

Recovering from provoked vestibulodynia: Experiences from encounters with somatocognitive therapy

Physiotherapy Theory and Practice

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ABSTRACT

Although provoked vestibulodynia (PVD) represents a significant challenge for many young women in the Western world, little is known about how these women experience therapeutic efforts. The aim of this paper is to enhance our knowledge of the way that the therapeutic process is experienced by women with PVD undergoing somatocognitive therapy (SCT). The study enhances insight into this recently developed therapy through a detailed description of the physiotherapy approach. The empirical data are based on interviews with six women who participated in SCT. The empirical data analysis is guided by thematic analysis. Our findings demonstrate how the women experience SCT as a bodily process of wholeness. The process of wholeness relates to new experiences in the women's own bodies, awareness of muscular and mental tension and relaxation, breathing patterns, and perceptions focusing on pain. The findings are presented as three interrelated themes: 1) sensitising the body as an interconnected unit; 2) incorporating the painful pubic region into the body; and 3) developing a new understanding of oneself. The women who participated in this study found that SCT contributed significantly to the process of their recovery from PVD.

KEYWORDS

Provoked vestibulodynia, somatocognitive therapy, physiotherapy, body awareness, empathic therapeutic alliance.

INTRODUCTION

Longstanding vulvar pain is a distressing and debilitating condition representing a significant challenge in today's clinical practice. The condition of provoked vestibulodynia (PVD) is characterised by cutting or burning pain upon contact with the vulvar vestibule (Danielsson, Sjöberg and Wikman, 2000; Pukall et al, 2002). With an estimated prevalence of between 10 and 28% among premenopausal women in the Western world (Arnold, Bachmann, Rosen and Rhoads, 2007; Harlow and Stewart, 2003; Reed et al, 2004), it is considered the most common cause of pain during sexual intercourse among women of reproductive age. Diagnosis is based on a history of the illness and a gynaecological examination where the following criteria are met: pain in the vulvar area upon contact or attempted vaginal penetration, acute pain during the cotton-swab test (pressure at random points in the vulvar vestibule) and physical findings limited to varying degrees of vestibular erythema (Friedrich, 1987). Currently, a variety of different etiological hypotheses are being explored to help understand the condition of PVD. These include hormonal and genetic factors, local pathology in the vestibule (such as inflammatory, neuroproliferative and muscular conditions) and processes involved in sensitization of the central nervous system (Pukall et al, 2016). Several studies report an increased tendency towards dysfunctional cognitive, emotional and behavioural responses to pain among women with PVD, including fear avoidance, hypervigilance, pain catastrophizing and low self-efficacy (Desrochers, Bergeron, Landry and Jodoin, 2008; Pukall et al, 2016; Sutton, Pukall and Chamberlain, 2009; Thomtén and Karlsson, 2014). Collectively, the literature indicates that a complex interplay of different factors may contribute to the development and maintenance of this condition (Micheletti, Radici and Lynch, 2014; Pukall et al, 2016; Sadownik, 2014; Thornton and Drummond, 2015).

Several studies report that sexual desire, satisfaction and confidence are lower among women with PVD (Desrochers et al, 2008; Smith and Pukall, 2011; Smith, Pukall and Chamberlain, 2013; Sutton et al, 2009). Women report feeling anxious in sexual situations and many tend to withdraw from sexual intimacy with their partners (Brotto, Yong, Smith and Sadownik, 2015; Connor, Robinson and Wieling, 2008; Sadownik, Seal and Brotto, 2012).

There is a lack of efficient and well-documented treatment options for women with PVD (Andrews, 2011). Vestibulectomy, a surgical procedure where part of the painful vestibular mucosa is excised, is normally only considered after more conservative approaches have proved unsuccessful (Landry, Bergeron, Dupuis and Desrochers, 2008). Although the use of vestibulectomy has some support in the literature (Andrews, 2011; Landry, Bergeron, Dupuis and Desrochers, 2008), there is concern that surgical interventions do not take the full complexity of this condition into account (Basson, 2012; Sadownik, 2014). Recent studies indicate that multimodal treatment forms, such as cognitive behavioural therapy (CBT), and multidisciplinary interventions, which integrate psychological skills training, pelvic floor physiotherapy and medical management, offer potential for the treatment of PVD. A wide array of different physiotherapeutic approaches have been tested on women with chronic gynaecological pain including psychosomatic physiotherapy, stretching, trigger point therapy, Thiele massage and somatocognitive therapy (SCT) (Loving, Nordling, Jaszczak and Thomsen, 2012). Loving et al have emphasised that SCT is particularly promising (2012).

[Somatocognitive therapy \(SCT\)](#)

SCT is a newly developed physiotherapeutic approach aimed at dealing with longstanding pain disorders. It combines elements from cognitive psychotherapy with therapeutic principles from Mensendieck physiotherapy (Haugstad et al, 2011; Klemmetsen and Rugseth, 2005;

Winterowd et al, 2003). With regard to the new recommendations for interventions in chronic pain conditions (IASP, 2009, Nijs et al, 2013, Fersum et al, 2013), the SCT approach, as developed in this study, addresses both the physical and the psychological dimensions of chronic pain. In addition, the SCT process undergone by the women in this study took the fear avoidance (FA) model into account (Vlaeyen et al, 1995).

By explicitly focusing on somatic functions, SCT differs from cognitive therapy, which focuses mainly on cognitions. In SCT, the areas of central focus include developing a good working *alliance* between patient and therapist, an explorative approach to the body and its functions, cognitive restructuring of negative thought patterns and home assignments between sessions that are linked with the activities of daily living. As part of the home assignments in this study, patients were encouraged to explore and familiarise themselves with their own vulvas. This involved experiencing the different sensations elicited by warm and cold cloths and showers, as well as gently exploring the vulva with their fingers, self-massaging, and alternating between tensing and relaxing the muscles of the pelvic floor. Patients were encouraged to use tampons of gradually increasing size (Fougner and Haugstad, 2015). In SCT, an important goal for the patient is to develop body awareness, gain new bodily experiences, and develop coping strategies and a sense of mastery of one's own life (see a further description in (Haugstad et al, 2011).

SCT is currently being offered at the outpatient physiotherapy clinic affiliated to Oslo and Akershus University College. Here, physiotherapy students in their final year administer the treatment under the close guidance of experienced physiotherapists. Based on the fact that the patients in this study spoke of the students as physiotherapists, and that their role as students is not the focus here, we have chosen to refer to the students as physiotherapists in this article. The therapy course involves eight weeks of therapy sessions, with two sessions per week (each lasting an hour).

The aim of this article is to gain knowledge about what women encountering SCT experience as important in order to recover. The following research question is posed: How do women who undergo SCT experience the therapeutic process?

METHOD

This study is based on a qualitative method. In order to obtain information about people's experiences and feelings about PVD, interviews are considered a particularly suitable method (Järvinen, 2005; Kvale and Brinkmann, 2009). The empirical interview data derive from a project that explored experiences with SCT among women with PVD and include interviews with six women with this diagnosis. The study, which went through a human subject review process, was approved by both the Norwegian Social Sciences Data Services and the Regional Committee for Medical and Health Research Ethics.

Participants

The 6 participants are Scandinavian women between the ages of 22 and 37, with a mean age of 29. Most had lived with PVD for several years with the duration of pain ranging from just under a year to over 13 years, with an average duration of 5,5 years. Five of the women were in a committed relationship, while one referred to herself as single. All six women identified themselves as heterosexual. None of the participants had any children. Most of the women had or were in the process of getting higher education. Two of the participants were seeing a psychologist at the time of the study. A mental health referral was not deemed necessary for the remaining four women. Table 1 provides an overview of the women who took part in this study.

Table 1. Overview of the six women who participated in the interviews.

Participant	Liv	Silje	Kine	Mia	Tove	Jenny
Age	22	33	29	27	37	28
Ethnicity	Nordic	Nordic	Nordic	Nordic	Nordic	Nordic
Civil status	Domestic partnership	Married	Domestic partnership	Single	Married	Domestic partnership
Sexuality	Hetero-sexual	Hetero-sexual	Hetero-sexual	Hetero-sexual	Hetero-sexual	Hetero-sexual
Number of children	0	0	0	0	0	0
Level of education	High school	University college	University college	University college	University college	University college
Occupation	Assistant job	Admin. job	Admin. job	Student	Admin. job	Student

The study did not collect any quantitative data concerning the level of pain intensity before and after therapy. The level of pain reduction experienced by the women, as depicted in Table 2, is based on descriptions provided by the women during the interviews.

Table 2. An overview of years lived with vulvar pain, and the amount of pain reduction experienced by the participants following therapy.

Participant	Liv	Silje	Kine	Mia	Tove	Jenny
Pain duration	1 year	8 years	<1 year	8 years	>13 years	2 years
Pain reduction following treatment	Significant	Moderate	Moderate	Small	Moderate	Significant

Procedure

All participants had been referred to the outpatient clinic by a gynaecologist working at a University Hospital. All women were diagnosed with PVD by this gynaecologist. The participants were recruited into this study from the outpatient clinic based on information about the study provided by the outpatient clinic. None of the women in this study were treated by the same therapist. As the treatment period came to an end, the names of the students currently treating women with PVD were provided by the administrative staff. The student physiotherapists were then contacted by the interviewer and assisted in setting up a meeting with their respective patients at the clinic. At this meeting, the patient was given information about the project and why she had been invited to participate. All those who were invited agreed to participate and signed an informed consent form. There was no compensation for participation. All names used in the article are pseudonyms.

The interviews took place at the outpatient clinic within a week of the end of treatment to ensure rich and vivid recollections of the treatment course. The women were interviewed individually to allow for sensitive topics to be brought up in a confidential setting. Three interviews were conducted by the first author and three by the third. Each interview started with a briefing, giving the participant an opportunity to familiarise herself with the interview setting.

Each interview lasted between 60 and 120 minutes. The study used a semi-structured interview guide to ensure that all the important topics were raised during the interviews. At the same time, the therapist allowed for both flexibility and sensitivity to the topics being raised by the participants themselves (Kvale and Brinkmann, 2009). The conversations were tape recorded with the informant's written consent. This allowed the interviewer to free herself from taking notes and, instead, to devote herself to being present and attentive during the conversations. As these interviews touched on a sensitive topic, there was a particular

need for the interviewer to be responsive to the dynamic and thematic aspects of the interview situation. The participants were encouraged to talk freely about their experiences. By opting for open-ended questions, they were encouraged to steer the conversation towards those aspects of their experiences with the SCT course that were most important to them. The participants were invited to elaborate where there were elements in their stories that the interviewer felt were unclear or that needed to be expanded. Interviewers emphasised the value of insights into both negative and positive experiences to avoid a situation where the participants might feel obliged to give only favourable feedback.

Each interview concluded with a debriefing (Kvale and Brinkmann, 2009). While the tape recorder was on, the interviewer gave a short résumé of what she had understood to be the most important aspects of the participant's experiences. Each participant was then invited to validate or clarify and to bring up other aspects that she felt had not been covered (adequately) during the interview. Only minor clarifications occurred during these debrief sessions.

Data analysis

Thematic analysis provides a useful and flexible method for qualitative research (Braun and Clarke, 2006). The analytical process in this study was guided by an inductive thematic analysis (Braun and Clarke, 2006; Patton, 2002). Shortly after each interview, the respective interviewer transcribed the interviews. The first author then started reading the interview texts to get an overview of the women's experiences. *Preliminary themes*, identified during this read through, related to salient aspects of the women's experiences in line with the research question. Data relating to these initial themes were then identified and marked as initial codes (Braun and Clarke, 2006). The coding process enabled both common and diverging

experiences to become visible. Discussions between the authors, both through face-to-face communication and via e-mail, increased insight into important aspects of the women`s experiences. Thus, the preliminary themes were reduced into a single code – or a *preliminary main theme* – representing the main topics in the interviews, which in this analysis was the bodily process. The material was further explored through different ways of organising the text, which allowed for a further refinement of the preliminary main theme into three *sub-themes*. The sorted meaning units or preliminary themes from all six interviews were then synthesised into analytical texts for each of the sub-themes, representing the explicitly conveyed experiences across the six participants. The authors took care to ensure that all the women were represented in the final results. The analytic texts made the differences in the women`s views visible. Quotations from the empirical material were carefully chosen to illustrate the analytical summaries. Based on new insight gained through the analytical process, a final main theme was formulated, capturing the essence of the three sub-themes previously identified. The analytical texts and the quotations comprise the findings of this study. Table 3 gives an overview of the analytical process, moving from the preliminary themes to the final *main theme*.

Table 3. An overview of the analytical process, moving from the preliminary themes to the final main theme.

Preliminary themes	Effects of breathing Negotiating pain Being acknowledged New experiences with patient`s own body and sexuality Understanding bodily connections New awareness and presence in patient`s own body
Preliminary main theme	Bodily process
Sub-themes	Sensitising the body as an interconnected unit Incorporating the painful pubic region into the body Developing a new understanding of oneself
Main theme	A bodily approach of wholeness

FINDINGS

Our findings show that the women experienced SCT as a bodily process of wholeness. The following three interrelated themes were significant with regard to how the women experienced the therapeutic process as wholeness: 1) sensitising the body as an interconnected unit; 2) incorporating the painful pubic region into the body; and 3) developing a new understanding of oneself. We present these themes in more detail in the following paragraphs.

Sensitising the body as an interconnected unit

The analysis shows how the SCT encounter denotes a bodily approach of wholeness where working with breathing patterns and muscular tensions is important. Through the bodily approach of wholeness, all six women experienced increased awareness of how breathing, tensions, thoughts and emotions could affect their painful condition:

Because the vulva is connected to something . . . and that is connected to something and that is connected to something else. You get to understand *how everything is tied together*, and that you can't just treat the vulva, but you have to *treat the whole body*. So the relaxation exercises and the breathing exercises and practicing to walk in a different way . . . *it's all connected*. (Jenny)

This quotation illustrates the experience of the body as an interconnected unit, where the different parts of the body are connected. Jenny further elaborates on how breathing turns out to be important for sensitising the body as an interconnected unit:

The breath . . . working with the breath, it goes into everything in a way, breathing before going to bed is a nice way to fall asleep . . . breathing in the morning is a nice way to wake up . . . breathing during sex, breathing when I am stressed in a work situation . . . I have become much more aware of what breathing is, and noticing the difference between being tensed and not tensed. (Jenny)

As highlighted in this quotation, gaining an increased understanding of how the body works as a closely interconnected unit is an important experience in the women's process of

recovering from PVD. Typically, the women expressed how approaching the body as wholeness helped give them a new relationship with their own bodies. The women strongly emphasised an increased ability to be present in their bodies and a growing awareness of their bodily sensations:

What stands out the most is how I've developed an increased awareness of how I function and what can trigger the pain down there . . . an *increased awareness of the body*. . . . Eventually, *breathing* came automatically. I'm a lot better at it now. There is a big difference compared to how it was in the beginning . . . just tuning out . . . *experiencing how the breath moves* into the belly and a little further down . . . *sensing and becoming aware of the breath*. (Kine)

Also, the experience of being more sensitive to their bodies seemed to be quite new to them:

The *sensation* of being completely relaxed. It was a long time since I had been that relaxed, it was wonderful . . . just *feeling so comfortable in my body* somehow . . . content . . . no tensions . . . no pain. I think that has been the most important experience for me . . . that it was so pleasant. (Liv)

The feeling of being comfortable in their own bodies boosted the sensation of the body being a whole, where different parts relate to each other as an interconnected unit. The SCT encounter also focused on an approach to the painful pubic region as being connected to rather than disconnected from the body as wholeness.

[Incorporating the painful pubic region into the body](#)

All participants described how the vulva area had become associated with pain and negative thoughts and emotions, such as shame, guilt and worry. The women described their vulvas as dirty and gross and some expressed anger towards this painful and dysfunctional area. In sum, the vulva had become an area of their bodies that they pushed aside and almost deleted:

Everything has been so negative. It has rather become a place I don't want to seek out It doesn't work . . . so I almost can't bear to have a relationship with it. (Silje)

As highlighted in this quotation from Silje, the painful vulva and pubic region is experienced as being disconnected from the rest of the body. During the SCT process, the women worked both with the body as a whole and with the painful vulva area. Explicit work with the painful vulva area involved different home assignments in which the women were directed to explore their own vulvas. In the interviews, the women described how the home assignments entailed looking at their vulva in a mirror, touching themselves and flushing this area of their body with hot and cold water in the shower:

Every time I take a shower I'm supposed to put in a finger and press, or to flush with the shower or use a dildo . . . I mean, it's a little weird. But at the same time, that's where the problem is, so actually it would be even weirder if we didn't have these exercises, when I think about it. I think I would have hesitated more if the whole area had been ignored. . . . I've discovered that the pain is located in several other places than I initially thought. I thought it was just a small area, but it's bigger. And I wouldn't have discovered this if she hadn't asked me to explore. So I think that's important . . . I'm becoming more familiar with it myself. (Mia)

This quotation pinpoints how several of the participants found the assignments exploring their painful vulva to be strange or unfamiliar at the beginning. However, they also described how working with these assignments was meaningful as they focused directly on the area where the pain was located. Their explicit focus on the vulva suggested that they gradually felt the vulva to be a part of their bodies.

The women appreciated the fact that the therapist explained pain mechanisms to them at the same time that they were working on approaching the painful area. In this way, the therapist helped them understand how their thoughts and emotions could influence their pain experience. Learning that pain did not necessarily equal danger also helped reduce some of the fear associated with touching and penetrating the vagina:

It's kind of nice to have someone be a little authoritarian and tell you [explaining pain mechanisms] . . . someone who knows something about it . . . who tells you that it might hurt a little, but that doesn't mean it's dangerous. You don't have to be afraid. And then you take those words with you into the situation, and you're not so afraid. (Liv)

The women described how approaching the body as wholeness helped them develop a more familiar and relaxed relationship with the vulva, seeing it as incorporated into their body rather than being a disconnected part. The home assignments focusing on the vulva helped them develop positive associations with the painful area. They were also a valuable tool for exploring their sexuality and their needs as part of the body viewed as wholeness:

But it's actually a part of my body. It's not something . . . disgusting, and it's not dangerous . . . you know. . . . Just developing a more natural relationship with it. Because I don't feel like I have had that before. . . . It's about gaining more knowledge about yourself which helps you to say, 'Oh, well I guess it wasn't so dangerous after all.' (Tove)

Tove's quotation demonstrates how several of the participants started to acknowledge their vulva as being a natural part of their body towards the end of the treatment period.

Pinpointing the painful area helped it become less associated with shame and anxiety. Instead, it became incorporated into the body as a natural wholeness. This acknowledgment was related to a greater cognitive-based knowledge about pain. In addition, it was influenced by the way the women were approached by the therapist, a point to which we will return.

[Developing a new understanding of the self](#)

The SCT encounter encouraged the women to develop a new understanding of themselves which involved seeing themselves as being normal. With their vulvar pain being invisible and viewed as a taboo subject, the participants spoke of how PVD had led to a sense of social isolation. For many of the participants, not even their close friends or family members were let in on their secret suffering; learning that there were many women like them who suffered from the same condition was therefore a relief:

You get a confirmation of your own feelings . . . and learn that maybe you're not as abnormal as you thought. Because you realise that there are actually many women who suffer from this. And that was sort of good to know. (Jenny)

This quotation illustrates how the women developed a new understanding of themselves by feeling a normalisation of their pain experience, reducing their feelings of being wrong or flawed. As a result, the women no longer felt so alone with their vulvar pain; rather, they sensed they were part of a community of women sharing the same experiences and struggles. This new understanding of themselves also implied that the aim of the treatment was not only to recover from PVD but also to develop a greater self-acceptance of their situation:

It has been important for me that my emotions and my situations are recognised. That the therapist acknowledges what you're saying, or that she can relate to or confirm my experiences Because I feel like I'm revealing my soul here, in a way. And it feels like I'm opening up everything. So to have a person who can give something of herself back, that helps. (Tove)

As this quotation illustrates, it was important to the women that the therapists were able to relate to and confirm the patients and their situation. In other words, the *alliance* between the therapist and patient turned out to be significant in enabling the patient to progress.

This alliance concerned the value of being acknowledged by the therapist, which was a central theme permeating all six interviews. Several of the participants emphasised that this was the first time they had ever really been listened to by a therapist:

Everyone is so friendly here. It makes you feel safe. What I've experienced when I've sought help before is that they don't really listen to you and that you don't . . . everything has to happen so fast, and then you're done. But here I've felt that we had a lot of time. (Liv)

As highlighted by Liv, meeting an empathic and interested therapist who took the time to listen to them gave the women a sense of being validated, respected and taken seriously. The

physiotherapists thus had an impact on the women's recovery processes. This improvement developed in parallel to their new understanding of themselves:

I've had homework where I had to touch myself . . . get to know myself better. . . . And that isn't something I would have initiated on my own really, at all. And in a way, it has been a sort of pressure, but a positive pressure from the therapist . . . now your home assignment will be to use your hands when you're in the shower. When you shower you will use your hands to become better acquainted with yourself down there. . . . In the beginning, it was unpleasant, but now it feels a lot more natural. So it's been a process. (Silje)

Silje here points to how progress is rooted in an *alliance* with the therapist. This alliance also fosters a 'sort of pressure' described as 'a positive pressure' that seemingly enables the patient to move forward in a way she would not be able to initiate on her own. The process Silje describes involves a new understanding of herself. Typically, this new understanding implies agency:

Here you really *do* something, you know . . . when you come home. Touching the painful area . . . inserting things . . . breathing. It makes sense. It feels like it's important to do. . . . I'm taking care of something that I haven't really taken care of before . . . I'm *doing* something. That gives me a sense of having some control over it as well. . . . That [the pain] is mine, and not just something that's there. (Mia)

As pinpointed in this quotation, Mia's feeling of agency is core to the development of her new understanding of herself. When asked specifically for negative experiences, some participants brought forward concerns that the treatment period was too short for them to maintain the effects of the treatment on their own and, in particular, to continue developing a new understanding of themselves:

The only problem is that the period is too short in a way. That is my answer to what has been negative here . . . I feel that dammit is it [the treatment period] over now? Do I have to do it on my own, that is much more demanding, much more. (Mia)

Whereas Mia, Liv and Tove feel that they could have benefited from a longer treatment period, Jenny, Silje and Kine feel that they are ready to move further on their own:

I told the therapist that I think it is important that I try a bit by myself now. And if I need more help then I can come back later because one cannot be in therapy the whole time if you see what I mean. You have to go back to your own life because in therapy is it also like a sort of bubble that you are in. In a way. In a good way. Then you go into the real world and start to use what you have learned. (Jenny)

As demonstrated in this quotation from Jenny, some women feel that they are able to move on alone and use what they have learned. Although they see the fact that they can go back to therapy as a backup and a safety net, they emphasise the need to continue the development of their new understanding of themselves in the real world.

DISCUSSION

Our findings highlight the value of encompassing the whole individual when addressing PVD as opposed to focusing solely on the painful area. The women found it valuable that the therapist saw them as a whole person, with thoughts, feelings and experiences, rather than just as a body part, a 'dysfunctional vulva' that needed to be fixed. Based on these findings, we recommend that surgical interventions such as vestibulectomy should not be considered before conservative procedures like SCT have been tested.

Previous qualitative studies have shown that PVD can have a significant negative impact on a woman's self-esteem (Ayling and Ussher, 2008; Connor et al, 2008; Groven, Råheim, Håkonsen and Haugstad, 2015; Sadownik et al, 2012). Studies have reported that a woman's sexual function and behaviour have a significant relationship with her genital self-image (Herbenick et al, 2011). As demonstrated in this study, the onset of pain appears to create a disrupted relationship with the vulvar area: this part of the body suddenly becomes alien and unfamiliar and no longer functions in the seamless manner that the women are used to. Our findings show how a bodily approach of wholeness can help women change this trend by

developing a more comfortable and familiar relationship with their own bodies. By approaching the painful area in a gentle, curious and explorative manner, the women were able to develop a new relationship with their vulvas so that this area of the body no longer felt distant or threatening.

In the process of changing their perceptions of the painful vulva area, a process which implies moving from disintegration to integration, the women emphasise the value of exploring and replacing dysfunctional thought patterns. These findings confirm results from previous qualitative studies (Brotto, Basson, Carlson and Zhu, 2013; Sadownik et al, 2012). However, our study also illuminates the value of working with the body as wholeness and of gaining new bodily experiences through exploring movements, tensions and breathing patterns. Promoting body awareness has been shown to have positive effects on pain, depression, anxiety and health-related quality of life in chronic pain conditions such as fibromyalgia and chronic fatigue syndrome (Courtois, Cools and Calsius, 2015). The significance of body awareness, as demonstrated in this study, corresponds to the findings in these previous studies. In addition, the patient may develop a more positive relationship with herself and her body through new bodily experiences and reflections (Gyllensten, Skär, Miller and Gard, 2010). For women with PVD, we argue that moving between *the whole and the part* is an important aspect of the process of reintegrating the vulva back into the body.

As indicated in the present study, the distance between anxiety and pain and desire and joy can be surprisingly short. Sensitive body areas that elicit desire and pleasure can just as easily elicit threatening sensations of being defenceless and naked, which in turn may trigger a strong need to shut this part of the body away to protect oneself from sudden negative experiences. In this way, avoidance behaviour can easily become a habit that the patient needs help to discover and free herself from. Contemporary pain theories describe how pain conditions can be prolonged, enhanced or modulated (Vlaeyen and Linton, 2000; Moseley,

2004). The FA model describes how increased pain-related fear, dysfunctional movements, catastrophic thoughts and the avoidance of pain-related situations often result in disuse of the body, anxiety and depression (Thomtén and Karlsson, 2014). In particular, these physical and psychological conditions enhance musculoskeletal pain. Evidence has accumulated over the last couple of decades that fear and anxiety enhance low back pain (Moseley, 2004). Although we know far less about the way that genital and vulvar pain is modulated, some authors have asked whether the FA model could be extended to enable an understanding of persistent genital pain at a deeper level (Desrochers et al, 2009; Pukall et al 2016). Since these women experience intercourse as painful, the condition may disturb sexual response both at the physiological and the psychological level. Thus, the risk of a further increase of sexual dysfunction deepens and the vicious circle is enhanced (Thomtén and Karlsson, 2014). Our findings suggest that encouraging women to explore their own bodies by moving gently back and forth across their own particular comfort zones offers them the opportunity to experience the subtle transitions between pleasure and pain and between joy and anxiety.

Our findings also highlight the importance of providing a safe and nurturing atmosphere for talking about sensitive issues when working with women suffering from PVD.

Acknowledging the patient's pain experience by taking the time to listen to her and by showing empathy for her situation proved to be an important part of this approach. In particular, this contributed to the patients' development of a new understanding of themselves. In line with previous findings by Brotto et al (2013) and Sadownik et al (2012), this study also supports the value of normalisation. In their studies, this normalising effect was largely attributed to the group setting, where the women could meet and share their experiences with others suffering from the same condition. Our findings indicate that a similar normalising effect may take place through one-to-one conversations with a therapist. Simply learning that their pain is a 'real' and highly prevalent condition and that they are part of a

community of women suffering from the same condition seems to have helped reduce feelings of being abnormal and socially isolated. We therefore argue that the therapist can play an important role in normalising this condition for the patient.

In this context, we suggest that it is very valuable for women to have their own feelings of satisfaction in this area normalised and validated, even if this is not in line with the leading social norms. Our findings indicate that taking an empathic approach may help build the kind of therapeutic relationship that is needed for raising difficult and embarrassing subjects. By listening empathically and non-judgmentally, the therapist may succeed in creating an atmosphere where the patient feels comfortable to speak openly and freely, and to discuss and influence the home assignments that have been given. Here, the importance of empathy, dialogue and collaboration is in line with Bordin's definition of the therapeutic alliance, where agreement on the treatment goals and content is essential (Bordin, 1979).

Regarding the success of the recovery process, measured as a self-reported reduction in pain, our findings show that the women who had suffered from PVD for a shorter duration reported a stronger reduction in pain than those who had suffered with PVD for longer. In addition, the women reported different outcomes regarding the length of the therapeutic process. Whereas half of the women in our sample felt ready to move on in their own journey of learning, the remaining three wanted a longer period of treatment and felt that they had not yet come far enough to move ahead on their own. This raises the question as to how long treatment periods should be. Although it may seem obvious that this depends on the individual patient and her circumstances, the shortness of the treatment period remains an issue with the somatocognitive approach.

SCT differs in this respect from other physiotherapeutic approaches working with body awareness. For example, the physiotherapy traditions of psychomotor physiotherapy

(Thornquist and Bunkan, 1991) and body awareness therapy (Roxendal, 1995), developed over the last five decades in Scandinavia, are regarded as more long-term approaches. These physiotherapy traditions are built on psychodynamic theory (Freud 1923), where the approach aims at helping the patient to recognise and change habitual muscular tensions involved in the regulation and inhibition of emotional experiences (Thornquist and Bunkan, 1991). The therapy sessions often last for months or years, thus representing long-term dynamic therapy, where childhood experiences and mental defence mechanisms are at the forefront. CBT, in contrast (Winterowd et al, 2003), is a short-term, here-and-now therapy, whose primary goal is to change unhelpful or inaccurate thinking, problematic behaviour and distressing emotional responses.

Another difference between these approaches may relate to the fact that the women in this study were challenged to leave their comfort zones in order to recover and progress. For example, the women in this study described how the exercises aimed at the vulva were not something they would have initiated on their own. At the beginning of the process, these exercises were experienced as being somewhat weird, uncomfortable or even threatening. However, the women described how being pushed to approach their vulvas in this way helped them become more familiar with the painful area, discovering that it was not so threatening after all. The therapist thus needs to find a balance between acknowledging the patient's fears or ambiguous feelings about using a tampon or engaging in sexual intercourse with her partner, while at the same time knowing when a nudge is needed in order to keep the recovery process moving forward.

Clinical implications

The findings in this study highlight the value of encompassing the whole individual, adopting an explorative approach to the body and moving between the whole and the part. In this way, the therapist can help the patient become more familiar with and accepting of herself, her body and her vulva. This study also points to the importance of promoting a sound therapeutic alliance with the patient. By showing empathy and creating a safe environment for raising sensitive issues, the therapist can support the woman in developing a new understanding of herself. This study also suggests that finding the right balance between acknowledging and challenging the patient can be important in order to keep the recovery process moving forward. Encountering such an explorative physiotherapeutic intervention may help patients with vulva pain. However, more research on this form of therapy is required.

Methodological considerations

In order to ensure rich, nuanced and relevant data material, we recruited women who had experiences from the entire eight-week treatment course. This may have resulted in a skewed sample, in which only those women who chose to continue through all eight weeks were included in the study. It is therefore possible that the participants in this study are the ones who have experienced the best progress or found the most meaning in the somatocognitive approach. Therefore, in order to counteract a potential positive bias, it was important to be aware of negative experiences with SCT. However, the participants did not report on negative experiences although explicitly asked to. The only exception to this was that some of the participants wanted to extend the treatment period. The participants did report that exploring their own vulvas was challenging at the beginning and felt strange at first.

There is some variation among our participants concerning the degree of recovery after treatment and in other factors, such as age and the duration of pain. In this respect, it is worth noting that our sample includes three women who reported moderate pain reduction following therapy and one who experienced a small improvement of her pain. These differences may have strengthened the data material by providing it with greater variation.

The women's experiences with SCT are largely congruent across all six interviews and across the two researchers who contributed to the data collection. We argue that this strengthens the reliability of the findings. In addition, the first author continuously validated her interpretations against the original written transcripts, taking the original context of the women's statements into account. The authors re-read the transcripts critically in search of themes with the potential to challenge or contradict the conclusions drawn through the analytical process.

DECLARATION OF INTEREST

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of this article.

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