The Pelvic Floor

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1. Auflage 2006. Buch. 496 S.
ISBN 978 3 13 139211 4
Format (B x L): 17 x 24 cm

Weitere Fachgebiete > Medizin > Klinische und Innere Medizin > Gynäkologie, Geburtshilfe, Materno-Fetal, Hebammen

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patients are enrolled in multidisciplinary treatment programs that take into account all possible biopsychosocial aspects of the etiology and chronicity of the problems of the individual patient [Wesselman et al. 1997].

One-track treatments are less effective than conservative, multifaceted approaches that incorporate medical interventions aimed at symptom relief as well as physiotherapy and cognitive behavioral psychotherapy [ACOG 1996].

### Chronic Pain

In medicine, thinking has long been dominated by a dualistic view derived from Descartes, who divided the human being into body and mind. In this traditional view, pain is a response to a nociceptive stimulus. With their “gate control theory,” Melzack and Wall [1965] established a more dynamic view of pain as being the result of interactions between the peripheral and central nervous systems. Their work gave rise to a whole new era in pain research. Nowadays, pain is no longer seen as a simple stimulus–response process, but instead is described as a result of interactions between physiological, sensory, affective, behavioral, cognitive, and sociocultural factors [Turk and Kerns 1983].

The International Association for the Study of Pain (IASP) defines pain as “an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such language” [Merskey 1986]. Many chronic pain syndromes, defined as “non-malignant pain that exists for longer than 6 months,” are classified in the most recent taxonomy [Merskey and Bogduk 1994]. According to the IASP definition, it is not strictly necessary to establish an organic pathology to classify symptoms as a chronic pain syndrome. The IASP also emphasizes that “pain is always subjective and each individual learns the application of the word through experiences related to injury in early life.”

In general, a biopsychosocial conceptual approach includes neurophysiological theories about symptom perception and chronic pain, taking into account the fact that chronic pain syndromes have central and cognitive aspects that make it unlikely that surgical excision of painful areas would cure the pain [Wesselman et al. 1997]. Modern pain research based on the gate control theory of Melzack and Wall [1965] shows that pain perception is modulated by cognitive and psychological processes that are considered not merely as reactions to pain, but as an integrated part of pain processing. Pain is a multidimensional experience produced by multiple influences. In chronic pain syndromes, the brain plays an important role in filtering, selecting, and modulating input to such an extent that even the memory of pain can produce pain. Surgical treatments and the cutting of nerves and pathways in the treatment of chronic pain are therefore gradually being replaced by methods of modulating (or remodulating) the input [Melzack 1999].

Patients with chronic pain generally have a high degree of comorbidity with psychiatric diseases such as depression, anxiety disorders, personality disorders, and/or substance abuse [Kaplan et al. 1994]. Somatization and somatoform disorders—characterized by the presence of physical symptoms that suggest a general medical condition, but are not fully explained by a general medical condition, by the direct effects of a substance, or by another mental disorder—share many common features with chronic pelvic pain, defined as a pain disorder [Kaplan et al. 1994, Ehlert et al. 1999]. The often observed comorbidity of genital, gastrointestinal, sexual, and urological pain [Walker et al. 1996] suggests that the specific localizations of these pain complaints in the lower abdominal and pelvic area have a common origin. One possible explanation for the specific localization of lower abdominal and pelvic pain syndromes is the evidence that hyperactivity of the pelvic floor is a major contributing factor. Most likely, this pelvic floor hyperactivity is a conditioning of a functional defense mechanism to threat [van der Velde and Everaerd 2001].

pain syndromes involving openings and structures related to the pelvic floor.

Another possible explanation is that the association between chronic pelvic pain, irritable bowel syndrome, and pelvic floor dysfunctions, on the one hand, and traumatic sexual and/or physical experiences on the other, might lead to changes in body image, symptom perception, pain thresholds, and vigilance [Toomy et al. 1995, Walker et al. 1996, Badura et al. 1997, Jamieson and Steege 1997, Bodden-Heidrich et al. 1999, Chang et al. 2000, Devroede 2000, Reed et al. 2000, Lampe et al. 2000].

The comorbidity of pelvic floor complaints, anxiety disorders, somatization, and traumatic experiences are indicative of circular processes in which pelvic floor hyperactivity, psychological distress, and physical symptoms reinforce each other: traumatic experiences lead to psychological reactions and muscle tension, muscle tension produces symptoms, and symptoms cause anxiety and distress, which aggravates symptoms that in turn may provoke dissociative memories of traumatic experiences, and so on.

### The Pelvic Floor as a Sexual Organ

In the gynecological and urological literature, the pelvic floor is generally described in terms of its supportive functions and its role in the mechanisms of urinary and fecal continence and outlet. From an evolutionary perspective, these functions of the pelvic floor are secondary to its sexual and procreative functions and only became necessary when *Homo sapiens* started to walk on two feet, thus creating the need for the pelvic floor to counteract the effects of gravity. In women, the pelvic floor plays an important role in parturition. In women and men, the pelvic floor is an active sexual organ.

During early phases of sexual arousal, voluntary pelvic floor contractions are used by men and women to increase vasocongestion and physical sensations [Messé and Geer 1985, Colpi et al. 1999]. An increasing ability to contract and relax the pelvic floor improves sexual functioning in men with erectile dysfunction and women with female sexual arousal disorder [Perry and Whipple 1981, Messé and Geer 1985, Colpi et al. 1999, van Kampen et al. 2003]. A certain degree of pelvic floor relaxation is needed to allow coital penetration. In vaginismus—in its classical form defined as reflexogenic involuntary contractions of the perivaginal musculature upon attempts at coital penetration—this relative pelvic floor relaxation is absent. On the other hand, a lack of basal pelvic floor tone results in pelvic floor laxity, associated with a lack of sexual feelings [Graziotin 2000].

Initiation of orgasm in men and women is characterized by a series of involuntary pelvic floor contractions with an interval of 8 ms, described already by Masters and Johnson [1966] as the contractions in the “orgasmic platform,” the congested perineal body, in women and in the second phase of ejaculation, the expulsion phase, in men. These involuntary contractions are associated with the physical sensations of orgasm. Pelvic floor contractions are probably the key eliciting event in the occurrence of orgasm. According to Sherfey [1974], orgasm is a spinal reflex triggered by firing of the stretch receptors in the pelvic musculature. Stretching of the pubococcygeus muscle is caused by the progressive vasocongestion during sexual arousal in men and women. In a correlational study of anorgasmic, coitally anorgasmic only, and orgasmic women, the orgasmic group showed the highest sustained pubococcygeal muscle strength [Graber and Kline-Graber 1979], suggesting that pubococcygeal muscle condition is important in female orgasm. Mould [1980] proposed that the principal effect of vasocongestion is to cause biasing of the fusimotor muscle spindles. Once the muscle spindles become highly biased and a dynamic stretch reflex is initiated in the alpha fusimotor system via genital stimulation, the necessary conditions become established for orgasmic contractions to occur. The clonic nature of the contractions is attributed primarily to the effects of motor spindle biasing, which is, in turn, progressively diminished by the dynamic contractions of orgasm, because these contractions reduce the degree of vasocongestion, which therefore gradually disappears [Rosen and Beck 1988].

These mechanisms illustrate the fact that pelvic floor hyperactivity may reduce vasocongestion and cause erectile dysfunction and lubrication disorder, and may reduce orgasmic capacity [Shafik 2000]. Moreover, these mechanisms might explain the fact that, in patients with hyperactive pelvic floor disorders during orgasm—in contrast to physiological dynamic contractions in other subjects—orgasmic pelvic floor contractions may lead to clonic contractions causing discomfort and pain, as is reported by many patients.
The Hyperactive Pelvic Floor Syndrome

The pelvic floor plays an important role in physical and sexual responses. Hyperactivity/hypertonia of a situational character hampers sexual activity by causing vaginistic complaints and dyspareunia. More generalized and permanent hypertonia causes symptom complexes in women and men that are identified as constituting the hyperactive pelvic floor syndrome. Based on a review of the available scientific data and on clinical observations, a theoretical framework for the pathogenesis of hyperactive pelvic floor disorders has been developed in the concept of the hyperactive pelvic floor syndrome (HPFS) [van Lunsen and Ramakers 2002]. Hypotheses regarding the etiology of this syndrome, with comorbidity of symptoms concerning gastrointestinal, urogenital and sexual functions, are operationalized in a multifaceted, multidisciplinary clinical approach in the diagnosis and treatment of the complex symptomatology in patients with long histories of unsuccessful medical, surgical, and psychiatric treatments, which in general do not take into account the psychophysiological aspects of muscle tension originating from psychological, psychosocial and/or psychosexual distress, resulting in physical symptoms that tend to be fixated by a vicious circle of pain, anxiety, and muscle tension.

The observed comorbidity of various syndromes such as vulvar vestibulitis syndrome (VVS), chronic pelvic pain (CPP), irritable bowel syndrome (IBS), and urethral syndrome has led to the question of whether or not these conditions have etiological factors in common [Bodner 1988, Peters et al. 1991, de Jong et al. 1995, Walker et al. 1996, Monga et al. 1997]. Similar comorbidity has been observed in men with CPP, unexplained genital pain, bladder outlet obstruction, and prostatodynia [Maxton et al. 1991]. Based on these observations, we postulate the hypothesis that pelvic floor hyperactivity is the organic substrate that causes not only different kinds of urethral, vaginal, and anal outlet obstruction and different kinds of lower abdominal/genital pain, but also the sexual dysfunctions that many of these patients also experience [van Lunsen and Ramakers 2002].

Most of these symptoms can be explained by the mechanical effects of constriction by the pubococcygeus muscle of the different orifices, and/or by vascular and neurological changes caused by compression or entrapment as well. If pelvic floor hyperactivity is responsible for the symptoms of obstruction and pain—and there is increasing scientific support for this hypothesis [Foster et al. 1993, Glazer et al. 1998, Mehik et al. 2002, Hetrick et al. 2003, Potts 2003]—the main question to be answered in each individual case of hyperactivity of the pelvic floor is what it was that initially caused the pelvic floor to start dysfuctioning.

In 35–80% of cases, IBS is associated with traumatic experiences in childhood [Walker et al. 1996, Tally et al. 1994], particularly when this traumatization is reinforced by other traumatic experiences in later life [Jamieson and Steege 1997]. The likelihood of a major traumatic experience in the past is significantly higher in patients with both IBS and CPP in comparison with patients with IBS alone [Walker et al. 1996]. In patients with IBS and CPP, moreover, there is also comorbidity with psychiatric conditions associated with traumatic experiences: depression, anxiety disorders, dissociative symptoms, and somatoform disorders [Walker et al. 1996]. Women with CPP and pelvic venous congestion tend to report more childhood sexual abuse than women with CPP alone [Fry et al. 1997].

Other symptoms related to pelvic floor hyperactivity include: detrusor instability, hyperactive bladder [Messensink 1999], interstitial cystitis [McCormack 1990], anal fissure, hemorrhoids [van Lunsen 1996], perineal pain/prostatodynia, “prostatitis” not accounted for by a bacterial infection [Segura et al. 1997, Potts 2003], varicocele, and coccygodynia [van Lunsen 1996]. Comorbidity with other musculoskeletal problems not accounted for by an identifiable medical condition, and even breathing problems, speech problems, and unexplained orofacial symptoms, is also common [van Lunsen 1996].

In more severe cases of pelvic floor hypertonia, there are long histories of many different medical and surgical interventions without relief of symptoms: appendectomies, urethrotomies, hysterectomies, transurethral prostatectomies, ovariecetomies, or even orchidectomies and ostomies. In traumatized patients, these medical interventions seem to be the result of a process of somatization, with a self-destructive character comparable to the mechanisms of self-mutilation. In these patients, the criteria for post-traumatic stress disorders, somatoform disorders, and chronic pain syndromes are met simultaneously. In a minority of cases, however, the onset of symptoms of pelvic floor hyperactivity cannot be related to different kinds of sexual, physical,
or psychological trauma and appear to be related to behavioral aspects (dysfunctional voiding behavior), muscle overexertion, or life events. On the basis of current clinical and scientific evidence, we have defined the following diagnostic criteria for the hyperactive pelvic floor syndrome:

- Comorbidity of three or more symptoms known to be associated with pelvic floor dysfunction (Tables 1.16, 1.17).
- Evidence of pelvic floor dysfunction based on physical pelvic floor assessment and/or functional tests.
- Comorbidity with one or more sources of psychological distress.

The predictive value of comorbidity with three or more physical complaints with regard to pelvic dysfunction appears to be high [van Lunsen 1996]. Physical assessment by experienced clinicians of pelvic floor functions by means of history, inspection, and palpation, with a clinical judgment about pelvic floor awareness, control, strength, basal tone, and degree of relaxation is at least as reliable as pelvic floor assessment by means of perineometer assessment or electromyography measurements [Isherwood and Rane 2000, Van der Velde et al. 1999].

### Sexual and Physical Abuse

Intimacy, sexual desire, and procreation are motivations for many men and women that may stand on their own or may be combined in one way or another when people engage in sexual activity. There is no doubt that sexuality is a biopsychosocial activity par excellence. Sex has wider psychosocial implications than connecting people with or without the production of offspring. The dominance of men over women is an important dimension in the whole discussion about sexual and physical abuse. Since the end of the last century, there has been growing awareness of the consequences of sexual abuse for the victims. During the last few decades, we have become increasingly conscious of the fact that a percentage of women in all social classes fall victim to sexual and physical abuse in the circle of their own family members and/or other acquaintances [Finkelhor 1984, Draijer 1988, Herman 1992]. The term “survivor” rather than “victim” better conveys the ability people have to recover from abuse [Maltz and Holman 1987].

Incest occurs in all social classes. The background to sexual abuse is usually a problem family with disturbed relationships in which people transgress boundaries, leading to sexual activity of parents and/or other close individuals with their own children, which in turn provides the opportunity for other adults to abuse the children. The tragedy is severe, as male victims who have been neglected and abused can become offenders in turn and so create a transgenerational effect in certain families. In most cases of incest and physical abuse, women are victimized by men, but recent research has also brought to light the abuse of boys and men by both men and women.

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**Table 1.16** Symptoms of hyperactive pelvic floor syndrome in women

| Chronic pelvic pain (CPP)          |
| Irritating bowel syndrome (IBS)   |
| Constipation                      |
| Urethral syndrome                 |
| Overactive bladder                |
| Interstitial cystitis             |
| Dyspareunia                       |
| Vulvodynia                        |
| Sexual arousal disorder           |
| Perineal pain                     |
| Perianal pain (fissures)          |
| Hemorrhoids                       |
| Pelvic congestion                 |
| Orgasmic pain                     |
| Coccygodynia                      |
| Lower back pain                   |
| Hyperventilation                  |

**Table 1.17** Symptoms of hyperactive pelvic floor syndrome in men

| Chronic pelvic pain (CPP)          |
| Irritable bowel syndrome (IBS)     |
| Constipation                       |
| Obstructive voiding (“prostatism”) |
| Prostatodynia                      |
| Sexual dysfunction                 |
| Orchialgia                         |
| Penile pain                        |
| Ejaculatory pain or obstruction    |
| Perineal pain                      |
| Perianal pain (fissures)           |
| Hemorrhoids                        |
| Varicocele                         |
| Coccygodynia                       |
| Lower back pain                    |
| Hyperventilation                   |
The Relationship Between the Pelvic Floor and Threat (of Abuse)

Experimental animal research shows that in threatening situations, specific groups of muscles such as the pelvic floor show higher motor activity [Vanderhorst and Holstege 1997]. Van der Velde and Everaerd [1999] exposed women with vaginistic complaints and control individuals to film fragments containing threatening sexual and nonsexual elements. Higher muscle activity in the neck, shoulder, and pelvic floor muscles was found in both threatening situations in both groups of women.

One can imagine that in case of chronic threat, either by repeated incest (or other forms of sexual and physical abuse) or by repeated confrontation with traumatic flashbacks, nightmares, and reliving of the trauma, this type of muscle tension can also become chronic. It is not that surprising that the pelvic floor in particular should be one of the muscles reacting to sexual threat, since the genital region is the threatened area.

Reflex action of the pelvic floor muscles in cases of obstetric, gynecological, rectal, and urological interventions can be situational and in a sense a healthy defense reaction, but also can become a more chronic problem if there are repeated traumatic invasive investigations.

Multidisciplinary Approach

Descartes actually had scientific reasons for dividing the human being into body and mind. It allowed a better understanding of the way in which human beings functioned. In the past, this division has therefore been helpful in producing scientific insights. Today, probably everyone is convinced of the usefulness of looking at human functioning in a more modern and integrated biopsychosocial way—meaning that the somatic aspects of a clinical problem should be seen against the background of the patient’s psychological, emotional, and sociocultural make-up. But for doctors and physical therapists, who are predominantly somatically trained, it can be difficult to gain insight into the often complicated manner in which somatic complaints can be interwoven with psychosocial aspects. Working in a multidisciplinary team provides an opportunity for consultation and feedback.

Tips and Pitfalls for Physical Therapists

In patients with pelvic floor problems, it is very useful to inquire specifically about sexual symptoms, since sexual dysfunctioning is commonly observed in these patients.

It is evident that being aware of the relationship between chronic pelvic and/or abdominal pain and earlier traumatic experiences, a physical therapist professionally working with patients with hyperactive pelvic floor problems should be able to address issues such as sexual abuse and incest routinely. If one inquires regarding traumatic experiences during the first assessment phase, it makes it clear to the patient that there is an opportunity to talk about his or her problems. Even if the patient may not initially be willing or able to talk about abuse that has been experienced, a physical therapist who is able to discuss abuse as a source of chronic pain creates an opportunity for the patient to come forward later on when therapy is ongoing.

For therapists who are not familiar with the distortive power of chronic abuse and/or chronic pain, it is sometimes hard to establish good contact with the patient. Abused people have not had an opportunity to gain confidence, respect, safety, trust, and equality. If a patient reacts very resistively, defensively, or evasively and shows signs such as sleeping problems, nightmares, and flashbacks these are indications of a likely post-traumatic stress disorder (PTSD). In contrast to defensiveness and avoidance, however, unworkable openness about traumatic experiences can be a sign of an ineffective coping strategy as well.

Denial and dissociation are defense mechanisms for coping with trauma. A common coping method used by victims during incest is a process known as dissociation. The French psychiatrist Janet in the nineteenth century introduced a theoretical framework for the phenomenon of dissociation, which is still being in use by modern researchers and therapists [Boon and Draijer 1995]. Dissociation enables victims to blank the experience out and be somewhere else in their minds, which in turn may result in impaired memory. If a patient has a vague look and seems to be inwardly disappearing, the existence of a dissociative fugue can be suspected. Poor memory (even for homework) can be a signal of this.
Some patients may be so hurt and abused that they initially need personal attention and care before treatment measures can be started. The therapist should be aware of signs of overcommitment suggesting that he or she is becoming too involved and entangled in the patient’s problems. Countertransference is a potential pitfall for every therapist working with traumatized people. It is necessary to work in a team with other physical therapists and with a psychologist or psychiatrist so that one has an opportunity for consultation and feedback. One of the possible consequences of ineffective handling of transference and countertransference is that one may be surreptitiously provoked into transgressing boundaries oneself by a patient who due to his or her prior history is unable to observe boundaries.

Abused women are sometimes unable to recall their incestuous experiences until something triggers the memory. Uncomfortable feelings that occur during the physical examination, or merely on physical contact, can cause flashbacks of the traumatic experiences. Safety and control of the patient must be ensured in every situation. It is sometimes better to postpone a physical examination until greater confidence has been established. The patient should of course be examined in a relaxed position and in a quiet, safe, and warm room. One should always inform the patient beforehand about what one wants to examine and should always ask for permission before an invasive investigation. Abused people are usually not very good at protecting their own boundaries, so that they may sometimes say “yes” when they mean “no.” When examining the pelvic floor, one should tell exactly what one is doing and observe his or her reactions (see also section 4.4 on the treatment of sexual dysfunctions).

Psychotherapists must have a clear reason for reviving the patient’s memories and should avoid repeating the traumatization. A physical therapist should not ask the patient for details, but should only provide an opportunity to mention any abuse and describe its quality. What the physical therapist needs to know is what factors in this specific patient originally caused the dysfunction of the pelvic floor and what factors are responsible for its persistence. Causing further trauma by inquiring unnecessarily about details should be avoided.

Most women who have experienced incest situations feel more comfortable with a female physical therapist than a male one, because they tend to generalize the characteristics of the offender (in most cases male).

### Case study

**Presentation.** A 70-year-old man in good general health was referred to the pelvic floor team due to a 10-year history of incapacitating perineal and scrotal pain that was not accounted for by any identifiable organic disease and had not responded to any form of pain treatment. While he was still on the waiting list, his wife and both of his adult daughters called the outpatient clinic several times because the situation at home was no longer bearable either for the patient or his family. After the family doctor also intervened, the patient was seen as soon as possible both by the team’s urologist and medical sexologist. At the first visit, the patient was accompanied by one of his daughters, who insisted that something needed to be done immediately, as her father’s pain had become an unbearable burden round the clock for the whole family. They were no longer able to cope with his constant complaints and his endless theories about the possible causes of the pain.

In the waiting room, the patient walked up and down restlessly and when called to each of the doctors’ offices he asked to stand during the consultation, as the pain made it impossible for him to sit down.

**History.** The patient’s current symptoms were scrotal pain, described as a superficial stabbing pain on both sides, but on the right more than the left, and all sorts of accompanying symptoms. The pain was radiating to the perineum and to the inner side of both thighs. Any kind of pressure caused by sitting, wearing trousers, or touch contact increased the pain. The pain had started about 10 years previously, shortly after he had retired from working as a solicitor in a small company. At the same period, but before the pain first started, he had developed an erectile dysfunction. He had never dared mention this to any of the many different medical specialists he had consulted in the intervening years, and none of them had ever asked about it. After penetration had failed on one occasion, he had given up all sexual activity and had avoided any form of physical intimacy. This made his wife assume he no longer loved her, and she became very suspicious about possible extramarital affairs. His evasive behavior and...
her overt jealousy led to several marital crises. Shortly after the onset of the pain, there had been increasing complaints of obstructive voiding, lower urinary tract symptoms (LUTS), and constipation. Lower back pain was another reason for increasingly frequent visits to physicians. Despite innumerable attempts at treatment, the pain had become worse over the years.

An initial transurethral prostatectomy procedure was followed by a second, and three further intraurethral procedures also failed to resolve the urethral obstruction. Several periods of antibiotic treatment due to possible chronic prostatitis did not relieve the perineal pain. A wide variety of medications were tested to treat the hyperactive bladder and LUTS. Neuro-modulation, physiotherapy, and electromyofeedback treatments were also attempted, without success. The patient described the electromyofeedback treatment as a traumatic experience. Painkillers, benzodiazepines, opioids, tricyclic antidepressants, and Botox injections had no effect on the pain whatsoever.

Medication at the time of the examination consisted of amitriptyline, morphine, and a nocturnal benzodiazepine. Due to obstructive voiding and retention, he was applying self-catheterization twice a day.

More detailed history-taking in connection with the urogenital and gastrointestinal tract revealed that he had had dysfunctional voiding and irritable bowel disease since childhood.

Psychosocial and sexual history. At the first visit, it was almost impossible to raise any subject other than the pain, and the patient was very reluctant to reveal anything about his feelings except for his annoyance about not being taken seriously by either his wife or the doctors, who were always telling him that there was no actual medical problem and that he had no need to worry about anything serious.

The patient had met his wife when he was 30, and she was his first sexual partner. Before this period, he had experienced difficulties and feelings of anxiety in contact with women. The patient denied having masturbated, except for a short period at the beginning of puberty around the age of 13. He discontinued masturbatory activity because "it did not feel right." During his marriage he had had regular coital sexual contact, always with a tendency towards premature ejaculation. He had had episodes of depression throughout his life.

On the basis of the obvious aspects of a somatization process and evidence of a chronic pain disorder, it was decided to postpone taking a more extensive psychiatric and psychosocial history, and to make the patient feel more confident that he was being taken seriously and was receiving serious attention by carrying out physical examinations for every aspect of his symptoms.

Physical examination. It was explained to the patient that, on the basis of the results of the many examinations he already undergone, a hypothesis about the causes of his symptoms was being established that would initially have to be checked by carrying out a physical examination of the genitals and of the pelvic floor and by repeating a urodynamic study. During the physical examination, there was a massive "vaginistic" defense reaction to the first gentle touching of the withdrawn perineum. The patient was unable either to contract or to relax the pelvic floor when requested. The genital examination revealed no abnormalities except for an extremely vivid cremasteric reflex. Superficial and rectal examinations of the pelvic floor showed high tone, a lack of muscle strength, twitching, and an inability to relax. The urodynamic study showed hyperactivity of the pelvic floor and an overactive bladder.

Working hypothesis and psychological work-up. The finding of pelvic floor dysfunction was explained to the patient, and anatomical illustrations were used to show him in great detail the way in which the compression of structures passing through the pelvic floor would explain most of the symptoms he was experiencing.

It was explained to him that he had apparently already had pelvic floor hyperactivity at an early age and that physical therapy had probably not been successful because the decisive question about the possible underlying causes of the pelvic floor dysfunction had never been answered. It was also explained to him that pelvic floor hyperactivity might be the result of a simple learning process, but that in many cases it was associated with threatening experiences in childhood. Identifying where the causes might lie would mainly depend on introspection.
Psychosexual background. After three visits devoted to explanation and psychological clarification, which led to the patient feeling that we might be on the right track, he became more open and talkative with regard to non-medical issues. He spontaneously offered a possible explanation for why he had become withdrawn during childhood. As an Austrian boy with a German accent, his life in Amsterdam during the Second World War had not been easy, and his Dutch peers had harassed him badly, even though his parents had fled from Austria for political reasons immediately after the Nazi occupation of their country. Shortly after the war, there had been a period of sexual abuse by a group of these older boys in his neighborhood. This experience directly caused a sudden disruption of his normal sexual development. Touching his genitals, which had been pleasurable, became repugnant to him. He never felt confident enough to resume sexual activity, and a feeling of inadequacy in relation to women was induced by a negative self-image and body image associated with the harassment and sexual trauma. It was only his meeting with the love of his life, who reacted reassuringly during their first awkward and anxiety-provoking sexual encounters, that enabled him to overcome his feelings of shyness, embarrassment, and inadequacy. However, the couple’s sexual practices were always characterized by goal-oriented coital behavior, as he was anxious about losing his erection. He had always avoided direct genital stimulation, because touching of his genitals continued to trigger flashbacks of scenes from when he was abused. He had had periods of depression throughout his life in which the feelings of anxiety from that time were reactivated. He had always succeeded in overcoming and repressing these feelings by throwing himself into extremely hard work at his job, up to the time when he retired. At around the same time as he retired, he became unable to reach and sustain an erection without direct genital stimulation, due to the physiological process of aging. The same feelings of sexual inadequacy that he had had as a boy recurred, and he started reliving his traumatic experiences of teasing, harassment, and sexual abuse. This had triggered the development of a late-onset post-traumatic stress disorder, with flashbacks, anxiety, evasive behavior, and depression leading to a build-up of physical tension concentrated in the pelvic floor. The psychological and physical symptoms had been aggravated by renewed traumatization during the invasive diagnostic procedures, physiotherapeutic treatments, and other treatments that he had undergone, and by the fact that he never dared speak about the trauma, of which even his wife was unaware. And of course, no one ever asked.

Diagnosis. Hyperactive pelvic floor syndrome, post-traumatic stress disorder, and somatization, associated with several traumatic experiences in early puberty.

Treatment. A complex multidisciplinary program was started, with extensive attention to physical symptoms, a pelvic floor rehabilitation program, cognitive behavioral therapy, psychotherapy aimed at the post-traumatic stress disorder, and relationship therapy to restore his marital relationship. Gradually, the physical and psychological symptoms disappeared almost completely; he was able to manage without self-catheterization, and medication was reduced and finally stopped completely. The couple succeeded in regaining emotional and physical intimacy. The erectile dysfunction did not resolve, mainly because the couple decided not to resume sexual activity, as they were afraid that approaching this painful area might jeopardize the healing process for both of them. After a year of intensive treatment, they were able to take their leave of the pelvic floor team.

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