Dedicated to:

...with great appreciation
UNDERSTANDING GENITO-PELVIC PAIN/PENETRATION DISORDER ‘VAGINISMUS’ WITHIN CULTURAL CONTEXTS:
A NEURO-PsyCHOTHERAPY APPROACH

MITRA RASHIDIAN, PH.D., LMFT., ACS
ROBERT B. JAFFE, PH.D., LMFT

UNIVERSITY OF NEW ENGLAND - SCHOOL OF HEALTH
AUSTRALIA
MRASHID3@UNE.EDU.AU
DRJAFFE1@AOL.COM
RASHIDIANMITRA@AOL.COM
VIDEO CLIP 1,2

VAGINISMUS
IN THE CLIENT'S OWN WORDS

NEDA’S STORY
Educational Objectives:

1 – Explain the role of culture as an etiology to vaginismus ‘Genito-Pelvic Pain/Penetration Disorder’ among sub-population women.

2 – Review and practice specific neuro-psychotherapy approaches, used to assist therapists, in assessment and interventions for this disorder, within cultural contexts.
The Neuro-psychotherapy applications within a biopsychosocial paradigm.

A holistic treatment modality for sub-population women.
Who are sub-population women?

Each minority group contains subpopulations that may be defined by geographic origin, national origin, cultural differences, or mixed racial and/or ethnic parentage. The minority group or subpopulation to which an individual belongs is determined by self-reporting.
What is Vaginismus?

1 – Vaginismus is a sexual health issue (WHO, 2019).

2 – Vaginismus, is a condition characterized by the spasm of the muscles that surround the vagina, causing occlusion of vaginal opening, so that penile entry is either impossible, or painful. (WHO, 1992).

3 – Vaginismus may result from injury to the Vulval area and repeated vigorous sexual acts (https://www.who.int/gender/other_health/teachersguide.pdf).

4 – Vaginismus is a subset of the Genito-pelvic pain/penetration disorder. It is a penetration disorder in which any form of vaginal penetration such as tampons, digit, vaginal dilators, gynecologic (GYN) examinations, and intercourse is often painful or impossible. Genito-pelvic pain/penetration disorder further collapses dyspareunia and vaginismus into one entity. (DSM – V)

5 – A widely misunderstood & neglected area in research/clinical practice (Rashidian et al. 2014; Rashidian, Jaffe 2019).
Video Clip 2
What is Neuropsychotherapy?

“Neuropsychotherapy is a neurobiologically informed framework for psychotherapy that conceptualizes thought and behavior as emerging from the influence of motivational schemata developed to preserve or enhance basic psychological needs. Therapeutic processes start from the development of a safe and enriched environment to activate positive approach motivational schemata utilizing a bottom-up neurological approach, and proceed from a top-down approach to facilitate long-term change in neural architecture” (Dahlitz, 2015).

What is Neuropsychotherapy? (Conti.)

It has been labeled as:

- Brain-Based Therapy (ARDEN & LINFORD, 2009)
- Interpersonal Neurobiology (SIEGEL, 2010)
- Social Neuroscience (CACIOPPO, VISSE, & PICKETT, 2006)
What is the aims of Neuropsychotherapy?

“Neuro-psychotherapy aims to change the brain, but it does not directly target primarily the brain but focuses on the life experiences encountered by the person. The brain specializes in the processing of life experiences. Life experiences are meaningful with regard to the needs that are embedded within the brain structures of each human being. Neuro-psychotherapy strives to shift the brain into a state that enables these basic needs to be fully satisfied. The best method for improving the health of the brain, then, is to ensure basic needs satisfaction” (Grawe, 2007, p.424)


To create safety where there was fear.
QUOTES FROM WELL-KNOWN NEURO-PSYCHOTHERAPIST AND NEUROSCIENCE RESEARCHERS:

“It is difficult to overstate the importance of understanding mirror neurons and their function. They may well be central to social learning, imitation, and the cultural transmission of skills and attitudes perhaps even of the pressed together clusters we call words. (V.S. Ramachandran, The tell-tale brain: a neuroscientist’s quest for what makes us human”

“Early experience shapes the structure and function of the brain. This reveals the fundamental way in which gene expression is determined by experience.”

Daniel Siegel, The developing mind: how relationships and the brain interact to shape who we are.

“The problem is, when you depend on a substitute for love, you never get enough. “

Louis Gozolino; The neuroscience of human relationship: attachment and the developing social brain.
Clinical Application of Neuropsychotherapy

Neurobiological empathy between client and therapist.

Strengthening clients’ resources from the core of their motivational system.

Facilitate an increasingly robust approach to self and the world (Flückiger, Wüsten, Zinbarg, & Wampold, 2009).

It leads to better need satisfaction and subsequent mental well-being.

Entails establishing a “safe” therapeutic alliance.

Facilitates approach patterns that will satisfy basic needs, down-regulate stress activation, and optimizes new, positive neural connections while reinforcing existing ones (Rossouw, 2014).
Video Clip 3
1 - The subconscious anticipates emotional/physical pain, fear & anxiety.

2 - The body automatically tightens vaginal muscles.

3 - Tightness makes sex painful; penetration becomes difficult/ impossible.

4 - Anticipatory pain creates reflex response.

5 - Body reacts by 'tightening' on ongoing basis.

6 - Avoidance of intimacy, lack of desire/orgasm may develop.

THE PSYCHO-PHYSIOLOGY OF VAGINISMUS
Understanding Genito-Pelvic Pain/Penetration Disorder...

Do you experience vaginal pain during sex

Do you feel pain during gynecological exam

Are you able to become aroused

(Rashidian et al. 2002)
Initiate Sex

<table>
<thead>
<tr>
<th>Count</th>
<th>Almost Always</th>
<th>Frequently</th>
<th>Not at all</th>
<th>Some times</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>5</td>
<td>10</td>
<td>15</td>
</tr>
</tbody>
</table>

Do you initiate sex

When do you must have sex

<table>
<thead>
<tr>
<th>Count</th>
<th>At arousal</th>
<th>Mutual agreement</th>
<th>Partner Initiation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5</td>
<td>15</td>
<td>25</td>
</tr>
</tbody>
</table>

(Rashidian et al. 2002)
Sexual Attitude

- Education
- Friends
- Parents
- Partner
- Religion

Do you keep your body covered during sex

- No
- Yes

Do you feel frightened about having sex

- Almost always
- Frequently
- No at all
- Sometimes

What did you learn about the role of sex in a relationship

- Both
- Don't know
- Female Pleasure
- Male Pleasure
Video Clip 4
The main outcomes of my study

(i) Primary vaginismus can be difficult to treat; treatment failures are common.
Must role out the organic cause.
In psychotherapy, women, used their own terminologies, languages.
They were able to identify cultural factors as roadblocks to the understanding of their sexuality and sexual-selves.
Female role within relationships.
Received education and awareness about female sexuality.
The main outcomes of my study

(ii) Understanding the nature of vaginismus allowed us to properly support these women.

Not having any form of treatments.

Not have any form of education and awareness about what was going on.

Caused them high levels of fear and anxiety about themselves and about the stability of their marriages.
The main outcomes of my study

(iii) The factor analysis and narrative study new insight for treatment of the psychological fear and anxiety

Negative view of selfhood, as female, impacting the physical vaginal spasm.
The main outcomes of my study

(iv) Some patients who showed no improvement after a few months.

Some had to continue psychotherapy for much longer time, had improvement.

Vaginismus is not a surgical problem.

Hymenectomy and episiotomy are inappropriate treatments for this condition.
The main outcomes of my study

(iv) We must be aware of the many secondary challenges these women face.
To be prepared for ongoing treatment or referrals.
Residual fear and anxiety for penetration.
Inability to progress to intercourse despite using dilators, low Libido (sometimes of both partners).
Heightened harm avoidance and pain catastrophizing.
disgust issues.
Anorgasmia.
Partner hostility, infidelity, and erectile dysfunction.
AUTHENTIC TRUE SEXUAL-SELF VS. LIMBIC CULTURAL CONSTRUCT

AUTHENTIC TRUE-SELF

- Hard Wired: Open, Curious, Honest, Sexual, Trusting
- Capacity for: Calm, Emotionally Available, Connected, Confident, Compassionate

ENVIRONMENT

- Individual's Life Experiences
- Social, Culture, Norms, Religion, Economic, Politics

<table>
<thead>
<tr>
<th>Infancy</th>
<th>Early Childhood</th>
<th>Adolescent</th>
<th>Adulthood</th>
</tr>
</thead>
<tbody>
<tr>
<td>Imposed Messages About Sexuality</td>
<td>Imposed Gender Role</td>
<td>Gender Identity Messages</td>
<td></td>
</tr>
</tbody>
</table>

The Initial Sexuality Perceptions, Beliefs, Values

The Initial Sexual Experiences

The Experienced Sexual Feelings, The Meaning Making, Emotions

Core Emotions: Fear, Anger, Grief, Joy, Excitement, Disgust Sexual Excitement

STATE OF THE SEXUAL-SELF CONSTRUCT

BIO-PSYCHO-SOCIAL PHENOMENON

- Sexual desires, Needs, Ideas, Sense of freedom of expression,
  Education, Social expectations, Self-development
- Gender role, Sexual-identity, Sexuality, Beliefs, Challenges

Thoughts and feelings in relationship with others

Self-perceptions

The value one gives to oneself in a sexual role

Different meaning within different forms of interactions

Understanding Genito-Pelvic Pain/Penetration Disorder... (Rashidian et al. 2002)
Video Clip 5
Etiology - Primary:

Vaginismus, a culture-bound syndrome, versus a disorder and/or a deficit perspective.

The cultural and religious strict massages about being a female. Negative messages about sex, Sexual relations. A female upbringing, causing phobic reactions. Poor body image. Limited/controlled understanding of the female genital area. A family problem rather than the sole problem of the couple.
“If it is true that at the core of our traumatized and neglected patients’ disorganization is the problem that they cannot analyze what is going on when they reexperience the physical sensations of past trauma but that these sensations just produce intense emotions without being able to modulate them, then our therapy needs to consist of helping people to stay in their bodies, and to understand these bodily sensations...” (BESSELL VAN DE KOLK, 1998).
A Psycho-physical Experience - 20% PTSD
Large ‘T’ Traumas
Small ‘t’ Traumas
Trauma (Conti.)

Affects Limbic System
Adrenocortico-tropic hormone
Epinephrine
Norepinephrine

We can think of the limbic system as being central to:
The center for emotional responsiveness
Motivation
Memory formation and integration
Olfaction
The mechanisms designed to keep us safe.

**LIMBIC SYSTEM**

- **HIPPOCAMPUS** – plays an important role in emotion, learning and memory.
- **AMYGDALA** – plays role in aggression, eating, drinking and sexual behaviors.
- **HYPOTHALAMUS** – monitors blood levels of glucose, salt, blood pressure and hormones.
TRAUMA (CONT.)

Fight or Flight
Freeze
TRAUMA (CONTI.)

PREDISPOSITION
EARLY CHILDHOOD TRAUMA
HEALTHY VS. UNHEALTHY ATTACHMENT
NEUROPLASTICITY
TRAUMA (CONT.)

Stages of Recovery

Safety
Reconstructing the trauma story
Reconnecting survivor(s) to their authentic true-self
Reconnecting survivor(s) to significant others/community
Small ‘t’ traumas are sneaky.
When chronic may create deeper wounds
Core emotions are needed and hard wired within our biology.
PTSD symptoms are easily misdiagnosed.
TRAUMA (CONTI.)

Meanings are formed in relationships
Trust is foundation of faith
Trauma breaks the connection to others
Meaningful connections heals the break
Internal locus of control
An indestructible kernel of mental health
### CULTURAL-RELATED DIAGNOSTIC ISSUES

<table>
<thead>
<tr>
<th>Cultural</th>
<th>Emotional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family conflict</td>
<td>Anxiety about sexual activity</td>
</tr>
<tr>
<td>Frightening and punitive father/mother</td>
<td>Insecurity in own sexual role</td>
</tr>
<tr>
<td>Cultural pressures, shame, guilt and fear</td>
<td>Vicious cycle: Pain; Worry, Fear, Anxiety; Phobias; Fear of physical/emotional pain</td>
</tr>
<tr>
<td>Strictly patriarchal upbringing</td>
<td>Bereavement; Depression</td>
</tr>
<tr>
<td>Strict religious views</td>
<td>Anger; resentment</td>
</tr>
<tr>
<td>Arranged and forced marriage</td>
<td>Large ‘T’ &amp; small ‘t’ Traumas</td>
</tr>
<tr>
<td>Limited support network</td>
<td>Stress, Pressures, Tiredness</td>
</tr>
<tr>
<td>Remembered negative family messages about sex from upbringing</td>
<td>Fear of: Rejection; Intimacy; Losing Control; Pregnancy; Being blamed</td>
</tr>
<tr>
<td>Lack of expression of physical and emotional affection in formative years</td>
<td></td>
</tr>
<tr>
<td>External stresses, e.g., bullying, work pressures, harassment, economic insecurity</td>
<td></td>
</tr>
</tbody>
</table>

Markovic, Desa (2017); Rashidian et al. (2014)
Understanding Genito-Pelvic Pain/Penetration Disorder ...

<table>
<thead>
<tr>
<th>Cognitive</th>
<th>Relational</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Lack of sexual knowledge</td>
<td>• Constrained communication about sex, intimacy &amp; own needs</td>
</tr>
<tr>
<td>• Negative attitude about sexuality</td>
<td>• Conflict</td>
</tr>
<tr>
<td>• Negative messages about men</td>
<td>• Lack of trust in partner</td>
</tr>
<tr>
<td>• Negative believes about female sexuality</td>
<td>• Passive &amp; unassertive partner</td>
</tr>
<tr>
<td>• Anticipation of pain, catastrophizing &amp; hypervigilance</td>
<td>• Partner’s sexual dysfunction</td>
</tr>
<tr>
<td>• Belief in own inability to cope with pain</td>
<td>• Partner’s criticism and anger; rough sexual treatment</td>
</tr>
<tr>
<td>• Negative self-concept</td>
<td>• Violence</td>
</tr>
<tr>
<td>• Idea about own genitals being unclean and unpleasant</td>
<td>• Partner’s sexual inexperience</td>
</tr>
<tr>
<td>• Attributing responsibility for sexual pleasure to the partner</td>
<td>• Power struggles</td>
</tr>
<tr>
<td>• Medicalizing the problem</td>
<td>• Lack of affection and negative experiences in previous relationships</td>
</tr>
<tr>
<td>• Medicalizing the problem</td>
<td>• Lack of committed relationships</td>
</tr>
</tbody>
</table>

MARKOVIC, DESA 2017; RASHIDIAN ET AL. 2014
Video Clip 8
Intervention

Memory Reconsolidation

“Discovery of the brain’s ability to delete a specific, unwanted emotional learning, including core, non-conscious beliefs and schemas, at the level of the physical, neural synapses that encode it in emotional memory” (ECKER ET AL., 2012, P. 13)

It can lead to the complete and permanent elimination of psychological symptoms. (ECKER, TICIC, & HULLEY, 2012; PEDREIRA, PEREZ-CUESTA, & MALDONADO, 2002)—
Approach/Avoid networks

Basic needs
Motivational goals
Personal motivational schemas

From a neuropsychotherapeutic perspective: Therapy should aim to reduce the use of avoidance goals, and promote more positive approach goals to satisfy basic needs.
Video Clip 9
The “Social Brain”

We are social creatures.

We collectively form families, communities, and cultures, that define us as much as we define those systems.

Relationships nurture us, and shape us into who we are.

“Social Brain”: Those neural systems that form, and perform, within the scope of interpersonal relationships (Cozolino 2014)
Intervention (Conti.)

The Window of Tolerance (Siegel, 1999)
Describes a model of autonomic arousal levels, in which an optimal arousal zone, or window of tolerance, between hyper- and hypo-arousal of the autonomic nervous system (Ogden, Minton, & Pain, 2006).

From a Neuropsychotherapy Perspective:
The importance of widening a client’s window of tolerance, especially in the case of trauma, becomes a central goal.

Achieving this will increase their capacity to tolerate and integrate thoughts and feelings, and keep the ventral vagal social engagement system operative.
Video Clip 10
THE SCIENCE OF AFFECT
From a neuropsychotherapy perspective:

It is the paradigm shift in psychotherapy, from explicit, left-brained, conscious, cognitive processes, to implicit, right-brained, unconscious, affective–relational processes (SCHORE, 2014).
Orientation and Control
The need for orientation and control is the most fundamental of all human needs (Epstein, 1990).

Self-esteem Enhancement
“An individual’s subjective evaluation of her or his worth as a person.” (TRZESNIEWSKI, BONNELLAN, & ROBINS, 2013, P. 60).
Change From a Clinical Perspective

Controllable Incongruence
It becomes the mechanism of change within the therapeutic dyad. It is the discrepancy between an individual’s perception of reality (his or her actual experience) and beliefs, expectations, and goals. Such incongruence will cause inconsistency within the mental system (Grawe, 2007).

Uncontrollable incongruence
It is a circumstance that exceeds one’s ability to cope, or belief that one can cope, with the mismatch between what is experienced and one’s goals. Uncontrollable incongruence is a stressful state that heightens arousal potentially beyond one’s window of tolerance (Kandel, Schwartz, Jessell, Siegelbaum, & Hudspeth, 2013).
Current Treatments

Medical Model
- Vaginal dilators
- Lubricants
- Botox injection
- Numbing lotions

Psychological Model
- Physical therapy
- Sex and relationship counseling
- Psychotherapy
- Cognitive behavioral therapy
- Hypnotherapy
A

B

- # 3 Dilator = 2.5 inches or 63.5 mm (length = 3.5 inches)
- # 4 Dilator = 3.25 inches or 82.55 mm (length = 3.5 inches)
- # 5 Dilator = 4 inches or 101.6 mm (length = 3.5 inches)
- # 6 Dilator = 5 inches or 127 mm (length = 3.5 inches)
- # 7 Dilator = 5.5 inches or 139.7 mm (length = 3.5 inches)
- # 8 Dilator = 6.25 inches or 158.75 mm (length = 3.5 inches)
Conclusion

VAGINISMUS, A CULTURE-BOUND SYNDROME, VERSUS A DISORDER AND/OR A DEFICIT PERSPECTIVE.
REFERENCES

AMERICAN PSYCHIATRIC ASSOCIATION. 5TH ED. AMERICAN PSYCHIATRIC ASSOCIATION; WASHINGTON, DC: 2013. DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS. [GOOGLE SCHOLAR]

2. BINIK Y.M. THE DSM DIAGNOSTIC CRITERIA FOR VAGINISMUS. ARCH SEX BEHAV. 2010;39:278–291. [PUBMED] [GOOGLE SCHOLAR]


5. ROSENBAUM T. AN INTEGRATED MINDFULNESS-BASED APPROACH TO THE TREATMENT OF WOMEN WITH SEXUAL PAIN AND ANXIETY: PROMOTING AUTONOMY AND MIND/BODY CONNECTION. SEX RELATSH THER. 2013;28(1–2) [GOOGLE SCHOLAR]


8. PACIK P.T. ODYNE PUBLISHING; MANCHESTER, NH: 2010. WHEN SEX SEEMS IMPOSSIBLE. STORIES OF VAGINISMUS & HOW YOU CAN ACHIEVE INTIMACY. [GOOGLE SCHOLAR]


15. SIMS J.S. ON VAGINISMUS. TRANS OBSTET SOC LOND. 1861;3:356–367. [GOOGLE SCHOLAR]

16. CROWLEY T., GOLDMEIER D., HILLER J. DIAGNOSING AND MANAGING VAGINISMUS. BMJ. 2009;338:B2284. [PUBMED] [GOOGLE SCHOLAR]


REFERENCES


REFERENCES

ADAM, D. (2013). MENTAL HEALTH: ON THE SPECTRUM. NATURE, 496(7446), 416-418. DOI:10.1038/496416A