# *Limits of Pelvic Floor Physical Therapy in the Treatment of GPPD*

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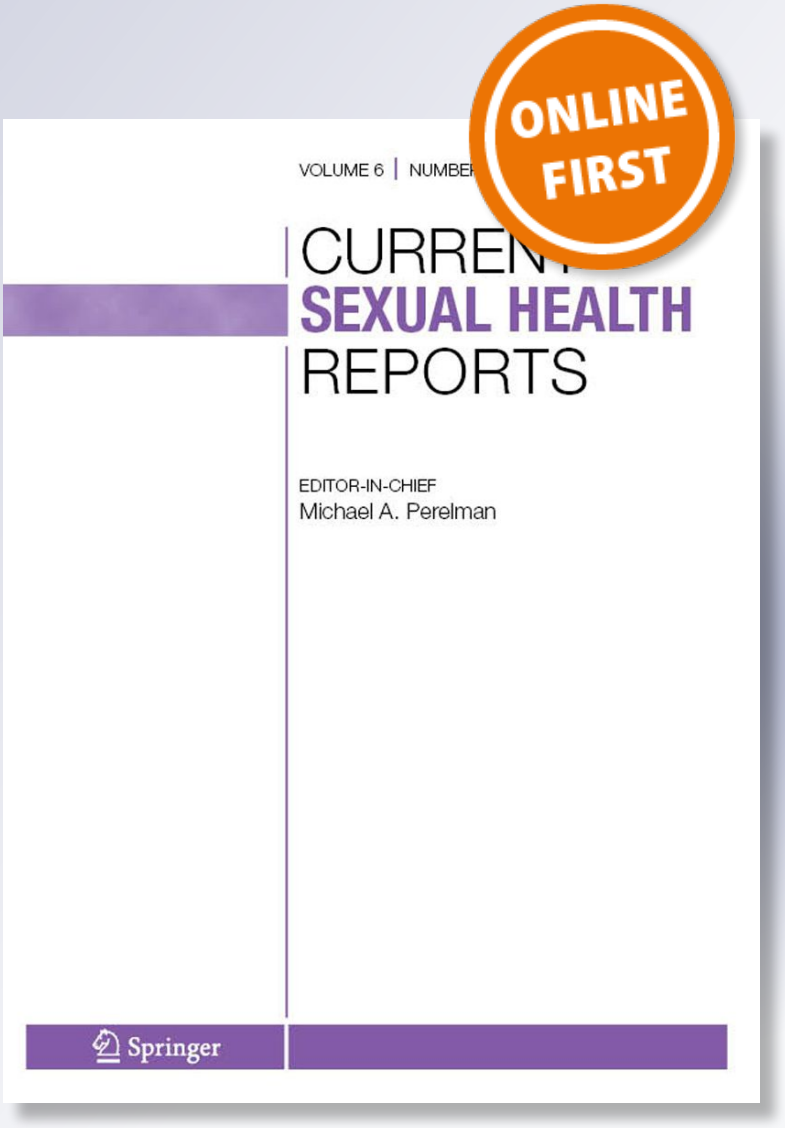
**Current Sexual Health Reports**

ISSN 1548-3584

Curr Sex Health Rep
DOI 10.1007/s11930-018-0144-7




Springer

Current Sexual Health Reports
https://doi.org/10.1007/s11930-018-0144-7

INVITED COMMENTARY

# Limits of Pelvic Floor Physical Therapy in the Treatment of GPPD

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Genito-pelvic pain/penetration disorder (GPPD) first appeared in the most recent edition of the DSM [1]. It is a consolidation of presentations listed in the previous DSM [2] under the category of "sexual pain disorders" (SPDs). The former binary division between vaginismus, an involuntary spasm of the musculature of the outer third of the vagina, that interferes with sexual intercourse, and dyspareunia, the actual experience of pain with penetration, likely contributed to the incorrect conceptualization of dyspareunia as organic and vaginismus as psychological at the core. The new designation acknowledges a multifactorial experience for both pain and defensive reactivity, as they co-exist, but continues to focus on the ability to be penetrated as a fundamental determinant of sexual function in women [3].

The generality and inclusiveness of GPPD represent the lack of a clear and concise understanding of the specific etiology and treatment needs of women who present for treatment. The definition continues to attribute responsibility for the disorder primarily to reactive pelvic floor muscle tightening, and the acknowledgment of the experience of anxiety is limited to fear of penetration.

It is precisely this focus on function that has driven behavioral approaches to GPPD, and which inspired the entry of physical therapy in to the field. As noted by this author in this publication 10 years ago [4], "Physical therapists play an important role in facilitating optimal sexual function by providing treatment to restore function, improve mobility, and relieve pain."

Since the turn of this century, research studies, literature reviews, and clinical papers began to appear in sex therapy and sexual medicine journals [5–7]. A chapter dedicated to physical therapy in a sex therapy textbook first appeared in 2007 [8]. These publications indicated that physical therapists are to be recognized as members of the multi-disciplinary team involved in the treatment of sexual pain disorders.

Most of the physical therapy literature on sexual pain highlights the contribution of physical therapists to the treatment of the pelvic floor musculature. Physical therapists appropriately address the physical aspects of SPDs through modalities that are unique to the physical therapy profession. Common modalities include exercise, myofascial release, electrical stimulation, electromyographic (EMG) biofeedback, and more recently, pelvic muscle training with assisted ultrasound imaging. Outcome measures are functional and include subjective pain report and improvements in mobility of the vaginal and pelvic muscle and fascia [9]. More recent approaches consider the biopsychosocial model and suggest integrated methods that incorporate mindfulness, psychoeducation, and cognitive behavioral therapies [10–12]. Dilators, or vaginal trainers, are widely regarded and offered by sex therapists, who are limited by mental health ethical guidelines to verbal instruction in their use [13]. To date, research has not demonstrated the effectiveness of physical therapist-aided dilator use or how common this intervention is. However, in vivo use of dilators appears to have become a common intervention amongst physical therapists, who work with women hands-on.

There are a number of limitations to treatment that must be considered both within the profession of physical therapy and by health professionals at large, who refer their clients for this intervention. I disclose at the outset that I offer this commentary based not only on my study of the literature, but through clinical experience as a former physical therapist, and a current psychotherapist, couples therapist, and sex therapist. My journey to becoming a mental health professional was largely informed and inspired by these limitations.

The pelvic floor is complex and multi-dimensional, and so too are women who seek treatment. In addition to validating and treating the physiological realities related to pelvic floor complaints, addressing the distress of patients who present with pelvic floor disorders requires recognition of the complexity of psychosocial, relational, and sexual components. This includes recognizing that treating the pelvic floor means

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Published online: 20 March 2018

meeting people in their most intimate and vulnerable space. The word "pudendal" is, in fact, Latin for "shame."

Pelvic floor muscle activity has been found to be reactive in response to fear of penetration and pain [14], but also reactive to non-sexual stressful stimuli [15]. Addressing the pelvic floor with only a physical therapy approach, therefore, is not only reductionist, but may be harmful. Pelvic floor dysfunction is not simply an isolated mechanical condition, but a physical expression of an emotional state.

There is a robust body of literature demonstrating association between pelvic floor disorders, sexual pain, and childhood sexual abuse [16, 17]. Pelvic floor overactivity disorders may be an emotional response resulting from chronic activation of the defensive stress system by trauma such as sexual abuse or insecure attachment [18]. It is likely, therefore, that patients with a history of trauma may dissociate in a clinical setting, and reports from many of my clients have confirmed this. In my experience, patients may also become triggered and reactive, and experience flashbacks. While many physical therapists are sufficiently trained to provide limited counseling and psychoeducation, they are not always trained to recognize signs of dissociation or address acute or chronic anxiety.

Physical therapists do have the opportunity to address shame and anxiety and help their patients improve their sexual role identities. They are not trained, however, to explore the narrative of the patient or the couple. Although they provide exercises and interventions to individuals and couples, they are not equipped to address the meaning of a patient's resistance to doing the exercises (which the medical model judgmentally refers to as "non-compliance") or to identify the dynamic power struggles that frequently ensue as couples organize around those interventions [19, 20].

The "social" in the biopsychosocial model includes attention to the cultural, ethnic, and religious narratives of patients. Physical therapists may be insufficiently trained to identify partner, familial, or communal sexual coercion, and even if they do, may lack the skills or resources to address it. A woman's perceptions of her role in society may include the belief that she must allow vaginal penetration to please or fulfill her partner's sexual needs [21]. In some traditional societies, this "mate guarding" includes the expectation that she be available for sexual intercourse in order to prevent her husband from masturbation, pornography, or sex outside the marriage [22]. Sexual pain patients often anxiously report that they must to be able to engage in intercourse. "I don't need to enjoy it- it just has to work," de-emphasizing any expectation of pleasure. With little background of the narrative, physical therapists could frame the patient's cognitive desire and motivation to succeed positively and attribute "success" to the ability to allow penetration of a larger vaginal dilator, even when this occurs in a disconnected or painful manner.

Feelings of guilt and responsibility for not having sex compel women to engage in intercourse when un-aroused and to undergo treatments and procedures that are so painful and exposing, that dissociation occurs to get through the experience [23]. Prior or concurrent psychotherapy/sex therapy, individual and/or couple therapy, is necessary to prevent, mitigate, process, and find meaning in these reported reactions. A psychotherapist would explore the client's motivations to succeed, be curious about her expectations for consent and autonomy and assess her developmental and emotional readiness for sexual intercourse. A concurrent or subsequent couple therapy process would address couple communication, dynamics, emotional intimacy, and feelings of guilt and rejection in both partners.

Physical therapy is an extremely valuable resource, which addresses the physiological components of GPPD. Moreover, via psychoeducation, exposure, and limited sexual counseling, physical therapists can provide treatment that improves psychological variables such as aversion, anxiety, and avoidance. Nevertheless, there are limitations to the physical therapists' ability to assess and address critical psychosocial components. Physicians referring women with GPPD for physical therapy should routinely combine this referral with mental health consultation to assess the woman's psychological readiness to undergo this exposing intervention [24]. Ideally, physical therapy for GPPD should be combined with psychotherapy and/or sex therapy.

## Compliance with Ethical Standards

**Conflict of Interest** The author declares that he/she has no conflicts of interest.

**Human and Animal Rights and Informed Consent** This article does not contain any studies with human or animal subjects performed by any of the authors.

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