

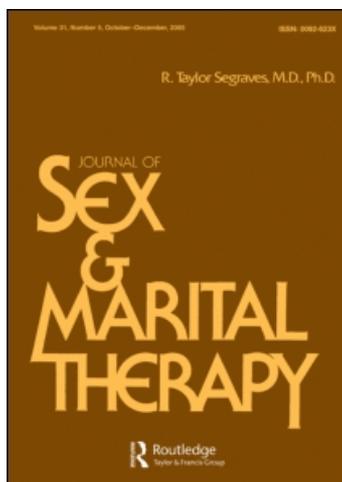
This article was downloaded by: [Rosenbaum, Talli]

On: 11 March 2011

Access details: Access Details: [subscription number 934772913]

Publisher Routledge

Informa Ltd Registered in England and Wales Registered Number: 1072954 Registered office: Mortimer House, 37-41 Mortimer Street, London W1T 3JH, UK



Journal of Sex & Marital Therapy

Publication details, including instructions for authors and subscription information:

<http://www.informaworld.com/smpp/title~content=t713723519>

Addressing Anxiety In Vivo in Physiotherapy Treatment of Women with Severe Vaginismus: A Clinical Approach

Talli Rosenbaum^a

^a Inner Stability, Ltd., Bet Shemesh, Israel

Online publication date: 10 March 2011

To cite this Article Rosenbaum, Talli(2011) 'Addressing Anxiety In Vivo in Physiotherapy Treatment of Women with Severe Vaginismus: A Clinical Approach', Journal of Sex & Marital Therapy, 37: 2, 89 – 93

To link to this Article: DOI: 10.1080/0092623X.2011.547340

URL: <http://dx.doi.org/10.1080/0092623X.2011.547340>

PLEASE SCROLL DOWN FOR ARTICLE

Full terms and conditions of use: <http://www.informaworld.com/terms-and-conditions-of-access.pdf>

This article may be used for research, teaching and private study purposes. Any substantial or systematic reproduction, re-distribution, re-selling, loan or sub-licensing, systematic supply or distribution in any form to anyone is expressly forbidden.

The publisher does not give any warranty express or implied or make any representation that the contents will be complete or accurate or up to date. The accuracy of any instructions, formulae and drug doses should be independently verified with primary sources. The publisher shall not be liable for any loss, actions, claims, proceedings, demand or costs or damages whatsoever or howsoever caused arising directly or indirectly in connection with or arising out of the use of this material.

Addressing Anxiety In Vivo in Physiotherapy Treatment of Women with Severe Vaginismus: A Clinical Approach

TALLI ROSENBAUM

Inner Stability, Ltd., Bet Shemesh, Israel

Physiotherapy for the treatment of vaginismus is perceived as an intervention aimed to normalize muscle tone of the pelvic floor in order to allow vaginal penetration in accordance with the traditional view of vaginal spasm as its defining feature. Newer definitions recognize the experience of anxiety as well as pain, and effective treatment approaches should address these components as well. Physiotherapists often encounter women who, as a result of severe anxiety, are unable to undergo examination and treatment, despite their expressed desire to do so. This article describes a therapeutic intervention designed to help women with vaginismus prepare for examination and treatment by addressing the component of anxiety in real-life situations. This approach is also appropriate for nurse practitioners and physicians who work with this patient population and may be adapted for sex therapists to teach as a home exercise.

Physiotherapy of the pelvic floor is recognized as an important component of treatment for women with vaginismus and dyspareunia and as adjunctive to sexual therapy and other psychotherapeutic interventions (Schultz et al., 2005). Reports in the literature have described multimodal cognitive behavioral therapy and physiotherapy as effective in the treatment of women with localized provoked vestibulodynia, and ascribe decreased pain and, pelvic floor overactivity to the physiotherapy component (Bergeron & Lord, 2003). There is, however, a paucity of literature that describes this team approach for women with vaginismus, despite agreement that variable pelvic floor muscle contraction is a defining feature of vaginismus (Basson et al., 2004).

Address correspondence to Talli Rosenbaum, Hatziporen 10, Bet Shemesh, Israel 99591.
E-mail: tallir@netvision.net.il

Penetration anxiety and vaginal muscle contraction were traditionally understood to be the defining characteristics for women with vaginismus (American Psychiatric Association, 2000). Negative views about sexuality (Ward & Ogden, 1994), anxiety (Watts & Nettle, 2010), aversion and disgust (Borg, de Jong, & Schultz, 2010), and a history of sex abuse (Reissing, Binik, Khalife, Cohen, & Amsel, 2003) have also been associated with this condition. Traditional treatment approaches have included psychodynamic therapy, existential-experiential psychotherapy (Kleinplatz, 1998), cognitive behavioral therapy, desensitization and exposure therapy as well as psychoeducation and instruction in dilators. Consistent with ethical codes, these therapies do not involve genital examination or touch, and do not replicate the woman's experience with attempted penetration.

Current definitions of vaginismus recognize the experience of pain as a salient feature (van Lankveld et al., 2010). This further underscores the overlapping natures of vaginismus and dyspareunia and explains the emerging use of medical therapies such as botulism toxin (Ghazizadeh & Nikzad, 2004), electric stimulation (Seo, Choe, Lee, & Kim, 2005) and physiotherapy (Rosenbaum, 2007). There is growing recognition that clinical counseling that does not replicate, *in vivo*, the experience of anxiety in real-time situations of attempted penetration, may not be sufficient and may explain the emergence of alternative therapies that utilize sexual surrogates (Ben-Zion, Rothschild, Chudakov, & Aloni, 2007) and psychotherapist aided exposure (Ter Kuile et al., 2009).

Physiotherapists treating women with vaginismus provide education, teach general and pelvic floor relaxation, provide manual therapy such as introital stretching techniques and pelvic floor massage, and work with dilators *in vivo* (Rosenbaum, 2005). Treatment often begins with genital observation using a mirror, genital touch, and eventually, penetration, although many women are far too anxious and aversive to begin therapy at this stage. The determination of when to begin is difficult, as women with vaginismus are often motivated to progress with treatment, but despite their cognitive desire to be examined, anxiety prevents them from allowing this to occur. In many cases, women with vaginismus disassociate in order to allow an examination to occur, especially in cases of trauma or past sexual abuse. A thorough history and a detailed explanation of the therapy are important in determining together with the client, when she is ready to undergo a gynecological examination.

TREATMENT INTERVENTION

The following describes an exercise program, designed to prepare a client, both physically and emotionally, for genital self-examination, genital self-touch, practitioner pelvic examination, finger and dilator insertion, and

sexual intercourse. This program is particularly suitable for women with vaginismus with generalized anxiety, or women with severe but specific vaginismus related anxiety. This program is also particularly suited to women with vaginismus from traditional populations, who cite the jarring transition from modest dress and manner to completely naked exposure as being particularly nonsyntonic (Ribner & Rosenbaum, 2004). Rather than provide directives for the client to “relax,” she is instructed to be present and fully aware of when she can feel relaxed. This may mean simply sitting in a chair in the practitioner’s office, or lying on the table fully dressed and covered with a sheet.

The purpose of this treatment intervention is to allow the client to perceive the exact moment that she begins to feel anxiety. Often, there is a discrepancy between the client’s cognitive desire and motivation to succeed, and her physical and emotional ability to do so without feeling anxious and defensive. The client’s cognitions are addressed throughout the intervention, however, the client is instructed to pay less attention to her thoughts and more to her feelings. Rather than try to “get rid” of the anxiety, she is encouraged to allow herself to feel and contain the anxiety with the understanding that she can always go back a step to where feels more secure. This method allows the woman to feel in control of the exposure process, and rather than view anxiety as frustratingly beyond her control, she learns to recognize and accept it, begin to feel it less acutely, and finally, no longer feel it.

The steps are as follows:

- Step 1: Lying on the table. The client is asked to lie on the table, fully dressed, covered with a sheet. She is asked to rate her level of anxiety from low to high (0–5), and then asked what she needs in order to reach the number 0. These needs may include lying on her side in a more protected posture, the practitioner moving away from the table, or, she may need to get up off the table and go back to sitting in the chair, where she was able to rate herself at 0. Other “lowering anxiety” tools are introduced including deep breathing techniques. The exercise is repeated until she is able to lie on the table on her back with her knees flexed and together, and rate herself at 0–1.
- Step 2: Lying on the bed, fully dressed (with pants) and covered with a sheet, the client is asked to bend her knees and separate her legs. She is reminded that if she feels anxious with her knees open, she may do what she needs to relieve her anxiety, which is likely to be a return to the position of knees bent and together. This exercise is repeated until she is able to rate her anxiety level with her legs apart at 0–1.
- Step 3: As in Step 2 but without the sheet. Covering herself again with the sheet is considered to be one of the lowering anxiety options available to her.

Step 4: As in Step 2 but wearing shorts instead of long pants, first with and then without, the sheet.

Step 5: As in Step 2 but with underwear only, with and without the sheet.

Step 6: As in Step 2 without underwear, with and without the sheet.

The duration of this process may vary from one visit to up to six. Inability to progress warrants referral to or discussion with the client's psychotherapist and possibly a referral to a psychiatrist for evaluation of antianxiety medications. The value of this process is that it allows the client to reach the genital examination when she is far more prepared for it and can be both physically and emotionally present during the examination with less likelihood of dissociation. Furthermore, it teaches the client to value her anxiety as a sign of her motivation to progress. Once she has proceeded through these steps, she may continue to utilize the anxiety reduction techniques as they apply to self-touch of the genitals, self-touch of the vulvar vestibule and vaginal finger insertion. She may further apply these techniques for gradual dilator use with the practitioner and with her partner. This progression includes self-insertion of the dilator, self-insertion with her partner holding dilator as well, her partner inserting the dilator with the client holding it as well, and finally, her partner inserting the dilator.

CONCLUSION

This article offers a progressive exercise program developed by the author, a physiotherapist and sexual counselor with expertise in treating women with sexual pain disorders. Because women with vaginismus tend to demonstrate aversion and anxiety, patience and empathy are required in order to allow the client to feel safe and contained. These techniques may be used by physicians and nurse practitioners treating women with vaginismus with dilator therapy. Similarly, sex therapists using a cognitive behavioral approach may incorporate these techniques by describing the steps and asking the client to do them at home alone and in the presence of their partners. Last, it is important to note that physiotherapy and cognitive behavioral therapy techniques may not be sufficient and that sex and couples therapy are important components of treatment for women with vaginismus.

REFERENCES

- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders*. Washington, DC: Author.
- Basson, R., Althof, S., Davis, S., Fugl-Meyer, K., Goldstein, I., Leiblum, S., Meston, C., Rosen, R., & Wagner, G. (2004). Summary of the recommendations on sexual dysfunctions in women. *Journal of Sexual Medicine, 1*, 24–34.

- Ben-Zion, I., Rothschild, S., Chudakov, B., & Aloni, R. (2007). Surrogate vs. couple therapy in vaginismus. *Journal of Sexual Medicine*, 4, 728–733.
- Bergeron, S., & Lord, M. (2003). The integration of pelvi-perineal re-education and cognitive-behavioural therapy in the multidisciplinary treatment of sexual pain disorders. *Sexual and Relationship Therapy*, 18, 135–141.
- Borg, C., de Jong, P. J., & Schultz, W. W. (2010). Vaginismus and dyspareunia: Automatic vs. deliberate disgust responsivity. *Journal of Sexual Medicine*, 7, 2149–2157.
- Ghazizadeh, S., & Nikzad, M. (2004). Botulinum toxin in the treatment of refractory vaginismus. *Obstetrics and Gynecology*, 104, 922–925.
- Kleinplatz, P. (1998). Sex therapy for vaginismus: A review, critique, and humanistic alternative. *Journal of Humanistic Psychology*, 38, 51–81.
- Reissing, E., Binik, Y., Khalife, S., Cohen, D., & Amsel, R. (2003). Etiological correlates of vaginismus: Sexual and physical abuse, sexual knowledge, sexual self-schema, and relationship adjustment. *Journal of Sex and Marital Therapy*, 29, 47–59.
- Ribner, D. S., & Rosenbaum, T. Y. (2004). Evaluation and treatment of unconsummated marriage among orthodox Jewish couples. *Journal of Sex and Marital Therapy*, 31, 341–353.
- 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 Press.
- 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.
- Seo, J., Choe, J., Lee, W., & Kim, K. (2005). Efficacy of functional electrical stimulation-biofeedback with sexual cognitive-behavioral therapy as treatment of vaginismus. *Urology*, 66, 77–81.
- Ter Kuile, M. M., Bulté, I., Weijnenborg, 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, 149–159.
- van Lankveld, J. J., Granot, M., Weijmar Schultz, W. C., Binik, Y. M., Wesselmann, U., Pukall, C. F., . . . Achtrari, C. (2010). Women's sexual pain disorders. *Journal of Sexual Medicine*, 7, 615–631.
- Ward, E., & Ogden, J. (1994). Experiencing vaginismus: Sufferers' beliefs about causes and effects. *Journal of Sex and Marital Therapy*, 9, 33–45.
- Watts, G., & Nettle, D. (2010). The role of anxiety in vaginismus: A case-control study. *Journal of Sexual Medicine*, 7, 143–148.