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Vulvodynia as a Possible Somatization Disorder

More Than Just an Opinion

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Vulvodynia, defined as vulvar pain, soreness or burning as opposed to pruritus, is a common and important problem. Despite its high prevalence and associated distress, the etiology, diagnosis and management of this disorder have not been clearly delineated. On the basis of recent advances in psychosomatic medicine, vulvodynia can be considered a somatiform disorder affecting the vulva. Psychosomatic assessment is useful in patients with vulvodynia. This review covered recent advances in psychosomatic medicine with reference to somatization disorders and their application to vulvodynia. According to the literature, vulvodynia shares some basic criteria by which functional pain disturbances are defined. Thus, all patients with vulvodynia should undergo psychologic and sexual evaluation since in some instances psychotherapy may offer the only successful approach to the alleviation of vulvar pain. (J Reprod Med 2007;52:107–110)

Keywords: somatization disorders, vulva, vulvar diseases, vulvodynia.

The role of somatization in obstetric and gynecologic disorders is well known in psychosomatic medicine. Somatization may be defined as a process by which physical symptoms, attributed by the patient to a physical cause, are due to psychologic distress—i.e., a somatic complaint not fully explained by a general medical condition.

Recently, advances in neurophysiology and the recognition of processes of mind-body interaction¹⁻⁴ have demonstrated that different disorders localized to the female genital tract may have a psychosomatic origin.

By the end of the 1990s, in papers published in gynecologic and psychologic journals, the role of somatization in vulvar disorders began to be taken in account,⁵⁻⁸ particularly in relation to chronic vulvar pain. The International Society for the Study of Vulvovaginal Disease (ISSVD) recently defined chronic vulvar pain in the absence of relevant physical findings as “vulvodynia.”⁹ This definition limits the diagnosis to those cases in which the pain arises in a vulva that, fully investigated from a physical point of view, appears to be normal. The

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concept of normality, not clearly expressed in the anatomic and physiologic literature, challenges the skillfulness of the physician in order to recognize vulvar anatomic variants, often unrelated to pain origin.

The role of somatization in vulvodynia was clearly expressed for the first time during the VIIIth ISSVD Congress, held in 1985 in Finland, by Peter J. Lynch in his presidential address, entitled "Vulvodynia: A Syndrome of Unexplained Vulvar Pain, Psychological Disability and Sexual Dysfunction."¹⁰ Lynch spoke about patients suffering from vulvodynia: "All patients indicate that no therapy used thus far had been helpful. A few of those whose initial episode had been triggered by candidiasis found that anticandidal treatment helped at first but was no longer useful. . . . They showed little interest in changing their patterns of sexual activity. . . ." And about therapy: "The greatest improvement seemed to have occurred in the several women who ended or markedly changed their relationship." These words, derived from the personal experience of a dermatologist without any acquired, specific cultural background and not written by a psychologist or a psychotherapist, describe the typical somatization process: the symptom disappears when it is no longer useful. According to this concept, even if the term *somatization* does not appear, it is evident that vulvar pain lasting months or years may have a psychologic and/or sexual origin. Nevertheless, for many years, in the literature on vulvar pain, no further mention can be found. That was probably for 2 reasons: clinicians were not ready to accept the existence of a symptom without any clinical sign, and the parameters to be adopted for the diagnosis of vulvodynia were based on the definition given by Dodson and Friedrich,¹¹ including vestibular erythema and, consequently, inflammation. Nevertheless, these authors noticed the "reluctance to accept the suggestion of a psychophysiologic cause and emotional liability and dependency."

To overcome this lack of information, different authors^{6,7} decided to investigate the psychologic and sexual effects of vulvar pain on daily life. In these papers, women with vulvar pain "reported a high degree of frustration with their illness and also reported symptoms of depressions, including depressed mood, irritability, fatigue, concentration difficulties, anhedonia (impossibility of experiencing pleasure), nervousness and tearfulness." Several participants reported suicidal ideation. Even if

these findings represent an important step in the comprehension of the etiologic mechanism of vulvodynia, in the papers cited above the attention was focused principally on the psychologic effect of vulvar pain on personality, with no mention of the possibility that the pain could have a central nervous system origin in the alteration of the psychologic balance of the person.

The first author to formally include vulvodynia among somatization disturbances was Bitzer, in 2003.¹² Bitzer found an obvious inclusion of vulvodynia with other somatization processes in obstetrics and gynecology, giving a detailed definition of somatization: "Somatization refers to the phenomenon of physical symptoms not being conditioned by physical structural defects but primarily by mental processes. The basic understanding integrating psycho-dynamic, cognitive behavioral and systemic views conceptualized the underlying process as a signal processing circle in which the perceptual, interactive and the affective-behavioral part interact in a dysfunctional manner. . . . In obstetrics and gynecology somatization disorders are quantitatively and qualitatively important. . . ." Bitzer described different models of understanding the somatization process from the biologic, psychodynamic, behavioral, systemic and biographic-humanistic approach. All these models share several common features:

1. The biographic-developmental perspective: all models include a timeline of symptom formation that can be categorized as predisposing, precipitating and maintaining factors of symptom formation.
2. The multifactorial perspective: all models refer to the individual as a unit of different systems: the biological person, the psychological (meaning- and information-based) person and the social (interactive) person.
3. The circular-interactive perspective: symptom formation is mainly understood as the result of a circular interaction much more than linear causality—the interaction between signal-giving and -receiving processes, the interaction between different systems and the interaction between person and context.

These observations fit well with the theory expressed at the beginning of the 20th century by Wundt¹³ and Titchener,¹⁴ focusing the conceptual differences between sensation and perception; they looked for the origin of pain in mental processes, defining the borders among psychology, philoso-

phy and natural sciences. Among psychologists, it was thought that a pure sensation cannot exist since any stimulus, mediated by sensorial receptor biologically well defined, is processed, modified and transformed in the brain according to the person's knowledge and background. That is the perception.

Considering the role that the vulva assumes in sexuality and female identity, vulvodynia may be considered a somatoform disturbance. In addition, according to the literature,^{12,15,16} vulvodynia shares some basic criteria by which functional pain disturbances are defined:

1. Usually they are chronic and described in a very imaginative way
2. They can come and go during the day or over seasons
3. They can present a co-morbidity with other functional forms of pain (glossodynia, cephalgia, digestive troubles, etc.)
4. They can be related to a particular real "life event," such as desertion, sentimental breaking off or mourning or to something unreal (an inner psychodynamic event)
5. They do not cause insomnia
6. They have been formerly diagnosed as a somatic disease (typically candidiasis for vulvodynia)

According to the neurophysiology of somatization processes,^{12,15,17} it is now well accepted that a body signal is perceived and processed in terms of interpretation and attribution and on the basis of in-born and partially learned psychophysiologic patterns. In this sense, the meaning of the signal is elaborated by the central brain under individual variability. Somatization represents dysfunction in this process, in which a persistent pattern of signal processing and response leads to the global self-evaluation of bodily threat and danger, which induces a behavioral response of help seeking to reduce or eliminate this inner state of alarm.

From our experience,¹⁸ >15 years long and regarding >100 patients with vulvodynia studied from a psychodynamic point of view, we can state that vulvodynia should be considered and treated as a somatoform disturbance. Vulvodynia may represent the best way that a woman found to hide the conflict she does not want to face. A basic concept in psychosomatic medicine reveals that when it is not possible to show a conflict or a distress condition by psychological symptoms, it is possible to use the body as a stage. Thus, the vulva can be the theater on which some issues are played out. Nevertheless,

the processes that induce some people to generate somatic symptoms as a consequence of psychological distress instead of anxiety or depression are not clearly understood. The symptom represents a sort of defense against something much more dangerous that cannot be acknowledged.

Probably, the mechanism that induces a woman to choose the vulva as a target of somatization is influenced by the first sexual and emotional experiences; the recurrences of somatic diseases; the family, social and cultural context, and other individual factors. This situation may lead to distorted central nervous perception and misinterpretation, with subsequent collateral activation of sympathetic fibers and secretion of nociceptors and substances like bradykinins. This is the reason why trying to eliminate vulvodynia using only drugs or surgery might be dangerous if the therapist does not decode what the pain does really mean and what role it is playing. This means that the patient is invited to participate as much as possible in the decision making regarding diagnostic procedures and that the patient is enabled to continuously assimilate information and learn more about her body and the mind/body interaction.

With this perspective it is mandatory to discuss with the patient what the objectives of therapy are and what is intended as recovery in order to avoid excess expectations.

The concept of recovery represents an important starting point for the success of therapy and should be negotiated with the patient. In the concept of recovery clearly emerges the real value that the symptoms assume for the patient. "Happiness in love" is an expectation that rarely will lead to the relief of symptoms since it is too vague. One of the patients in our study group explained exactly what she intended for recovery: "To live with low vulvar pain. To dress normally. To have sex without fear. To understand in a better way what's happening to me."

From our experience,¹⁸ in the case of pain lasting months or years, the mechanism of somatization has reach a high degree of structuration and appears deeply integrated into the patient's life. In this situation, recovery from the symptoms is rarely reached, and the therapeutic approach may be considered successful if the pain can be tolerated by the patient.

Vulvodynia appears in a body area that appears to women and men as hazy and vague, untouchable, marked by blood, by pain and pleasure. The vulva can be also a taboo place, a place with some

risk, a place of pleasure for women of any age and, depending on her own body representation, a place closely related to her psychic life and sexual patterns. The vulva has naturally evolved as a sexual communication organ, not only involved in reproductive function but also in building and maintaining enduring couple, social bonds and female identity.

Taking into account this context of intimacy and sexuality behind a somatoform disorder of a genital organ, it appears that, in the case of vulvodynia, once dermatosis, infections and other organic lesions are excluded, the correct approach to a woman with this disorder should be multidisciplinary, using clinical psychologists, psychosexual counselors and psychiatrists.

Conclusion

On the basis of our experience and according to the recent literature we can summarize:

1. Vulvodynia can be considered a somatoform disorder affecting the vulva.
2. Any patient with vulvodynia should always be investigated from a sexual and psychodynamic point of view.
3. In selected cases, psychotherapy seems to be the only way available for recovering or reducing the symptoms.
4. The concept of "recovery" should be negotiated with the patient to avoid excessive expectations.
5. It is mandatory to seek the origin of the pain in mental processes.

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References

1. Stewart DE, Reicher AE, Gerulath AH, et al: Vulvodynia and psychological distress. *Obstet Gynecol* 1994;84:587-590
2. Kirmayer LJ, Robbins JM: Patients who somatize in primary care: A longitudinal study of cognitive and social characteristics. *Psychol Med* 1996;26:937-957
3. Manu P: *Functional Somatic Syndromes: Etiology, Diagnosis and Treatment*. Cambridge, Cambridge University Press, 1998, pp 32-57
4. Sharpe M, Bass C: Pathophysiological mechanism in somatization. *Int Rev Psychiatry* 1992;4:81-97
5. Danielsson I, Sjöberg I, Wikman M: Vulvar vestibulitis: Medical, psychosexual and psychosocial aspects: A case control study. *Acta Obstet Gynecol Scand* 2000;10:872-878
6. Danielsson I, Eisemann M, Sjöberg I: Vulvar vestibulitis: A multi-factorial condition. *Br J Obstet Gynaecol* 2001;108:456-461
7. Sackett S, Gates E, Heckman-Stone C: Psychosexual aspects of vulvar vestibulitis. *J Reprod Med* 2001;46:593-598
8. Green J, Hetherington J: Psychological aspects of vulvar vestibulitis syndrome. *J Psychosom Obstet Gynaecol* 2005;26:101-106
9. Moyal-Barraco M, Lynch PJ: 2003 ISSVD terminology and classification of vulvodynia: A historical perspective. *J Reprod Med* 2004;49:772-777
10. Lynch PJ: Vulvodynia: A syndrome of unexplained vulvar pain, psychologic disability and sexual dysfunction. *J Reprod Med* 1986;31:773-780
11. Dodson MD, Friedrich EG: Psychosomatic vulvovaginitis. *Obstet Gynecol* 1977;51:23-25
12. Bitzer J: Somatization disorders in obstetrics and gynecology. *Arch Womens Ment Health* 2003;6:99-107
13. Wundt W: *Principles of Physiological Psychology*. London, Allen and Unwin, 1912
14. Titchener EB: *Lectures on the Experimental Psychology of the Thought-Processes*. New York, MacMillan Company, 1909
15. Consoli SG: Approche psychosomatique des vulvodynies. *Gynecol Obstet Fertil* 2003;31:948-953
16. Shahrokh NC, Hales RE: *American Psychiatric Glossary*. Sacramento, Campbell Editions, 1994
17. Taylor GJ: Somatization and conversion: Distinct or overlapping constructs? *J Am Acad Psych Dyn Psych* 2003;31:487-508
18. Mascherpa F, Micheletti L, Bogliatto F: Psychosexual approach to vestibulodynia in selected amitriptyline non responder women. *Proc XVIIth ISSVD World Congress, Salvador, Brazil, October 10-16, 2003*. *J Reprod Med* 2004;49:931