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The Genito-Pelvic Pain/Penetration Disorder Paradigm and Beyond

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CHAPTER 1

A Woman with Coital Pain: New Perspectives on Provoked Vestibulodynia

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INTRODUCTION AND AIMS

Provoked vestibulodynia (PVD) is characterized by pain at the vulvar introitus, in particular the vulvar vestibule, provoked by touch, pressure, and vaginal penetration. Although distinct and interesting hypotheses have been put forward, the pathogenesis of PVD still remains largely unknown. In general, the etiology is considered to be multifactorial. Problems arise in PVD when normal protective functions "overreact": when normal behavior or a psychophysiological state is *too extreme, too prolonged,* or *too intense*. This attention to contextual appropriateness is one of the key principles of psychosomatic obstetrics and gynecology. It is therefore the major reason why PVD symptoms should always be put into a biopsychosocial perspective.

DEFINITION IN LAY TERMS

Provoked vestibulodynia (PVD) is characterized by pain at the vulvar entrance, in particular the vulvar vestibule, provoked by touch, pressure, and vaginal penetration.

DIDACTIC GOALS

After reading this chapter, you will:

- Be able to recognize PVD as a *sexual* as well as a *chronic pain* problem
- Know that its onset often has the character of an acute *disease* but that this disease easily turns into a chronic pain *syndrome* through the particular psychological makeup of the patient or couple
- Be aware of the most recent insights into diagnostic and therapeutic options in PVD
- Know that a multidimensional treatment provides the best options for long-term success
- Know that the key element of this treatment is to end the vicious circle of pain and fear
- Be able to inform patients and partners about diagnostics and therapeutics, including complications or disturbances that may occur throughout the treatment process
- Know that even after what can be considered as successful treatment, the motto at the resumption of intercourse remains: "Handle with care!".

Case History

Bianca Olive, a 30-year-old woman, para 2, enters your consultation room alone. She is referred by her general practitioner (GP) for gynecological examination. Her main problem is pain during sexual intercourse, which started after the birth of her second child, about 2 years ago. At that time she also suffered from some vaginal discharge. Her GP treated her with antimycotic vaginal suppositories against vaginal infection. The treatment alleviated her complaints for a few weeks but then the pain returned. She describes the pain as a very intense burning pain starting from the moment of penetration. The pain is always present during sexual intercourse and it can even hold on for hours afterward. She is using OAC (ethinyl estradiol 30 ug/levonorgestrel 150 ug), no other medication or drugs. Bianca has no history of illnesses or sexual or physical abuse.

FACTS AND FIGURES: EPIDEMIOLOGY, CLASSIFICATION, AND DIFFERENTIAL DIAGNOSIS

Epidemiology

The prevalence of PVD is unclear and depends on a number of intermediating variables, such as age, cultural background or ethnicity, and setting:

- *Age*: with regard to the prevalence of dyspareunia, there appears to be a bimodal age distribution that varies from 14 to 34 % in younger (premenopausal) women and from 6.5 to 45 % in older women [1]. In premenopausal women, PVD is the most frequent cause of chronic painful sexual intercourse [2].
- *Cultural background/ethnicity*: the prevalence of dyspareunia in Northern European countries seems low, whereas in the USA, relatively high prevalence figures have been reported. Historically, PVD was primarily considered to be a disorder that only affects white Caucasian (young nulliparous) women [3]. However, it has become increasingly clear that the lifetime prevalence of PVD is the same regardless of ethnicity [4].
- *Setting*: a prevalence of 3–18 % has been reported in the general population, 3–46 % in general practice populations, and 10–20 % at outpatient gynecology clinics [5].

Besides these more general mediators, *time frame* (as specified by researchers), *comorbidity*, and the *physician's initiative* in bringing up the topic seem to play important roles in determining the prevalence [1].

Classification

For several decades, there has been debate about the classification and terminology of vulvar pain in general. Its origin lies merely in the many different dimensions that are used to underpin the classification process, such as quality, quantity, localization, origin, and duration of the pain or (more generally speaking) discomfort:

- *Quality*: where the International Society for the Study of Vulvovaginal Diseases (ISSVD) refers to the pain as burning, others describe the pain as sharp (knifelike).
- *Quantity*: the degree of vulvar pain experienced varies per patient. PVD is characterized by hyperalgesia, i.e., increased response to a painful stimulus, and allodynia - the experience of pain in response to a normally not painful stimulus.
- *Localization*: depending on the anatomical site of the pain, vulvodynia can be divided into a generalized and a localized subtype. The *generalized* form is far less common and has been understudied. The more customary *localized* subtype chiefly occurs in the vulvar vestibule. The locus of the allodynia is limited to specific areas and is symmetrical in the majority of women. It occurs particularly at the 5 o'clock and 7 o'clock positions exteriorly to the hymenal ring [3]. In a very small percentage of women, the hypersensitivity is localized in the anterior part of the vulva. These cases in particular are usually therapy-resistant.
- *Origin*: vulvar pain can be divided into provoked, unprovoked, and mixed. The most common presenting symptom of *provoked vestibulodynia* is severe vulvar pain during sexual intercourse. In extreme cases, sexual intercourse is virtually impossible. However, the pain also can occur during other forms of penetration, such as the insertion of a finger, vibrator, tampon, or speculum. Furthermore, the pain can occur during nonsexual activities, such as cycling or horse riding.
- *Duration*: PVD can be divided into a primary form and a secondary form. In the primary form, the pain has been present since starting intercourse or tampon use, whereas in the secondary form, there has been a period of pain-free intercourse or tampon insertion prior to the onset of symptoms. After intercourse, the pain may last for several hours to several days and mainly occurs during micturition.

There is long-term ongoing debate about whether vaginismus can be differentiated from dyspareunia/PVD categorically, dimensionally, or not at all [6]. In 2013, the diagnosis of genito-pelvic pain/penetration disorder (GPPPD) was introduced in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5), to replace the diagnoses of dyspareunia and vaginismus [7]. GPPPD is defined as:

A. Persistent or recurrent difficulties with one (or more) of the following:
   - Vaginal penetration during intercourse
   - Marked vulvovaginal/pelvic pain during vaginal intercourse/penetration attempts
   - Marked fear/anxiety about vulvovaginal or pelvic pain in anticipation of, during, or as a result of vaginal penetration
   - Marked tensing or tightening of the pelvic floor muscles during attempted vaginal penetration
B. The symptoms in criterion A have persisted for a minimum duration of approximately 6 months.
C. The symptoms in criterion A cause clinically significant distress in the individual.
D. The sexual dysfunction is not better explained by a nonsexual mental disorder or as a consequence of a severe relationship distress (e.g., partner violence) or other significant stressors, and it is not attributable to the effects of a substance/ medication or other medical conditions.

There is a lifelong and acquired subtype of GPPPD. Furthermore, based on the degree of distress in criterion A, GPPPD is categorized into mild, moderate, and severe. Up to date, the validity and reliability of the GPPPD diagnosis has not yet been established. Regardless of the new DSM diagnosis, the debate on the classification of dyspareunia and vaginismus still continues [6].

Differential Diagnosis

The diagnosis of PVD is based on exclusion, which is largely established through client history. The most important differential diagnoses are:

- Recurrent vulvovaginal candidosis:
  - In a proportion of women, PVD simply starts with recurrent vulvovaginal infections. It is likely that PVD develops because these women continue to have sexual intercourse with the accompanying pain, despite having an infection.
- "Ordinary" dyspareunia:
  - If there is insufficient sexual arousal, then there will be insufficient lubrication. Penetration may become painful and lead to "the anticipation of pain," also in the absence of chronic inflammation. The difference between "ordinary" dyspareunia and PVD is found in the number of times that there is sufficient sexual arousal, without the experience of pain. Moreover, sometimes in women with PVD, penetration may succeed without pain. That's because in women with sufficient

arousal (and orgasm), the pain threshold temporarily increases. However, in these cases the pain continues thereafter. (See Chap. 20 for discussion on insufficient sexual arousal)

- Vaginismus and other overactive pelvic floor dysfunctions:
  - Although vaginismus can be accompanied by pain, its main characteristic is involuntary contraction of the vaginal sphincter, which makes penetration impossible. (See Chap. 17 for discussion of vaginismus)
- The presence of anogenital dermatoses:
  - Chronic disorders of the female genital skin may interfere with sexual contact, because they cause pain. Examples are lichen sclerosus, Zoon's vulvitis, mucosal lichen planus, etc. Diagnostic uncertainty can be ruled out by vulvoscopy or by taking a biopsy and performing histological examination. (See Chap. 19 for discussion of the sexual consequences of lichen sclerosus)

ETIOLOGY AND PATHOGENESIS

Before discussing the etiology of PVD, some critical comments must be made from a biopsychosocial perspective about syndrome diagnoses in general. This perspective is summarized under the label "functional complaints."

Functional Complaints

Although this is often forgotten in health care, the two main characteristics of syndromes such as PVD - i.e., pain and fear - are extremely important aids to human survival. In the case of threat or actual danger, high levels of fear and/or pain are "healthy reactions to an unhealthy situation." The same holds true for somatic stress reactions, such as increases in muscle tension, heart rate, blood pressure, etc. With (the threat of) sexual harassment and violence, the vaginal sphincter should contract, and the genital area should become hypersensitive, including an inflammatory reaction, to protect against and inhibit hostile invasion or reduce the negative consequences should this occur. In essence, these are normal psychophysiological reactions. Therefore, the question of pathology does not lie in the phenomenon itself, but in its *appropriateness*, i.e., the match between action and reaction. Problems arise when normal protective functions "overreact": when normal behavior or a psychophysiological state is *too extreme, too prolonged,* or *too intense*. This attention to contextual appropriateness is one of the key principles of psychosomatic obstetrics and gynecology. It is therefore the main reason why symptoms should always be put into a biopsychosocial perspective.

Etiology

Although distinct and interesting hypotheses have been put forward, the pathogenesis of PVD still remains largely unknown. In general, the etiology is considered to be multifactorial. PVD is generally considered to be a *chronic pain syndrome*, because clusters of characteristics, especially symptoms and risk factors, often coincide, such as:

- The typical vicious circle of chronic pain and psychosomatic complaints
- Comorbidity with other pain syndromes, such as fibromyalgia and the irritable bowel syndrome
- Comorbidity with pelvic floor dysfunction

Other observations have also been made that give PVD a more chronic pain disease-like character, such as:

- The presence of a peripheral and central neuropathic process [8, 9]
- Accompanying pathology in terms of increases in mast cells and nerve tissue in the vestibulum [10, 11]
- Histology of the vestibule showed markedly increased mast cells as well as pain nociceptors [12], such that touch was perceived as painful
- Lower pain thresholds in nongenital parts of the body [13], which supports the notion that PVD is characterized by central pain center dysfunction

An explanation for the “hybrid” character of PVD - i.e., disease combined with syndrome - might be found in its chronological development. What often starts as an ordinary acute disease (vaginal infection) or normal reaction to an averse stimulus (having intercourse without sexual arousal) gradually turns into a chronic pain syndrome. It is believed that psychological and social variables play an important role in why this occurs and why no normal adaptation takes place.

Psychological Factors

Many studies have been performed on the relationship between PVD and psychological characteristics of the patient and/or couple. Dimensions have been distinguished such as intrapersonal variables, interpersonal variables, social variables, and variables related with sexual behavior. Some of the studies focused on the psychosomatic perspective, i.e., the psychological makeup as the cause of the complaints or the contributing factor. Other studies concentrated on the somatopsychological perspective, i.e., the effects of PVD on the psychosocial functioning of the patient and/or couple. Although

conclusions were often drawn about cause–effect, most epidemiological studies were performed without any clear starting hypotheses, which makes causal inferences highly speculative.

Intrapersonal Variables

Psychological morbidity is significantly higher in PVD-affected women than in asymptomatic women. Many studies reported high levels of anxiety, depressive symptoms, somatization disorders, and hypochondrial symptoms. However, no convincing evidence is found of a psychological cause for the vestibular pain [14]. Epidemiological studies reported higher prevalences of comorbid anxiety disorders and depression in women with vulvodynia compared to healthy control groups [15]. With regard to obsessive–compulsive behavior, inconsistent results were found [16]. Additionally, PVD-affected women are more prone to specific personality traits, such as shyness, perfectionism, harm avoidance, increased tendency to catastrophize, hysterical personality, reward dependency, low self-esteem, and fear of negative evaluation than asymptomatic women [1, 5].

Interpersonal Variables

Women with PVD were found to have more negative feelings toward sexual-partner contact, but their marital satisfaction with the nonsexual aspects of the relationship was similar to that in normative groups. Nevertheless higher pain ratings in women with PVD were associated with lower marital adjustment and higher levels of harm avoidance and reward dependence [1].

Sexual Behavior

Women with PVD demonstrated impaired sexual functioning, namely, lower levels of sexual desire, arousal, frequency of intercourse, lower sexual pleasure, and erotophobia [15, 17]. They experienced more difficulties with sexual arousal and lubrication during partnered sexual activities than during masturbation [1]. Childhood physical abuse and sexual abuse were found to be potential risk factors for the development of PVD [17].

Vicious Circle

Pain is a complex sensation that encompasses sensory, affective, and cognitive features. Similar to many other chronic (pain) syndromes, PVD starts like or as an ordinary disease, e.g., a vaginal infection, cystitis, etc. Whereas normally recovery occurs, symptoms fade

away or are treated successfully; in chronic syndromes, a vicious circle develops. In the case of pain during sexual intercourse, this circle may have several different components, such as:

- PAIN → Fear → PAIN
- PAIN → No genital sexual response (blood flow, transudation, etc.) → PAIN
- PAIN → Pelvic floor muscle hypertonia → PAIN
- PAIN → Inflammation → PAIN
- PAIN → Elevated nerve density → PAIN

Once the circle has developed, in no time these strings of components become a toxic cocktail of stress reactions: PAIN → stress reactions → PAIN.

In order to complete the circle, there must be a stimulus that provokes the pain response. This means that the consequences of PVD must be intrusive. Fortunately, the psychosocial impact of chronic pain has been well documented, and the burden is indeed devastating. Feelings of hopelessness, depression, and anxiety are common [18]. Chronic pain can be debilitating and demoralizing. Pain associated with sexuality can decrease self-esteem and disrupt relationships [19]. Coital pain is not the patient's only problem. Some women who considered themselves cured of coital pain reported fear of intercourse due to the long-term experience of painful intercourse [20]. This information about the consequences of PVD enables us, while making use of the biomedical perspective, to combine medical knowledge with insights into psychological finality. This combination model not only makes PVD easy to grasp for health-care providers but also for patients and partners. A key factor in this model is the role of the *vicious circles*. As mentioned previously, in chronic pain syndromes, none of the so-called risk factors, or the general stress reaction patterns, are pathological in themselves. On the contrary, each phenomenon is a sound reaction to danger or threat. The question is why normal adaptation does not take place, when the context makes it clear to the woman that she is not being "threatened."

Relevant questions in the light of PVD are as follows: When is "attempting to have intercourse" part of normal adaptive behavior, and when is it a neurotic habit and thereby a serious sign of threat? What does it mean when some women try to break through the pain while having intercourse? And if you want to break through the pain as a form of desensitization, why choose the most difficult and complex way of doing so, by having intercourse?

It is therefore important to obtain a clear view of the interaction between all those involved, preferably when faced with problems that require collaboration. In other cases, the present may be safe, but memories of the past are so intrusive that they interfere with current functional behavior. Especially sexual encounters, with their focus on emotional openness and closeness, are vulnerable to this type of interference from the past, as, for example, research into cancer survivorship has shown [21]. So even when there is no clear-cut post-traumatic stress disorder, sensitization may take the place of adaptation. In order to grasp this sort of understandable but still problematic coping behavior, thorough exploration of the personal (sexual) history of the patient and/or the couple is needed.

Case History: Continued

Bianca Olive is devastated. Until now, nothing has alleviated her complaints. Instead, they have worsened. She fears that her relationship will end due to the painful sexual encounters. She admits that, once in a while, she let her husband penetrate, while she tries to hide her pain from him. Recently, it was too painful and they stopped all sexual activity. Even intimacy is difficult for her now, afraid as she is, that intimacy "turns into sexual intercourse."

SPECIFIC DIAGNOSTIC ASPECTS

Aims and Strategies

Owing to the lack of any clear etiology, the vicious circle of pain, and the prospect that the complaints are functional, it is not surprising that PVD is difficult to treat or, in other words, PVD is highly therapy-resistant. This has consequences on the treatment aims and strategies that can be used to fulfill the aims:

- *Aims*: it is wise to not strive for immediate success in terms of pleasurable sexual intercourse, but to focus instead on breaking the vicious circle of pain.
- *Strategies*: given the multitude and heterogeneous character of the intermediating variables (the elements in the vicious circle), many options are available. This plurality enables us to tailor the treatment to the individual characteristics and needs of the patient and/or couple (Table 1). In order to be able to do so, a number of preconditions must be met, such as the presence of a multidisciplinary team.

TABLE 1. Multidimensional and multidisciplinary approach of PVD

Careful history taking (in a safe atmosphere/setting)
An educative gyneco-sexological examination that the patient is able to follow with a hand mirror (and when applicable with the partner present)
Providing information about provoked vestibulodynia (PVD), its natural course, treatment options, and a treatment plan
Involvement of the patient and partner in the decision process about potential treatment options
Prescription of an inert cream (simple eye ointment or petroleum jelly 20 % in cetomacrogol) to protect the vestibular area and to urge the woman to touch the painful area (mucosal desensitization) (local corticosteroids are contraindicated)
Vaginal EMG biofeedback, pelvic floor physiotherapy (by a registered pelvic floor physical therapist) with the aim of alleviating pelvic floor hypertonia
Homework assignments that comprised self-exploration of the genitals and biofeedback by means of digital control, or with the aid of vaginal dilators and lubricants, together with a temporary coitus prohibition
A hygienic protocol, e.g., no vaginal douching, no press-on panty liners
Normalizing, reframing, and encouraging sexual activity without penetration to avoid development of feelings of guilt If appropriate, individual sexological counseling that aims to improve the woman's self-image, body image, and autonomy, with the aid of a registered psychologist/sexologist
If appropriate, sexological partner-relation therapy that primarily aims to improve physical and noncoital sexual contact, with the aid of a registered psychologist/sexologist
If appropriate, nerve stimulation by means of transcutaneous electrical nerve stimulation
If appropriate in some cases of persistent PVD, surgical intervention (vestibulectomy) as an additional form of treatment to facilitate breaking the vicious circle of irritation, pelvic floor muscle hypertonia, and sexual maladaptive behavior (end-of-line treatment)

Psychosocial Aspects/Biopsychosocial Approach

Research into the treatment of PVD still pays too little attention to the biopsychosocial model. From this perspective, all the phases of the treatment process are interdependent. It is only for didactical reasons that we discuss the phases separately, according to the following standard categorization [22]:

- Problem and patient orientation
- Diagnostic phase
- Indication and differential diagnosis
- Informed consent and shared decision-making

It is important to note that these stages are interdependent-like buttoning up a white lab coat: If you start at the wrong buttonhole or miss one, the coat will not fit properly! After the aforementioned phases, the therapeutic phase and the follow-up and evaluation phase will follow (described later in the section on *Specific Therapeutic Aspects*).

Problem and Patient Orientation

The acquaintance phase is especially important when dealing with patients who are coping with chronic illness. These patients are often at the end of their tether, because they have been looking for treatment for many years. In women with PVD, a quest of 5 years or more is no exception [19], and the mean number of physicians consulted prior to diagnosis is three [4]. PVD patients are likely to be feeling ashamed about having to reveal their very intimate problems to yet another health-care provider.
During history taking, it is important to decrease the woman's anxiety level by selecting a low-pressure setting, somewhere in private, with the woman fully clothed and not sitting on an examination table [19]. An important first step toward recovery is for patients to understand and accept their diagnosis. Providing clear and concise information is essential (psychoeducation). Over the years, women with PVD are likely to have received misinformation or ambivalent information from the different health-care providers [23].

PVD has a highly negative impact on quality of life. Patients are often young women at the start of their sexual life, when the couples' problem-solving skills (as a duo) still need time to develop. A negative male attitude toward PVD was found to be a significant predictor of decreased dyadic adjustment and sexual satisfaction, as well as increased psychological distress, although it failed to predict sexual functioning. These findings indicate that partners should be involved in the treatment of PVD [24]. It is likely that facilitative male partner responses will improve sexual functioning, whereas solicitous and negative responses may be detrimental. Psychological interventions that target partner responses can help to improve the sexual functioning of the affected couple [25, 26]. However, it is suggested that PVD is not necessarily associated with general relationship maladjustment of the woman and her partner [27].

Especially the lack of a clear or acceptable cause is experienced as an extra burden. All in all, this supplementary stress makes the patient (hyper)sensitive to the course of events during the first encounter. A reassuring but sensitive approach combined with ample communication about the current emotions and feelings often helps a lot. Whereas in acute situations, swift medical action can be a blessing; in these cases, it is essential to take your time. *Festina lente* (make haste slowly)!

Diagnostic Phase

As there are no clear causal pathways in the case of syndrome diagnoses, the diagnosis of PVD is mostly determined by exclusion. Even then PVD is difficult to recognize, because if the women is sufficiently sexually aroused, intercourse can still be pleasurable, even in the presence of PVD. In some cases, the pain manifests itself *after* sexual intercourse.

Case History: Continued

After she has given her consent, Bianca Olive is gynecologically examined, while she watches herself with a hand mirror. Her vulvar skin is reddish. There is no visible vaginal discharge. Upon request, it is difficult for her to relax her pelvic floor muscles. There are two bright red spots at 5 and 7 o'clock visible in the vulvar introitus, which are extremely painful when touching them with a wet cotton swab. Careful examination, after explicit permission of Bianca, with one gloved, lubricated finger, reveals firmly tightened levator muscles, eliciting the pain she recognizes when starting penetration.

Indication and Differential Diagnosis

Because there is no clear etiology and there are so many targets (i.e., risk factors to deal with), in the eyes of beginners or outsiders, the indication process and the differential diagnosis appear to be "trial and error driven." However, in the hands of an experienced clinician, the complaints and behavior of the patient become usually quite easily meaningful, and thereby a diagnostic and therapeutic pathway emerges for all involved. However, between sharing a rationale and complying with a treatment regime often lies a great distance - at least for the patient. This makes patient education more than a moral but a legal obligation. In case of PVD, it is a *sine qua non.*

Informed Consent and Shared Decision-Making

In many countries, informed consent is already a legal condition to start treatment, while shared decision-making is rapidly gaining ground as a moral condition. However, research has shown that in practice, neither of these conditions are adequately met [28]. This can even be a problem when treating illness with a clear biomedical cause. We know that adherence to lifestyle changes is extremely low in most chronic illnesses such as rheumatic arthritis, multiple sclerosis, etc., but in the case of chronic sexual problems, it is almost nil. We therefore pay ample attention to both conditions as follows:

Informed Consent

In medical practice, understanding why things happen does not guarantee therapeutic success. Moreover, even when success is possible, the way to achieve it is not always the solution the patient is seeking. In some situations, as we already pointed out when discussing the etiology of PVD, a reaction or symptom can have a protective function. In such cases, it is very difficult to eradicate, because the problem is also a solution. It is precisely this functional characteristic that raises the (ethical) question of whether health professionals should try to resolve the problem. Especially when there is no clear biomedical pathology, it is important to discuss and deliberate explicitly with the patient about the aims of the treatment process and the potential positive and negative consequences. In the case of PVD, the following possible aims could be discussed:

- Promoting quality of life in general
- Promoting quality of sexual life in particular, with or without intercourse
- Reducing morbidity and complaints
- Attempting to make intercourse non-harmful and as pleasurable as possible

Sometimes a patient's grasping of the situation, or gaining a clearer understanding, resolves the problem or the request for help. If the request for help persists, the elements that make up the vicious circle need to be clearly explained, and special attention must be paid to the need for full symptom prevention.

Shared Decision-Making

It should be clear to all those involved that the only way to resolve this sexual variant of the old "chicken and the egg dilemma" is to establish a different means of "sexual self-management." The object of this self-management should not be the act of sexual intercourse, but full symptom prevention. The term "self-management" in itself stresses that this can only be achieved with the active involvement and participation of the patient and/or couple. Just like many other lifestyle issues, such as eating, drinking, physical activity, etc., sexual habits are difficult to change. Besides informed consent and sexual literacy, shared decision-making is a sine qua non for the treatment of PVD. Therefore, preferably during the whole process, but at least when you have established the diagnosis of PVD, explain to the patient what you are going to do and repeatedly ask for her consent. Keep in mind that in psychological terms, these patients are at risk anyway. They may also have been "mistreated" medically and been traumatized for years. If a gynecological examination is needed, do it in an educational way, and give maximum control to the patient. Ask her whether she wants her partner, if present, to be

involved; ask her if she would like to use a hand mirror to see what is happening. Listen to her answers carefully, and look closely at how the patient and her partner interact as a couple. Having to make changes to their sexual lifestyle will put extra stress on the relationship. Therefore, careful observation might provide important information about the need to reconsider some treatment aims or procedures. In the end, it should be clear exactly which aims have been set, for which reasons and which procedures are needed. The patient should not only be informed but should also be the one who has made the decision to start treatment. This means that the patient and/or couple should be sexually literate in general, but particularly about the most important therapeutic options regarding PVD.

SPECIFIC THERAPEUTIC ASPECTS

Therapeutic Phase

In terms of the actual treatment, it is of eminent importance to keep in mind that the primary aim is not the reuptake of intercourse, but full symptom prevention: breaking the vicious circle! As stated previously (see the section on Aims and Strategies), several different, but not mutually exclusive, strategies can be used.

Follow-Up and Evaluation Phase

The importance of follow-up and evaluation lies in the opportunity to make adjustments to the current case and to learn from it, in order to improve the approach to future cases (reflection). Given the complex nature of PVD, a number of possible pitfalls can be distinguished and thereby points for evaluative reflection.

Examples of Patient-Related Topics for Reflection

- Some patients are unwilling to adopt a psychosocial stance and insist on receiving somatic treatment. If this occurs, it is important to realize that it is unbearable for many patients that their PVD complaints are rooted in more fundamental psychological or interpersonal (sexual) problems. This means that our good news, i.e., that we have solved the puzzle, is perceived by the patient as bad news. When discussing future action, the rules of a bad news consultation should be followed. Do not try persuasion, but ask questions about the patient's emotions and what the message means to her.
- Make a decision in the multidisciplinary meeting regarding who will be the one to talk with the patient.

- Sometimes young patients are accompanied by one of their parents, or a dominant partner, whose ideas and behavior interfere with the treatment process. It is important to address these types of disturbance first, before actual treatment can start. An elegant strategy is to relate PVD to the theme of autonomy versus dependency.
- Some patients feel very embarrassed about discussing intimate details with a health-care professional. Having sexual problems and being forced to talk about them is a way of expressing who they really are as a person. Unmasking themselves - and often their partner as well - makes people extremely vulnerable. It is easy to implicitly presume that the partner is the ideal co-therapist or that he will at least provide social support for the patient. However, for him, treatment also means being exposed, and moreover, it is the start of an intimate triangular relationship. Owing to the fact that health-care professionals in sexology often deliberately act as "the ideal partner," their therapeutic behavior alone may induce intense feelings of jealousy, anger, etc. Beware of this transference, also on the part of the partner, and if it happens, eradicate the disturbances first before starting actual treatment.

CRITICAL REFLECTION AND CONCLUSIVE REMARKS

When dealing with syndrome diagnoses such as PVD, it is always the match between the patient and the professional that in the end determines failure or success. This does not mean that it is unimportant to follow a clear road from hello to goodbye. On the contrary, but as a health professional, one has to be able to discover or, better, to co-create with the patient the pathway that serves her best. Moreover, many patients look back at the treatment process as "a difficult yet rewarding process of personal and relational growth."

Case History: Continued

After getting dressed and at the desk, Bianca Olive learns about the vicious cycle she has entered. She acknowledges that it has been a long time since she had experienced sexual excitement and lubrication - afraid of the coming pain. She understands that she needs to quit the attempts for penetration until she has more control of her pelvic floor musculature. She will bring her husband for the follow-up visit, in order to talk about the mechanism of the complaints. In the meantime she will start pelvic floor physical therapy and apply emollients to smoothen her irritated skin. She is willing to find out alternative sexual stimulation. Some leaflets and websites are provided to her, so she can orientate herself on which aspects might stimulate her in an erotic sense if desired. During the standard telephone follow-up evaluation 6 months later, Bianca says that she now realizes how sexually ignorant she and her partner were at the beginning of the therapy. Together they are now exploring a whole new dimension in their relationship that goes beyond having intercourse.

TIPS AND TRICKS

1. During the problem and patient orientation phase:
    - Realize that when dealing with syndrome diagnoses such as PVD, a patient-physician relationship of excellent quality is of utmost importance. Therefore, keep in mind that “There is no second chance to make a first impression” and “The medium is the message.”
2. During the diagnostic phase:
    - Combine empathy with moral neutrality; try to put apparently problematic phenomena, such as pain and fear, into a functional perspective without “blaming the victim.”
    - In the case of a vicious circle, shift the focus from the normal elimination of causes to breaking the circle.
    - Before you share your ideas about the ultimate diagnosis and treatment options with the patient, inform the patient that you will discuss and check them within the multidisciplinary team. Listen carefully to all the arguments, because they will probably reoccur in your discussions with the patient.
    - Be aware of the possible influences of sexual traumata. Ask proactively about previous sexual traumata!

3. When talking things over with the patient:
   - Be careful using terms with "psy" in them (psychic, psychogenic, psychosomatic, or even psychologist), because they mean bad news to most patients who are suffering from a syndrome diagnosis.
   - Do not impose your solutions; offer them as neutral options.
4. During the therapeutic phase:
   - PVD is a multifactorial disorder that should be treated in a multidimensional way in accordance with etiological factors, the risk profile, and context.
   - If you try to follow a stepped care model, beware: the more you become involved in the treatment process, the greater the intimacy and the stronger the bonding. Do not wait too long before referring the patient on.
   - When referring, make it clear that you are not doing it due to the complexity or magnitude of the complaints but due to the limitations of your professional repertoire.
5. During the follow-up and evaluation phase:
   - Even with timely referral, intimacy will have developed during the treatment process; therefore, attention should be paid to the way the patient, the couple, and/or the professional "return to normal."
   - When looking back on successful treatment, parallel lines can be drawn between effective coping with PVD and other often coexisting problems, such as fibromyalgia, etc.

TEST YOUR KNOWLEDGE AND COMPREHENSION

1. **The lifetime prevalence of PVD is the same regardless of ethnicity.**
   A True
   B False

2. **In women, with sufficient arousal (and orgasm), the pain threshold temporarily increases.**
   A True
   B False

3. **Evidence is found of a primary psychological cause for PVD.**
   A True
   B False

4. **In women with PVD, the marital satisfaction with the nonsexual aspects of the relationship is similar to that in normative groups.**
   A True
   B False

5. **Childhood sexual abuse is found to be a potential risk factor for the development of PVD.**
   A True
   B False

6. **Which of the following statements referring to allodynia in women with PVD is *not* true? The allodynia areas:**
   A Chiefly occur in the vulvar vestibule
   B Are limited to specific areas
   C Always coincide with local redness
   D Are symmetrical in the majority of women

7. Choose the option that is contraindicated in the treatment of PVD.

A Local corticosteroids
B Penetration prohibition
C Pelvic floor physiotherapy
D Multidisciplinary approach

8. The primary aim of the treatment of PVD is:

A The reuptake of intercourse
B Full symptom prevention
C Recovery of sexual response
D Removal of negative feelings toward sexual-partner contact

9. What is the most essential condition for the treatment of PVD?

A Sharing a rationale
B Shared decision-making
C Complying to treatment
D Patient education

10. What is the mean number of physicians consulted prior to the PVD diagnosis?

A 1
B 2
C 3
D 4

Answers

1.	True	**6.**	C
2.	True	**7.**	A
3.	False	**8.**	B
4.	True	**9.**	D
5.	True	**10.**	C

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PART

Treatment