Sexual and Relationship Therapy
Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/csmt20

An integrated mindfulness-based approach to the treatment of women with sexual pain and anxiety: promoting autonomy and mind/body connection

Talli Y. Rosenbaum [a]
[a] Inner Stability Ltd, Bet Shemesh, Israel
Version of record first published: 28 Jan 2013.

To cite this article: Talli Y. Rosenbaum (2013): An integrated mindfulness-based approach to the treatment of women with sexual pain and anxiety: promoting autonomy and mind/body connection, Sexual and Relationship Therapy, DOI:10.1080/14681994.2013.764981

To link to this article: http://dx.doi.org/10.1080/14681994.2013.764981

Sexual and Relationship Therapy, 2013
http://dx.doi.org/10.1080/14681994.2013.764981

Routledge
Taylor & Francis Group

An integrated mindfulness-based approach to the treatment of women with sexual pain and anxiety: promoting autonomy and mind/body connection

Talli Y. Rosenbaum*

Inner Stability Ltd., Bet Shemesh, Israel

(*Received 14 October 2012; final version received 6 January 2013*)

Sexual pain disorders are understood to have multi-factorial components. Traditional biopsychosocial treatment models, goal-oriented towards achievement of painless penile-vaginal intercourse, designate the physiological aspects of treatment to physicians and physiotherapists and the psycho-social aspects, including anxiety and aversion, to mental health professionals, including psychotherapists and sex therapists. However, as fear, aversion to touch and pain avoidance are significant characteristics of the patient's response to physical examination and treatment, there is a recognized need for practitioners to be skilled in addressing cognitions, anxiety and pain-related emotional responses in the clinical setting. This clinical paper offers a mindfulness-based approach to physical and behavioral interventions, which promotes feelings of safety and aims to encourage clients to suspend self-judgment, stay connected and present during treatment and experience personal autonomy such that they may find meaning in the sexual connection. This approach is useful in both mental health and medical settings.

Keywords: cognitive behavior therapy; physical therapy; dyspareunia; mindfulness; vaginismus

Introduction

Sexual pain disorders (SPDs) have been divided into vaginismus and dyspareunia, with the former diagnosis implying a fear-based reactive inability to allow vaginal penetration and the latter implying a condition characterized by the essential experience of pain with sexual intercourse or other vaginal penetration (American Psychiatric Association, 2000). The proposal to replace these two DSM-IV sexual dysfunction categories with a "genito-pelvic pain/penetration disorder" (Binik, 2010a, 2010b) recognizes the significant overlap in these conditions, as well as their non-sexually related symptoms. Pain and anxiety are understood to be salient and interactive (Borg, Peters, Weijmar Schultz, & de Jong, 2012) components of both vaginismus (van Lankveld et al., 2010; Watts & Nettle, 2010) and provoked vestibulodynia (PVD) (Khandker et al., 2011), which is the most common cause of dyspareunia in women in their childbearing years, affecting 12–21% of women in this population (Harlow, Wise, & Stewart, 2001). Chronic pelvic pain, a syndrome encompassing such conditions as interstitial cystitis/painful bladder syndrome, irritable bowel syndrome and endometriosis, is also associated with sexual pain, bowel and bladder symptoms, decreased quality of life and psychological distress (Rosenbaum, 2011c). A recognized component of these sexual pain-related conditions is overactivity of the

*Email: talli@tallirosenbaum.com

muscles of the pelvic floor and pelvic floor muscle therapy, which is aimed to normalize and reduce pelvic floor muscle tone and has become a standard intervention (Gentilcore-Saulnier, McLean, Goldfinger, Pukall, & Chamberlain, 2010; Rosenbaum, 2005, 2007).

While the outmoded approach to sexual pain had classically been to treat medically if organic findings were present, and to consider psychological etiologies in the absence of physical findings, SPDs are currently understood to have multi-factorial components (Schultz et al., 2005). Proposed physiological mechanisms of PVD include alteration in central pain processing, local tissue mast cell and nerve proliferation and overactivity of the pelvic floor musculature (Goldstein & Burrows, 2008). However, PVD is also associated with psychological, relational and sexual distress. Higher catastrophizing, fear of pain, hypervigilance and lower self-efficacy have been associated with increased intercourse pain intensity (Desrochers, Bergeron, Khalifé, Dupuis, & Jodoin, 2009; Payne, Binik, Amsel, & Khalifé, 2004). Vaginismus, traditionally defined as a reflexive reaction of vaginal spasm in anticipation of intercourse and associated with reporting higher moral values, restricted sexual standards and increased levels of disgust (Borg, de Jong, & Schultz, 2010), has also been re-conceptualized and validation of the actual experience of pain has been included in the newer definition (Basson et al., 2004). Moreover, this definition highlights that penetration of a finger or a tampon is also problematic, emphasizing that the problem may not be exclusively or specifically sexually based. In fact, the clinical experience of this author is that many women with fear, aversion and pain with penetration report sexual feelings, desire, arousal, and orgasm and overall satisfaction with non-penetrative sexual activities.

Criticisms of the biopsychosocial model

Recognizing the multi-dimensional nature of SPDs, the current biopsychosocial treatment paradigm designates treatment of the medical aspects of SPD to physicians and the psychological aspects, including anxiety and aversion, to mental health professionals such as psychologists or sex therapists. In this model, treatment of the overactive pelvic floor muscles, or what is referred to as "pelvic floor dysfunction", is designated to physical therapists.

While this model recognizes the multi-factorial nature of sexual pain, there are several problems with its compartmental treatment approach, and with the implication that these factors can be separated clinically. Furthermore, the psychological and the sociological. aspects require distinction from one another. While emotional responses are psychological, the perception that women must allow vaginal intercourse for satisfactory sex, to please her partner, fulfill his need for sex or to be "normal" are sociocultural and the sociological context should be appreciated by all practitioners. Furthermore, the assertion that the pelvic floor can be addressed with only a physical therapy approach is problematic as well. Pelvic floor dysfunction is not simply an isolated mechanical condition, but may be a physical expression of an emotional state. Pelvic floor muscle activity has been found to be reactive in response to anxiety (van der Velde, Laan, & Everaerd, 2001), fear of penetration and fear of pain and most recently has been found to be reactive to visual stimuli of even non-sexual scary films (Both, van Lunsen, Weijenborg, & Laan, 2012). Increased pelvic floor muscle tone may be a baseline state as well, related to early habits such as rigid toilet training and may be related to multiple pelvic floor symptoms (van Lunsen & Ramakers, 2002). The experience of physical therapy, which involves internal examination and muscle treatment, or other potentially exposing treatments may elicit significant emotional responses, trigger past traumatic episodes and, if not properly

identified, may result in dissociation, which may be misinterpreted as cooperation. This is a particular concern as, often, women with SPD are very cognitively motivated to cooperate and allow examinations. Often they feel responsible for the relationship distress that results and carry a burden of guilt for being unavailable to "provide" sex (Ayling & Ussher, 2008). They may perceive their anxiety and difficulty with allowing penetration as something they must overcome. Thus, they suppress their growing sense of anxiety as they will themselves to comply. As this decreases their sense of autonomy and control, it often results in an anxious reaction of aversion and muscular contraction upon attempted examination, which often mirrors that which occurs in the sexual setting as well. This results in frustration for the client and the practitioner, self-criticism and feelings of failure. Therefore, while aversion, anxiety and self-criticism are considered the domain of mental health professionals, it is precisely the physicians, nurses and physiotherapists who are most likely to encounter these responses in vivo and who must learn to contain and discourage rather than foster and perpetuate these negative feelings (Rosenbaum, 2011b).

Criticism of classic sex therapy approaches to SPD

Traditional sex therapy behavioral models for SPD may also fail to fully recognize the existential conflict of women who desire penetration so cognitively, that they fail to value their own autonomy and to recognize their need for boundaries. These women, and often their practitioners, attribute "success" to the ability to allow penetration, even when this occurs in a disconnected or painful manner. Criticisms of the traditional cognitive and behavioral-oriented sex therapy models for the treatment of vaginismus have been published in the literature. In 1994, Shaw proposed that "behavioral techniques that manipulate a woman's genitals in the name of normality" (p. 48) change behavior without allowing for personal emotional development and consist of shaping a woman's behavior to fit her partner's (and society's) expectation that she perform. Kleinplatz (1998) published a comprehensive critique of the traditional approach to treatment of vaginismus as well, pointing out the pitfalls of treatment that is goal oriented rather than pleasure oriented, conforms and reinforces social norms of vaginal penile penetration as the only legitimate form of heterosexual sex and focuses on objective, behavioral and physiological achievements and performance rather than meaning and connection.

Sexual pain disorders can be a source of great personal distress to women who suffer from pain with vaginal touch or penetration. This condition also represents a source of distress to couples wishing to engage in sexual activity and, in particular, to hetersosexual couples who wish to engage in sexual intercourse. Consequently, women and their partners may seek therapy that will provide the treatment necessary to achieve the specific goal of achieving painless sexual intercourse. In the clinical setting, women motivated to succeed in treatment express cooperation, yet upon attempted examination, display an aversive response. Practitioners' attempts to address the patients' cognitions with statements such as "just try to relax" are ineffective because the behavior is not cognitively driven.

The practitioner may collude with the couple's desire to perceive sexual penetration as the ultimate goal, joining in the language that perceives sex primarily as intercourse, or considers "successes" with vaginal dilators (referred to in this paper as "inserts') worthy of praise. This treatment dynamic may infantilize young women already attempting to resolve developmental dissonance with their sexuality. Cognitive messages that an adult "should" be able to allow sexual intercourse, even when framed in the therapeutic

environment as psychoeducation, may be perceived as yet another coercive voice. This is further complicated by sociological and cultural expectations of intercourse as an inherent aspect of the sexual relationship and the burden of responsibility and guilt already being carried by the female partner for not "providing" sex.

Mindfulness: an alternative approach

Mindfulness in the treatment of sexual dysfunction has been addressed in the literature related to women's sexual functioning (Brotto, Basson, & Luria, 2008) and has an important role in the treatment of chronic pain (Kabat-Zinn, Lipworth, & Burney, 1985) and anxiety (Kabat-Zinn et al., 1992). Basson (2012) recently elucidated the neurophysiological mechanism whereby mindfulness training as applied to sexual pain may reduce pain perception. This author's mindfulness approach to women with SPD was originally developed to address in vivo anxiety with pelvic examination and physical therapy interventions. The "Rosenbaum Protocol" (Rosenbaum, 2011a) assists practitioners in helping women recognize and contain, rather than battle with their growing anxiety, avoid disassociation and remain present during examination and treatment. However, the approach, as described in this paper, has expanded to explore and address the existential conflict between the cognitive desire that motivates women to allow exposure to penetration when they are emotionally unready and the anxiety they perceive, but are attempting to repress. Furthermore, it allows women and couples to challenge the cognitive notions of intercourse as critical and primary to the integrity of the sexual relationship, resist self-judgment and experience, rather than achieve, sexual joy and connectedness.

Mindfulness principles

Rather than considering mindfulness as a meditative state induced by breathing or an altered state of consciousness, mindfulness is utilized here as an approach that addresses perceptions, feelings, attitudes and thoughts and allows clients to recognize how cognitive judgment of their feelings and their symptoms actually negatively affects their symptoms (Bishop et al., 2004). Applying mindfulness in treatment allows the client to focus on and accept feelings and perceptions, whether they refer to physical perception of pain, the physical manifestations of anxiety or emotional feelings such as of shame, exposure, sadness and frustration, and to recognize thoughts as mental sensations that may be simply observed rather than followed.

Once the client stays present and attentive to her feelings and refrains from self-judgment, she becomes capable of holding herself and containing, rather than battling with, those feelings. She learns to recognize thoughts that are unhelpful or catastrophizing ("If I don't fix this, I will never get married or have a family") as well as recognize the feelings underlying those thoughts. When she gives herself permission for her feelings, she can better perceive when boundaries are necessary and she is encouraged to verbalize them without apology and gain comfort with saying "no". Consequently, she begins to experience feelings of control of her own body. Pain and anxiety are no longer her enemies with which she is constantly embroiled in conflict and avoidance, but valuable perceptions that she learns to recognize, accept and appreciate.

Hypervigilance and a heightened response to painful stimuli are common in women with sexual pain. The reactionary response to pain, which is often accompanied by guarding and tightening of the body, serves to increase the perception of pain. The mindfulness approach encourages the client to reconsider her response to pain. Rather than consider

pain as the enemy and react to pain aversively and with negative associations ("I hate you, pain, I don't want you, I am afraid of you"), the patient, when touched in a specific location by the practitioner, is asked to attribute a number to her pain and stay with it, paying attention to how the pain feels as she allows her body to relax. She then notes how allowing herself to accept the pain as part of her experience reduces the actual perception of pain. In addition, she is encouraged to remember that each moment in time will be replaced by another one. Therefore, a painful moment of pain becomes just another moment and not a permanent aspect of her experience.

In addition to staying present and perceiving physical and emotional feelings with acceptance and non-judgment, mindfulness principles that may be emphasized include patience and "beginner's mind". Behavioral treatment models as well as physical therapy treatment plans are often progressive, goal oriented and achievement-based. Vaginal inserts are gradated according to size and the ability to contain a larger size insert is generally considered a mark of success in the treatment progression. However, clinical progress is rarely linear, as feelings, external stressors, hormones, relationship homeostasis and pain perception may vary. Rather than emphasize a need to "do better" than the prior session and demonstrate objective progress each time, clients are encouraged to experience each session with a beginner's mind. This means experiencing the activity as if or the first time, without any preconceived notions or expectations based on prior experiences.

A beginner's mind can also be utilized in helping to break the cycle of pain that is triggered by increased pelvic floor muscle contraction, which is reactionary to the anticipation of pain from previous experiences, or, if she has not yet engaged in intercourse, the expectation of pain based on accounts she has heard. The client can be encouraged to touch her vaginal entry regularly, but as if for the very first time each time, without preconceived notions of what it feels like based on past experiences. This can be applied to practice with inserts as well.

Mindfulness-based dilator therapy

Both standard sex therapy and physical therapy interventions include the use of vaginal inserts in the treatment of SPDs (ter Kuile et al., 2009). Yet, there is little literature describing technique or protocol for dilator insertion, including method of insertion, number of times to insert or amount of time the dilator should be inside the vagina. Sex therapists who are not medical professionals, must rely on providing a description to patients to insert at home, while medical practitioners have the advantage of working with the patient in vivo. The disadvantage of not working "hands on" with dilator insertion, is the lack of opportunity to confront and deal with anxious reactions, but also to witness whether the client inserts the dilator in a disassociated manner or, if her partner is assisting, experiences the insertion in a disconnected way. There is a paucity of literature looking at the experience of women using inserts. However, in a qualitative study that did examine the experience of gynecological cancer patients using vaginal inserts, patients reported experiencing them as technical, embarrassing, invasive and aversive (Cullen et al., 2012). Mindfulness dilator insertion allows for the act of using inserts to be combined with an awareness of the clients emotional state while using them, thus reducing feelings of resentment, obligation, lack of autonomy or disassociation. In insertion work, clients may experience frustration and express cognitions betraying their feelings of responsibility and the need to succeed despite not really wanting to ("I was a good girl this week and made myself do my exercises", "If I don't fix this, he will leave me") These cognitions

may be challenged by containing the client without judgment or disappointment and providing the option to not work with inserts. This models differentiation and gives her permission to be autonomous about her body, without worrying about disappointing anyone. She is encouraged that she has the choice: it is her body and she can stop at any time. She is discouraged from using judgment words such as "failure" and encouraged to stay focused on and accepting of her feelings and perceptions. Instruction in using inserts that encourages disconnecting, such as thinking about something else, watching television, sleeping or using anesthetic agents may reduce the client's sense of autonomy and connection.

Mindfulness-based dilator insertion does not view insertion therapy as necessary in order to stretch the vagina enough to accommodate a penis, but rather, emphasizes experiencing vaginal penetration in a positive, desired and controlled way. Admittedly, referring to this experience as vaginal dilation is unfortunate, and some suggest that sexual health professionals consider an alternate nomenclature to dilators, such as inserts or accommodators. The following principles may be helpful in creating a more mindfulness-based experience when working with inserts:

- Create a space for the activity. Turn off communication devices, put on soft music and candles and begin with several minutes of deep breathing.
- Always begin with the smallest dilator and work up gradually to the next size.
- Allow, rather than push the insert inside. First, gently contract and then relax the pelvic floor muscles. Upon relaxation of the muscles, wait until you feel the vagina allowing the insert to enter.
- Consider fantasy and masturbation while using the inserts in order to best simulate arousal, which is the circumstance under which vaginal penetration is most comfortable.

When working with couples, the woman can gradually transition with her partner from self-insertion to inserting with her partner's hand on hers. The next transition involves the partner inserting with her hand on his until gradually she can stay relaxed while he inserts the insert into her. It is emphasized that she is not expected to be passive or submissive or give up her autonomy or control. Rather, the mindfulness principle of trust is being developed.

Mindful couples interventions

Sex therapists with training in couple's therapy are generally well versed in addressing the relationship dynamics present in couples presenting for treatment, even when the identified patient is the symptomatic woman. Sex counselors, physicians, nurses and physiotherapists may be less skilled in identifying the often problematic ways in which couples organize around female sexual pain and difficult relational dynamics may emerge around the technical and behavioral intervention (e.g., "My wife isn't doing her exercises") (Rosenbaum, 2009). Practitioners should avoid collusion with the male partner in pathologizing the female partner as the identified patient. Furthermore, both partners often present with a great deal of anxiety about the situation, particularly when intercourse is nearly or actually impossible. They tend to frame intercourse as a goal, utilizing achievement-oriented language such as "we tried" and "we failed".

Mindfulness-based couples interventions change the script from male partner playing the supportive and patient role to that of the couple taking a journey together. The couple

is asked to set aside intercourse attempts and to not view intercourse as a goal. Often, all forms of physical intimacy have been avoided as the female partner fears sending the wrong message "if I hug or kiss him he will think I want to have intercourse" or not being able to "finish what she started", thus depriving herself of the physical intimacy she desires but does not believe she deserves. The couple is encouraged to engage in and experience physical intimacy for its own sake and not as foreplay to intercourse. Non-demanding sensual and sexual activities and respect of boundaries enables that both partners to feel safe and contained. Reference to "achievements", whether they be of erections, orgasms or penetrations, are discouraged. Rather, the couple is instructed to focus on the sensations of breathing together, touching each other and ascribing new meanings to their sexual connection.

Conclusion

Mindfulness-based treatment approaches encourage practitioners to support client autonomy rather than request passive submission. Using this approach allows the treatment to address cognitive dissonance and the conflicts between emotions and thoughts. The approach is de-pathologizing, as the client is encouraged to view the process as a journey of discovery, rather than treatment for dysfunction. The client is encouraged to reframe sex as something to be experienced with meaning rather than an achievement and goal oriented language ("we tried, we succeeded, we failed") is pointed out and discouraged. The client is encouraged to put up the boundaries that are necessary for her to feel safe. Finally, these principles and techniques can be adapted in medical, physiotherapy and sex therapy settings.

Notes on contributors

Talli Y. Rosenbaum, MSc, is an AASECT certified sexual therapist in private practice as well as a pelvic floor physiotherapist. She lectures in the sex therapy program at Bar Ilan University, the Puah Institute, and the Israeli Institute for Marriage and Family Studies. She serves as an associate editor of the Journal of Sexual Medicine.

Reference

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Ayling, K., & Ussher, J.M. (2008). If sex hurts, am I still a woman? The subjective experience of vulvodynia in heterosexual women. *Archives of Sexual Behavior*, *37*(1), 294–304.

Basson, R. (2012). The recurrent pain and sexual sequelae of provoked vestibulodynia: A perpetuating cycle. *Journal of Sexual Medicine*, *9*(8), 2077–2092.

Basson, R., Leiblum, S., Brotto, L., Derogatis L., Fourcroy, J., Fugl-Meyer, K., . . . Schultz, W.W. (2004). Revised definitions of women's sexual dysfunction. *Journal of Sexual Medicine*, *1*(1), 40–48.

Binik, Y.M. (2010a). The DSM diagnostic criteria for dyspareunia. *Archives of Sexual Behavior*, *39*(2), 292–303.

Binik, Y.M. (2010b). The DSM diagnostic criteria for vaginismus. *Archives of Sexual Behavior*, *39*(2), 278–291.

Bishop, S.R., Lau, M., Shapiro, S., Carlson, L., Anderson, N.D., Carmody, J., & Segal, Z.V. (2004). Mindfulness: A proposed operational definition. *Clinical Psychology: Science and Practice*, *11*, 230–241.

Borg, C., de Jong, P.J., & Schultz, W.W. (2010). Vaginismus and dyspareunia: Automatic versus deliberate disgust responsivity. *Journal of Sexual Medicine*, *7*(6), 2149–2157.

Borg, C., Peters, M.L., Weijmar Schultz, W., & de Jong, P.J. (2012). Vaginismus: Heightened harm avoidance and pain catastrophizing cognitions. *Journal of Sexual Medicine*, *9*, 558–567.

Both, S., van Lunsen, R., Weijenborg, P., & Laan, E. (2012). A new device for simultaneous measurement of pelvic floor muscle activity and vaginal blood flow: A test in a non-clinical sample. *Journal of Sexual Medicine*. Advance online publication. doi:10.1111/j.1743-6109.2012.02910.x

Brotto, L.A., Basson, R., & Luria, M. (2008). A mindfulness-based group psychoeducational intervention targeting sexual arousal disorder in women. *Journal of Sexual Medicine*, *5*(7), 1646–1659.

Cullen, K., Fergus, K., Dasgupta, T., Fitch, M., Doyle, C., & Adams, L. (2012). From "sex toy" to intrusive imposition: A qualitative examination of women's experiences with vaginal dilator use following treatment for gynecological cancer. *Journal of Sexual Medicine*, *9*(4), 1162–1173.

Desrochers, G., Bergeron, S., Khalifé, S., Dupuis, M., & Jodoin, M. (2009). Fear avoidance and self-efficacy in relation to pain and sexual impairment in women with provoked vestibulodynia. *Clinical Journal of Pain*, *25*(6), 520–527.

Gentilcore-Saulnier, E., McLean, L., Goldfinger, C., Pukall, C.F., & Chamberlain, S. (2010). Pelvic floor muscle assessment outcomes in women with and without provoked vestibulodynia and the impact of a physical therapy program. *Journal of Sexual Medicine*, *7*(2, pt. 2), 1003–1022.

Goldstein, A.T., & Burrows, L. (2008). Vulvodynia. *Journal of Sexual Medicine*, *5*, 5–15.

Harlow, B.L., Wise, L.A, & Stewart, B.G. (2001). Prevalence and predictors of chronic lower genital tract discomfort. *American Journal of Obstetrics and Gynecology*, *185*, 545–550.

Kabat-Zinn, J., Lipworth, L., & Burney, R. (1985). The clinical use of mindfulness meditation for the self regulation of chronic pain. *Journal of Behavioural Medicine*, *8*,163–190.

Kabat-Zinn, J., Massion, A.O., Kristeller, J., Peterson, L.G., Fletcher, K., Pbert, L., . . . Santorelli, S. F. (1992). Effectiveness of a meditation-based stress reduction program in the treatment of anxiety disorders. *American Journal of Psychiatry*, *149*, 936–943.

Khandker, M., Brady, S.S., Vitonis, A.F., Maclehose, R.F., Stewart, E.G., & Harlow, B.L. (2011). The influence of depression and anxiety on risk of adult onset vulvodynia. *Journal of Women's Health (Larchmt)*, *20*(10), 1445–1451.

Kleinplatz, P. (1998). Sex therapy for vaginismus: A review, critique and humanistic alternative. *Journal of Humanistic Psychology*, *38*(2), 51–81.

Payne, K., Binik, Y., Amsel, R., & Khalifé, S. (2004). When sex hurts, anxiety and fear orient attention towards pain. *European Journal of Pain*, *9*, 427–436.

Rosenbaum, T.Y. (2005). Physiotherapy treatment of sexual pain disorders. *Journal of Sex and Marital Therapy*, *31*, 329–340.

Rosenbaum, T.Y. (2007). Physical therapy treatment of sexual pain disorders. In S. Leiblum (Ed.), *Text principles and practice of sex therapy* (pp. 157–180). New York, NY: Guilford.

Rosenbaum, Talli Y. (2009). Applying theories of social exchange and symbolic interaction in the treatment of unconsummated marriage/relationship. *Sexual and Relationship Therapy*, *24*(1), 38–46.

Rosenbaum, T. (2011a). Addressing anxiety in vivo in physiotherapy treatment of women with severe vaginismus: A clinical approach. *Journal of Sex and Marital Therapy*, *37*(2), 89–93.

Rosenbaum, T.Y. (2011b). How well is the multidisciplinary model working? *Journal of Sexual Medicine*, *8*(11), 2957–2958.

Rosenbaum, T.Y. (2011c). Pelvic floor rehabilitation: Indications and methods. *Minerva Urologica e Nefrologica*, *63*(1), 101–107.

Schultz, W., Basson, R., Binik, Y., Eschenbach, D., Wesselmann, U., & van Lankveld, J. (2005). Women's sexual pain and its management. *Journal of Sexual Medicine*, *2*, 301–316.

Shaw, J. (1994). Treatment of primary vaginismus: A new perspective. *Journal of Sex & Marital Therapy*, *20*(1), 46–55.

ter Kuile, M.M., Bulté, I., Weijenborg, P.T., Beekman, A., Melles, R., & Onghena, P.J. (2009). Therapist-aided exposure for women with lifelong vaginismus: A replicated single-case design. *Journal of Consulting and Clinical Psychology*, *77*(1), 149–159.

van der Velde, J., Laan, E., & Everaerd, W. (2001). Vaginismus, a component of a general defensive reaction: An investigation of pelvic floor muscle activity during exposure to emotion-inducing film excerpts in women with and without vaginismus. *International Urogynecology Journal and Pelvic Floor Dysfunction*, *12*, 328–331.

van Lankveld, J.D.M., Granot, M., Weijmar Schultz, W.C. M., Binik, Y.M., Wesselmann, U., Pukall, C.F., … Achtrari, C. (2010). Women's sexual pain disorders. *Journal of Sexual Medicine*, *7*, 615–631.

van Lunsen, R.H.W., & Ramakers, M.J. (2002). The hyperactive pelvic floor syndrome (HPFS): Psychosomatic and psycho-sexual aspects of hyperactive pelvic floor disorders with comorbidity of urogynaecological, gastrointestinal and sexual symptomatology. *Acta Endoscopica*, *32*(3), 275–285.

Watts, G., & Nettle, D. (2010). The role of anxiety in vaginismus: A case-control study. *Journal of Sexual Medicine*, *7*(1, pt. 1), 143–148.