

# CLASSIFICATION AND TREATMENT OF DYSPAREUNIA\*

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THE arrangement on the Gynecological Service whereby each morning clinic of the Out-Patient Department is reserved for the study of a special group of cases, has made it possible to concentrate the series of cases of dyspareunia.

The treatment of dyspareunia must be individualized because the cases do not conform to a single type. They vary as to cause, as to the individuals, and as to the domestic situation.

In general, the causes may be classified as follows:

## 1.—Organic:

(A) Introital: rigid hymen; reflex spasm from trauma or infection or both; operative overcorrection of plastics; atrophy of the senile type and that following x-ray treatment; kraurosis; urethral, e. g., caruncle, urethritis, cystitis; anal fissure; neuritis of the pudic nerve.

(B) Pelvic: diseased adnexa; shortened parametria; prolapsed ovary.

## 2.—Psychogenic:

(A) Initial dyspareunia: fear of injury (narcissistic type); fear of pregnancy; as a symptom of severe neurosis; as a symptom of psychosis.

(B) Secondarily acquired dyspareunia: fear of pregnancy; hysterical manifestation (of a negative attitude toward the husband, equivalent in many cases of frigidity).

## 3.—Combinations of Organic and Psychogenic:

The above may be combined in any quantitative relationship: (a) Where an organic lesion is secondarily invested with a mental significance, with emphasis on the factor of morbid gain. (b) Where a vaginal spasm has led to secondary organic changes, as for instance, the results of trauma from attempts to overcome it.

## DIAGNOSIS

First importance should be given to the history; not only the material, but the way of eliciting it. It should go without saying that the first step is to estimate the personality of the patient and make every effort to get a certain measure of confidence before proceeding with the history itself. In addition to the ordinary gynecologic history, it is essential to determine the familial setting, the developmental history, other complaints, and other experiences in the past. Among the most important of the facts in the present history are the severity, duration, onset, the patient's attitude toward the complaint and to her mate, the previous attempts at treatment, the frequency, duration, position, etc., of coitus, the presence or absence of orgasm. One should realize the transference situation in taking the history, and that often there is an initial attitude toward the doctor as an enemy who threatens to duplicate a painful situation and who somehow seems to be in alliance with the husband, against whom the symptom may be a defense.

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## TREATMENT

This will, of course, depend upon the type of dyspareunia and its cause. It may be classified as follows:

1. Prophylactic: May I mention at this point that Dr. Dickinson in his articles and numerous discussions on the subject of premarital instruction as well as in his excellent study of *A Thousand Marriages*, has correctly emphasized the importance of prophylaxis, and I can do no better than to refer you to his recommendations. Unfortunately, the gynecologist, both in clinic and office practice, sees the majority of cases when it is far too late for prophylaxis.

2. Actual Treatment: The actual treatment should be radical. If the cause is mental, the treatment should be mental, though it must be understood that this does not preclude local measures and that the patient may very well attribute a cure to these local measures. The treatment of the husband in these cases may be of great and even paramount importance. Incidentally, there is a high incidence of gentle, timid and inexperienced men, often relatively impotent, among the husbands of these women with primary dyspareunia. Perhaps this is due, in part, to their unconscious selection, on the somewhat mistaken assumption, that a gentle person would hurt them less; in part, it is the result of far more complex, deep-seated, psychologic reasons that I cannot enter into now, except to state that they are associated with their castration anxiety and envy of the male.

A. Rigid Hymen: The hymen will have to be stretched or cut. It might often seem simpler to cut it, yet actually, it is more practicable to stretch it by gradual dilatation. In cases of local trauma, vulvitis or vulvovaginitis, the inflammation must be treated before any attempts at stretching are made. One cannot over-emphasize the need for the most scrupulous care to avoid the slightest pain. Douching is in most cases inadvisable. A useful method is to insert an endoscope, and through this, a strip of gauze impregnated with Lasar's paste. This keeps the surfaces apart and dry and has the additional advantage of preventing any attempts at coitus. It should be changed daily.

B. Postoperative. Postoperative dyspareunia is the result of various types of operative misjudgments. (1) Too high a perineum of the shallow type may act as a thin commissural band which has the effect of a hymen. (2) Too narrow a vagina as the result of sacrificing too much mucosa in the anterior plastic. (3) Too tight levator sutures catching the muscle bundles with the consequent constriction ring at the vagina. (4) Too tight a vagina left after a vaginal hysterectomy. The treatment will depend upon the severity of the case. Some cases respond to non-operative dilatation which should be tried. Others require the so-called reverse plastic in which a nice judgment must be exercised to maintain the proper balance between the coital and supportive functions.

C. Atrophy: In the senile type of atrophy the relative infrequency of coitus plays a rôle and it seems important to prevent further shrinking by the wearing of vaginal plugs of appropriate size for rather considerable periods at regular intervals. Good lubrication is very important, and in douching one should avoid the stronger astringents. The hormonal treatment of these cases is feasible, but at present not practicable.

D. In the urethral type of dyspareunia, it seems advisable to toughen the meatus

with proper applications, but more important is instruction in altering the coital position to avoid catching the urethra underneath the pubic arch. "A posteriori" sometimes answers the purpose very well.

E. In the case of dyspareunia due to diseased adnexa. In addition to the usual general, hydrotherapeutic and thermal method, the *colpeuryxis* treatment with mercury is sometimes very efficacious. If because of the great chronicity of the condition, coitus cannot be interdicted, the following position should be advised: After intromission in the lithotomy position, the woman's thighs are fully extended and approximated, her knees inside the slightly separated knees of the man. This gives the minimum penetration, the minimum pelvic pain without sacrificing mutual stimulation.

F. In the cases of prolapsed ovary, the insertion of a Hodge pessary worked very well in two cases.

G. In the cases of dyspareunia associated with shortened parametria, the treatment is more or less like that with diseased adnexa.

### PSYCHOGENIC

The treatment of psychogenic dyspareunia commands extended attention. Obviously, one cannot enter here into the intricacies of the dynamics of its genesis. In the severer cases, this is a task for the specialist. It is very important for the gynecologist to recognize and differentiate those cases in which he can reasonably expect to get a good result from the suggestive measures at his disposal and those which he had better refer to a psychotherapist.

This much should be said: that the majority of cases of dyspareunia coming to the gynecologist are primarily psychogenic, although all the cases have some psychologic factors. The more these factors are taken into account, the more efficacious the treatment. It is of great importance to interview the husband, as obviously he may be the one to require attention.

In approaching the treatment of psychogenic dyspareunia, it seems advisable for the time being, to forget anatomic considerations and consider the individual. The cases may be simply grouped into:

1. The mild, in which there is a somewhat excessive reaction to an unfavorable situation, as for instance, an inept, inexperienced husband, an unusually thick hymen, a timid individual; the patient is cooperative and has insight. In these cases, the treatment can be rapid and one can very well combine local treatment with psychotherapy in the following way:

This method embodies the dynamics of the psychotherapeutic cure without any attempt to give the patient conscious insight. In this respect it is similar to many forms commonly used in medical treatment, but differs in that the physician is more or less aware of the mechanism.

At the first visit the patient is interviewed, (mostly listened to) and preferably not examined. When an examination is made, it is but an inspection. There should be no pain. The doctor concentrates his efforts in gaining the woman's confidence.

An endoscope is inserted through which a wick of medicated gauze is passed and left in. At subsequent visits very gradual and mechanical dilatation, combined with the local treatment, finally permits the easy introduction of a small vaginal speculum. This is replaced by a series of graduated test tubes, up to 1½ in. in diameter. Then the patient is shown how to introduce this test tube herself, which she does with ease. Then she is given the test tube and instructed to introduce

it herself at home for several days. The husband is then interviewed and instructed, and all treatment tentatively discontinued before the couple make any attempts at coitus.

The underlying principle is the establishment of confidence and the transference through which the fear, resentment and anxiety are partially overcome. This permits the alleviation of the local condition by a mechanical means which is presently replaced by an instrument with phallic significance. The patient is encouraged to be cooperative in its introduction. The treatment is then terminated and the patient returns to her coital function with an altered point of view. I do not think one need fear the danger of instituting autoerotism, principally because these women are not yet vaginally erotised.

2. The severe. In severer cases we see an inadequate response to a not unusual situation; there is no disproportion; there are other manifestations of a neurotic make-up; cooperation is not complete and insight is often lacking. In these cases, the treatment should be psychotherapeutic purely, up to the point where the patient is herself desirous of instituting local treatment.

3. The extremely severe forms, as for instance, in the cases of persistent virgins for many years; we must be extremely cautious. They are frequently psychopathic personalities. Interference here is not without considerable danger of a complete breakdown and even suicide.

#### ACQUIRED DYSPAREUNIA

In the first group resulting from fear of pregnancy, one may combine a brief psychotherapy with adequate contraceptive advice. In the group in which the dyspareunia is a result of a negative reaction against the husband, local treatment is of no avail. Brief psychotherapy of the suggestive type is almost always doomed to failure. Prolonged psychotherapy only offers a reasonably fair prognosis as far as the dyspareunia is concerned; though the prognosis is poor, quoad frigidity.

Combinations are treated after a careful evaluation of the factors. I do not wish to convey the impression that the rapid treatment, or for that matter, any treatment offers a guarantee for cure. Many cases do not respond rapidly. One cannot emphasize too strongly the necessity for individualization of the cases as well as the necessity for the utmost patience.

Dyspareunia, then, is due to a variety of causes, that manifests itself in all degrees of severity. The causes may be organic or mental or combinations of both. Treatment should be instituted in both directions. The condition may seem a minor one, when it is really of major importance in the life of the individual. There is a need for marked individualization of the cases. The prognosis varies considerably. It is least favorable in those cases which show absolutely no organic manifestation. As far as psychotherapy is concerned, in the mild cases, simple suggestion seems best; in the severer cases, formal psychotherapy and in the most severe cases, as in the case of persistent hymen over many years in a psychopathic person, "*noli me tangere*."

Training in psychoanalysis has a triple usefulness in the treatment of these cases: (1) It offers the road to the possible understanding of the complex mechanisms through which these conditions arise. (2) It

offers a technic for intelligent listening in the eliciting of an adequate history. (3) In very carefully selected cases, it offers a radical therapy which attempt to combine the removal of symptoms with an adjustment or readjustment of an unhappy individual.

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