VAGINISMUS AND THE CULTURAL CONTEXT: ADDRESSING HER STORY

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#HerStory
OBJECTIVES OF THE SESSION:

1. Recognize ways in which culture informs our perception and expression of sexuality

2. Describe the elements to assess regarding a patient’s “sexual culture”

3. Identify points of intersection of psychosexual aspects with the practice of Pelvic Physical Therapy in treatment of vaginismus

4. Explain the providers’ responsibility in sensitive interviewing, sexuality education and treatment planning
WHAT ABOUT YOU?

What are your needs?

What are your challenges?
PREVALENCE AND PRESENTATION

7,000 British women, found that women in their late 50s and early 60s were most likely to experience pain during sex, followed by women ages 16 to 24.

KR Mitchell et al BJOG 2017
PREVALENCE AND PRESENTATION

Vaginismus rates of between 12% and 17% have been reported in women presenting to sex therapy clinics

- Spector, Carey Arch Sex Behav 1990

Lifelong/Acquired

Onset with medical exam, initial coitus/wedding plans, by accident, fear
LABELING THE CONDITION

Per definition on ICD-10 “vaginismus” describes painful sex or that intercourse is impossible

1978 Lamont described a classification of vaginismus to describe the severity of the vaginismus. All vaginismus patients were noted to have generalized tightness of the pelvic floor.

2010, Pacik added to the Lamont classification by introducing a Level 5 vaginismus severity

2010 GenitoPelvic Pain/Penetration Disorder = DSM V
- Binik, J Sex Med 2010
FOR THE PATIENT:
“WHAT DOES THAT MEAN?”

How does the label help the patient or society perception AND understanding of their condition?

Is it associated with other conditions, does it define prognosis, does it have a stigma, does it help patients find help with the right providers/intervention.

Ultimately what is the goal and what are the barriers?
Patients not only want to be understood but especially want to be accepted within their cultural experience.

(Audio of patients explaining their sexual expression within their culture while in treatment)
# CLINICAL INTERVENTION MODELS

<table>
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<tr>
<th>Model</th>
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<td>CBT approach</td>
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<td>Interdisciplinary</td>
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MULTIMODAL

All providers must have the ability to screen and identify areas in another discipline that are part of the patient's clinical need and assist in getting them to the next part in clinical journey.

Team approach vs Anchor provider
COMMON ASSUMPTIONS ABOUT CONDITION AND CARE

Treatment can be easily broken up into physical and psychological factors.

Women with vaginismus are not orgasmic, have low desire, have arousal problems.

Treatment is straightforward and usually successful.

Patients are unaware of the connection of their culture to their condition.

Once successful penetration is achieved; the problem is solved.
WOMEN’S EXPERIENCES OF USING VAGINAL TRAINERS (DILATORS) TO TREAT VAGINAL PENETRATION DIFFICULTIES DIAGNOSED AS VAGINISMUS: A QUALITATIVE INTERVIEW STUDY

“The practical and emotional demands of using vaginal trainers may be underestimated by professionals.”

“At times vaginal trainers may be prescribed to women who are unlikely to benefit from this treatment in isolation.”

Macy et al
BMC Women’s Health 2015
NOT THE WHAT WE DO BUT THE HOW...
OVERVIEW OF INTERVENTIONS
WITH PELVIC PHYSICAL THERAPY

Assessment: Scope of problem, personal goals, screening for DV or sexual trauma, abbreviated sexual history, appraisal of sexual physiology knowledge, medical history, comorbid conditions of PF or intersection systems

Exam: Education, consent, observational, progressive, descriptive and review findings. Includes skin and neural integrity, lumbo-pelvic-hip complex screening for robustness and coordination for function, local unit assessment of responsiveness to desired activity (relax, contract or elongate)
OVERVIEW OF INTERVENTIONS
WITH PELVIC PHYSICAL THERAPY

Identify: Reported thoughts, emotional experience, sensation descriptions. Review possible biopsychosocial explanations.

Tools for progress: assess patients interest, comfort level, and the purpose of use of progressive “vaginal accommodators, dilators, trainers”, most valuable use, functional carryover.
THE SEXUAL HEALTH TEAM MEMBER PT

Longer intake to understand the history and goals clearly, **active listening with restating and clarifying questions**

**Establishes what the patient is comfortable** with in terms of family involvement, discussion of partner, partner involvement

**Outlines the domains of sexual expression and the sexual response cycle**, answers questions, offers validation

**Practices mindfulness and awareness in patients non verbal language**, gives time and options for comfortable expression

**With every progression asks patient their goal** and offers options for visit

Able to **communicate with the other team members in sexual health terms** and able to answer questions about responsiveness of the physiological system in clinic and in vivo reported
CLINICAL TIPS FOR PT'S INTEGRATING PATIENT CONTEXT INTO UNDERSTANDING THE CONDITION AND CARE

Hearing her story – what is her goal (provider dissonance)

When in doubt about sexual practices, ask (permission)

Encourage whole person explanations (don’t encourage compartmentalizing)

Appreciate what is at stake with these patients (relational, social, cultural, legal)

Tailor your physical techniques to progressive steps patient is making within her personal readiness for change and belief system

Make it functional. Always.

Communicate often with other providers involved (case conference)
CONSIDERATIONS IN WORKING WITH PSYCHOSEXUAL COUNSELOR / SEX THERAPIST

Understand and identify the patients sexual attitudes, beliefs and formative experiences.

Include clarifying questions that can outline patients personal and relational goals with addressing sexual problems.

Includes assessment of partner roles, experiences, goals, and interaction.

Help patient explore tolerances to introduction of sexual exploration and their boundaries.

Often patients can take time for introspection of how their thoughts and emotions interact during sexual encounters.

Homework that is complementary to the progress made.

Increases compliance and helps to work through challenges in the treatment journey.

What other behavioral interventions compliment your work?
OUR JOURNEY TODAY

• Knowledge

• Attitude

• Practical considerations and tools
KNOWLEDGE
WHAT WE NEED TO KNOW!
GENITO-PELVIC PAIN/PENETRATION DISORDER

New in DSM-5 is genito-pelvic pain/penetration disorder which combines vaginismus and dyspareunia from DSM-IV

For at least 6 months, a person experiences persistent or recurrent difficulties towards vaginal penetration manifested as at least one of the following:

1. Intense fear/anxiety in anticipation of, during, or as a result of vaginal intercourse
2. Actual pain experienced in pelvis or vulvovaginal area during attempted or as a result of vaginal penetration
3. Marked tensing or tightening of the lower pelvic/inner-abdominal muscles during attempted vaginal penetration

Diagnostic criteria requires that these symptoms cause the female significant distress.

WHAT IS IN THE LANGUAGE?

• Painful sex

• Unconsummated marriage (UCM)

• Working definition:

“Failure to perform successful sexual intercourse within a marital constitution within the timeframe expected by the couple's cultural context.”
WHAT IS PSYCHOSEXUAL THERAPY (PST)

- A subspecialty of psychotherapy
- Deals specifically with sexual behavior and functions
  - Holistic history taking (including medical, psychological, relational and socio-political).
- Methods used for PST
  - Cognitive-behavioral approaches rather than the classic psychoanalysis and psychodynamic
  - Discussing sensitive topics with individuals as well as couples in the context of PST
PSYCHOSEXUAL THERAPY

• Solution focused
• Homework
• Focuses on thought process
• Sex as a legitimate problem not as a sign of underlying issues
• Short term
• Follows the holistic and multi-disciplinary model
• Systems Theory Approaches
  ▪ Interactions, relationship, partner, context (culture, religion, family, environment, etc.)

Cognitive-Behavioral Therapy
  ▪ Directed sexual techniques, e.g. masturbation for Orgasmic Disorders
  ▪ Anxiety reduction techniques
  ▪ Systematic Desensitization
  ▪ Sensate Focus
  ▪ Kegel Exercises

• Sex Education and Bibliotherapy
• Assistive devices (e.g. vibrator, dildo, dilators)
• Psychoanalytic Psychotherapy
• Physical Therapy
• Medical interventions/Pharmacotherapy

PLISSIT Model:
Permission, Limited Information, Specific Suggestions, and Intensive Therapy

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The use of physical homework (Sensate focus) to:
- Increase willingness
- Improve relaxation
- Improve partner bonding
- Increase sensuality
- Reduce anxiety attached to performance
- Provides opportunity to learn about self and partner
- Expands couple’s repertoire
- Has an overall structure but works best if individualized

- The use of communication methods
- The use of bibliography and educational props
- PLISSIT (Permission, Limited Information, Specific Suggestions, Intensive Therapy)
- Sexual Health and hygiene coverage
DEFINING SEXUAL DYSFUNCTION

- What is normal?
- What is dysfunctional?
OVERALL TYPES OF SEXUAL DYSFUNCTIONS

- Lifelong-Primary
- Acquired-Secondary
- Situational
- Generalized
BIO-PSYCHO-SOCIAL

FIRST POINTS OF CONTACT

- Psychosexual therapists (sex therapists?)
- Sex coaches
- Physical therapists
- Medical professionals and surgeons
- Spiritual guides
- Body workers
- Somatica coaches
- Psychoanalysts
- Surrogates


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CONSIDERATION FOR WORKING WITH A PT

- Not rushed
- Actually look!
- The whole person
- PT might be second level of care in some cultures
- Burdened with psychological and relational issues
- Management of partner involvement/role
- Quick fixes?
- Lithotomy tables are scary and intimidating
- Observing resistance, compliance
- Intrusive or not
- What overlaps or complements your work?


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PROS AND CONS OF GIVING A DIAGNOSIS

Pros

- She is not alone
- There is an explanation
- There is possibly for a treatment
- Opportunity for sexuality education as a part of the treatment process
- Opening communication between the couple

Cons

- High expectations from the medical treatment
- Medicalization
- Labeling
- Polarizing the sexual relationship

SEXUAL CULTURE: CORE CULTURAL COMPETENCY

- Sex before marriage
- Sex outside marriage
- Acceptable number of sexual partners in lifetime
- Monogamy vs. polygamy
- Same sex marriage
- Virginity, hymen, first night bleeding
- Fertility and contraception
- Link between clothing and sexual openness
- Marriage for sex vs. marriage for having children vs. marriage for love
- Acceptable sex positions
- Alternative sexual gratification and behavior
- Male vs. female roles and expectations during a sexual intercourse


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Genito/pelvic pain and penetration disorders: Life-style, taboos, scared of men, fear of pregnancy, age gaps, power games by women, fear of letting go, lack of foreplay, lack of techniques…. 

What else have you heard?
PRACTICAL CONSIDERATIONS
WHAT NOT TO DO, NOT TO CAUSE HARM. HELPING WILL BE A BONUS
USE OF THE PLISSIT MODEL

• Permission
• Limited information
• Specific Suggestion
• Intensive Therapy
• Refer

How much knowledge is enough?
How not to harm?
SESSION MANAGEMENT

Importance of individual sessions

- Particularly for self-focus programs

Dress code and setting

Sensitive approach for domestic violence and sexual abuse

Awareness of nondisclosure possibility when discussing the family; respect and prejudice towards original family

Define the goals and success

Opportunistic sexuality education

- Anatomy
- Sexual response model
- Practicalities
- Giving permission


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INFORMATION GIVING STYLES

Formal Authority
Demonstrator
Facilitator
Delegator

Original model by Fischer and Fischer (1979)
Adapted for psychosexual therapy by Nasserzadeh, S (2014) MESSM Newsletter

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7 THINGS TO CONSIDER FOR THE USE OF EDUCATIONAL PROPS IN PST

• Feel comfortable with it (including to know how it functions)
• Explain why you are using it
• If you don’t know the clients well enough or you suspect that their spiritual/cultural beliefs might contradict with the use of specific material, ask them in advance if this form (e.g. picture) will be ok to use with them and why it is important to do so
• Consider using specific props/discussion on technique in individual sessions (e.g. perineum massage)
• Take extra care to choose bias-free props (size, color, shape)
• Store with caution
• With more explicit props, use more of formal authority style

Nasserzadeh, S. (2014), MESSM Newsletter

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DEFINING AND MEASURING SUCCESS

Definition for each, the couple and other stakeholders

The focus is on:

- Sexual function
- Sexual satisfaction and its effect on the individual and the relationship
- Increased quality or quantity of sexual encounters
- Increase sexual ability/capacity
- Any other criteria that couple brings to the table (e.g. conception)

Ultimately, the outcome is what is defined by the clients.

REFERENCES & FURTHER READINGS (1)


REFERENCES & FURTHER READINGS (2)


DISCUSSION POINTS

• Concerns
• Blocking points
• Making yourself and expertise known
• Get in touch
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