

## Psychosexual therapy in an interdisciplinary approach

Case study: patient with anxiety disorders  
and excessive pelvic floor muscle tension

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### ABSTRACT

#### Aim

This article presents psychosexual conceptualization and methods of therapeutic work with a patient in an interdisciplinary approach. It was based on the techniques of cognitive-behavioral psychotherapy (CBT) and urogynecological physiotherapy.

#### Methods

The most important elements of the diagnostic interview and work techniques based on the CBT approach and physiotherapy were presented. The therapy was focused on the issues of anxiety, helplessness, and anger. At later stages of the therapy, sexological topics and physiotherapy were introduced. In addition, the patient received treatment from other specialists: a psychiatrist and an endocrinologist.

#### Results

The patient managed to achieve some of the goals set together with the therapist and eliminate genito-pelvic pain. An additional benefit was the complete medical diagnosis of the patient and commencement of the treatment related of her hormonal imbalance.

#### Conclusions

Interdisciplinary treatment resulted in beneficial effects. This type of cooperation of many specialists in treating patients reporting emotional, mental, and sexual difficulties seems

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to give the best results. This indicates the value of teamwork and the need for the cooperation of specialists in various fields.

**Keywords:** CBT, urogynecological physiotherapy, interdisciplinarity, anxiety disorders, pain syndromes

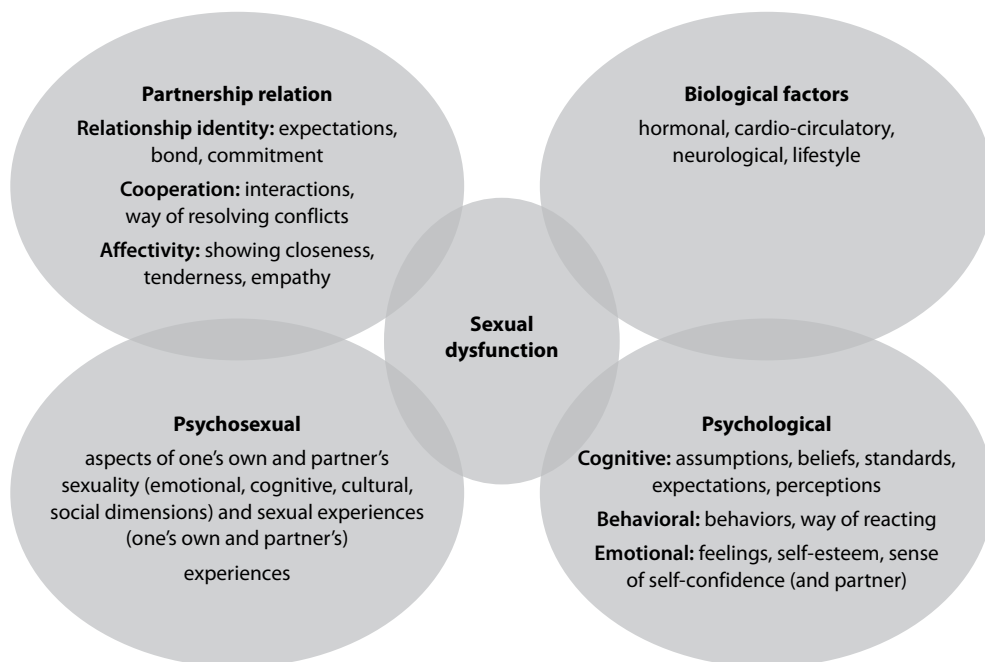
## Introduction

Therapy of sexual disorders concerns many areas of human functioning, which is its strength, but it is also a difficulty. Therapeutic methods based solely on the training model, so eagerly used in sexual therapy in the last century, had focused almost exclusively on the technical aspect of sexual activities, which deprived them of the emotional aspect, like feelings and desires that accompany every human being (Masters & Johnson, 1974). Focusing only on early childhood experiences, in turn, is long-term, often omits cognitive aspects of functioning, does not give results as quickly as the patient reporting to the sexologist would expect (Lew-Starowicz, 1997). Furthermore therapeutic work focused on relational aspects may omit biological elements such as cardiovascular disease or hormonal disorders, which may be a direct cause of sexual dysfunction (Rawińska, 2019). A good model of sexual therapy should therefore be interdisciplinary – assume combining many perspectives; psychological and medical. Often important elements of treatment are: pharmacotherapy, urogynecological physiotherapy, as well as endocrine treatment. An appropriate model of therapy, taking into account the most important factors that are necessary for diagnosis and proper treatment in the sexual therapy is presented in Figure 1 (p. 111).

Sexological diagnosis is a complex process and can last even throughout the entire process of therapy. Sexological examination, which usually precedes the psychotherapeutic process, contains both elements of psychological diagnosis and determination of somatic health and medical diagnostics, including laboratory diagnostics (Rawińska, 2017). Very often, the etiology of sexual disorders is so diverse that it is difficult to determine the boundary between psychogenic and somatic factors. Often, the most important element of treatment is considered to be a proper psychological diagnosis determining the primary diagnosis, followed by a sexological diagnosis determining a secondary diagnosis. Finally, there are situations in which patients, as a result of untreated sexual disorders, begin to experience long-term stress, tension, which leads to negative consequences in the area of mental functioning (Lowen, 2022; Rosenbaum, 2011; Sapolsky, 2010).

Cognitive-behavioral therapy is sometimes considered one of the best empirically documented forms of working with patients. Attention is drawn to its effectiveness against many disorders of mental etiology (Chambless & Ollendick, 2001; Ruscio, 2008; Wells, 2010). Treatment of sexual disorders in the cognitive-behavioral approach is consistent with the strategies used in this trend for other clinical diagnoses. Among the most commonly diagnosed patients reporting sexual difficulties are anxiety disorders. Patients reporting to a therapist with

a problem of sexual dysfunction do not combine the fear of an unsuccessful sexual act with generalized or social anxiety (Hoyer & Uhmman, 2009). And often the same anxiety mechanism is present in the case of situations of a sexual nature.



*Figure 1.* A multidimensional model of sexual dysfunction (Rawińska, 2019).

## Case Study

The 33 years old patient, came for a psychiatric and sexological consultation because of “fears and panic attacks”. The direct reason for the decision to consult were intimate experiences related to her partner, with whom she “is afraid to have intercourse, because these experiences are accompanied by pain”.

Recently she has “lost her breath, felt strong anxiety, trembling all over her body several times” in social situations (social meetings, with clients at work). In her life, there were many previous bouts of panic anxiety in social situations (also in public transport), there was a “terrible fear of airplanes” (the patient avoids airplane flights, uses alcohol if she has to go on such a journey somewhere). Her concerns also apply to any “interference with the body” (medical examinations, blood draws).

From the age of 7, the patient was raised by her mother, who left her husband due to his alcohol addiction. The mother became involved with a new partner when the patient was in her teens. She describes her stepfather as a calm,

good man. The patient's father tried to contact her in her early years, after the divorce. He was always drunk during these contacts. The patient stopped taking calls from him. The contact stopped. She recently learned from her aunt that her father was dead. She describes her mother as nervous, unstable, full of anger. Sometimes her mother had beat her and had called her names. The patient also mentions that the house was dirty, messy; "My mother didn't want to clean or cook." There were many quarrels between her and her mother. She often felt helpless, powerless, avoided contact with her mother; "You never knew what I was going to get harmed again, or if she was going to hit me." The patient locked herself in her room, drawn, wrote – in this way she felt that she was doing something good, controlling her emotions. In later years, conflicts with the mother intensified and ended with aggression from the patient – she rebelled, often challenged her mother, was aggressive.

In the patient's early years, there are numerous medical examinations related to diagnostics (the patient was diagnosed with anemia, was a thin and sickly child). The patient's mother often came with her to the hospital for tests. The patient describes these situations as painful, violent, screaming from medical staff, pressing her to a chair for blood sampling and examination. She remembers the worst visits to the dentist, where she was tied to the dentist's chair and forced to be cured. She considers these situations "the worst manifestation of helplessness she has ever experienced." He adds violence on the part of the mother. In one of her memories she describes:

It was somehow in the first years of primary school. I really liked it when my mother washed my hair, it was so pleasant. Once, when she rinsed my head, I started splashing water on her and fidgeting. Then she painfully pulled my hair, pulled out a lot of it and screamed to stop because she would go crazy. Since then, I never wanted her in the bathroom again. She was so unpredictable. I was afraid of her.

In her teenage years, the patient became arrogant towards her mother, and even aggressive in her reactions. Her mother had pushed and punched her in anger.

In contacts with peers, during school she was often overlooked in play, rejected, due to violent reactions, tendency to confront in conflict situations – "I said what I thought, and I did not like it". It also happened that she openly had been refusing to participate in some school or social projects. Over time, she began to avoid larger groups. Actually, he has few close friends.

The patient works professionally (she runs her own company), has been in a partnership for several years, lives with her partner, plans to get married. They met on a professional basis. He has occasional contact with his mother, "formal rather than warm." She claims that her mother does not remember how she had been beating her and called her names. She denies everything, which hurts and angers the patient. In a current partnership, the patient sometimes shouts and calls her boyfriend names: "especially when he does not listen to me, or does something that I think is stupid". The patient does not like to feel helpless, avoids situations in which she has no control, tries to avoid stressful contacts

with other people, at the same time she is confrontational towards them: “especially when someone annoys me”.

Over the last few years, sexual acts in the form of penetration have occurred sporadically. Each time the patient felt severe pain, anxiety, felt tense, avoided close-ups. It happened that the contraction of the muscles entering the vagina prevented intercourse. Despite many attempts of intercourse, they have not yet taken place for over a year. She has never been to a gynaecological appointment.

## Medical History and Pharmacotherapy

Treatment of the patient began with the referral of the patient to psychotherapy associated with panic attacks and the introduction of pharmacotherapy to reduce the level of anxiety. The doctor diagnosed F41.0, F52.5 in nosological terms.

- Venlafaxine 75 mg (1–0–0)
- Trazodone 150 mg (0–0–1)
- Lamotrigine up to 200 mg (later discontinued)
- Alprazolam 0.25 mg in case of an anxiety attack

At later stages of treatment, the patient took Velaxin 150mg and Trittico 50mg and was consulted endocrinologically, where, in addition to the diagnosis of mood disorders, hypothyroidism, oligomenorrhoea (menstrual irregularity) was found. Euthyrox 75mg has been prescribed.

## Conceptualization of the Patient’s Problems

The patient shows symptoms of social anxiety and panic attacks in situations that she interprets as threatening, dangerous. In situations where she loses her sense of control, she feels anger or avoids contact with others. In last few years she has begun to avoid “any unpredictable situations” (those that are emotionally or physically threatening). A very strong increase in glucocorticoid concentrations, specific to life-threatening situations (not necessarily objectively, but subjectively in the patient’s assessment) causes two possibilities of behavior: fight or flight (Sapolsky, 2010). Although the patient has not been diagnosed in this area (which could be an element deepening the diagnosis and versifying the thesis), many of her behaviors and reactions indicate a high probability of large fluctuations in the so-called “stress hormones”. Anxiety levels were measured using the Liebowitz Social Anxiety Test (LSAS) scale. The patient scored 84 points, which indicates increased social phobia. In addition, a diary of automatic thoughts (NAM) with accompanying feelings was proposed.

Conceptualization of the patient’s functioning was applied, taking into account problem areas in the cbt approach (Figure 2, p. 114). Conceptualization refers to both anxiety disorders and sexual situations. The sexual area is one of the elements of the patient’s reactivity, although it is not the leading one. In intimate situations, the patient experiences automatic thoughts and emotional states analogous to social situations.

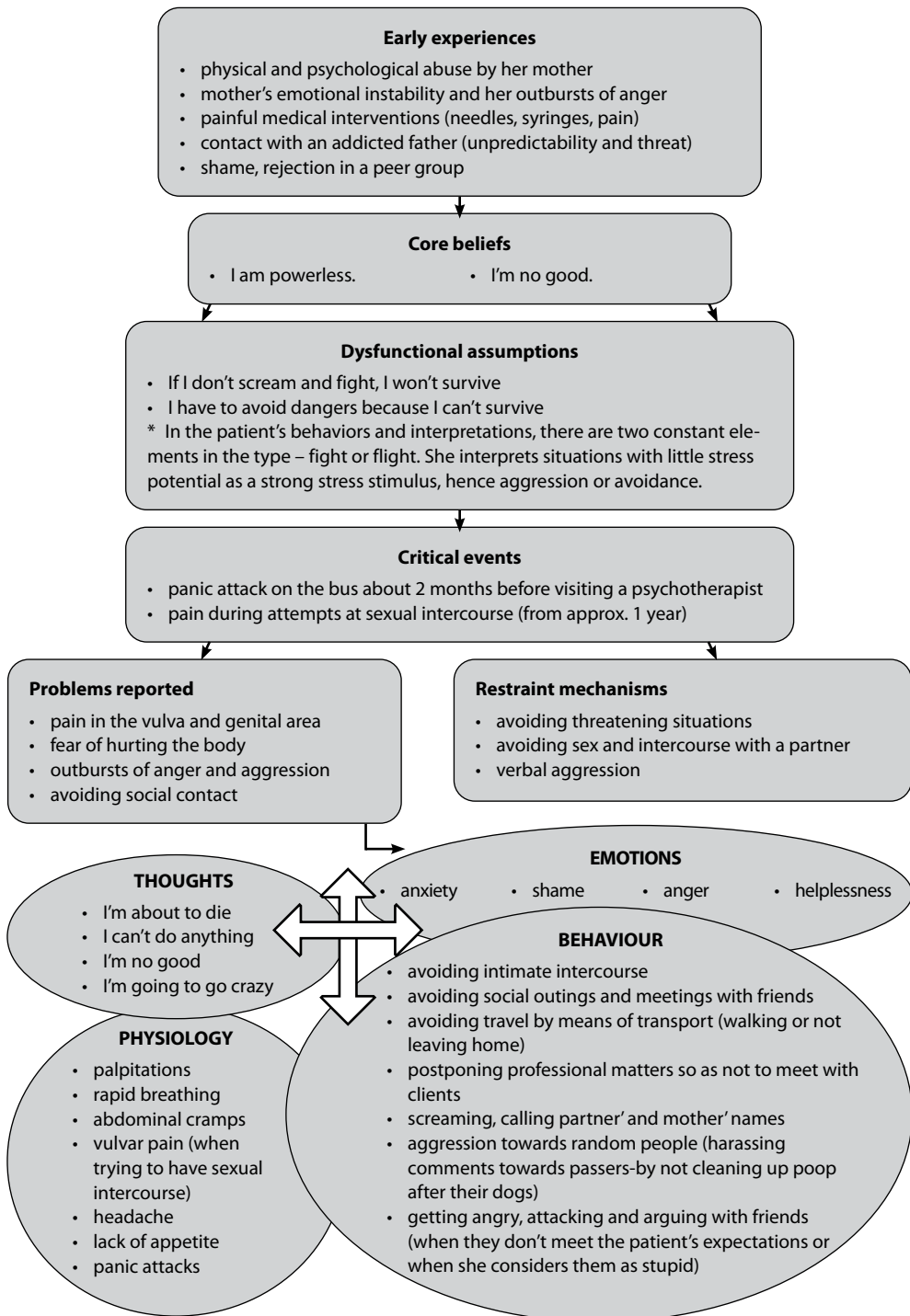


Figure 2. Conceptualization of the patient's functioning.

## Psychotherapy

The process of cognitive-behavioral psychotherapy was divided into several stages and was focused on anxiety issues (with particular emphasis on panic attacks, behavior and aggressive reactions) and sexual dysfunctions at a later stage of work. It was based on the above-mentioned conceptualization. Consultation with a physiotherapist, as well as regular physiotherapy, were not planned from the very beginning of the therapy and were introduced later, at a specific stage of psychotherapy. This decision was primarily dictated by the fact that the patient had never been consulted gynecologically, and any attempts by her partner to touch her intimate areas were painful for her. In addition, the reduction of the level of anxiety and the patient's readiness to work on the physical area, as well as the intensity of psychotherapy around sexual issues, increased the likelihood of the physiotherapist's work being effective.

- 1) Establishing contact with the patient: detailed interview, establishing a therapeutic relationship. Creating a conceptualization and discussing it together with the patient. Looking at specific situations.
- 2) Identification of problems (concerned both sexual and anxiety difficulties of the patient in various situations). This was an important diagnostic stage determining that the patient's difficulties were acquired. The patient experienced many situations of rejection from her peer group, she was the object of violence from her mother (both mental and physical). Anxiety disorders were therefore the first diagnosis, and sexual dysfunctions – secondary.
- 3) Identification of automatic thoughts in social and sexual situations (diary, records).
- 4) Familiarizing the patient with the CBT model. Education and psychoeducation related to anxiety disorders and sexual dysfunctions. In addition, measurements were made of anxiety level (LSAS), scaling in specific situations.
- 5) The goal of therapy was determined: reduction of anxiety and tension, gynaecological visit, flying without paralyzing fear, no discomfort during intercourse.
- 6) Work with automatic thoughts and behaviors in social situations (Socratic question techniques, “down arrows”, work on specific current situations with a partner, telephone conversations with mother).
- 7) Working with thoughts and behaviors (especially avoidance) in sexual situations.
- 8) Cognitive work (the use of specific techniques modifying negative automatic thoughts and cognitive distortions) + the introduction of physiotherapy as parallel work with sexual difficulties.
- 9) Behavioural exposures and experiments or agreed exercises, homework tasks with the patient (e.g. tasks in situations with clients at work, social role-playing in therapy sessions, exposures to situations that the patient has so far avoided and discussing results, sexual tasks with a partner).

- 10) Due to menstrual irregularity, additional medical diagnostics (gynecologist, endocrinologist) were proposed.
- 11) Summary of the changes achieved so far in a therapy process (discussion with the patient).
- 12) Establishing a strategy for maintaining achieved goals and coping with relapses.\*
- 13) Termination of psychotherapy (directing the patient's attention to "life without therapy", proposing a monitoring period.\*\*

\*, \*\* these steps were not completed because the patient had to give up further treatment because of financial reasons

## Physiotherapy

The physiotherapy diagnostic process revealed:

- 1) Fear of inserting something into the vagina, difficult gynecological visits, only a few intercourses (painful and associated with psychological discomfort).
- 2) Urinary urgency, especially in situations of increased stress, frequent urination, urgency and nocturia.
- 3) Gastrointestinal problems, frequent diarrhea.

In the physical examination of the musculoskeletal system, increased muscle tone was observed in the thigh adductor muscles of the thigh, the iliotibial band, the short rotators of the hip joint. Additionally, pressure pain in the area of the sacroiliac ligaments was noted. Due to the patient's problem, a transvaginal examination of the pelvic floor muscles (PFM) was not performed. An "indirect" examination was completed – an evaluation of PFM activation based on visual assessment of the movement of the perineal structures. The patient could activate PFM in isolation (without co-activation of the abdomen, gluts, and thighs) and coordination with breathing. The sensation of movement was preserved, the amplitude of movement was reduced, and the relaxation phase was disturbed (incomplete relaxation).

Taking into account the patient's symptoms, physiotherapy was based on a biopsychosocial model. In addition to traditional urogynecological physiotherapy methods, adaptation of cognitive-behavioral psychotherapy (CBT) principles to the area of physiotherapy was implemented (cognitive functional therapy, O'Sullivan et al., 2018). Urogynecological physiotherapy included patient education, pelvic floor reeducation, graded exposure, and home exercise therapy. It was conducted in parallel with CBT therapy with psychotherapist and involved the following stages:

**Education.** Consisted of:

- pain neuroscience education (King et al., 2017; Nijs et al., 2020)
- education on the anatomy and function of the pelvic floor, viewing the pelvic model and working with a mirror.



**“Re-mapping” of the pelvic area.** Location of the bony landmarks and muscles on the model and the patient’s body; tasks, and movement experiences with the observation of PFM tension:

- “sit on a chair back to front”
- “keeping your hand close to the perineum, outline its shape in the air above it. Draw letters of the alphabet and various shapes in the air”
- “sit on the armrest of a chair/sofa”
- “imagine you perineum as a clock surface and touch each hour; observe the occurrence of feelings such as anxiety/discomfort/pain”.

**Reeducation of the pelvic floor.** Awareness and coordination training, relaxation techniques and exercises, proprioception training – learning how to feel various PFM tension levels, learning to coordinate PFM work with breath, eccentric PFM exercises (“reverse Kegel”), learning techniques to control the PFM and breathing, facilitating the introduction of an object into the vagina, elements of gentle PFM conditioning training (after getting reasonable control of PFM and tension normalization) (Morin et al., 2021; Gentilcore-Saulnier et al., 2010; Haugstad et al., 2018; Haugstad et al., 2019).

**Graded exposure (Ariza-Mateos et al., 2019).** Carried out in the form of assisted exposure to a stimulus (therapist-aided exposure, ter Kuile et al., 2013). It relied on recreating the experience of fear and penetration in real time. It was focused on preparing the patient for examination and therapy, with a plan to prepare for a gynecological examination (Rosenbaum, 2011) and learning “grounding” techniques to be used during difficult moments of graded exposure (breathing techniques, feeling tension and relaxation in various parts of the body) (Rosenbaum, 2011; Rosenbaum, 2013). The following elements were introduced at this stage:

- Techniques to desensitize and reduce allodynia (hypersensitivity to touch)
- graded imagery: imagining insertion of the dilator into the vagina while controlling breath and PFM tension
- gradual insertion: performed with fingers (one then two), dilators (size gradation), biofeedback equipment (perineometer, surface electromyography electrode, and pelvic floor electrostimulation electrode) (Morin et al., 2021; Gentilcore-Saulnier et al., 2010)
- working with dilators in vivo (dilator inserted by the physiotherapist) and in vitro (dilator inserted by the patient) (Schnyder et al., 1998; Morin et al., 2021)
- desensitization of pain areas using electrostimulation (Gentilcore-Saulnier et al., 2010).

**Home exercise programme.** Suggested:

- self-therapy techniques aimed at increased muscle tone in the PFM (rolling with the use of a massage ball and roller, positions that make

the pelvic area and the PFM more flexible, autogenic training – Schultz relaxation)

- modification of toilet habits (proper micturition, defecation)
- desensitizing techniques – pleasant touch, re-mapping, self-massage
- auto-therapy techniques with a dilator – specific techniques to be repeated at home.

## Results

The patient had 30 therapeutic meetings and 10 meetings with a physiotherapist over a period of one and a half year. She was endocrinologically consulted. She remained under the constant care of a psychiatrist. Undoubtedly, pharmacotherapy could have contributed to reducing emotionally unstable reactions, and especially to reducing the level of anxiety. The pharmacological reduction of the level of anxiety also contributed to the fact that the patient began to undertake exposures and behavioral experiments in situations previously interpreted as threatening. It is likely that without pharmacotherapy, the patient would not be able to engage in exposure behavior in difficult situations. The result of teamwork were the following achievements of the patient:

- completion of a full gynecological examination with cytological examination
- taking care of the patient due to hormonal disorders
- change of drugs to less invasive and the use of „rescue pharmacology”
- at the last meeting with the physiotherapist, the patient was able to introduce the largest dilator without pain and fear
- departure for vacation (air travel without alcohol or drug usage!)
- increasing the number of social contacts
- improving the intimate relationship with the partner; increase in closeness, emotional bond, attention to her own and partners’ needs
- visit to the dentist.

The patient suspended further therapeutic appointments and physiotherapy due to the uncertain financial situation. It is also possible that resistance to further work was one of the factors that influenced her decision. The stage of preventing relapse and repeated measurements of the level of anxiety and functioning in intimate situations with a partner has not been introduced! The patient is still under constant endocrine and psychiatric care.

## Interdisciplinary Model of Care – Conclusions and Limitations

The available body of evidence still lacks studies that consider all aspects crucial in diagnosing and treating sexual dysfunctions (Bancroft, 2012). Most data is based solely on the effectiveness of pharmacotherapy, while the elements of psychotherapy and physiotherapy are still not sufficiently explored (Ariza-Mateos et

al., 2019; Chambless & Ollendick, 2001; Nijs et al., 2020). Psychological, emotional, relational, and contextual factors deserve a chance to be taken into account, especially since only a few studies show excellent therapeutic effects in an interdisciplinary model (Chambless & Ollendick, 2001; Nobre, 2009; Nobre & Pinto-Gouveia, 2006). Thanks to their competence, a urogynecological physiotherapist can play an active role in the interdisciplinary treatment of sexual disorders related to anxiety and pain. An integral and coherent form of work (shifting from multi to interdisciplinary model of care) seems to bring the best results.

The primary and most important limitations of the interdisciplinary model in the treatment of patients with pelvic pain syndromes are the small number of multi-specialized centers and the treatment-related costs. In addition, the limited availability of specialist trained in the field of sex therapy and urogynecological physiotherapy means that there are still few specialists who provide comprehensive assistance to all patients with sexual dysfunctions. Often, in patients reporting emotional difficulties (e.g., anxiety or depression disorders), the sexual aspect is completely overlooked, or the specialist appears helpless in relation to the patient's intimate life. Due to the lack of knowledge or access to a urogynecological physiotherapist, many psychotherapists face the patient's difficulties on their own, thus, omitting such an essential element as the physical aspect of human functioning. Medical diagnosis alone may be insufficient to achieve good therapeutic effects. Comprehensive action affects both the mental and physical spheres (Lowen, 2022). The value of teamwork is invaluable, resulting in a healthy, satisfied, and well-functioning person.

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