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CASE STUDY ON PENETRATING GENITO-PELVIC PAIN DISORDER AND PROPOSAL FOR EVALUATION AND TREATMENT BY DIGITAL S-ON*app* APPLICATIONS

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Abstract

Objective: The case study shows an improvement in genito-pelvic pain at acquired penetration, with moderate severity, characterized by persistent recurrent pain for 7 months.

Therapeutic methods: According to the patient's evaluation and psychometric tests, the result consisted of differentiated diagnosis of dyspareunia, with moderate severity. During the treatment, psychotherapeutic techniques were applied - purely cognitive therapy validated and standardized by Delcea et al., Relaxation techniques, desensitization therapy and pelvic floor.

Outcome of therapy: During sex therapy for a period of 4 months, with individual sessions - two with each individual and 10 couple sessions, the sexual disorder was improved, from 4 to 2, the quantification of the pain by the patient, on a scale of 1 to 5.

Conclusion: Sex therapy has been a real success by improving the relationship and sex of the couple. The two managed to improve their communication, to manage stress and nervousness situations through conflict management and in particular, to reconnect sexually through a better intimacy of the couple, rediscovering eroticism and sexual desire, thus ameliorating the genito-pelvic pain disorder. penetration.

Keywords: penetrating genito-pelvic pain sexual disorder, S-ON*app*, sexual dysfunction, dipareunia, vaginismus, vulvodynia, penetrating genito-pelvic pain.

INTRODUCTION

Penile genito-pelvic pain disorder (PGPPD) is present in both women and men, with a higher prevalence among women. Penile genital pain is indexed as an immediate sexual disorder caused by a medical, organic, or mental disorder.

In the latest edition, DSM V (Diagnostic and Statistical Manual of Mental Disorders), genital pelvic pain penetration disorder, [F52.6] - 302.76, includes several clinical forms such as dyspareunia, vaginismus, vulvodynia, vulvar dysesthesia (vulvar vestibulitis, clitoridine, bulodinia) as well as pelvic pain and vaginal atrophy.

The sexual response is a biological foundation experienced in a psychological, interpersonal and socio-cultural context. Thus - sexual function - is a complex interaction between biological, social, cultural and psychological factors, coordinated by the nervous, vascular and endocrine systems.

As sexual functioning is a complex process, the evaluation must include a detailed analysis of the patient's and the partner's health, psychological state, professional experience, socio-demographic situation, ethnicity and family, social and religious beliefs.

Over the years, specialized studies have shown a particular concern for human sexual activity, in particular, the mechanism of sexual response and its disorders.

Thus, in 1966, William H. Master & Virginia E. Johnson, pioneers of research in the field of sexology, mentioned that the sexual response (sexual response cycle) has 4 successive phases - emotion - plateau - orgasm and resolution.

After less than 10 years, Helen S. Kaplan claimed, in 1974, according to research conducted on a group of women who never had an orgasm, that the 4 successive phases were different from the original model being changed to - desire - emotion (arousal) - orgasm and resolution. Later, based on this model, the classification of sexual disorders was developed and validated.

In 1989, Amy Levine - American sex couch, presented the 7 existing components in adult sexuality as well - gender identity - sexual orientation - intention (what she wants from her partner's body and what she did with his body in the sexual context) - desire - arousal - orgasm - and emotional satisfaction. The first 3 phases determine sexual identity and desire, arousal and orgasm - sexual function. (Avasthi, A. Ajit et al., 2017)

Penile genito-pelvic pain disorder is a complex sexual dysfunction and difficult to diagnose, because in the pelvic area everything is interconnected. The autonomic (vegetative) nervous system is responsible for the neuronal coordination of the urogenital system - the menstrual cycle, urination, defecation. Any condition of the autonomic nervous system triggers disorders in the organs and their functions. The causes are multiple and unclear, the hyperactivity of the pelvic muscles - contractures, physical abuse, sexual abuse, demanding sports, body positions that affect the pelvis (defective standing, sitting, toilet) but also poor gait.

According to numerous studies in recent decades, the chapter on sexual dysfunction in the DSM has undergone many changes and additions. The first painful sexual disorder mentioned in the DSM, Dispareunia - was listed as a medical condition. Then, Vaginal disorder and Volvodynia disorder were included. Currently, all these are included under a single name - genito-pelvic penetration pain disorder, in the category (F 52.6) - 302.76, classified as a sexual problem and not a medical condition.

In the latest edition, DSM V of 2013, the largest and most complex since its first appearance in 1952, sexual dysfunctions are classified as Disorders of Sexual Desire and Arousal; Orgasm disorder; Genito-pelvic / penetration pain disorder; Sexual dysfunction due to substance / drug use; other specific and non-specific sexual dysfunctions.

For the past 20 years, the US authorities have provided sustained financial support to research and to the institutions involved in the development of this field. Thus, several associations have been established that are involved in the exclusive research of sexual dysfunction of genito-pelvic pain.

- International Society for the Study of Vulvovaginal Diseases - ISSVD, an international society for the study of vulvovaginal diseases, consisting of over 250 specialists from 30 countries;

- International Society for the Study of Women's Sexual Health - ISSWSH;

- International Pelvic Pain Society - IPPS;

- National Vulvodynia Association - NVA.

In 2015, these international scientific societies created a consensual framework called "Consensus Terminology 2015", specifying the terminology and classification of vulvar pain and vulvodynia. (Jacob Bornstein, Andrew Goldstein, Caroline Pukkal, Amy Stein et al., 2019).

Pelvic Floor Anatomy

The pelvic floor is located inside the lower torso between the pelvic bones. This essential part of the body represents the center of gravity and the place where the movement of the whole body comes from. Imbalances and

conditions in the pelvis can cause a multitude of sexual symptoms and dysfunctions.

The pelvis is made up of genitals (vagina, uterus and ovaries), urine, intestines, colon, which are supported by pelvic floor muscles, tendons - the fibrous tissue that connects muscles to bones, ligaments - connective tissue that anchors bones and fascia - the covering tissue anatomical structures and bones of the lower limbs.

The functions of the pelvic floor are performed using coordinated mechanisms between muscles, tissues (tendons, ligaments, fascia), bones, joints and the nervous system. The main functions of the pelvic floor are support - supports and cushions the pelvic muscles and internal organs, sphincter - controls the urethral, vaginal and rectal sphincters, stability - maintains the spine and joints, the mechanism of sexual function - contracting muscles as a sexual arousal response and that of blood and lymphatic irrigation of the pelvis. The factors that unbalance the floor are various: age, obesity, sustained / excessive exercise, frequent weightlifting, constipation, chronic cough.

Genital pain

Pain is a discomfort, transmitted by the neural network, through the nerve endings in the brain, more precisely in the center of the pain that is close to the center of the sensation (arousal and orgasm). Pain can be felt through a physical sensation, but also as a mental and / or emotional interpretation (eg anticipating pain accentuates the sensation). The intensity of the pain is difficult to explain and analyze, because the pain is perceived differently by each person.

According to the International Association for the Study of Pain (IASP), the definition of pain is an unpleasant sensory and emotional sensation and experience associated with existing or potential tissue damage. (Merskey Harold, 1994)

For various reasons, the main decoder of pain, the nervous system can misinterpret the message and thus, the pain is felt elsewhere than the main source. The nervous system works with two types of neural processes: acute (occurs suddenly and is limited) and chronic (persists for a long time, between 3 and 6 months). Also, vague pain can have various intensities and can be felt as a mild, sharp, sudden pain but also of maximum intensity (paroxysm).

Genital pain occurs on the surface of the skin of the genital area, in the vestibular mucosa, in the pelvic muscles or in the neural network of the central nervous system. Thus, genital pain can be felt before sexual intercourse, during penetration, after sexual intercourse and at urination, for a period of time, after sexual intercourse.

Skin pain, felt in the vulvar tissues (complex network of nerves), affects the nerves of the genital area which can intensify and turn into a deep pain. The example of vestibulodenia (a condition of the vaginal entrance) can cause pain and spasms in the pelvic muscles triggering discomfort and pain in the bladder, but also / or can compress the pudendal nerve, triggering various forms of pain (neuropathy).

Pain during the initiation of penetration is a pain with various locations in the genito-pelvic region, being superficial, vulvo-vaginal pain or that during penetration and deep pain, pelvic pain felt at deep penetration. Pain can occur when it is caused during intercourse and by mechanical stimulation, both spontaneous and unprovoked, without a clear source. Therefore, the evaluation must be carried out thoroughly, in detail in order to be able to detect the causes as well as possible and, implicitly, to be able to treat them properly and effectively.

The pain can be felt as a burning, stinging, cutting, hitting, twitching, stinging, and stinging in several areas, from the surface of the vulva to the inside of the pelvis.

The prevalence of denitural pain in penetrative sexual intercourse

According to the literature, sexual dysfunction has a prevalence of over 40% of women and 30% of men. Sexual disorders can occur at any age, but the most common are between 40 and 65 years old (DSM V, 2013).

In the case of penetrating genito-pelvic pain disorder, the prevalence is over 15%. This

percentage is not relevant, because women with such sexual dysfunction do not talk about this problem and do not ask for specialized help.

According to a study conducted by Dr. Dean A. Seehusen, in 2014, the incidence on the American population between 15-46% of women. (Seehusen, D.A., Baird, D.C., Bode, D.V., 2014).

Etiology

The etiology of pain is represented by psychosexual, physical factors - trauma or injury to the tissue, genetic predispositions - errors in certain genes that regulate inflammation and especially genital infections, especially with recurrent vulvovaginal candida, which causes an inflammatory reaction of the skin and mucosa that persists long after healing and causes discomfort and pain during intercourse.

Pain can be felt at the vaginal entrance, at the touch and at the beginning of the penetration, inside the vagina, felt as a deep pain and in the lower part of the pelvis, during penetration (eg vaginismus).

Vaginal pain can be caused by insufficient lubrication - lack of foreplay or inadequacy, medication that affects sexual desire, by decreasing arousal and libido, especially in the case of hypertensives, antidepressants, antihistamines and contraceptives, irritations due to underwear, Hygiene, injuries or trauma - pelvic surgery, episiotomy at birth (about 45% of women develop dyspareunia), genital mutilation or accidents, vaginismus - involuntary spasms of the muscles around the vagina, genetic abnormalities - incomplete development of the vagina or a hymen imperforate, inflammation of the opening of the vagina (vaginal vestibulitis) and last but not least infections - genitals - candida, genital herpes, bacterial vaginosis, HPS and other STDs, urinary tract infections or diseases of the vulvar dermis (dermatosis, lichen planus and sclerosis, eczema).

Pain inside the vagina occurs due to diseases - pelvic inflammation, endometriosis, uterine fibroids, ovarian cysts, irritable bowel syndrome and other gynecological diseases, surgical and medical treatments (chemotherapy, radiation therapy).

The emotional factors that contribute to the onset of TAGPP are especially mental disorders and mental disorders: depression, anxiety, persistent stress (pelvic muscles tend to contract), self-esteem, fear of intimacy or problems with relationship and history of physical and sexual abuse.

Psychological causes can be multiple in the case of painful sex, from these can be a precarious sex education, dysfunctional family environment, non-communicative parents, rigid, aggressive, with strict traditions and religious rules - "you have to be a virgin when you get married, sex is a sin"), aggressive partners (verbal and / or sexual abuse). TAGPP is also influenced by maladaptive states, low self-esteem, negative body image, feelings of guilt, attitude to avoid and deny sex, anxiety (fear of BTS, pregnancy).

Studies by Aristotle and colleagues have identified a behavioral or family pattern in women with sexual dysfunction. Almost all the women who participated in the study were marked by the family conflict environment from childhood. The evaluation of the participants revealed a submissive behavioral pattern, a pattern of obedient woman, who can not express her anger, constantly seeking validation and approval. (Aristotle, G., Anastasiadis, D.M., Dimitry Droggin, Anne, R. Davis, Laurent Salomen, Rudwan Shabsigh, 2004)

W. Weijmar Schultz presented in 2005 the psychological factors in the possible etiology of the three major disorders of sexual pain dyspareunia, vulvar vestibulitis syndrome (also called unidentified dyspareunia) and vaginismus. In the case of women who suffer from dyspareunia in addition to comorbidities such as depression and anxiety, they are considered more erotophobic, have negative attitudes, aversion to sex.

According to the American Academy of General Practitioners (AAFP), approximately 20% of American women experience painful sexual activity. The prevalence of the disappearance on the age segment is a worrying one among young women, registering a percentage of 14-34%, and those aged between 6.5 and 45%.

Weijmar Schultz, W. et el., 2005

		dyspareunia	Vulvar vestibulitis	Vaginismus
Psychological factors in etiology (results of controlled comparisons / experimental manipulations)	Lower thermal pain threshold		+	
	- Lower threshold of tactile pain		+	
	- Depression	+		
	- Anxiety		+	
	- Marital adjustment		+	
	- Harmful to pain stimuli		+	
	- Lower genital arousal associated with sexual intercourse	+		
	- Attributing pain to psychosocial factors	+		- #
	- Poor control of the pelvic muscles			
	- Pelvic muscle contractions in response to threats			- #
				- - #

no more than healthy controls; + significant; ++ more than one study, - not significant, different from healthy controls, - more than one study; +/- in one or more studies

Dyspareunia is the equivalent of pain during intercourse with moderate or severe intensity, superficially or deeply localized. The main causes are physical, psychological and / or due to hormonal imbalances.

Pain is felt as a burning, twitching, or a sharp sensation of pain that, when left untreated, causes anxiety about sexual intercourse, leading to avoidance of sexual intercourse. Women with dyspareunia may have anxiety and depression - generalized anxiety, social phobia / phobia, eroticism and obsessive-compulsive disorder and sexual aversion.

The organic causes of dyspareunia are multiple endometriosis - thickening of the uterine tissue, fibroids - benign tumors, ovarian cysts - fluid accumulation, interstitial cystitis, pelvic inflammatory disease - in general, infections cause inflammation of the genitals, but can also occur due to inflammation of the wall. caused by bacterial infections, irritable bowel syndrome - functional disorder of the digestive tract and uterine prolapse.

Vaginismus was first described in 1547 as impossible to penetrate due to involuntary spasms of the pelvic and vaginal muscles around the vaginal opening. In 1961, Sims first used the name vaginismus, which is still used today.

Involuntary spasms around the vagina make penetration impossible, gynecological consultation and the impossibility of using intravaginal tampons. The pain is perceived as burning and severe pelvic pain.

The causes are not yet clear, but the main factors are the emotional and mental ones that can trigger this sexual disorder. In most cases, patients who have had unpleasant sexual experiences, fear of penetrative intercourse, low self-esteem - shame, disgust with the genitals, or a history of sexual abuse - suffer from vaginismus. Emotional factors and the body's normal reaction to anticipation and avoidance of pain, spontaneously trigger the contraction of the vaginal muscles. The more you insist on vaginal penetration, the stronger the contracture becomes.

The psychological causes of vaginismus are unpleasant childhood experiences - rigid parents, exposure to shocking sexual images, religious teachings - "sex is a sin", inadequate sex education, relationship problems - verbal / physical / sexual abuse, mistrust, emotional detachment , anxiety or stress - generalized anxiety, social anxiety and depression inhibit sexual arousal by producing vaginal dryness or vaginismus, guilt, unhealthy emotion about sex, fear of getting pregnant, fear of sexually

transmitted diseases - STDs, anticipatory anxiety - fear and stress give contractions of the pelvic muscles, fear of pelvic trauma, traumatic experiences - sexual abuse, rape, sexual violence, physical aggression, repressed memories.

Among the physical causes are hormonal imbalances - in the pre and post menopausal period hormonal fluctuations can cause inadequate lubrication, vaginal dryness, but also urinary and fungal infections, endometriosis, STDs (sexually transmitted diseases), pelvic inflammation, postpartum, abortion , cesarean section and side effects to some medications.

Currently, the successful treatment of vaginismus, in a proportion of 80-100%, is achieved through psychosomatic approaches - cognitive behavioral therapy, pelvic floor therapy with exercises to relax the vaginal muscles.

Vulvodynia

Vulvodynia can be generalized or localized (vestibulodynia, clitoridinia), induced or unprovoked (pain on sexual, non-sexual or mixed stimuli).

This sexual disorder was first mentioned in 1889 by Sken as "vulvar hypersensitivity," and in 1976 by the International Society for the Study of Vulvovaginal Diseases (ISSVD), established in 1970.) indicated vulvar pain as a pathology.

Over time, vulvodynia has had various names: essential vulvodynia, vulvar dysaesthesia, psychosomatic vulvovaginitis, and vulvar vestibulitis syndrome. This sexual disorder is now called generalized and localized vulvodynia.

In 2003, at the 17th World Congress organized by the ISSVD, the term vulvodynia was associated with vulvar pain. (Micheline Moyal - Barracco, 2004)

In the case of vulvodynia, the etiology is multifactorial triggered by inflammatory factors, psychosexual changes or disorders in the neuroceptors and nerve endings. Vulvodynia is more common during premenopause.

Generalized vulvodynia is a pain that feels like a burn that can affect the entire vulva (sometimes no changes are seen in the dermis of the vulva). Specialist studies show that in order to alleviate or remit this sexual dysfunction, it is supplemented with drug treatment, tricyclic antidepressants or anticonvulsants.

Experimental theoretical approaches

According to the literature, various experimental theoretical approaches have been developed. Of these, the most significant and effective in the case of sexual dysfunction and especially for dyspareunia are presented by the theory of development, developed in the '80s, by psychologist Richard Lazarus; the theory of learning and the model of operant conditioning, elaborated in 1994, by psychologists Meana M. and Binik Y. M, and the newest cognitive approach, scientifically validated on the Romanian population is the Standardization S + X® (2019), by Cristian Delcea.

Diagnosis of genital penetration pain

In order to have a complete picture of possible medical conditions, the patient must make specialized consultations - gynecological, urological, dermatological, endocrine, gastroenterological and neurological and psychiatric.

Maintaining uncertainties and conceptualization controversies has led to increased attention to evaluation for a differentiated diagnosis.

Therefore, the evaluation should analyze the history associated with the symptoms perceived in the urinary system, digestive tract, sexual pain or other organic pain as well as checking for the existence of injuries or skin problems, orthopedic problems, etc. After eliminating medical conditions and mental disorders. Genital pain associated with penetrative sexual intercourse is treated as a sexual dysfunction.

For a more accurate diagnosis and an effective treatment, several methods and techniques are used in the therapy to outline a clinical picture. The psychotherapeutic intervention begins with the evaluation of the patient - the clinical history and screening are completed with the help of validated and standardized

psychometric instruments for sexual, mental and personality disorders.

Psychometric tools

In the case of TAGPP, tests are used to detect mental and personality disorders and specific tests to measure the intensity of the pain.

Mental health testing is done to rule out any suspicion of anxiety, depression or sexual abuse. Thus, the most used test batteries used in sexual dysfunction are: Hamilton Depression Scale - Max Hamilton (HRSD) developed in 1960 as a standard psychometric tool for assessing the severity of depressive symptoms. Hamilton Anxiety Scale - Max Hamilton, in 1959, psychiatrist Max R. Hamilton developed the Anxiety Assessment Scale, Post-Traumatic Development Scale (PTSD), Dysfunctional Attitude Scale, Psychiatric Screening and Diagnostic Questionnaire (PDSQ) - Mark Zimmerman.

For the evaluation of personality disorders, the batteries of psychometric tests adapted and standardized on the Romanian population are used: Minnesota Multiphasic Personality Inventors® - (MMPI-2), Millon® Clinical Multiaxial Inventory - III (MCMI - III), Personality Disorders Inventory (OMNI - IV).

The Questionnaire to Measure sexual quality of life (SQOL-F) determines sexual self-esteem as well as emotional and couple issues.

Sexual function is probed with multidimensional psychometric tests - Female Sexual Function Index (FSFI), Index of Sexual Satisfaction (ISS), Mc Coy Female Sexuality Questionnaire (MFSQ), Relationship Adjustment Test, Adjustment Scale.

The Mc Gill Pain (MPQ) test is used to measure pain mediators.

Clinical observation, assessment, testing of mental, personality and couple disorders as well as sex life provide a detailed picture and size of the disorder.

Treatment of penetrating genito-pelvic pain disorder

Because TAGPP is a multisystemic and multifactorial disorder, it is treated multimodally with the help of psycho-sexual education, psychological therapy and sex therapy, physiokinetotherapy, pharmacotherapy, when necessary, surgery is also used.

The goal of treatment is to reduce discomfort and genital pain during intercourse.

After completing the clinical picture, the patient is presented with the size of the disorder, the causes of sexual dysfunction as well as treatment options and recommendations for pain management.

The most effective psychotherapeutic interventions in the case of penetrating genito-pelvic pain disorder are performed with the help of cognitive psychotherapy, cognitive behavioral psychotherapy to identify, modify cognitions and maladaptive behaviors using techniques to focus on healthy sensations, combined with various relaxation techniques. for solving couple problems. Systemic couple and family psychotherapy improves the level of communication, developing the relationship and support for solving the couple's problems, especially due to sexual dysfunction. This therapy identifies unhealthy patterns of relationships and communication, applies techniques to develop sexual compatibility, and focuses techniques on desirable and pleasurable sensations and methods for developing the patient's ability to perform adaptive sex and discomfort.

Relaxation techniques are recommended in all the psychotherapeutic interventions presented to create an appropriate framework for homework and to reduce and even eliminate anxiety. They are recommended as homework to relieve the patient and learn to increase the tolerance to discomfort more easily. By applying mindfulness techniques, autogenic, you get a better relaxation of the two and a better state in the couple, to achieve an adaptive sexual act.

After presenting the treatment options, especially the details of the costs and benefits, the patient decides together with the partner the agreed option and thus the therapeutic plan is established. The therapeutic plan is individualized, with individual and couple sessions. During the couple's meetings, the two's compliance is established for the more efficient application of homework. At the beginning of therapy, homework contains pleasant and

relaxing sexual activities without penetrative acts.

Pharmacotherapeutic options

The drugs used for genito-pelvic penetration disorders are: Bubpropin 75 mg - 100 mg (Welbutrin SR 100 mg, 150 mg, 200 mg, XL 150 mg - 300 mg, Zybran, Aplenzin) and IRND - noradrenaline reuptake inhibitors and dopamine. (DSM - V, 2013). The treatment period is recommended for a period of 4-8 weeks.

Carolina Pukall, in a study conducted in 2001, recommends as a medication for genital pain associated with penetrative sexual intercourse, anti-inflammatory - Cromolin, chromoglic acid and as an antifungal for the prevention of candida infection - Fluconazole. (Carolina Pukall, 2001).

Recent studies suggest that botulinum toxin injections have a significant effect on pain and sexual function.

METHODOLOGY

Amnamnesis

Madalina - a 27-year-old lawyer, has had discomfort and genital pain at penetration for 7 months, for 4 years she has been in a relationship with Mihai - an engineer, 30 years old, without children. Madalina asked for specialized help to solve the couple's problems. At the first meeting, Madalina invoked as the main reason misunderstandings in the relationship that appeared for almost 3 months, motivating that Mihai became very nervous. She considers that these changes in attitude and behavior occurred after they started remodeling the apartment where they have lived together for a year. He believes that this would be the trigger for frequent tensions, misunderstandings and quarrels between them.

Assessment

According to the anamnesis and the clinical interview, the patient does not present a medical, psychological history, being influenced by our cultural and traditional values, nor did she suffer any physical, sexual abuse or any trauma. Madalina has a good relationship with her parents, and a friendly relationship with her mother.

Asked about her sexual life and her former relationships, she said that she had two relationships but that they were "closed chapters" and that she was no longer concerned about the past. He currently wants to marry Mihai and have a baby.

About the sexual life, she wanted to specify that she is no longer compatible with Mihai because he wants to have sex more often, insisting even without foreplay, and she accepts, motivating that she is afraid to refuse him, not to upset him or not to leave her. Sexual intercourse is short and she doesn't even feel pleasure anymore, because for 7 months she has had a discomfort accompanied by pain during penetration. He did not know whether this change in sexual life was due to misunderstandings between them or why their sexual life changed.

As soon as the pain started, he went to the gynecologist. According to the consultation and the results of the tests, the gynecologist concluded that everything is fine and does not show any medical condition or infection - STDs and the results of hormonal tests did not indicate the changed parameters. However, she was prescribed another contraceptive and the gynecologist will check for changes in her sexual response. The administration of the new drug did not improve any sexual intercourse, the discomfort and pain during sex remained even worse. Thus, when identifying the intensity, on a scale from 1 to 5, the patient noted that the pain is felt by 4.

According to the negative gynecological and endocrine diagnosis, without any medical condition, infection or hormonal imbalance, with a medical history without other surgeries, abortions, autoimmune diseases, diabetes, we recommended Madalina a clinical mental evaluation, to be able to identify and delimit, if is a somatization to a mental disorder or symptoms are present due to sexual dysfunction.

Psychometric tools

According to the battery of tests applied - Hamilton and Millon® Clinical Multiaxial Inventory III depression and anxiety scale,

negative results were recorded, no mental / emotional (anxiety, depression) or personality disorders were identified.

Since the symptoms mentioned by Madalina have organic causes, medical conditions or mental disorders, we proposed to analyze the sexual relationship with the help of batteries of tests validated to detect sexual disorders. The result of the Questionnaire to Measure sexual quality of life (SQOL-F) indicated the existence of emotional and couple problems coupled with low sexual self-esteem.

The patient's sexual function was assessed with the multidimensional psychometric test - Female Sexual Function Index (FSFI). Low scores on almost all sexual functions resulted in impairment of desire, arousal, lubrication and even orgasm, also contributing to dissatisfaction and pain. And to identify the intensity of the pain, the test for measuring pain (MPQ Mc Gill Pain) was probed, the score being moderate.

The test results showed psychometric validity indicating sexual dysfunction with genital pain associated with penetrative sexual intercourse.

Diagnostics

According to the results of the evaluation, the clinical interview, the screening - to identify the properties and mediators of pain, but also the tests applied, the discomfort and pain during sexual intercourse indicate a dyspareunia, acquired, located in the vagina and of moderate intensity.

After outlining the differentiated diagnosis, the patient was presented with detailed information about this sexual disorder.

Therapeutic plan

The principles of treatment are improving communication, mutual responsibility, information and education, changing sexual attitudes and behaviors, eliminating sexual anxiety, changing sexual role and last but not least changing lifestyle.

The goals were set together with the two, starting from Madalina's greatest desire, namely, not to hurt her anymore and to be able to have sex as before, because she wants to have children.

During the therapy, two individual sessions and 10 couple sessions were scheduled, completed with homework.

The purpose of therapy

The main goal was to alleviate and possibly relieve discomfort and pain during intercourse. I informed her that it is not advisable to have unrealistic expectations, because after a long period of time, 7 months, in which this problem persisted, the symptoms will not pass instantly, and therefore, it takes time to remit this sexual disorder. .

Mihai was delighted to learn that they will start sex therapy, being responsible and supportive in the healing process, he was open to support in order to solve this problem in their lives as soon as possible. At the end of the meeting, Mihai added, "I'm sure that during the therapies, sexual problems will be detected in me as well, since Madalina has this pain, I started to get stressed when we have sex, I keep thinking that it will hurt".

Among the proposed goals were - increased pain tolerance, greater desire and arousal and improved sexual performance through a better erotic connection.

Treatment

We provided information on the importance of psychotherapeutic interventions, explaining that the application of psychosomatic approaches can improve and even remit dyspareunia. With the help of cognitive therapy, a validated and standardized psychotherapeutic intervention, through relaxation techniques and desensitization therapy, vaginal relaxation exercises that decrease the intensity of pain, diminish or eliminate the anxiety of the painful act and thus will have desirable sexual intercourse.

The painful sexual intercourse determined the appearance of the negative emotional response to the sexual stimuli that led to the avoidance of intimacy, a poor communication, so the two cooled down and implicitly there were discussions between them. Recom-

mended cognitive therapy changed maladaptive thinking patterns with distributive thinking techniques with description and focus on pleasure stimuli, developed the technique of anticipatory steps (foreplay, preparation for penetration and penetration), and managed performance anxiety.

During the first therapy session, information on sexual psychoeducation was presented. The couple received information about the mechanism of sexual intercourse, anatomical elements of the reproductive system and intimate hygiene recommendations and an increased emphasis on allocating time for relaxing activities: light sports, especially swimming, yoga, relaxation massage, breathing exercises.

As a homework, they had to organize a romantic meeting ending with an erotic connection, without penetrative sex. I recommended to participate in a sensual massage, with scented oils, combined with conscious breathing, caresses and kisses, erotic massages with masturbation. The purpose of the theme is erotic reconnection and relearning exciting stimuli.

The feedback received was very good, they were both satisfied and surprised by how they felt and wanted to repeat the theme. Especially Madalina who also had an orgasm during masturbation. After a few erotic reconnections, penetrative sex was included.

During the sessions, the patient realized that during sexual intercourse she processes with maladaptive thoughts that amplify her suffering and discomfort and with the help of the proposed techniques she can adapt more easily and manages to better manage sexual intercourse.

The new recommendations for the following homework were to communicate during the exercise - how everyone feels, with detailed descriptions, to say any discomfort that occurs, the moment of penetration to be delayed until the maximum moment of arousal, the use of a lubricant based water and try new positions, recommended the "on top" position, more advantageous for the patient having the opportunity to adjust the penetration. All the recommendations were well received by Madalina, who feels much more comfortable when she is not pressured to start penetrating.

With the help of the anticipated steps, according to the standardized model of intervention and distributive thinking, the defocusing on pain was achieved, with the change of attention on pleasant sensations, so that in repetitive association Madalina managed to turn pain into pleasure.

According to the 7 protocols followed in cognitive therapy for the diagnosis of moderate dyspareunia, the technique of managing sexual anxiety was applied to reduce anticipatory anxiety to pain. These were supplemented with relaxation and somatotherapy techniques, followed by the technique of anticipatory steps, with an appropriate prelude, changes of position, testing the most appropriate and comfortable and preparation for penetration, (P5, P4, P3, P_{2-1}, P_{2-4} , P_{2-2} - Delcea C., 2021).

In the following homework, other elements were added to increase the arousal - sex games and toys, erotic outfits, so the foreplay became suitable for a satisfactory sexual response. After the first homework, the pain subsided. The grade of pain intensity was 2, on a scale of 1 to 5. Sometimes it happens that Mihai does not follow the "rules" trying to jump over them, which causes discomfort when penetrating.

The most popular techniques were the descriptions, the focus on the areas and the sensations of pleasure. All the techniques approached made the patient feel more relaxed, much more aroused, with a more abundant natural lubrication and without anticipatory fear of pain, managing to feel good and have an orgasm during sexual intercourse, which made- she will be much more confident in their sexual relationship.

The result of therapy

Currently, the two have a satisfying sexual relationship, with sexual intercourse with mild pain, decoded by 1 (on the scale from 1 to 5).

The goals of the therapy have been achieved, the two have managed to find themselves erotic and can have pleasurable sexual intercourse completed with orgasm. It handles nervousness much better and communicates

much better. Sexual intercourse is evolving well, the two introducing "negotiation" in sexual intercourse and thus eliminating maladaptive expectations.

CONCLUSION

In recent decades, there has been a particular concern for research into sexual dysfunction, and various associations and institutions have been set up to participate in the development of research programs. Specialist studies constantly bring additions and adjustments and thus have led to a better understanding of sexual dysfunctions and the development of a more effective treatment scheme for their remission. There is also a greater openness among women to openly discuss sexual issues, to seek solutions and even to participate in studies undertaken by specialists.

Although it is not very clear whether it is a sexual disorder, a medical condition or a mental illness that mediates a sexual condition, such as genital pelvic pain, we can be confident that through the sustained interest of specialists and the help of new technologies. all of these sexual dysfunctions may be much easier to diagnose and treat.

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