GENITO PELVIC PAIN/ PENETRATION DISORDER:

GPPPD

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Sexual PSYCHOLOGY

OVERVIEW

- GPPPD Diagnosis & Prevalence
- Pain or Sexual Disorder?
- Multiple Aetiology
- GPPPD Assessment
- Multi-Team Treatment Approach
- Psychological Treatment

GPPPD

- Previously Dx Vaginismus or Dyspareunia: DSM-5 fused into GPPPD due overlap Sx and clinically indistinguishable.
- ICD-10 still separate Dx

✓ Intercourse specific
✓ Difficulty with penetration: persistent or reoccurring
✓ Genito-pelvic pain with penetration attempts
✓ Fear or anticipation of pain with penetration
✓ Tight pelvic muscles
✓ At least 6 months duration: Life Long or Acquired
✓ Severity = Distress: Mild - Severe

➥ Not sexual pain, rather PAINFUL SEX

GPPPD PREVALENCE

- Hard to say as new DSM criteria, vaginismus 1-6%, dyspareunia 5-25%. Different ranges due study design definition.

- Australian Longitudinal Study of Women's Health 2012.
  - N= 4366, 1 month duration painful sex 5%
  - 12 month follow up N= 955 persistent 35%
  - Non cohabiting increased incidence x2

IS IT A PAIN DISORDER OR SEXUAL DISORDER?

- Both! Most genital pain syndromes will impact sexual function
- Well established fact that pelvic floor reacts to emotional states

- Anticipation of pain/pain turns on the protective system F/F/F and turns off the sexual system.
- Women w aversion experience pain once they attempt I/C.

DIAGNOSTIC CONFUSION

- No uniform assessment protocol
- Different methods assessment depending on discipline

- Multifactorial
- Involves multiple high value systems:
  - reproductive, digestive,
  - excretory, sexual, musculoskeletal systems

- Interconnected and turning on and off automatically

- Problem in one system can generalise to other system interconnecting muscle and nerve systems (VD =IC)

MULTIPLE PHYSICAL AETIOLOGY

- Musculoskeletal
- Dermatological: Vestibule/vulvodynia, lichen sclerosis/planus
- Vaginal infections (HSV/Candida) / PID
- Bladder infections/Interstitial Cystitis
- Ovarian cancer and treatments
- Pudendal neuralgia/ Pudendal entrapment (trauma)
- Endometriosis/ Adenomyosis/Fibroids
- Constipation, IBS, diverticulitis
- Ulcerative colitis/Crones

PHYSICAL AETIOLOGY CONT.

- Anal fissures, pilonidal sinus
- Ovarian cysts/PCO
- Ectopic pregnancy/miscarriage
- Kidney stones
- Child birth trauma/surgery
- Hernia
- Fibromyalgia
- Hormonal changes/ contraception
- Allergic reactions

PSYCHOLOGICAL CONTRIBUTIONS .

- GAD: increase IBS, pelvic tension
- Somatic symptom disorder: negative appraisal, reduce pain resilience, preoccupation, Google Dr, low pain self-efficacy
- Specific phobia: birth fear, penetration fear.
- PTSD: sexual assault
- Unpredictable family of origin (ETOH, DV family, emotional abuse)

PSYCHOLOGICAL CONTRIBUTIONS .

- Sexual desire discrepancy (pressure to please) leading to inadequate stimulation (mercy sex), persistence with I/C despite pain
- Sexual Interest/ Arousal Disorder (secondary to GPPP)
- Co-morbid depression, perfectionism, neuroticism, disgust
- Less knowledge of sexual response, body
- Reduced masturbation practices

GPPPD: ASSESSMENT

- Normal sexual health/medical assessment with specific focus on:
- Hx of penetration: tampons, PAP, digital penetration, intercourse, generalised or context specific (partner specific vs masturbation)
- Viewing of own genitals or avoidance (looking for disgust reaction)?
- Can they orgasm: how…rubbing with sheet, pants on: idiopathic sexual arousal, different nerve systems for different orgasms

GPPPD: ASSESSMENT CONT.

- Non-provoked pain: identify where exactly on the genitals (abdomen, vestibule, anus, vagina)
- Pain on urination: bladder infections, difficulty urinating or defecating: musculoskeletal problems.
- Provoked pain on penetration: when (at beginning I/C, during, after) where? introitus or deep

PAIN @ INTROITUS

- Vaginal and vulvar skin issues – dryness and splitting, dermatological conditions, recurrent fungal, bacterial or viral infections HSV

- Vaginal thinning (atrophy) – dryness, burning, and itchiness (Hormone changes seen w polycystic ovaries/anorexia/CA Treatments/ menopause/high athletic training/low body weight)

- Unperforated hymen

- Congenital abnormalities

DEEP PAIN ON PENETRATION

Deeper pain in pelvis, low back or abdomen

- Endometriosis – significant pain with periods, bowel movements, pain between periods, very heavy bleeding and clots.
- Trauma after having a baby, from a fall or injury.
- Pelvic scarring or adhesions – after an infection, surgery or radiation treatment
- Bowel issues such as IBS, constipation and straining, loose stool.

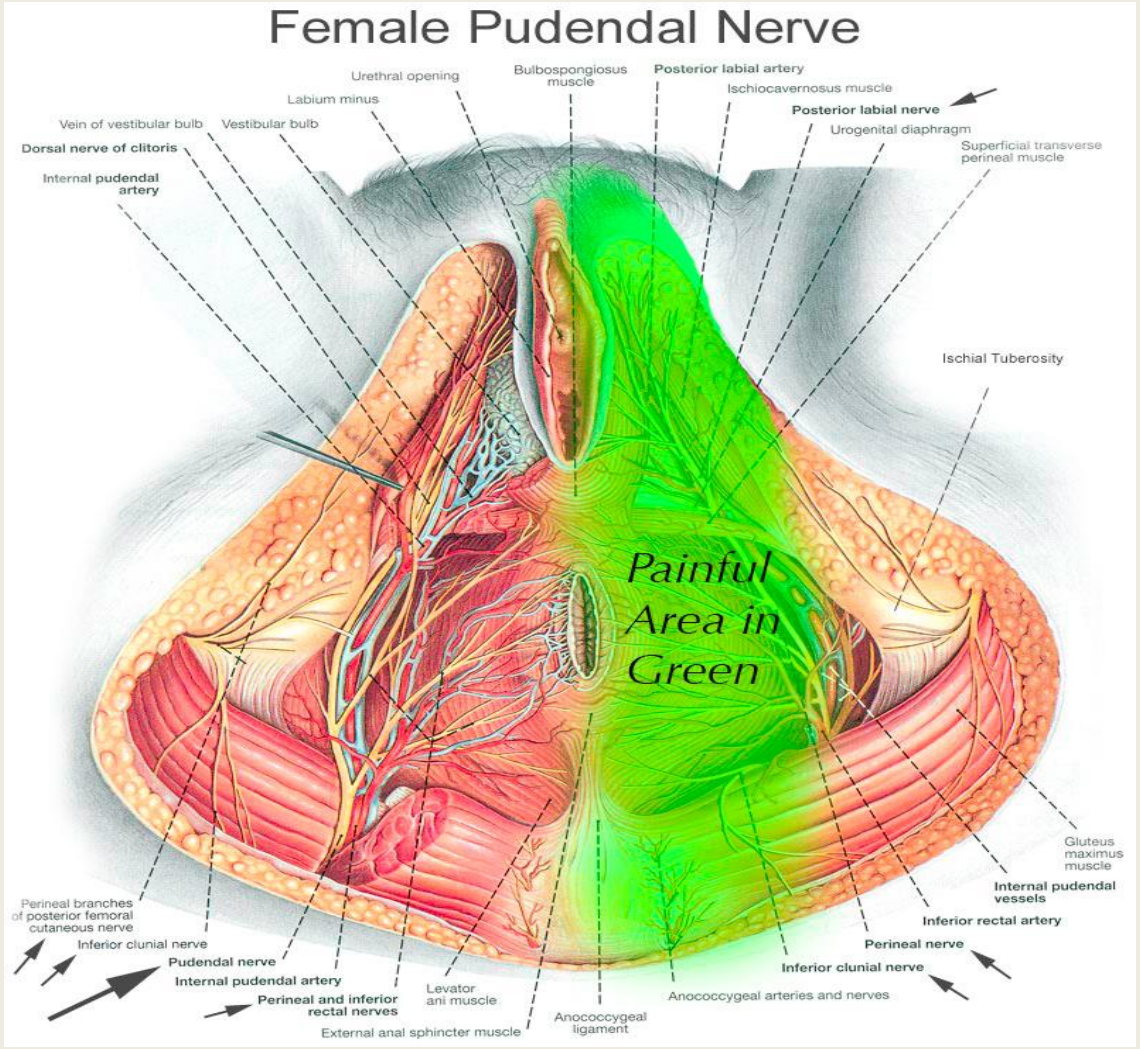
DEEP PAIN ON PENETRATION

- Musculoskeletal, ssacroiliac or hip joint pain, aching in the low back, hips, pelvis or low abdomen, limping (gait and posture)
- PID –other indicators of infection such as fever, diarrhoea, cramping, coloured or smelly discharge, stinging urination or a history of unprotected sex
- Sexual positions related to sensitive cervix; penis size

PERSISTENT PAIN CAN BE SUPERFICIAL OR DEEP OR BOTH

- Nerve injury/trauma after surgery and post baby
- Bladder issues such as recurrent infection or Painful Bladder Syndrome, IC
- Pain getting worse at end of day or with prolonged sitting:
- Pelvic floor hypertonicity/Pudendal neuralgia

PUDENDA: SHAMEFUL PARTS



GPPPD: TREATMENT

- Majority of women are ashamed and don't disclose until unbearable
- Women usually seen more that 2 different clinicians prior to diagnosis
- Previously 2 distinct treatment approaches:
  - psychological or medical
- Pain is biopsychosocial: physical/environmental/relationship and psychological factors, exacerbate and maintain pelvic pain.

MULTIDISCIPLINARY TEAM APPROACH

PHYSIOTHERAPIST

- Physiotherapist to identify musculoskeletal conditions, pelvic floor relaxation, myofascial release, behavioural exposure/motivation to vaginal trainers.

- Sydney Pelvic Floor Clinic Bondi Junction

https://www.sydneypelvicclinic.com.au/

Loads of resources: on line education video's

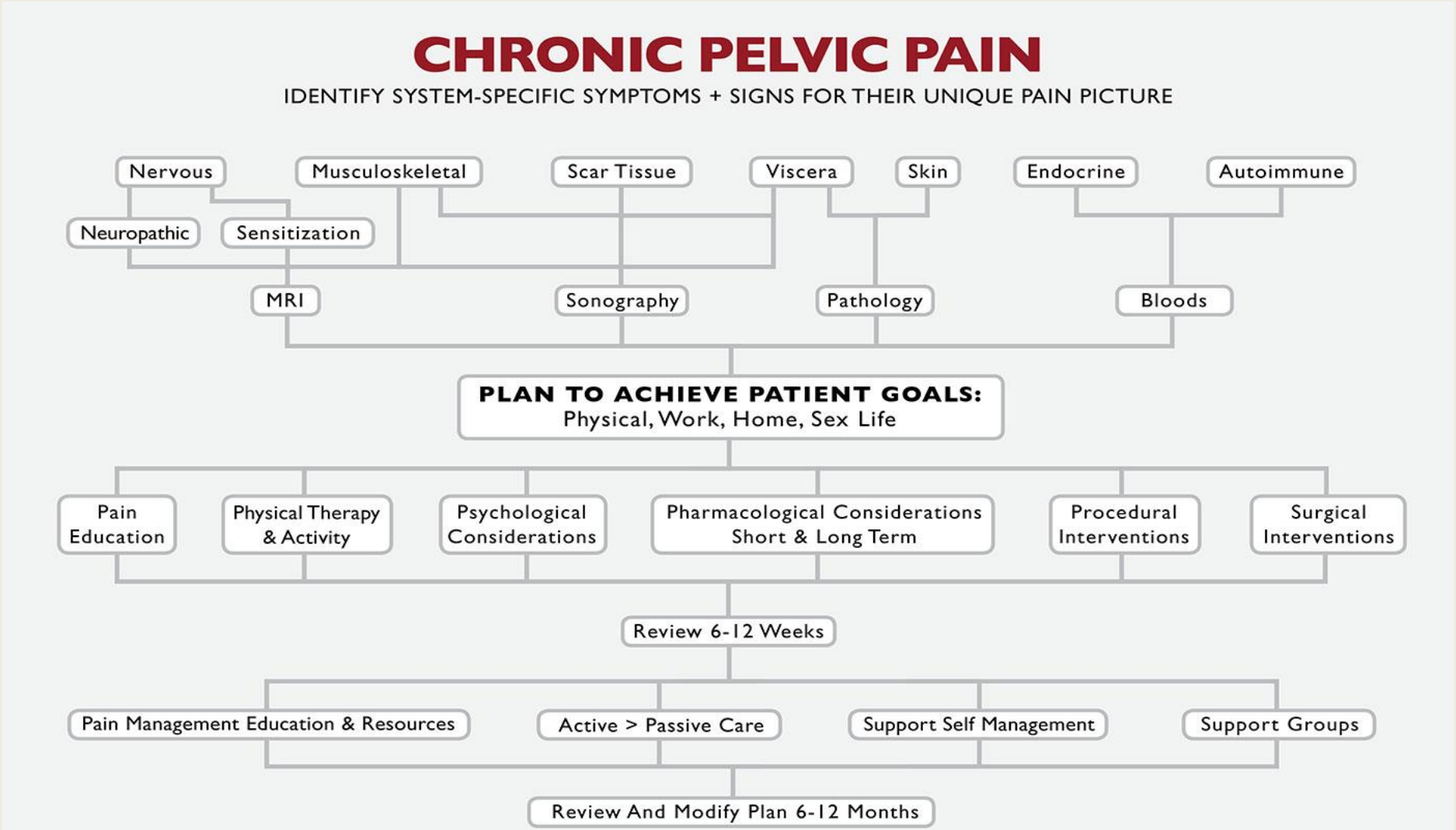
- Pelvic stretches online
- Run 2 hour group education session: Pelvic Pain and Your Brain

WHRI:WOMEN'S HEALTH RESEARCH INSTITUTE:

- Inhouse multidisciplinary team
  - Gynecologists, Pain specialists, osteo/physio and counsellor

- Pain specialist for chronic pain conditions:
  - somatic pain disorder
  - pelvic nerve conditions
  - Interstitial Cystitis
  - Endometriosis
  - Persistent vulvar/vestibuldynia

WHRIA



WHRIA
Women's Health & Research
INSTITUTE OF AUSTRALIA

GPPPD: PSYCHOLOGICAL INTERVENTIONS

- Realistic goal setting around pain management and penetration
  - Pain resilience and self-efficacy vs pain free
  - Outercourse vs intercourse
  - Improved sexual communication/relationship satisfaction
  - Subjective sexual satisfaction rather than goal oriented I/C focus…reduce the push through and shame/disgust

- Motivation and importance of homework:
  - Diary with mood graph and pain scale
  - Procrastination
  - Avoidance

GPPPD: PSYCHOEDUCATION ON PAIN

- Pain is worse when you don’t understand it!
- WHAT is going on: Identify initial injury and what is maintaining or exacerbating it
- Increases pain self-efficacy and control
- Partner facilitated active coping

GPPPD: PAIN EDUCATION: MIND BODY CONNECTION

- Explain Pain handbook: Protectometer. Moseley & Butler

http://www.noigroup.com/documents/noi_eps_course_flyer_christchurch_1117.pdf

- Lorimer Moseley Mind and Pain education TED talk
- https://www.youtube.com/watch?v=bj9CUGzw6fs (24.10 minutes)
- https://www.youtube.com/watch?v=lCF1_Fs00nM(1.23 hours)

GPPPD: FEAR AVOIDANCE MODEL

VLAEYEN& LINTON(2000)

- Identified the what….move to the maintaining cycle
- What/medical/physical become less focused
- Change to why it is still happening
  - Time to diagnosis, unclear diagnosis? Unsuccessful Rx.
  - Threatening information gained through clinicians: Chronic, Endo invading my body/organs, coming back…..

COGNITIVE RESTRUCTURING: PAIN CATASTROPHISING

- Pain Catastrophising:
  - Getting worse, I cant stand it, My day is ruined
  - I'll never have a baby/relationship/Ill be alone

- Explain CBT: Catastrophic thoughts = threatening thoughts= increase emotional reaction = hypervigilance= increase tension in the pelvis physical sensations = freeze, tucking under, avoidance (behavioural or thinking about it)

- Change language: I cant stand it, I cant do it, it hurts, I'm dry, its rubbing, wrong position, not in the mood, not arouse, distracted

COGNITIVE RESTRUCTURING: SHAME& DISGUST.

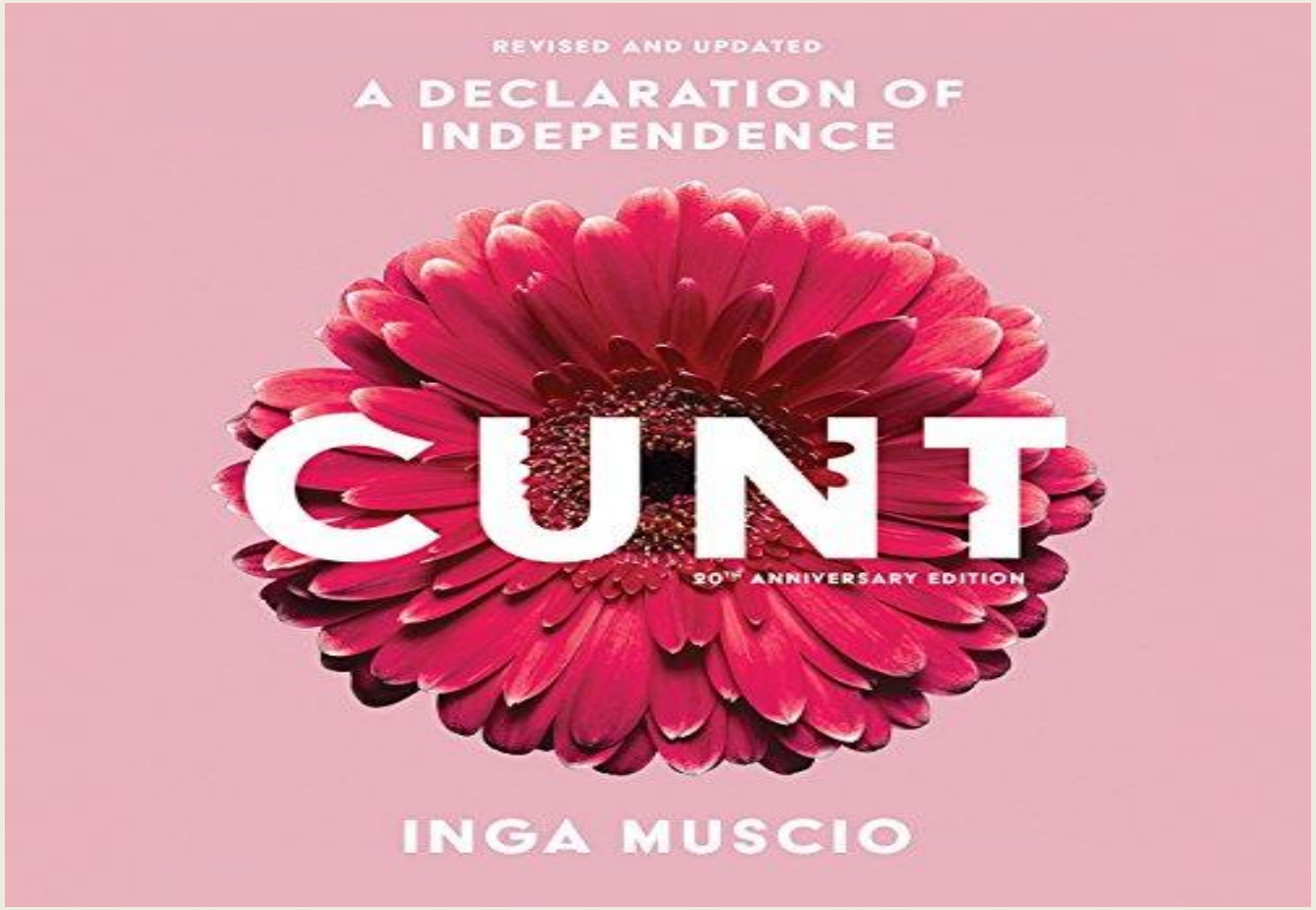
- Shut down sexual system turn on threat

- CBT: Shameful thoughts “I'm a freak, no one will want me” = avoiding, secretes, silence, turning away, relationship conflict.

- CBT: Disgusting thoughts “Yuck, gross” = moral distancing, expelling, rejecting.
- Can’t let anyone in (literally) if disgusted by self/genitals/body fluid

- Change to self loving talk, kindness, personal encouragement, more neutral, curious, feminist thoughts

SHAME AND DISGUST: FEMININE PRIDE CONT.



https://www.audible.com.au/pd/Cunt-20th-Anniversary-Edition-Audiobook/B07DVRSJN3

KNOWLEDGE OF FEMALE GENITALS & MENSTRUAL CYCLE

- Flow app https://flo.health/
- Sexual Psychology: Links: Female Genitals http://www.sexualpsychology.com.au/female-sexual-health-and-sexuality/
- Betty Dodson: https://www.dodsonandross.com
- Sex Smart Films: http://www.sexsmartfilms.com/
- Stop self treatment of thrush/douching

COGNITIVE RESTRUCTURING: HYPERVIGILANCE

- Address hypervigilance (attention focus) on pain:
  - High value area, prioritized over other body parts.
  - Brain is keen to keep safe and responds in sensitised/dramatic way to perceived threat
    - E.g. leg cramp vs pelvic pain response
  - Brain wired to focus threat over sexual stimuli

- Teaching mindfulness skill: Change perception to non-judgmental awareness of body: brain controlling pain perception

MINDFULNESS

- Connect body and breath and pelvic floor;
- Calming the pelvis, down regulating the system
- General relaxation exercises, look at lifestyle: “BUSY” is a problem.
- Make time essential to treatment: Life Skill
- Sleep, food (carbs/sugar/stimulants spike FF system) exercise
- Can’t relax pelvic floor if unable to slow down, take time for self and reduce general anxiety and stress.

GPPPD: **GRADUAL** EXPOSURE

- Avoidance: never have opportunity to learn and change.
- Avoidance spreads: avoid sex, avoid affection, avoid intimacy
- Disuse: poor condition: Sexual dysfunction
- Cheer Leader: Motivator, get excited with them

GPPPD: **GRADUAL** EXPOSURE

- Body exposure genitals/ self exploration (Rx disgust)
  - Look mirror, identify anatomy, feel fingers.

  - Betty Dodson: https://www.dodsonandross.com

  - OMG YES. Sexual arousal/ orgasm https://www.omgyes.com/

GPPPD: **GRADUAL** EXPOSURE

- Graded exposure sensate focus, fingers outside, fingers inside.
- Fingers with mirror
- Trainers, get sexually excited to reduce the clinical experience
- Preparation for intercourse.
- Improvement not linear: always lapse, plateau

GPPPD: INFORMATION PROCESSING MODEL (JANSSEN 2000)

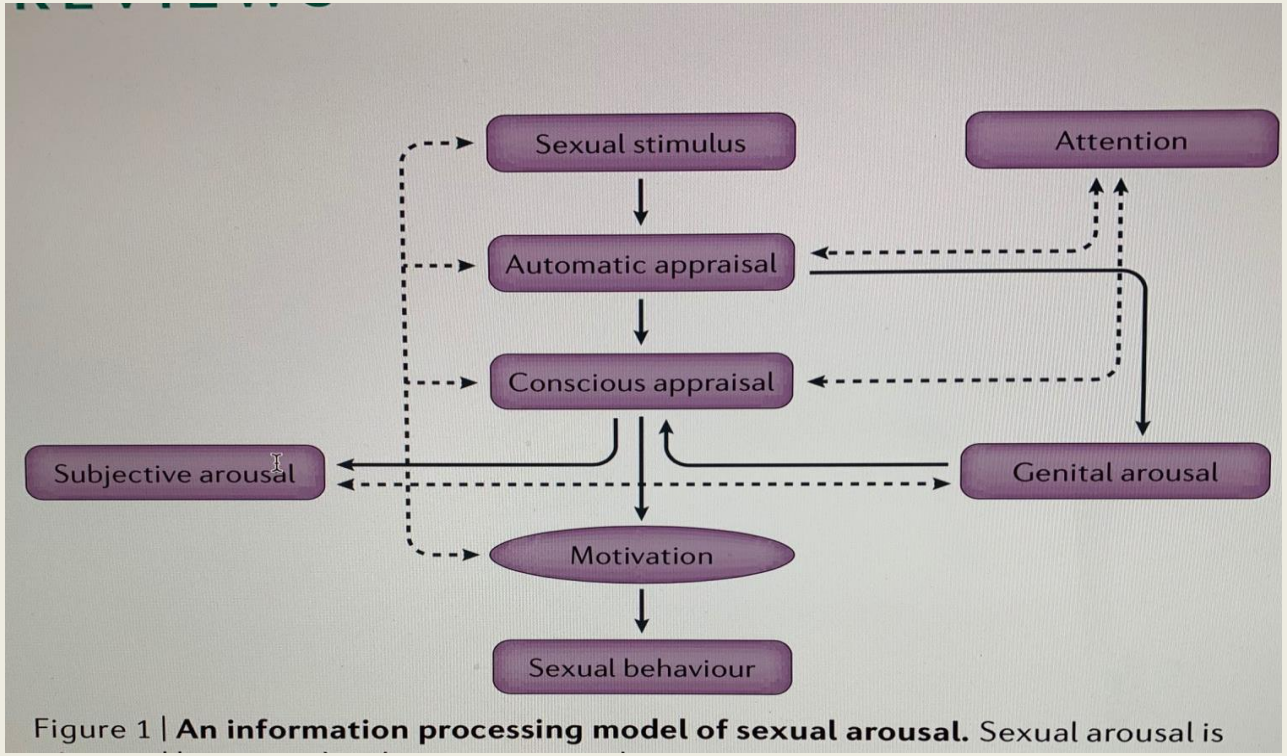


Figure 1 | **An information processing model of sexual arousal.** Sexual arousal is

- (fear of) pain increased attention to pain and, therefore, less attention to sexual stimuli, more negative appraisal of sexual stimuli, decreased motivational tendencies, and lower subjective and genital sexual arousal/ also describes why is some women low subjective arousal and genital arousal