

**SEX THERAPY IN THE TREATMENT  
OF VULVODYNIA**

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## **Sex Therapy in the Treatment of Vulvodynia**

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Many women who suffer from vulvodynia and related gynecological disorders receive only partial treatment for their disease, although they may not realize this is so. Historically, vulvodynia has been characterized as a psychogenic disease, leading women to struggle with the adage, "It's all in your head." Recent research has illuminated alternative conceptualizations, including the discovery of physiological maladies of the pelvic floor muscles, or consideration of vulvodynia as a pain disorder in which nerves are damaged in such a way that normal pain feedback loops are disturbed (Wesselmann, 2001). These advanced conceptualizations, though, may lead practitioners to lean the other way and consider solely the physical treatment of these disorders. Recent advances in mind/body medicine, however, suggest that nearly all physical disorders have a psychological component, if only because having a disorder is, in and of itself, a life stressor (Walton & Thorton, 2003). In the case of vulvodynia, the neglect of psychological aspects, including sexual concerns, may prevent a woman from obtaining the most optimal relief for her problem.

Sex therapy is a good choice for the woman who seeks psychological services to augment medical treatment because the sexual concerns that a concomitant with vulvodynia can be devastating (Elliott, 2002; Katz & Tabisel, 2002). Unfortunately, there are many misconceptions about sex therapy. Women, and possibly their partners, may fear that they will need to disrobe in the therapy room, or that there will be inappropriate touching. Other myths are that sex therapy is only a few old-fashioned

exercises, or that it ignores other parts of a couples' relationship. In reality, sex therapy is simply a specialized type of psychotherapy in which the focus is on sexual function, including genital health and reproduction. Our purpose in writing this article is to provide readers with basic information about sex therapy and the treatment modalities that are commonly employed to optimize a woman's ability to cope and function, no matter where she may be in terms of her medical treatment.

### **Assessment**

Since a sex therapist is a licensed mental health professional (psychologist, marital therapist, or social worker), the sex therapist can take a much broader view of a woman's presenting problem. Thus we begin with a general intake to gather the patient's basic demographics, information about family of origin, psychiatric history, substance abuse history, and so forth. We also assess for depression, anxiety, pain disorders, body dysmorphic disorder (distorted body image), history of sexual abuse or assault, fertility issues, substance abuse or dependence, inability to cope, relational problems, and so on. Part of the reason for this level of assessment is to make a judgment whether a referral to a psychiatrist may be appropriate, as well. Once we have a sense of the woman before us as a whole, we conduct a complete sexual health history (Gomes).

### **Common Treatment Modalities**

Once we understand the exact nature of the presenting problem, we create a treatment plan that may include some or all of the following interventions.

#### **Individual Therapy**

In individual treatment sessions, a woman can relate an illness narrative (Kleinman, 1989; McDaniel & Doherty, 2003) or story. The opportunity to have a

nonjudgmental, supportive therapist listen to one's narrative detailing her symptoms, her attempts to get a diagnosis, and how she (finally) obtained appropriate treatment can help a woman integrate her experience as a whole, as well as voice frustration, anger, disappointment, fears, and even hope. In addition, sometimes women find that they have "worn out" even the most supportive families and friends, and having someone listen empathically can be healing in and of itself.

In individual treatment a patient can also identify and explore pre-morbid issues such as sexual inhibitions generated by the beliefs of one's family, religion, or culture; sexual abuse or unhealthy sexual experiences such as being exposed to a parent's pornography; or mourning changes in one's body or sexual function. Underlying issues such as depression or anxiety are also generally best addressed in an individual context (Gurman & Nichols, 2002).

A woman's partner may also benefit from individual sessions in which he can ventilate his own anger and frustration. Despite years of feminism, many men--even young men who ostensibly believe in equality for women--may have a sense of entitlement about sex, or view sex as a genital activity rather than a pathway to physical and emotional intimacy (Schnarch, 1997). Men are often confused about their partner's diagnosis, perhaps themselves having bought into the "it's all in her head" adage. Receiving education about dyspareunia, vaginismus, and other vulvar pain disorders can help create empathy and gain the man's cooperation in treatment.

### Couples Therapy

In our view, couples therapy is almost an imperative in the treatment of vulvodynia. Couples often have not sought treatment for years, and their sexual and

intimate relationship has been disrupted by vulvodynia. Women often avoid all sexual contact (not just vaginal, but oral and manual) because sexual activity has become associated with pain; men, afraid of rejection, stop seeking their partner (Kellogg-Spadt & Sernekos, 2003). With the disruption of sexual activity, there is often (though not always) a concomitant disruption in emotional intimacy Binik, et al, 2002). Despite these disruptions, couples often report that they have a commitment to one another because of shared history, having children together, their religious beliefs, or other reasons. Finding the couples' unique strengths and using these to overcome obstacles to physical and emotional intimacy can help them to re-establish their attachment bond. Finally, re-establishing a sexual relationship requires mutual cooperation, as at least some part of the intervention needs to be completed as a duo.

### Education

A surprising number of women have misconceptions about their anatomy (Foley, et al 2002; Glazer & Rodke 2002; Stewart, 2002). As long as a medical diagnosis has already been established, we can also use charts and models to show women and their partners how female reproductive anatomy and the pelvic floor are structured. Explanations and handouts can also help women identify, for example, their pubococcygeus (PC) muscle and appropriate ways to exercise the muscle to facilitate successful intercourse, if this is the woman's or couple's goal. For some women, this level of intervention has proven adequate, but for others, a referral to a physical therapist that specializes in pelvic floor work is definitely in order.

Sometimes couples, particularly young couples or couples from restrictive cultures, have very little information regarding sexual behavior such as foreplay. We had

a case of a couple who, on their wedding night, literally walked out of a taxi, into a hotel room, and attempted intercourse for the first time without foreplay, resulting in vaginismus and a year of painful attempts at intercourse and emotional tension. Sensate focus exercises or "nondemand pleasuring" exercises (McCarthy & McCarthy, 2003), as well as instruction about why foreplay is important in preparing the vagina for intercourse is often the key to achieving a normal sexual life.

Additionally, education is usually an important part of helping a woman and her partner gain new perspectives on sexual activity and encouraging them to explore possibilities both outside the bedroom--and outside of intercourse. Many times, couples stop being affectionate with each other because they are afraid that affection will lead to intercourse, which they quite possibly have been trying to avoid. Educating patients directly about this common confusion of sex and affection can lead to a fruitful discussion of how to put affection back into their lives. Reminding couples there is more to sex than penis-vagina intercourse can be helpful as is encouraging so-called "outercourse" (Klein, 1999) such as manual and oral play. Finally, there are the aforementioned sex therapy exercises that can help a couple re-connect and re-educate them about the purpose of sexual activity, which is to express and receive love and caring through touch. The use of such exercises also can serve as "outercourse" when intercourse isn't possible.

In addition, we have had good success with teaching women how to use vaginal dilators. Unlike a physical therapist, we cannot conduct such teaching *in vivo*, of course, but most women understand the concept of starting with the smallest dilator and learning

to relax the PC muscle. The benefit of learning within the context of psychotherapy is teaching the patient to manage overall anxiety or anxiety about her body...

### Pain Management

There are many pragmatic approaches to pain management that the sex therapist can use to augment medical treatment (Elliott, 2002). Several of these approaches utilize overall relaxation techniques, including progressive muscle relaxation (Benson,), hypnosis (Hammond, 1990), and guided imagery (Rossman, 2000). Biofeedback, such as heart rate variability biofeedback or galvanic skin response, can also help with overall relaxation and pain reduction (put in name). Part of the charm of these techniques is that they give a woman a sense of control over her own physiological responses and improve her relationship with her body. Not all sex therapists will employ these techniques, but in our experience they can be a very useful part of treatment.

### Coping Skills

Coping skills can be described as cognitive techniques or self-talk that can help a woman take a different perspective on whatever pain she might experience (Sharoff, 2004). Examples of self-talk that can be helpful are:

- Fighting pain makes it worse. I accept that I have pain.
- There is pain; I will use my tools to help myself. I will do the best I can.
- It is no use being angry with my body. I will forgive myself and my body and practice kindness and tolerance.

Other coping skills might include assertiveness about one's needs; increasing self-care; finding multiple sources of pleasure outside of sexual activity; joining a group or a listserv for support; bibliotherapy, or targeted reading; and so forth.

Sandy: A Successful Case

Sandy came to treatment with her husband Joe because they had been unable to resume their normal sexual activity after her cancer was treated with radiation in the pelvic region. Sandy complained of dyspareunia and secondary vaginismus. Because of the pain and embarrassment of being unable to have successful intercourse, Sandy avoided Joe, not even kissing him hello or good-bye when he went to work.

In Sandy's narrative, she related a great deal of anger that her sexual concerns had been dismissed or inappropriately addressed. In tears, she told about a radiologist that told her, "You'll have to stick something up in your vagina there to keep it open." He did not explain why she needed to do this, and all Sandy knew was that she did not want to put anything into her vagina. Thus, her vagina had atrophied, greatly contributing to her discomfort and pain.

Sandy had some psychotherapy during part of her treatment to cope with the fact that her cancer might prove terminal. Discussions of death and the possibility that the cancer could return someday made it difficult for Sandy to be intimate with her spouse. However, Sandy feared her husband might stray if she did not address her fears and work toward the goal of achieving sexual intimacy with her husband.

A couple's session was soon scheduled to understand Sandy and Joe's treatment goal, which was to honor their history together and to repair the disruption to their emotional and sexual bond caused by the illness. The couple was given a short book to read that would get them into a lively discussion of where their sex life had been (fun and

adventurous), where it was now (nowhere) and where they wanted it to be (intimate and relaxing). They also explored how sex and affection had become confused, and were given sensate focus exercises to encourage them to participate in non-demand pleasuring.

In addition, Sandy was referred to an endocrinologist who prescribed an estrogen cream, which helped resolve the issue of dryness. Sandy was told she would soon be ready to use dilators. Once she did, however, she was surprised that doing so caused negative sexual thoughts to erupt, such as equating sex with chores. Now she looked at how these negative thoughts affected her sexual desire, and she began to make a conscious effort to think about sex in a positive way—connecting to her husband through touch. She also utilized the muscle relaxation CD that was made for her, and was happy to find that it made a difference if she listened to it before trying to insert the dilator.

In the middle of treatment, the couple made a decision to take a weekend away for themselves without children. Although they went off with some trepidation about what, if any, sexual activity might occur, Sandy returned with a wonderful report—the couple had had successful intercourse. She did report some soreness afterward, but liked the idea of applying a cold pack wrapped in a towel afterward. The glow on her face, however, was hard to miss!

Treatment ended soon thereafter. Sandy knew that she still had some emotional recovery ahead of her, but she was happy that she and her spouse had overcome the physical and emotional barriers to intimacy. Sandy left therapy knowing that she could return at any time if she re-experienced pain or had a relapse of vaginismus.

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Sex therapy is an excellent adjunct to medical treatment and physical therapy in the treatment of vulvodynia. Not all sex therapists have an interest in treating this disorder, but those who do generally have obtained appropriate training. To find a sex therapist, the best resource is the American Association of Sexuality Educators, Counselors, and Therapists at [www.aasect.org](http://www.aasect.org). If there is not a certified sex therapist in your area listed on the website, contact AASECT via phone to find a sex therapist who is not certified, but who may have appropriate training nonetheless. . Another resource is your medical doctor or gynecologist who may know a psychotherapist who treats sexual problems but is not an AASECT member.

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