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A Multi-Disciplinary Approach to Female Sexual Pain: Focusing on Couples Therapy and Childhood Sexual Trauma

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Introduction

Sexual Problems and dysfunctions remain one of the prominent reasons for marital and relationship problems, often resulting in divorce. Sexual problems do not occur in a vacuum and are often symptoms of deeper relationship and individual problems and need to be assessed and addressed when a couple presents with a sexual problem. 'The quality of what happens in bed depends largely on the quality of the relationship outside of the bedroom'. The dysfunction/s must be viewed within the context of the total client system.

Masters and Johnson were the ground breakers in terms of acknowledging the relationship dynamic as part of sexual dysfunction in the couple. Individual sex therapy started to shift from being considered an individual problem, to being a couple problem. Although the short-term, behaviourally oriented approach to the treatment of sexual dysfunction has proven to be an effective treatment modality, couples that experience severe marital or relationship distress demonstrate a poorer prognosis for treatment in a variety of forms of sex therapy.

As sexual dysfunction and relationship dysfunction are interlinked a comprehensive and multi-dimensional approach to the treatment of sexual dysfunctions must include a thorough evaluation of the couple's relationship. Some marital therapists may not even be aware after months of treatment, or even after termination, that the couple had a sexual dysfunction. Often clients and therapists seem to have a collusive taboo against dealing with sexual problems. Clients with sexual problems or dysfunctions are often sent from therapist to therapist without being treated effectively. This is very disturbing for clients and has an important influence on client motivation and prognosis.

Therapists therefore agree that, the types of cases commonly seen in sex therapy clinics today, have changed dramatically from the earliest days of sex therapy. The proportion of the clients who simply needed education and direction dwindled, the proportion of clients with more complex and multi-dimensional pervasive and chronic sexual problems increased, creating an even bigger need for a multi-professional and multi-disciplinary team approach.

Culture shifts and mass media also impact on sexuality and dysfunction. The importance of sexuality for couples and life satisfaction is often overemphasized, resulting in confusion, dissatisfaction, and performance anxiety. The cultural milieu has gone from one extreme (repression, rigidity, lack of information and communication) to the other (sexual overload, confusion, intimidation about one's body and

sexual performance, and emphasis on medical interventions, especially for male sexuality). Clinical Handbook of Couple Therapy, (2008). Second, sexual comfort, skills, and functioning can be learned. A crucial third concept in modern sex therapy is the bio psychosocial approach to understanding, assessing, and treating sexual dysfunction (Metz & McCarthy, 2007a).

Corresponding to the changing nature of the cases that sex therapists typically encounter, therapeutic approaches have changed as well. With increasing frequency, systemic approaches have been used to treat the more complex, relationship-bound sexual problems presented to sex therapists. Also, greater attention has been paid to the role of early sexual trauma in subsequent sexual dysfunction.

With the continuing development in the field of sexual medicine as well as continuing research into human sexuality and relationships, new models and techniques for sex and marital therapy are constantly being developed. There is a movement today towards combining sex therapy and marital therapy, and also to use a more holistic approach by which the medical practitioner as well as other health care professionals are more actively involved in the therapeutic process.

First, sexual dysfunction is best conceptualized, assessed, and treated as a couple issue. Secondly, sexuality is multi-dimensional in nature and an integrative, holistic, post-modernistic, bio-psycho-social approach to understanding, assessing and treating sexual dysfunction needs to be followed to ensure the success of the treatment process.

Renshaw (1983: 32) states that sex therapy includes:

- An explicit sexual history of each partner, plus a complete medical and family history;
- Exploration of the overall and sexual relationship: tasks, roles, nurturance, interdependence, trust, problem-solving, acceptance, caring, commitment and love;
- Consideration of the context of the sexual problems;
- Excluding physical causes by a thorough physical examination;
- Suggestions for step-by-step home practise of sensual pleasuring;
- Intensive-therapy for specific problems or symptoms.

The primary goal of sex therapy is to relieve the couple's sexual dysfunction or sexual problem. Successful sex therapy however employs both acknowledged sex therapy techniques, as well as psycho – and couples therapy, in order to enhance the couple's physical and emotional intimacy. The sexual dysfunction is thus always viewed from the context of the relationship between the couple and how the various subsystems (e.g. marital, extended family, individual, biological and social) interact with each other and impact on one another. The marital relationship impacts on the problem, and, in turn, the sexual problem impacts on the marital relationship.

Couples Therapy

Communication between couples should also be improved during couples and sex therapy. Effective communication is profoundly important in sexual relationships, and improving communication can often produce dramatic improvements in the relationship and the sexual dysfunction. Therapy can help clients to understand the meanings that they have attributed to their sexual lives. This can often be very important in reducing guilt and anxiety.

Russell & Russell (1992:82) state that no matter what the presenting complaint is, it is essential to enhance physical and emotional intimacy by integrating sex therapy and couple therapy. Keystone & Kaffko (1992:48) state that couple and sex therapists should be aware of the fact that when couples present with a sexual problem, their sexual functioning may in fact be symptomatic of deeper intimacy issues within the relationship. Through the integration of both couple and sex therapy approaches, there is a unique opportunity to act in a dual role with clients. The therapist can educate and instruct clients about sexual attitudes and techniques, as well as help them to become aware of the significant impact that intimacy issues have upon their relationship.

Barnes (1995:355) mentions in this regard that the integration of couple and sex therapy is crucial but that many therapists avoid discussing sexual issues during therapy. One significant reason is that therapists are often uncomfortable with the discussion of sexual issues and maintain a therapeutic relationship that is isomorphic to their own "no talk" family rules. Once the therapist is able to find his or her own comfortable language concerning sexual issues, the door is often opened for the clients to follow suit.

The most frequent reason is that sexual issues are not identified in marital or family therapy as the presenting problem. Clients who experience shame and guilt about sexual issues will often enter marriage or couple therapy instead of treatment in a sex therapy clinic again opening the door for treating the problems holistically. Also, if sex therapy is contra-indicated, because of the presence of severe marital or relationship distress, this evaluation can indicate what needs to be addressed in couple therapy in order to pave the way for the future treatment of the sexual problems.

The integration of sexual medicine, sex therapy, physiotherapy, psychotherapy, hypnotherapy, pharmacology and marital therapy revitalised the field of sexology in South Africa by expanding the types of problems treated, providing new perspectives for understanding problems, and creating the opportunity for health care practitioners to develop effective treatment programs for specific problems. It changed the way sexual problems were treated and understood from an individual to a systems perspective.

Female Sexual Pain

Dyspareunia

Dyspareunia is often viewed as a specific pain disorder with independent psychologic and biologic contributors with context- dependent etiologies. Physical examination may be required to rule out underlying anatomic pathology.

Differential diagnosis: Introital dyspareunia, Vaginismus, Vulvovaginal atrophy, inadequate lubrication, vulvodynia, deep dyspareunia, endometriosis, pelvic inflammatory disease.

DSM V: Pelvic Pain/Penetration Disorder

1. Persistent or recurrent difficulties for at least 6 months with one or more of the following:
    a. Inability to have vaginal intercourse/penetration
    b. Marked vulvovaginal or pelvic pain during vaginal intercourse/penetration attempts
    c. Marked fear or anxiety either about vulvovaginal or pelvic pain or vaginal penetration
    d. Marked tensing or tightening of the pelvic floor muscles during attempted vaginal penetration
2. The problem causes clinically significant distress or impairment
3. The sexual dysfunction is not better accounted for by another Axis I disorder (except another Sexual Dysfunction) and is not due to the effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

Subtypes: Early-Onset (Lifelong) vs Late-Onset (Acquired)

Specifiers

1. Generalized vs. Situational
2. With concomitant problems in sexual interest/sexual arousal
3. Partner factors (partner's sexual problems, partner's health status)
4. Relationship factors (e.g., poor communication, relationship discord, discrepancies in desire for sexual activity)
5. Individual vulnerability factors or psychiatric comorbidity (e.g., depression or anxiety, poor body image, history of abuse experience)
6. Cultural/religious factors (e.g., inhibitions related to prohibitions against sexual activity)
7. With medical factors relevant to prognosis, course, or treatment

Vaginismus

Definition: (DSM IV)

Involuntary contraction of the musculature of the outer third of the vagina, interfering with intercourse, causing distress and interpersonal difficulty.

Definition: (International Consensus Statement)

Persistent difficulty to allow vaginal entry of a penis, finger and/or any object, despite the woman's expressed wish to do so. There is variable involuntary pelvic muscle contraction, (phobic) avoidance and anticipation/fear/experience of pain. Structural or other physical abnormalities must be ruled out or addressed.

Causes of Vaginismus

The causes of Vaginismus are more often than not a combination of physiological, psychological or interpersonal factors. Among the psychological factors most often associated with vaginismus are negative psychosexual upbringing, sexual fears and phobias and a history of sexual trauma or abuse. Persistent and recurrent involuntary muscle spasms are often associated with the fear of injury to the internal organs or trauma like rape or abortion. It can also be due to a strict religious upbringing, hostility or fear toward men or medical reasons.

Vaginismus as Treated Within the Multi-Disciplinary Approach

Psychological Intervention

Sexual History

Nearly all sex therapists will take a complete sexual history of the client before treatment begins. These histories are very thorough, and the length of time devoted to this will depend on how candid the client is about his or her past experiences. For more than 2000 years, religion has been a principal force in shaping sexual thought and still plays a major role in people's perceptions about sex and sexuality today and needs to be explored during sexual history taking. The five "E's" in sexual history taking: Experience, Etiquette, Empathy, Ethnic or cultural understanding and relaxed external environment.

Systematic Desensitization

Many patients have severe anxieties about sex in certain situations. Therapists often attempt to reduce this anxiety through muscle relaxation exercises or stress reduction techniques. A series of anxiety-producing scenes is presented to the patient, and he or she is told to try to imagine the scene. If this causes anxiety, the relaxation exercises are used until the scene can be imagined without anxiety. They then proceed to the next scene and repeat the procedure until the entire series can be completed without anxiety. Imagining a scene, of course, is not the same as a real-life situation, so a series of homework exercises are usually given as well.

Breathing Exercises, Relaxation Therapy and Grounding

To empower client with coping skills and tools to deal with anxiety and panic effectively.

Sensate Focus Exercises

Masters., *et al*. (1995:596) and King (1999:320) agree that many people are too goal- and/or performance-oriented during sexual relations (e.g., focusing on orgasm). Others have guilt or anxieties about enjoying sex. As a result, many people never really learn how to give or receive physical pleasure. Master's & Johnson (1966:176) created sensate focus exercises. The purpose is, to reduce anxiety and to teach nonverbal communication skills. Most therapists, therefore, instruct couples to use non-demand pleasuring techniques when touching each other.

They are instructed to go home, get undressed, and take turns touching each other without it immediately leading to the goal of having intercourse or having an orgasm. Touching of the breasts and genitals is forbidden at first, but all other areas of the body are to be explored. The receiver is instructed to focus on the sensations produced by the giver and to produce feedback as to what feels good and what does not. The giver learns what makes his or her partner feel good while simultaneously learning the pleasure of touching. The couple learns to be sensual in a non-demanding situation.

These behavioral exercises involve a couple taking turns pleasuring one another so each person has a heightened awareness of what types of strokes and caresses are most arousing and can convey that information to his/her partner. Sensate focusing can be both genital and non-genital in nature. It often begins with limited sensual massage of the face, hands and neck and progresses over time to include sexual intercourse. In fact, to reduce "performance anxiety" and help the couple establish emotional intimacy, the exercises are not goal- oriented (i.e., tied to intercourse) and intercourse is initially discouraged.

Mindfulness Training

Teaching the practice of mindfulness. Most people have become multitasks in an effort to keep up with everyday life. They may take this approach to their sexual life, and rush unfocused through intercourse as well, leaving little room for sufficient arousal, enjoyment, or satisfaction. Women with desire and arousal disorders are particularly vulnerable to being distracted by stressors during sexual encounters. The practice of mindfulness teaches the patient to focus on the here and now and on all of her sensations- sight, smell, hearing, touch, and taste-and to push distracting thoughts away. The technique can be particularly helpful in educating a woman about the way her body responds to sexual stimuli.

Specific Exercises Prescribed for Vaginismus

Treatment usually consists of sensate focus and relaxation exercises followed by gradual dilation of the vagina. Treatment approaches typically consist of a combination of systematic desensitisation, pubococcygeal muscle training (Kegel exercises) and the use of vaginal dilators. The involvement of the male partner appears to be an important determinant of treatment efficacy.

Use of vaginal dilators

Sex therapists have a number of tools at their disposal to help patients. For a woman suffering from vaginismus, they can suggest vaginal dilators along with a functionalized program that can help reduce patient anxiety and help facilitate stretching of the vagina. Successful treatment hinges on the patient being taught how to insert and use dilators appropriately- e.g., using them three times a week to once daily for 10 to 15 minutes and progressing slowly through larger-sized dilators this is where the physiotherapist plays a fundamental role.

The therapist however needs to prepare the patient (especially those with past sexual trauma) in terms of what to expect at the physiotherapist and the goal and process of dilator therapy. Where indicated, the patient can be empowered with tools such as

breathing, safe place ext. to manage possible anxiety. The medical specialist usually also prescribe a light sedative to be taken before physiotherapy such as Urbanol. The role of the therapist is furthermore to manage the process in conjunction with medical specialist, physiotherapist and couple. Support and motivation. Practical problem solving.

Individual Psychotherapy

Most survivors of sexual trauma find that therapy is an invaluable part of their recovery. It gives them a safe place to talk about their abuse as well as an opportunity to explore their feelings regarding sex, love, and their relationships. Talking about the abuse is a crucial part of healing, because nothing is worse than locking that abuse away and letting it fester. In order to let it go and move on, victims have to bring it to light and address what happened, even though that can be a very scary and challenging step.

- Helping patients develop realistic and appropriate expectations
- Anxiety management and coping. – CBT or Hypnotherapy
- Assigning sensate focus exercises that help individuals and couples desensitize to sexual activity that causes anxiety or avoidance and increase non-demanding pleasure
- Teaching the practice of mindfulness
- Discussing the use of lubricants, dilators, vibrators, and sexual enhancers as well as of an anti-irritant hygiene program. How to prevent urinary tract or vaginal infections hand out material.
- Patients may need help understanding female and male sexual response and what is arousing for them as individuals. They may not have explored their sexual responses, they may be pretending to have orgasms, they may be anxious or inhibited about their sexuality, or they may engage in a set pattern of sexual activity that is not arousing or satisfying to them. Exploration of wants, needs sexual turn on or turn off may also be used.
- Education about a sexual problem is often the first step in the treatment process and helps the patient better define her needs, goals, and expectations.
- Exploration of sexual fantasies.
- Fantasizing about sex is often a good step in recharging desire. Bassoon has suggested that many women (particularly those in long-term relationships) are not having spontaneous sexual thoughts or fantasies, but may be receptive to sex if mentally or physically stimulated. Sex therapists may recommend bibliotherapy or the use of erotic books or DVD's to spur fantasies. In addition, the sharing of fantasies with a partner can improve relationship communication about what a woman finds arousing and may help a couple revive an otherwise boring sexual script or repertoire.
- Identifying contextual catalysts for sexual activity and helping patients gain awareness of positive sexual cues/triggers. Review of the context in which sexual activity typically occurs in a woman's life- i.e. the sexual script-including the time of day, the interval between sexual encounters, and the way a partner indicates his/her desire for intimacy can be used by the sex therapist to make recommendations about how to increase a woman's desire for sex, arousal, and satisfaction. Triggered Desire.
- Cueing exercises. These exercises are designed to help a patient remember instances in their life when they felt sexy and had a good and satisfactory level of sexual desire. The patient is instructed to recall her physical appearance, the setting, the smells in the air, the music she was hearing, and the foods she was eating at that time and use these as "cues" for feeling sexual.
- Exploring alternate forms of sexual expression. This can include education on sensual massage; fondling and caressing; mutual masturbation; manual, oral, and anal stimulation techniques; use of sexual enhancing aids (vibrators) and trying alternative sexual positions (other than the missionary position) for sexual intercourse.
- Addressing sexual boredom. A couple who has been together for many years often falls into a sexual routine that is unimaginative and boring, often called a sexual rut that can dampen desire. A sex therapist can offer a number of suggestions for reviving this type of a sexual life, such as changing the venue for sex (moving it out of the bedroom, for instance, and into the back seat of the car or to a hotel room), as well as sex education books and DVD's.

Couples Therapy

Couples therapy and or couples sexual counselling to deal with the impact of the sexual dysfunction on the relationship and explore other dysfunctional components in the relationship. Manage non-demand and non-penetrating pleasuring techniques (as appropriate).

Relapse Prevention for both Male and Female Clients

Assist couple define intimacy, sexuality etc. based on their own wants and needs, not on societal constructions and help the couple establish comfort between each other. Assisting clients to set realistic expectations for sexual encounters, reduce shaming, guilt etc. between partners and encourage them to revisit sexual experiences if there are "hiccups" and make light of these instances when they do occur. Review the idea of "good enough sex" with couple to normalize expectations and reduce anxiety for partners. Encourage each partner to be open, find their "sexual voice" and be an active participant in each other's' desire, intimacy, wants and needs.

Physiotherapy

Involvement of Specialized Pelvic Floor Dysfunction Physiotherapists playing a crucial role in the multi-disciplinary approach. Explaining the nature of the involuntary reflex spasm, by prescribing specific exercises and by using dilators if indicated. Pelvic floor myofascial pain and guarding of pelvic floor muscle -Refer for manual pelvic floor muscle physiotherapy.

The impact of past sexual trauma on female sexual dysfunction with the focus on vaginismus.

Background

A history of sexual trauma can negatively impact on the enjoyment of sex. Sexual abuse often leads to severe and detrimental effects on any relationship in its wake. Many partners of people who have been abused feel helpless and confused, and yet they want more than anything to make things right and take away a partners pain. This is not an easy task because the long-term symptoms of sexual trauma are so complex and are often masked by certain behaviors, such as addiction or emotional imbalance, while others manifest as fear, unease, and guilt.

Childhood sexual trauma can have a profoundly devastating effect upon an individual. Some people appear to be relatively asymptomatic while others can be incapacitated to varying degrees. Sexual trauma is one of the most difficult and long lasting trauma's a person can endure. It can affect everything from the individual's mood to physical health, the relationship to the individual's sense of self-worth. Most importantly, it can affect feelings of safety and security. It might be difficult to trust anyone, even a partner. A healthy sexual relationship is very difficult to achieve without trust, and so is an open, loving relationship.

If you have been struggling with trusting your partner or opening up to him, it might be a good idea for both of you to go to therapy together. A couple's therapist can assist the partner in understanding the impact of the sexual trauma as well as in offering tools to help the couple on the journey of healing and recovery. Counseling can also help the survivor improve communication skills and gaining a level of comfort in opening up the partner about what is being experiencing.

Definitions

Childhood sexual abuse can be defined as any exposure to sexual acts imposed on children who inherently lack the emotional, maturational, and cognitive development to understand or to consent to such acts. These acts do not always involve sexual intercourse or physical force; rather, they involve manipulation and trickery. Authority and power enable the perpetrator to coerce the child into compliance. Characteristics and motivations of perpetrators of childhood sexual abuse vary: some may act out sexually to exert dominance over another individual; others may initiate the abuse for their own sexual gratification.

Although specific legal definitions may vary, there is widespread agreement that abusive sexual contact can include breast and genital fondling, oral and anal sex, and vaginal intercourse. Definitions have been expanded to include noncontact events such as coercion to watch sexual acts or posing in child pornography). Important note: Sexual trauma encompasses both the event and its impact on the individual.

Prevalence

The prevalence of childhood sexual abuse in the United States as well as in South Africa is unknown. Because of the shame and stigma associated with abuse, many victims never disclose such experiences. Most studies have found that among women, approximately 20% - or 1 in 5 - have experienced childhood sexual abuse. In South Africa statistics suggests that as many as 4/5 of girls and 3/5 boys are victims of sexual abuse.

Therapy

Most survivors of sexual trauma find that therapy is an invaluable part of their recovery. It gives them a safe place to talk about their abuse as well as an opportunity to explore their feelings regarding sex, love, and their relationships. Talking about the abuse is a crucial part of healing, because nothing is worse than locking that abuse away and letting it fester. In order to let it go and move on, victims have to bring it to light and address what happened, even though that can be a very scary and challenging step.

Past generations usually chose to cover up or deny the existence of childhood sexual abuse. This policy of silence and the resulting ignorance of the devastating consequences of childhood sexual exploitation created an environment that allowed the abuse to proliferate. Sexual trauma can interrupt many of the normal developmental processes of childhood. The suffering continues throughout one's life. Many adults who were sexually abused as children experience depression, anxiety and in some instances an overwhelming sense of panic. They may also be prone to nightmares and flashbacks. Many suffer from gastrointestinal disturbances, chronic bladder and yeast infections.

There are many contributing factors that determine the extent of the negative impact of childhood sexual trauma. Children are more likely to suffer to a greater extent if the perpetrator is a close relative such as a father as opposed to a neighbor. Children who were sexually abused during earlier stages of development have fewer resources which would allow them to cope and may suffer more adverse consequences. Sexual abuse may occur as a single incident or it may have continued over a number of months or years. Sexual violation can also range from inappropriate comments to penetration. The wounds incurred from as a result of childhood sexual trauma are often compounded by other forms of stress or trauma.

Other influences may help to lessen sexual trauma's destructive impact. Adults who are believing, caring and respectful in response to a child's disclosure of sexual abuse can help to mitigate the negative impact of the trauma. Children who come from loving and supportive families are more likely to have internalized other resources that would better enable them to cope. Memories and emotions associated with sexual trauma are stored within the body. We may feel tense and irritable as the feelings and memories begin to surface. Many cope by pushing the feelings back down inside of themselves.

Traumatic memories often become distorted and that may serve to protect us from even more disturbing memories. It's common for our minds to combine separate events so that it appears as if they took place during a single incident. Our minds can sometimes block out all awareness of the traumatic experience at the time of the abuse and that may be necessary to help us to survive. But that can make it difficult to recover the memories and emotions later in life as we begin to heal. Some people experience full and vivid recall of what happened, while others may only be able to access fragments of memory. Feelings and memories usually become more accessible as one move further along in their healing process. Memories may first appear as fleeting images or flashbacks. Many doubt the validity of these memories as they begin to surface. Survivors may even question their own sanity in some instances.

Flashbacks are often experienced as vivid reproductions of the original trauma and the intensely overwhelming emotions associated with these experiences. Flashbacks tend to have uncontrollable, freighting and intrusive qualities about them. They are often triggered by sensations or situations that act as a reminder of the initial trauma. A person in the midst of a flashback can feel as if they are reliving the trauma all over again.

The shame associated with sexual trauma may cause some children to make up stories to hide their wounds or to protect their family's secret. Children often feel that they are somehow responsible for what happened. They may feel that they are inherently bad, defective or abnormal. That may also be accompanied by an underlying sense of worthlessness. These feelings are often incorporated into their self-image. They sometimes try so hard to be good to compensate for these feelings, but that only reinforces their deep underlying shame.

Children who receive adequate love and nurturance internalize a sense of love, trust and safety. That helps to create an underlying sense of wellbeing. This foundation supports them as they go forward in their lives. Sexually abused children find themselves at the mercy of destructive forces beyond their control. They receive a whole different message that tells them that the world is not a safe place. Their inability to stop the abuse may cause them to feel they are not capable of protecting themselves, and that they cannot direct or control their own lives.

Impact of Childhood Sexual Trauma on the Body

Many were also struggling with addictions. Physical symptoms vary from one individual to the next, but I often hear complaints of frequent yeast and bladder infections. Others suffer from gastrointestinal disturbances, abdominal, pelvic, bowel or back pain. Some suffer from various autoimmune disorders where the body attacks itself. Others are diagnosed as having chronic fatigue, but what's happening is that the organs and systems of the body just start shutting down as a result of the trauma.

In addition to the psychologic distress that may potentiate survivors' symptoms, there is evidence that abuse may result in biophysical changes. For example, one study found that, after controlling for history of psychiatric disturbance, adult survivors had lowered thresholds for pain. It also has been suggested that chronic or traumatic stimulation (especially in the pelvic or abdominal region) heightens sensitivity, resulting in persistent pain such as abdominal and pelvic pain or other bowel symptoms. Again confirming the importance of psychological treatment of trauma associated with sexual pain.

Impact of Childhood Sexual Trauma on Sexual Functioning

Survivors of childhood sexual trauma may have difficulty functioning sexually. For many survivors, sexuality has become associated with a very negative and humiliating experience. The body and sexual pleasure, is seen as dirty and disgusting. Sexual activity can trigger flashbacks in which one experiences the emergence of old traumatic memories. It can also evoke feelings of pain, fear, betrayal, guilt, shame, revulsion, and helplessness. Aversion to sexuality may cause some to completely shut down. Others go numb or experience very little pleasure or satisfaction through sexual interaction or they may experience body memories because of the trauma being stored cellular memory level. Some are able to interact sexually if they maintain a certain distance, as they are reminded of the initial trauma if the relationship gets too close (dissociation).

Survivors of sexual trauma can sometimes feel as if, all they are good for is sex, and they often find themselves being used sexually in their relationships. Some of these individuals have very little comprehension of boundaries and have a tendency to acquiesce to the needs and demands of others. The problem here is that one cannot heal if they are continually having sex against their will. It takes time to recognize our own needs and develop appropriate boundaries. The first step involves getting in touch with our feelings. We need to be able to say no if we do not feel like having sex. We also need to learn to distinguish between sexual and emotional intimacy.

Many survivors of sexual trauma experience a sense of disgust for their bodies. That may also be accompanied by feelings of self-hatred. That can lead them to overeat, deprive the body of food or abuse alcohol and other drugs or engage in acts of self-mutilation. Survivors can encourage the healing process by working to develop a greater body consciousness. Bodies need adequate rest and nutrition. Appropriate physical contact with others helps us to feel safe in our bodies and our world. It can also help us to access our natural sense of pleasure associated with the body through Mindfulness Techniques.

Children who are being sexually abused are used to gratify the perverse needs of others. These children are not in control of their own bodies, their internal state of mind or their lives. Their feelings and needs are totally disregarded, so they grow up with the sense that their feelings and needs do not count. These individuals have difficulty developing a sense of healthy limits. They may not be able to separate their own needs from the needs of others, so they grow up having a very poor or no sense of boundaries.

Many children experience pain and numbness at the time of the abuse because of dissociation, others may experience sensations of arousal and orgasm. Sexual arousal is a natural physiological reaction but often creates huge amounts of shame and guilt for the adult survivor of sexual abuse and they often come to associate feelings of fear, pain and guilt with pleasure.

Impact of Childhood Sexual Abuse on Mental Health

Sexually abused children are deprived of their innocence. The resulting would is carried within them throughout their lives. Anger and rage are natural responses to being sexually violated. Survivors didn't have the opportunity to experience or express their true feelings at the time the abuse took place, because it could have jeopardized their survival.

Unexpressed anger and rage often becomes misdirected. Survivors often feel a sense of revulsion and hatred toward the parts of self that are hurt and wounded. The unexpressed anger turned towards ourselves feeds the negative feelings that cause us to engage in self-destructive behaviors. It also perpetuates our sense of victimization. That's why it's so important to connect with the underlying rage and direct it appropriately back at the perpetrator.

People often say things like "…That all happened in the past …Why can't you just let that go?" It would be really nice if those who have suffered these traumas could just forget and move on with their lives. It doesn't work like that. People who have not gone through these experiences cannot understand that these wounds never just go away and that survivors continue to suffer the effects of the trauma throughout their lives.

Impact of Childhood Sexual Abuse on Future Relationships

Sexually abused children are often violated by the very people who are entrusted to care for and protect them. That's why it can be so difficult for those who were sexually violated to trust or really open up in intimate relationships. Survivors of childhood sexual trauma may never develop the personal skills that enable them to function in social settings or develop intimate relationships. They may find it difficult to relate to others. Many have a tendency to hold others at a distance as they feel more comfortable with superficial relationships. Intimacy can feel suffocating, scary, invasive, threatening and confusing.

Internal representations of love and intimacy become distorted as a result of childhood sexual trauma. Love and intimacy are closely associated with the trauma that we could not escape from in childhood. Intimacy puts us in touch with all the pain, vulnerability and other feelings that we are trying to avoid. Painful feelings and memories are often projected onto our partner so that we come to associate them with the abuser. Many of survivors also experienced difficulty in their intimate relationships. They may be fearful and suspicious of their partners and their motivations or they may have difficulty functioning sexually. Others have shut down sexually and completely avoid any kind of intimacy.

The Partner

Survivors of childhood sexual abuse are not always easy to live with. They can be very moody, are often uncomfortable with normal and healthy expressions of intimacy and they have a tendency to withdraw. Their partners are often left wondering "…what did I do wrong?" Tremendous patience and understanding are required from partners of those who were sexually abused. The love and support of a committed partner can help to create a safe space where the abused partner can gradually feel safe with intimacy. Open communication can help to minimize the hurt, frustration and feelings of rejection. It helps the partners of those who were sexually abused to not feel responsible for their reactions and to not take matters so personally.

Healing takes place as we allow ourselves to be open and vulnerable to those whom we chose to be close to. We do that by learning to share our feelings, communicate our needs and to help others understand what we're going through. This helps us to gradually increase our tolerance for intimacy. Opening in this way can invoke anxiety and other uncomfortable feelings. We can soften the unpleasant feelings as we remember to breathe into them.

Dissociation: A powerful tool and pitfall

Children cannot process sexual trauma. The pain and fear are too overwhelming. They're forced to disconnect from the traumatic feelings and memories in order to survive the trauma. Shutting out feelings and memories causes us to disconnect from our body. It then feels as if we have disconnected from reality. Parts of us numb out and we feel a sense of deadness.

Sexually abused children have very limited resources that would enable them to cope with what is happening to them. They generally have very little comprehension of what is taking place and they may have no one to turn to for support or protection. Their pleas for help may be denied or ignored. In some instances they may be blamed for the abuse or threatened with further harm. Many have no other recourse except to push it all down inside of themselves.

Survivors of childhood sexual trauma often disconnect from their feelings. The pain and confusion they internalize interferes with their own natural protective mechanisms. As a result they are more likely to misread or completely miss cues from others that would alert them to potential dangers. Their deep emotional wounds can also create a vulnerability that makes them even more susceptible to further acts of physical or sexual violence.

Self-awareness is first experienced through our bodies. The pain resulting from sexual trauma can make it very difficult for children to be present within their own bodies. Being aware of and connected to the body can become so unbearable that many children are forced to shut down or disconnect. That may result in a sense of alienation from the body that can continue into adulthood.

People dissociate or leave their bodies when their experience becomes intolerable. They tend to disappear into fantasy when they are faced with painful realities that they are powerless to change. It takes consistent daily effort to pull ourselves back into our bodies so that we can really be present to our feelings and experiences.

Cellular Memory Level

Children often experience overwhelming emotional reactions to sexual trauma. Trauma can interfere with the normal and healthy development of the brain. Trauma can also induce powerful biochemical responses in the brain. The brain becomes habituated to these same biochemical responses. The body-mind is set to maintain a state of vigilance to protect from further assault. These responses are further reinforced whenever something occurs that triggers the memories and emotions associated with the sexual trauma.

Many of survivors are so imbued with the intrusively charged energy and emotion of sexual trauma. It so permeates them that it becomes part of the fabric of self. Survivors can feel like they're always on edge. That doesn't allow the real authentic self of the individual to emerge.

Symptoms vary from one individual to the next, but many of the survivors I encounter are still anxious, depressed and disconnected from their bodies. They may also suffer nightmares, flashbacks and other psychological symptoms related to post traumatic stress disorder. Survivors of childhood sexual trauma often contain volumes of highly charged emotion that they've held within themselves for many years. Many of these individuals have difficulty containing their emotions and they often find themselves feeling overwhelmed.

Traumatic experiences are often hardwired into the body-mind. A process of reformatting takes place within the body-mind during the healing sessions. That dismantles the triggers that repeatedly generate the same kinds of painful emotions and cause one to be so reactive to situations. Parts of the self-containing traumatic memories and emotions that had split off will gradually emerge and

reintegrate. Clients' energy level increases and they begin to thrive as they gain access to new resources and develop capabilities that allow them to become more fully functional and express their true nature.

Although responses to sexual abuse vary, there is remarkable consistency in mental health symptoms, especially depression and anxiety. These mental health symptoms may be found alone or more often in tandem with physical and behavioural symptoms. More extreme symptoms are associated with abuse onset at an early age, extended or frequent abuse, incest by a parent, or use of force. Responses may be mitigated by such factors as inherent resiliency or supportive responses from individuals who are important to the victim.

Even without therapeutic intervention, some survivors maintain the outward appearance of being unaffected by their abuse. Most, however, experience pervasive consequences. Survivors may fluctuate between being highly symptomatic and relatively symptom free. Health care providers should be aware that such variability is normal.

Physical health problems	Sexual Dysfunctions	Mental health problems	Health Risk Behaviours	Avoidance of Preventive Healthcare
• IBS • Abdominal pain • Vaginal pain • Breast pain • Headaches • Musculoskeletal pain • Auto-Immune Disease • Bladder infection • Yeast Infections • Dysmenorrhoea • Lower Back Pain • STI's • Cancer's (Cervical) • Asthma	• Vaginismus • Dyspareunia • Anorgasmia • HSDD • Chronic Pelvic Pain	• Anxiety • Depression • Suicide Attempts • OCD • PTSD • Dissociative States • Insomnia	• Smoking • Alcohol use • Drug use • Obesity and inactivity • Early intercourse and multiple partners • Poor Contraceptive practices • Compulsive Sexual Behaviours	• Pap Smear • Breast examinations • General Check- ups

Table 1: *Lists the long term health problems associated with sexual trauma in women.*

Women with a lifetime history of SV use health services more than non-victimized women but are often reluctant to disclose their experiences of SV to health professionals. As a result, these women may not receive timely and appropriate intervention to detect, treat and/or prevent health problems. In particular, women with a lifetime history of sexual trauma tend to avoid preventive healthcare such as Pap smears. This is concerning as women with a lifetime history of SV, including childhood sexual abuse, rape and sexual intimate partner violence, have an increased risk for sexually transmissible infections, cervical dysplasia and an increased prevalence of invasive cervical cancer.

The evaluation of common gynecological problems also places these women at risk for retraumatisation (e.g. triggered memories or dissociation) during gynecological and breast examinations. The ongoing impact of sexual trauma on mental health is an important consideration for health care providers. Depression, anxiety, stress and post-traumatic stress disorder (PTSD) may also increase the risk for alcohol abuse and substance abuse and for revictimisation.

Containment of patient/client by health care practitioner:

- Establish rapport and trust with the patient;
- Monitor own personal and professional attitudes and beliefs;
- Be nonjudgmental and open to discussing sexual trauma;
- Be prepared to acknowledge and validate the disclosure;
- Empathies never minimize!
- Make the patient feel safe and protected;
- Ensure confidentiality;
- Provide sufficient consultation time for discussion;
- Refer the patient to psychological or specialist services
- Staff training, confidentiality of patient records and clinic protocols for monitoring patient safety are also important.

Healing through the pain

It's important for survivors to realize that the perpetrator is always responsible for their actions. In most instances, there's little if anything a child could have done to protect them self. They had no power to stop the abuse. That's why it's so important for survivors to come to a place of acceptance, and know they did the best they could to under the circumstances.

Psycho-therapy serves as the first model of a healthy relationship for many survivors. Psychotherapy can offer survivors a model of a healing, nurturing relationship through which one can find a basis to experience trust. Expressing ourselves to someone who can truly listen and validate our feelings and experience, show compassion, and offer consistent support, encouragement and understanding provides us with a safe place to experience the painful memories and emotions so they can heal.

To appropriately treat and manage survivors of CSA, it is useful to understand that survivors' symptoms or behavioural patterns often represent coping strategies employed in response to abnormal, traumatic events. These coping mechanisms are used for protection during the abuse or later to guard against feelings of overwhelming helplessness and terror. This means in order to heal new healthy coping mechanisms or healthy management of coping strategies should be developed.

A therapist's understanding and support can help us to come to the place where we gradually begin to trust ourselves. Psycho-therapy gives us the opportunity to explore and define our history and understand its effects upon our lives. Within the therapeutic setting, we can experience and work through our self-doubts. It provides us with an opportunity to rework the trauma so that the damaged parts of ourselves can be integrated into our greater selves.

Therapy is an essential component of healing for survivors of childhood sexual trauma. Many of the survivors that I've worked with have done extensive work in therapy. Some have made considerable progress, yet the repercussions of past sexual trauma still pervade every aspect of their lives. Many still experience periods of painfully debilitating emotion in which they cannot function. The trauma never just goes away and many of these individuals continue to suffer throughout the course of their lives. Conventional therapeutic modalities will not change that.

It can be very painful as the memories and emotions associated sexual trauma begin to surface and it can feel overwhelming at times. Clients usually do go through some difficult periods. These periods will gradually decrease in frequency. The healing sessions have the effect of gradually taking the edge off of things, so that clients can begin to relax and feel more normal. They gradually become more comfortable and present in their bodies and many of the related health concerns are alleviated during the course of the work. They also feel greater comfort in their interactions with others and that makes it possible for them to experience a greater depth of intimacy in their relationships.

Clients become more solidly rooted in their core self. The emotional states associated with past traumatic experiences lose their power as they take on a more transparent quality. Clients experience an inner strength and stability that allows them to be present with the feelings even though they may feel uncomfortable at times. That allows them to remain in a more neutral space as they gain access to the feelings and memories. Clients gradually gain a whole new perspective as they step out of the victim identity and move into a greater sense of wholeness.

Conclusion

Sexuality is multi-dimensional in nature and an integrative, holistic, post-modernistic, bio-psycho-social approach to understanding, assessing and treating sexual dysfunction needs to be followed to ensure the success of the treatment process. As sexual dysfunction and relationship dysfunction are interlinked a comprehensive and multi-dimensional approach to the treatment of sexual dysfunctions must include a thorough evaluation of the couple's relationship. The primary goal of sex therapy is to relieve the couple's sexual dysfunction or sexual problem.

Successful sex therapy employs both acknowledged sex therapy techniques, as well as psycho – and couples therapy, in order to enhance the couple's physical and emotional intimacy. Female sexual pain dysfunctions are prevalent and can be treated with huge success. The best possible results in the treatment process have been obtained using an integrative model. This includes medical intervention, couple's therapy, psychotherapy, physiotherapy and where indicated clinical hypnotherapy.

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