

EDITORIAL

How Well Is the Multidisciplinary Model Working?

The classical approach to sexual dysfunction has traditionally followed a divergent paradigm. If an organic, physiologically based etiology was identified and could be addressed medically, the practitioner most likely involved in treatment would be a medical health provider, such as a physician, nurse practitioner, physician assistant, or pelvic floor physical therapist. If no organic cause was identified, the patient would leave the office with a referral to a mental health provider with the implicit (or even explicit) message that the problem is primarily “in your head.”

This “either/or” mentality continues to pit medical vs. mental health practitioners against one another in the battle of “whose patient is this?” Case discussions at multidisciplinary conferences are a predictable forum for participants to offer their often unidimensional perspectives. The case of a healthy young man with erectile dysfunction (ED), for example, can become the battleground over the significance of the insufficiently tumescent penis. To the physicians, the meaning is physiological; it may be a potential marker for heart disease, and anyways, why subject the client to talk therapy when a phosphodiesterase type 5 inhibitor can easily solve the problem? To sex therapists, however, blood flow is secondary to context, and ED may have psychological or sociological significance. Is this an unconsummated marriage in a traditional society where the man, with little or no prior experience, is expected to perform on his wedding night with his equally anxious or possibly vaginistic bride? What role does anxiety play in this man’s life? What is the meaning of pleasure and why does he have difficulty achieving it?

A paradigm shift has occurred, in theory at least, as the multifactorial nature of sexual problems has become better appreciated, in part due to publications in *The Journal of Sexual Medicine* (*JSM*) [1]. This is particularly true in the area of women’s sexual health [2]. The biopsychosocial model of women’s sexual function posits that physiological and organic factors, together with emotional well-being, mood, social and cultural influences, and relationship context, all play a role in sexual function. Practically, however, this model continues to

be problematic as medical practitioners deal with the “physical part” while mental health practitioners address the psyche. Too often, the woman’s “issues” are compartmentalized in treatment, leaving the woman feeling fragmented and her treatment, unintegrated.

We can look at sexual pain disorders to exemplify this problem. Sexual pain disorders are understood to have multifactorial components. While research has focused on physiological mechanisms, cognitive and affective factors are recognized to have an important role [3]. Higher catastrophizing, fear of pain, hypervigilance, and lower self-efficacy have all been associated with increased intercourse pain intensity [4]. Traditional biopsychosocial conceptualizations of vaginismus and dyspareunia compartmentalize the treatment by designating the physiological aspects to physicians, and the psychosocial aspects including anxiety and aversion, to mental health professionals including psychotherapists and sex therapists. In this algorithm, treatment of the pelvic floor muscles (the physical manifestation of the emotionally anxious state) is designated to physiotherapists.

This design is problematic for many reasons. In the physiotherapy clinical setting, for example, fear avoidance and anxiety are significant characteristics of the patient’s response, which mirrors their experience in sexual intercourse. Treatment, which attends to pelvic floor dysfunction without addressing the patient’s emotional experience of vulnerability and fear or the meaning of penetration in her sexual and nonsexual life, or the dynamics of her relationship may not only fail to help but may also cause additional harm. The physiotherapist may be perceived as one other coercive voice in her life. Addressing the patient’s anxiety and vulnerability later in the comfort and nonjudgmental psychotherapy office replaces the physiotherapy room as the safe and containing place.

As a pelvic floor physiotherapist, I struggled with my limitations in a multidisciplinary model that attributed to me only the woman’s pelvic floor. While physiotherapists know how to deal with pain avoidance, the treatment model is based on cognitive and behavioral motivation (“you can

do it!”) rather than empathy, active and reflective listening, and emotional containment. So, I went back to school and earned a master’s degree in a clinical sociology program with an emphasis on family systems therapy and embarked on supervision to earn AASECT sex therapy certification. This completely changed how I practice, as I have learned to integrate physical and sex therapy.

While not every physician, nurse practitioner, or physiotherapist working in the field of women’s sexual health can allow themselves to retrain in a mental health field, basic skills of sensitivity, empathy, listening, and addressing anxiety are necessary for everyone who practices in sexual health. For those who see women with sexual pain disorders in particular, it is crucial to be sensitive to the conflict of the woman who comes to us to be examined, yet is existentially terrified of the examination and likely to disassociate in order to get through it. I have heard many unfortunate stories from my patients of doctors and physiotherapists, perhaps well-meaning, who have shattered these women’s feelings further by infantilizing them, pathologizing them, or glibly stating their problem is all in their head and if they wanted it badly enough, they would try to relax and get through it.

At my first meeting with the International Society for the Study of Women’s Sexual Health (ISSWSH) in 2002 in Vancouver, I literally ran back and forth between the parallel pre-instructional courses named “Sexual physiology for the psychologically minded” and “Sexual psychology for the physiologically minded.” I was certainly not enough of either, but very much wanted to be more of both. If we can all be a little of both, we can provide better integrated treatment to our clients, regardless of our discipline. Of course, we each can’t do everything and we will always need to refer to one another, but we can certainly learn from each other’s skills and knowledge. In this vein, I recently published a treatment protocol for physiotherapists and other medical practitioners who treat women with sexual pain disorders yet are not traditionally trained in counseling methods, for addressing anxiety using a mindfulness based approach [5]. This nonjudgmental method encour-

ages full patient presence and prevents disassociation, allowing the patient to feel in control and safe, while addressing her penetration anxiety in vivo.

As I straddle the worlds of mental health and physical medicine, I am aware of the many obstacles in my path. It is far easier to become recognized as a sex therapist or sexologist in a typical profession such as medicine or social work and some certification frameworks continue to recognize only these specific criteria, regardless of clinical skill and experience. While I can’t fight city hall, I am grateful for the truly multidisciplinary organizations, such as AASECT and ISSWSH and publications like the *JSM*. I am satisfied to continue enriching my personal knowledge and skill so that I may provide the best treatment possible. I hope that the day will come whereby we are not pin-holed or defined by our profession but by our passion and our skills, and that multidisciplinary defines not only the treatment model but also the practitioner. Meanwhile, continue to read and write for your journal to provide support for those of us striving to live and embrace the multidisciplinary model for the study, diagnosis, and treatment of men and women with sexual health concerns.

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