Summer 2023 Newsletter

Lori A. Futterman RN, Ph.D.

Ways to Decrease Barriers in Healthcare for Minoritized Populations?

Lori A. Futterman RN, Ph.D.

There are numerous barriers of healthcare. One of the ways to assist with this is to enhance professional curriculum and further research related to targeted populations. Minorities are disproportionally affected by health care inequities and have poorer health outcomes than non-minorities (Thomas et al,2020). Biases contribute greatly to discrimination and perpetuate the disparities and inequities of care.

Education and curriculum development aimed at reducing implicit biases and highlighting the importance of the patient-provider interaction, can enhance trust in the healthcare environment. Assisting students to become mindful of their own beliefs and implicit bias towards diverse populations will enhance healthcare delivery and outcomes can facilitate collaborative learning environments. This necessitates having developed inclusive and comprehensive curricula needed to promote critical thinking and awareness, which would include ethnic, cultural, racial, and sexual/gender minorities. A comprehensive curriculum within professional education and training and would facilitate the development of cultural humility and social inequities.

Training programs that include skill development, perspective taking, and empathy training may help equip providers with sensitivity and skills to repair any difficulties with their patients in lieu of implicit racial bias (Gonzalez et al., 2018). In addition to training, research is needed on the intersectionality of race/ethnicity, sociocultural, and sexual and gender minorities among healthcare providers and patient populations and the impact that such interactions can have on health outcomes. Non-binary, genderqueer, or gender diverse, bisexual identities and racial diversity are factors that additionally are under-represented in the literature and must be considered in empirical data gathered on provider and patient interactions.

Premenstrual Syndrome (PMS) vs Premenstrual Dysphoric Disorder (PMDD)

Lori A. Futterman RN, Ph.D.

Premenstrual Syndrome (PMS) and Premenstrual Dysphoric Disorder (PMDD) are two menstrual cycle conditions that occur during the premenstrual phase of the menstrual cycle (Futterman & Rapkin, 2006). PMS is characterized as having psychological, physical, and behavioral symptoms associated with it. Depending on the severity of the symptoms, that is mild, moderate or severe symptom patterns determine the degree of interference within a person's life such as personal, social and occupational aspects (Futterman & Jones, 2000). Mild PMS symptoms occur for 1-3 days; moderate PMS symptoms occur for 7-10 days and severe PMS occur for two weeks. The incidence of PMS is estimated at 20-43-% of women (Futterman et al.2000; Futterman et al, 2006).

The incidence of PMDD in the USA is 5-8% of women (Futterman et al, 2006). It is characterized by psychological symptoms i.e., depression, anxiety, and irritability, during the premenstrual phase of the menstrual cycle, causing a marked interference in overall functioning. PMDD is a severe form of PMS. It is diagnosed based on the exclusion of any psychiatric disorder such as Depression, Anxiety, Bipolar, Personality Disorder, Postpartum, Eating Disorder or Substance Disorder.

Diagnostic and Statistical Manual of Mental disorders fifth edition, DSM-5-TR, American Psychiatric Association,2022) diagnostic criteria for PMDD requires two months of perspective calendars or diaries that track daily symptom ratings that are psychological, somatic, and behavioral. This allows for the typology and severity of symptoms to be determined. The symptoms must be:

- Limited to the last week of the premenstrual cycle in the previous year
- Intensified by at least 30% during premenstrual phase during 6 days prior to menses
- Be relieved within the first few days of menses and not recurrent during menstrual part of the cycle
- Limited to Affective type symptoms, one or more are present during premenstrual phase i.e., Depression, Anxiety, and Irritability, being overwhelmed, difficulty concentrating, hypersomnia or insomnia. These symptoms cause significant distress or interference is functioning (DSM-5-TR, 2022)

The best way to work with these conditions through a holistic type of approach:

- Track the type and severity of your symptoms using a daily calendars
- Psychological methods that focus on mood and cognitive stability
- Consult with practitioners that assist with nutrition, exercise, hormonal stability

LORI FUTTERMAN RN PhD
591 Camino de la Reina, Suite 705
San Diego, CA 92108

Dr. Futterman, Psy8636, is a clinical psychologist with a general practice in San Diego who specializes in sexual medicine and women's health, and provides various types of behavioral therapy. She is dedicated to helping both men and women achieve their highest potential, overcome difficulties and achieve inner balance and overall well-being.

References available upon request.

Are Sexual Pain Disorders Linked to Trauma?

Lori A. Futterman RN, Ph.D.

Female sexual pain disorders are complex with its etiology being multifactorial. The most effective treatments are utilizing a multidisciplinary approach (Fugl-Meyer et al., 2013; Al-Abbadey, Liossi, Curran, Schoth, & Graham, 2016). Sexual Pain Disorders present with complaints of penetrative discomfort with concerns and/or anxiety in anticipation of vulvovaginal penetration. Genito-pelvic pain/penetration disorder is characterized as marked difficulty having intercourse and may be caused by various changes within the body such as vestibulitis, interstitial cystitis, atrophic changes with dryness and thinning of the vaginal tissues. These conditions can be accompanied with tensing of the pelvic floor muscles which makes any penetrative sex more difficult and painful. Sexual pain disorders are commonly reported in 10-28% of females in the USA (Diagnostic and Statistical Manual of Mental disorders Fifth Edition, DSM-5-TR TM, American Psychiatric Association,2022). Research on the psychological and sexual functioning aspects of women with sexual pain disorders report higher levels of psychological distress with higher anxiety, lower levels of sexual satisfaction, sexual desire, arousal, genital self-image (Desrochers, Bergeron, Landry & Jodoin, 2008; Pazmany, Bergeron, Van Oudenhove, Vergaeghe & Enzlin, 2013; Al-Abbadey et al. 2016) and hypervigilant to possible discomfort with penetration (Payne, Binik, Amsel & Khalife, 2005; Al-Abbadey et al.2016). A common experience of women with a history of sexual pain is to experience feelings of a lack of worthiness, shame and avoidance of interactive penetrative experiences and report negative effect on quality of life (Xie et al., 2012; Al-Abbadey et al., 2016). In general, there are limitations on the current research done in this area. Research is needed on LBTQ+ individuals and pain disorders. There needs to be clear definitions of the type of vaginal pain being treated, a need for control groups in treatment outcome studies, description of the questionnaires used as outcome measurements, establishment of what criteria meets clinical significance and ample sample sizes to test the hypothesis in question.

Avoidance of sexual interactions are common and are associated with fear and anxiety (Brauer, Lakeman, Rik van lunsen, Laan 2014). In addition, posttraumatic stress disorder can occur with sexual difficulties (Bird, Piccirillo, Garcia, Blais, Campbell 2021). Trauma may be related to the experience of sexual or emotional abuse related to intimate and sexual encounters and result in either complete avoidance, disconnection during sexual encounter and/ or painful sexual penetrative encounters. It is not uncommon for sexual desire; arousal and orgasmic functioning to be compromised if a pain disorder is existing.

The good news is that with gynecological, urological, and psychotherapeutic treatments these conditions can be treated. An integration of different treatment modalities is supported in the research (Bergeron et al., 2015). Use of physical therapy, use of dilators, electrical stimulation, EMG biofeedback and psychological therapies support the biopsychosocial approach to treating sexual pain disorders and improving sexual functioning, psychological well-being and sexual satisfaction. (Bergeron et al., 2001; Danielsson et al., 2006; Bergeron et al., 2008; Goldfinger et al., 2009). Some invite yoga or acupuncture into the treatment as well. (Brotto, Krychman, & Jacobson, 2008; Khamba et al., 2013). For women with pelvic floor pathologies, physical therapy maybe recommended (Goldstein & Komisaruk, 2017; Fontaine et al., 2018). A meta-analysis on pelvic floor training on women with sexual disorders concluded the effectiveness of this strategy (Tennfjord, Engh, & Bø, 2017).

There are several treatment approaches of sexual pain which include medical pharmacological treatments, surgical interventions, physical therapies such as biofeedback, dilators, pelvic floor exercises, electrical stimulation, psychological therapies such as cognitive behavioral therapy (CBT), and hypnotherapy and eye-movement desensitization reprocessing (EMDR). Research on these different modalities vary in results.

Things that you can engage in:

- Dialogue with your clinician about your sexual functioning and intimate relationships
- Acknowledge and embrace your concerns and goals
- Consider possible etiologies: hormonal/endocrine; urological; history of trauma and its relation to intimacy and sexuality; psychological status; medications and medical difficulties that may impact sexual and emotional intimacy
- Consider treatment options by consulting with clinicians that work with sexual health, specifically with sexual penetrative difficulties
- Bring in balance and wellness into your life experience by sharing your experiences with others; developing a meditative practice to bring calmness into yourself and into your interactions with others; create a group of clinicians that support your situation and lean into your friends and family for comfort