Overcoming problems with penetration using vaginal trainers

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What are we hoping to achieve?

• What are the key mechanisms of action?
• What do we want the client to get from using them?
• How does this link with theory and evidence?

Vaginal trainer programmes - Key mechanisms of action

- **Physiological** – gaining skills in relaxation, normalize pelvic floor muscle function, interoceptive awareness, proprioception, desensitisation

- **Psychological** – reducing disgust and avoidance, graded exposure to reduce fear, repeated experiences of success, practising redirecting attention, cognitive restructuring

- **Sexual** – increasing comfort and knowledge with genital anatomy, taking ownership of sexual self, building up self touch and masturbation

Trainers as part of a wider approach

- Although graded exposure should be primary treatment, trainers alone = limited success (van Lankveld et al., 2010; ter Kuile, de Graaf, Tajigawa, & van Lankveld, 2013)

- Should always be part of a wider MDT approach (van Lankveld et al., 2010) including:
  • Psychoeducation on anatomy and cycle of pain
  • Pelvic floor muscle rehabilitation
  • Sex therapy
  • Relaxation and mindfulness
  • Pain management techniques
  • Cognitive restructuring
  • Peer support?
Pelvic floor muscle dysfunction: Assessment

- Listen
- Look
- Feel

OVER-ACTIVITY
TENSION
SPASM
ABILITY TO CONTRACT
ABILITY TO RELAX

STIFFNESS
TONIC
SHORT/ TIGHT
COMPLIANCE

TENSION
SPASM
ABILITY TO CONTRACT
ABILITY TO RELAX

If palpation is painful - are they EXPERIENCING or EXPECTING it?

Pelvic floor muscle dysfunction: Treatment

- Individualised treatment based on PFM assessment
- Aim to normalise pelvic floor muscle function
- ‘Biofeedback’
- ‘Downtraining’
  - Verbal cues – visualisation
  - Abdominal breathing
  - Relaxation – PFM, whole body scanning
  - Contract-relax techniques (Naess, I., & Bø, K., 2018)
- PFM stretches – global / local
- PFM exercises?
- Myofascial release?

Choosing type of trainers

- Material – plastic, silicone, glass
- Shape – straight, curved, shape of tip
- Size
- With or without vibration?
- Cost

Trainer treatment regime – variables

- Frequency
- Duration
- Position
- Lubricant +/- lidocaine
- Arousal
- Distraction
- In presence of HCP or alone (Melles et al., 2014; Molaeinezhad, Salehi et al., 2014; Ter Kuile et al., 2009; Ter Kuile, Melles, TuinmanFleurinkveld, Groot, & Lankveld, 2015; Ter Kuile & Reissing, 2014).
Case study 1 - Rebecca and Max

Rebecca is 27, and is in a relationship with Max. She has a diagnosis of vaginismus and feels very anxious about trying penetration. She has never had penetration without pain and hasn’t really tried it too many times. She expects it to hurt as it’s what she has heard from her friends.

- She is not comfortable using her fingers, so has bought a pack of 4 trainers (dilators)
- She is not sure exactly where her vaginal opening is and feels ‘weird’ about looking at her vulva

Confidence level- and when to move on

<table>
<thead>
<tr>
<th>Not ready</th>
<th>BEST ZONE</th>
<th>Move on</th>
</tr>
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<tbody>
<tr>
<td>0%</td>
<td>25%</td>
<td>75%</td>
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Partners and trainers – incorporating key principles

- Greater solicitous responses (sympathy) can lead to more avoidance, hypervigilance and increased pain (Rosen et al, 2010)
- Physical affection associated with higher sexual satisfaction, relationship satisfaction, and better sexual functioning in women with pain (Vannier et al, 2016)
- Higher sexual communication in couple = lower pain and increased sexual satisfaction (Rancourt et al 2015)

Challenges to using trainers?

Thank you

Questions? Comments? Thoughts?

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References


• Sophie Bergeron, Mélanie Morin & Marie-Josée Lord (2010) Integrating pelvic floor rehabilitation and cognitive-behavioural therapy for sexual pain: what have we learned and were do we go from here?, Sexual and Relationship Therapy, 25:3, 289-299.


References


