and still very often results nowadays in a situation when women who complain about pain related to their sexuality and sexual intercourse are in many cases still referred to a psychiatrist without prior gynecological diagnostics [5].

The first classification of women's sexual disorders which stood in opposition to the psychiatric DSM was compiled by American Foundation for Urologic Disease (AFUD) in 1998. It assumed the possibility of existence of pain of organic origin which was not accompanied by psychic suffering or partnership relation disorder. Thus, diagnostics of sexual pain called for the assessment of biological factors, i.e. allowance for gynecological examinations [1,6].

Similarly to DSM, the AFUD Classification included sexual disorders of the consecutive phases of the sexual cycle in items 1-3. The major difference consists in understanding of item 4:

1. Hypoactive Sexual Desire Disorder (HSDDD)/
2. Sexual arousal disorder
3. Orgasmic disorder
4. Sexual pain disorder occurring in the form of:
   a. dyspareunia,
   b. vaginismus,
   c. noncoital sexual pain.

Table 1. Comparison of pain-related sexual disorders classifications of AFUD and DSM

<table>
<thead>
<tr>
<th>AFUD</th>
<th>DSM - IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Dyspareunia – recurring or fixed coital pain</td>
<td>1. Dyspareunia - recurring or fixed coital pain, causing psychic suffering and disturbing partnership relationship</td>
</tr>
<tr>
<td>2. Vaginismus – recurring or fixed involuntary coital spasm of 1/3 of the orbicular muscles of vagina</td>
<td>2. Vaginismus – recurring or fixed involuntary coital spasm of 1/3 of the orbicular muscles of vagina, causing psychic suffering</td>
</tr>
<tr>
<td>3. Noncoital sexual pain disorder</td>
<td>3. none</td>
</tr>
</tbody>
</table>

There is also the third classification of sexual dysfunctions according to the World Health Organization, i.e. International Statistical Classification of Diseases and Related Problems (ICD-10) [1]. We will still not find any references to the changes included in DSM - there. It suggests that sexual dysfunctions should mean various situations in which a human being is not able to participate in a sexual relation desired by them. The dysfunctions are described therein with no scientific classification as:

1. decrease of sexual desire,
2. sexual aversion,
3. failures in genital response,
4. orgasm disorders,
5. inorganic vaginismus, inorganic dyspareunia,
6. excessive sexual drive.

The three classifications, i.e. have many items in common whereas in other positions they diverge from one another. This is so due to the fact that researchers cannot agree upon the essence and definition of a sexual disorder. Since it is not a simple issue of the border of psyche and soma, the problem is not only to distinguish and to set the border between what is an inorganic cause and what is an organic one, but also what is primary and what is secondary here. Up to the publication of the findings of R. Basson's research on the model of sexual response in women, the linear model had been assigned as a physiological one to both sexes. Basson's discovery was the beginning of a new view on feminine sexuality. However, the latest research prove that this is not the only model in women, and that we still need reliable research to explain the matter [7]. If we set the doubts upon the basis of 'unbalanced' and diversified times, partner relationship, factors of personality, culture and religion, the times we live in, we shall perceive the whole range of diagnostic difficulties in so interdisciplinary area as sexuality, including gynecological sexology.

DSM – V Classification, Genito-Pelvic Pain / Penetration Disorder

Following many years of discussions, the DSM – V Classification was published in 2013. It was the first one to indicate occurrence of dyspareunia of biological basis. Prior to its publication and following it, the Classification was critically dis-
cussed by researchers of various environments. The numerous drawbacks of the Classification should be acknowledged. Nevertheless, taking into consideration the difficulties of the research of feminine sexuality, the inclusion of the Genito/Pelvic Pain / Penetration Disorder into the terminology should be perceived as a success of the current version of the Classification, verification of its conclusions being assumed. It is a great progress in terms of the pathogenesis of sexual pain. It is the first time that a medical classification includes a woman’s pelvic floor, vagina together with the muscles of the pelvic floor and osseous system are a diagnostic-therapeutic area for gynecological sexology. This is quite a challenge for gynecologists the majority of whom also nowadays are not willing to see the sexuality of woman via gynecology or obstetrics [8].

The success of the DSM-V proposal are the following:

- taking the organic factor into account in the pathogenesis of sexual pain,
- description of pelvis as a multifunction organ and not as merely an element of the osseous system,
- description of the occurrence of sexual pain in relation with the pelvis minor as a sexual-pelvic function syndrome.

Currently, a correct diagnosis of a sexual disorder or dysfunction in woman should take into consideration the result of a gynecological examination.

Today, vulvodynia, vestibulodynia or clitorodynia cannot be omitted in the diagnostics of genito/pelvic pain / penetration disorder. Research and discussion are being carried on concerning experimental indication of similarities and differences between vaginismus and dyspareunia. In 2000, Kruiff et. al. published their research findings which showed that neither an interview nor a physical examination allow distinguish diagnostically between vaginismus and dyspareunia [9]. They, together with other authors, suggested more multidirectional describing and diagnosing of the symptoms than separate diagnosing of dyspareunia [9].

Vaginismus based merely on the spasm of the muscles is not a sufficient marker for the description of the syndrome. It is necessary to take into account the topical condition of the vulva, vestibule and opening of vagina, which may be assessed by a gynecologist only [11]. These doubts have been reflected in the DSM - V Classification.

Is each pain related to a sexual organ "pain only" or is it already a sexual dysfunction?

Nowadays, diagnosing of painful sexual intercourse by a gynecologist-obstetrician requires that questions about sexual function be included in the gynecological interview. Simple questions and a physical sexological examination as a basis of diagnostics shall allow an attempt to answer the question whether or not the woman experiences any genital, sexual or gynecological pain or perhaps the condition shall be considered as a sexual dysfunction. Genital pain takes forms of pain in the vulva, in the vagina vestibule, burning, itching sensations felt with no relation to sexual intercourse, while applying a vaginal pack, an intravaginal tablet or when a speculum is inserted in the course of a gynecological examination. Sexual pain is a genital pain related with sexual intercourse and is accompanied by ailments in the area of pelvis minor occurring during any sexual activity. Gynecological pain is an "independent" kind of pain which occurs only in course of a physical gynecological examination and/or which accompanies a sexual activity. Gynecological pain is commonly considered as pain in the abdominal cavity/abdomen whose diagnostics is by women requested from a gynecologist. In case such pain occurs chronically for three to six months, it is defined as a chronic pelvic syndrome of the pelvis minor. The occurrence of such pain is not directly related to sexual activity [12, 13].

The feature by which any pain related to the feminine sexual organ differs from a sexual dysfunction is the occurrence of woman’s fixed, chronic fear of pain and, thus, avoidance of sexual contacts [14, 15, 16].

REFERENCES: