

Dyspareunia Looks Sexy on First But How Much Pain Will It Take for It to Score? A Reply to My Critics Concerning the DSM Classification of Dyspareunia as a Sexual Dysfunction

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I was very impressed by the 20 commentaries I received. Unfortunately, they arrived in the middle of the baseball season and I usually resent anything that distracts me from my baseball addiction. The quality of these commentaries was so high, however, that they commanded my attention. I learned a lot from reading them. Nonetheless, I could not totally tear myself away from baseball while I attempted the important task of trying to absorb and summarize the many issues raised. I, therefore, adopted the traditional baseball shorthand: the box score.

Basically, I had suggested two ideas: (1) dyspareunia did not really fit the DSM-IV-TR (American Psychiatric Association, 2000) criteria for a sexual dysfunction; (2) dyspareunia fit better as a pain disorder. My box score was instructive. Only 3 out of 18 commentators agreed with me concerning both ideas while 5 out of 18 disagreed with me on both. The remaining 9 respondents agreed with me on either one or the other (3 commentators did not specifically address either of these ideas). When I computed my batting average, I realized that I was probably doomed to a career in the minor leagues.

Since I know that box scores do not tell the whole story, I decided to investigate the opposing lineup more closely. I quickly noted that the three individuals who totally agreed with me were all non-mental health professionals: one anthropologist (*Townsend*), one sociologist (*Kaler*), and one physician (*Markos*). Maybe I was playing in the wrong league? Although I did manage to convince most of the psychologists about at least one of my ideas, I struck out with most physicians. I guess this is not too surprising since the primary arbiters of

the DSM rulebook are physician/psychiatrists. Another baseball tradition: “blame the ump.” Even so, this was not really an adequate interpretation of the score. The ump, independent of league, suggested that I consistently missed the strike zone with at least four bad pitches: (1) I overgeneralized from one type of dyspareunia—vulvar vestibulitis syndrome (VVS); (2) my reclassification strategy for dyspareunia was of dubious clinical utility; (3) I did not recognize that dyspareunia really is a sexual dysfunction; and (4) I confused symptom and mechanism in my discussion of classification.

Overgeneralizing From One Type of Dyspareunia (Vulvar Vestibulitis Syndrome)

Many of the commentators (e.g., *Carpenter and Anderson*, *First*, *Grazziotin*, *Meana*, *Strassberg*, *Wakefield*) suggested that I was trying to sneak a fastball past them by overgeneralizing from one type of dyspareunia. I would remind them that the first part of my target article dealt with logical/theoretical arguments that are not specific to VVS (e.g., the pain of dyspareunia is not specific to intercourse; interference with function does not constitute a classification criterion, etc.). They correctly noted, however, that most of my empirical data were drawn from the study of VVS. I made this transparently clear in my article, but, to the extent that vulvar vestibulitis does not reflect other types of dyspareunia, my critics are correct. However, the only available data that anyone was able to cite concerning a possible subtype of dyspareunia that was not consistent with a pain formulation was described in *Meana's* commentary (see also *Meana*, *Binik*, *Khalifé*, & *Cohen*, 1997a, 1997b). If further study confirms the existence of such a group, then I would be happy to leave this group with a sexual dysfunction/dyspareunia diagnosis. Part of the difficulty, however, is that there are very

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little available data concerning this or other types of dyspareunia and no one really knows what these other types are. It is my prediction that when people get around to systematically studying these other types, they are going to find out that pain is a better model than sex.

Let me illustrate this with an example from so-called post-menopausal dyspareunia. The presumption for most clinicians and the DSM is that post-menopausal dyspareunia is the result of vulvovaginal atrophy and, therefore, would probably be diagnosed as a sexual dysfunction due to a general medical condition. In the absence of atrophy, a clinician might assume that this type of dyspareunia results from “vaginal dryness” or lack of subjective arousal. In the absence of all of these, it might be linked to the sometimes difficult psychosocial transitions associated with this time of life.

The evidence, not to mention the logic underlying this kind of reasoning, is questionable. Although the DSM claims to not make etiological assumptions, it hides behind poorly documented claims about general medical conditions causing dyspareunia. For example, the assessment of vulvovaginal atrophy has never been put to a serious test with respect to dyspareunia. The limited available evidence suggests that it cannot account for post-menopausal dyspareunia (Cutler, Garcia, & McCoy, 1987; James et al., 1984; Laan & van Lunsen, 1997; Weber, Walters, Schover, & Mitchinson, 1995). Even if vulvovaginal atrophy turns out to be the cause of post-menopausal dyspareunia, then this certainly does not qualify it as a sexual dysfunction.

Vaginal “dryness” has not been measured reliably and is often used synonymously with dyspareunia, thus making it both a symptom and a cause (e.g., Weber et al., 1995). It is interesting that there is cross-cultural evidence to suggest that vaginal dryness is sometimes highly desirable rather than being a problem (e.g., Brown, Brown, & Ayowa, 1995). It is also not clear how the lack of subjective sexual arousal is related to vaginal dryness (decreased lubrication?) or to vaginal pain or whether any of these are specifically related to post-menopausal dyspareunia. There are also no data to link psychosocial transition to dyspareunia though this is an interesting hypothesis. What exactly, then, is post-menopausal dyspareunia? Has anyone shown that it is really different from pre-menopausal dyspareunia? This should be carefully investigated. To me, the obvious and, so far, relatively unexplored way of doing so would be to carefully assess the pain.

It would certainly be wise to collect much more data concerning all the different types of dyspareunia. However, if one is going to attempt to generalize from admittedly limited evidence, it is probably best

to generalize from the most prevalent type or category. The best epidemiological (Harlow & Stewart, 2003), clinical (Goetsch, 1991), and experimental (Meana et al. 1997a, 1997b) estimates all suggest that VVS is the most prevalent type of pre-menopausal dyspareunia. Why rely on less frequent, less studied, and, perhaps, non-existent types?

I certainly cannot accept *First's* contention that we require a very high threshold of empirical evidence to eliminate DSM categories like dyspareunia. Why raise the empirical bar for change so high when the category was created without any empirical evidence at all?

Reclassifying Dyspareunia Will Be of Dubious Clinical and Research Utility

First, Meana, Strassberg, and others suggested that I threw them a curve ball by suggesting that the reclassification of dyspareunia from a sexual dysfunction to a pain disorder would be useful. They argued that it would not, in fact, improve practice and research but might even make things worse. This is possible and if I believed that they were correct, then I would certainly tone down my suggestion. I think, however, that the “worse off outcome” is highly unlikely since, as *Kaler's* commentary aptly demonstrates, the current quality of treatment for women with dyspareunia is shockingly poor. The growth of patient advocacy groups like the National Vulvodynia Association reflects a long history of clinical neglect. *Strassberg* is correct that I oversimplified when I discussed the reasons certain problems like dyspareunia get ignored; however, I think it would be fair to say that the very recent flurry of clinical interest and research in dyspareunia has been motivated, at least in part, by the application of a pain perspective.

One important point that several discussants made (e.g. *First, Meana, Levine, Spitzer*) is that the current DSM-IV-TR category of Pain Disorder is problematic and that shifting dyspareunia from one problematic category to another does not really solve anything. I think that there is merit to this objection but there is at least one relatively reasonable solution: fix the problems with the current Pain Disorder category. Much of this work has already been accomplished by the publication of the second edition of the *Classification of Chronic Pain* (Merskey & Bogduk, 1994) by the International Association for the Study of Pain (IASP). In fact, DSM-IV-TR has have already paved the way for using this model by discussing the relationship of the DSM Pain Disorder category to the IASP classification.

Several commentators (e.g., *Carpenter and Anderson, Strassberg*) implied that the sexual concerns

of women with dyspareunia might get ignored if they go to pain clinics. I think they underestimate clinician/researchers, such as Masheb and Richman, who work at such multidisciplinary clinics and are very sensitive to sexual issues. It is no more difficult for professionals at a pain clinic to learn about sex than for sexologists to learn about pain. I also strongly suspect that there are currently many more multidisciplinary pain than sex clinics. Even so, if you artificially forced me to choose one treatment strategy (i.e., pain management or sex therapy), I think the response is clear. There is very little hope of a woman having a satisfying, let alone acceptable, sex life involving intercourse while she is anticipating or actually experiencing pain. Removing or reducing the actual or anticipated pain is the first line of treatment. Of course, I never suggested that it was an either/or proposition and I made it very clear in my article that “sexual rehabilitation/therapy” was necessary and was a logical outcome in a multidisciplinary pain setting.

A basic problem in evaluating the clinical utility argument is how to do it empirically. Unfortunately, there is no simple model for how to accomplish this (see First et al., 2004). One important issue is from whose point of view do we measure clinical utility. For example, it might be easier for clinicians to remember the diagnosis of dyspareunia if it remained as a separate category in the sexual dysfunction section than if it became one of the very many possible pain disorders; however, this would not necessarily translate into better care for women. In fact, as *Kaler* points, out it hasn't. Clinical utility is also problematic because it may be closely linked to the health system in which it is evaluated. Overall, social scientists, among others, are not very good at predicting the future; most of the time clinical outcomes are neither as good nor as bad as predicted.

Dyspareunia Really Is a Sexual Dysfunction

Apparently, my “forkball” was way off the plate and did not fool many commentators into thinking that dyspareunia was anything other than a sexual dysfunction. They hit against this pitch in two ways. First, they suggested that relatively minor modifications to the current DSM-IV-TR definitions would acknowledge the role of pain but not dismiss sex. I could be convinced to accept ideas like “dual coding” (*Payne*) for sex and pain or renaming sexual pain as “pain interfering with sex” (*Meana*) or even as (gulp) “chronic obstructive vaginal disease” (*Levine*) if such strategies were to be adopted as interim solutions to prop up the crumbling edifice of sexual disorders as listed in the DSM-IV-TR. If I believed that the current sexual disorders framework in the

DSM-IV-TR were sound, then I would be happy to suggest other patches. Unfortunately after reading *Kleinplatz's* comments on the sexual dysfunction section of the DSM-IV-TR and *Moser's* comments on the classification of sexual pain and his incisive critique of the DSM-IV-TR paraphilia section, I think we need to redesign and rebuild this section totally.

In the second hit against “dyspareunia really is a sexual dysfunction,” several commentators proposed “new” or at least non-DSM definitions of sexual dysfunction and or dyspareunia. For example, *Tiefer* argued that “dyspareunia is the only true sexual dysfunction” because “. . . sexual problems [are best defined] as discontent or dissatisfaction with any emotional, physical, or relational aspect of sexual experience.” (p. XX). While I have some sympathy for this definition, it is too broad since everything that interferes regularly with sex (e.g., watching too many baseball games?) becomes a sexual dysfunction.

Wakefield's attempt to redefine sexual dysfunction as anything that interferes with evolutionarily intended reproductive capacity is also interesting. I appreciate that this definition and his “general harmful dysfunction analysis” avoids the circularity in most our definitions of mental disorders. Unfortunately, I am not sure if we should let the past evolution of reproduction limit our current non-reproductively based sexual evolution. *Basson* argued by analogy that most current sexual problems (e.g., erectile problems) are as variable in etiology and symptomatology as is dyspareunia and, therefore, that multiplicity of etiology and manifestation is not a reason to reclassify. I agree about the complexity and variability of most sexual dysfunction but this rationale could equally well be used as an argument to reclassify many cases of erectile failure as vascular problems rather than as sexual dysfunctions.

Basson, *Tiefer*, and *Wakefield* agree with me that the DSM-IV-TR definition is not a good one. If they could only agree among themselves on what the correct definition of sexual dysfunction is, then I would know if dyspareunia fits well or not. Unfortunately, even among sexologists, it has not been easy, as indicated by *Kleinplatz*, to reach a consensus. The sad truth is that at our current state of knowledge, sexual dysfunction is whatever sexologists or others say it is.

Confusing Classification by Symptom with Classification by Mechanism

Several commentators (e.g., *Dennerstein*, *Grazziotin*, *Levine*, *Wakefield*) felt that one of my pitches was an illegal “spitball” since I failed to make the important distinction between classification systems

based on mechanism versus those based on symptoms. This distinction goes to the heart of the science of classification in general and mental disorders in particular. I, perhaps, did not make it clear that I am not particularly in favor of symptom based classifications in general or for dyspareunia specifically. In fact, I agree that lasting classification systems will ultimately be based on underlying mechanisms or characteristics rather than superficial symptoms. Unfortunately, we are a long way from such mechanism based classifications for dyspareunia. Until we get closer, we should focus on the relevant symptoms which in my view are related to pain. At the very least, this facilitates communication between professionals; at the most, it provides important etiological clues.

I disagree with the suggestion (e.g., *Basson, First, Wakefield*) that inflammation is a potential explanatory mechanism for VVS or dyspareunia in general. In fact, the data concerning inflammation in VVS are highly controversial (e.g., *Bohm-Stark, Falconer, Rylander, & Hilliges, 2001; Lundquist, Hofer, Olofsson, & Sjoberg, 1997*). As a result, the most recent International Society for the Study of Vulvar Disease (ISSVD) proposal for classifying vulvodynia has omitted any reference to an inflammatory process (*Lynch & Moyal-Barracco, 2003*). More important, inflammation per se is not a mechanism. It is a very common symptom (albeit not a behavioral or cognitive one) that can reflect any number of underlying pathological processes. We are a long way from a science of mechanisms in either the study of sex or pain but if I were to embark on such an etiological study, for dyspareunia, I would use the pain rather than the sex literature as my guide.

Important Issues I Did Not Discuss Adequately

Several commentators pointed out important issues that I did not discuss adequately in my article. *Grazziotin* correctly pointed out that a longitudinal and perhaps a developmental perspective is crucial in understanding dyspareunia. I did mention that many women with VVS report vulvar pain from the first time they attempted to insert a tampon but it is crucial to investigate how early this pain really begins and how it develops. Furthermore, our clinical and research samples of women suffering from VVS have generally been comprised of young adults with an average age in their mid-20s. We have often wondered what happens to these women with age. Does the pain remit? Does it get worse? Do women learn to cope with pain? Do they stop engaging in intercourse?

Black and *Grazziotin* pointed out that I did not mention vaginismus, which according to the DSM-IV-TR,

is also a sexual pain disorder but distinct from dyspareunia. I should have done this because I do not believe that vaginismus and dyspareunia are as distinct as the DSM-IV-TR would have us believe nor do I believe the vaginal spasm is the defining characteristic of vaginismus. Most of the women that we have tested who are suffering from vaginismus also test positively on the cotton swab test for VVS. In another context, *Reissing* and I have suggested that the distinctive characteristic of what we currently call vaginismus is a vaginal penetration fear/phobia (*Reissing, Binik, Khalifé, Cohen, & Amsel, 2004*).

I am indebted to *Dunne and Najman* for pointing out published data on sexual abuse and dyspareunia of which I was not aware. Had I done my homework, I would have concluded, as they do, that the available data are conflicting. I am further indebted to *Dunne and Najman* for reporting on their unpublished data, which suggest that child sexual abuse was not, in fact, correlated with dyspareunia but was associated with a higher prevalence of anorgasmia, with not finding sex pleasurable, and with a higher degree of anxiety over performance. Needless to say, the relationship between sexual abuse and dyspareunia merits further careful study.

Finally, I was appropriately rapped on the knuckles by *Black, Grazziotin*, and others for suggesting that the ease of getting research and clinical funding should influence our classification of dyspareunia. They are correct and I retract this argument. The inflation in baseball salaries relative to the deflation in available research and clinical funding has obviously affected my judgment. According to *First*, such pecuniary considerations have had no effect on the DSM-IV-TR classification and I can only aspire to this standard.

Conclusion

It is clear that my article did not hit a home run; however, dyspareunia is looking sexy enough to have finally gotten to first base. I think it will finally score in the major leagues. Whether dyspareunia will ultimately stay on Team Sex or be traded to Team Pain is not clear but I'm hoping that the issues raised will get their playing time in the upcoming fifth DSM World Series.

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