Somatocognitive therapy for chronic pelvic pain

Somatocognitive therapy has proved highly effective for treating chronic pelvic pain in women. We believe that this therapy should be tested in more gynaecological departments.

Long-term pelvic pain is a common cause of women suffering functional impairment and reporting sick (1, 2). The term is used for pain that persists for more than six months in the lower abdomen and pelvis. The condition may be due to disease in a number of organ systems, including the peritoneum, gastrointestinal tract and urogenital system, but in many cases no specific pathological changes are detected by a gynaecological examination or laparoscopy (2). Pain that arises in connection with menstruation (dysmenhorrea) or intercourse (dyspareunia) is excluded from the definition. The condition can result in significant functional impairment.

Somatocognitive treatment

We have developed a new body-oriented form of therapy that we have called somatocognitive therapy. This is a type of short-term therapy concentrated on existing systems irrespective of aetiology. It is a hybrid of physiotherapy according to the Mensendieck tradition and cognitive therapy according to the Aaron Beck method (3).

The goal of treatment is that the patient should achieve a new recognition of his or her body through an exploratory approach with functional goals associated with everyday functions. As the therapy evolves, suppressed emotions may be released. This is not the primary aim of the treatment, but the emotions should be included in the therapy in an empathetic and dialectical manner. The main emphasis is on acquiring new experiences through the body, moving the focus from thoughts associated with pain, anxiety and depression, etc., to function, and restructuring dysfunctional cognitive schemata through bodily exploration and dialogue (4).

As in cognitive therapy (3, 5) the therapy sequence consists of three phases:

- The patient reviews his or her experiences since the last therapy session
- The patient learns new active movements in a gradual progression, with simple movements that are to be integrated into daily activities, and not performed as a separate exercise programme
- Review of new homework that is to be carried out in daily movements until the next therapy session

The alliance between patient and therapist is very important, as it is in all kinds of therapy (6). It has been demonstrated that therapeutic alliance is positively associated with therapeutic effect (7).

Own experience

We conducted a randomised study of 40 patients with chronic pelvic pain. The patients had undergone a total of 72 abdominal operations, including exploratory operations, hysterectomy and extirpation of adnexa, without satisfactory effect (1, 8). No specific somatic aetiology could be detected.

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A physical function test (Standardised Mensendieck Test, SMT) showed the women to vary widely with respect to posture, movement/coordination, gait, sitting posture and respiration, increased tension and reduced elasticity of a number of muscle groups and increased symptoms of mental stress (1, 4). Their condition was diagnosed as persistent somatoform pain disorder (ICD-10 F45.4).

The women were randomised to ordinary gynaecological guidance with or without a weekly session of 60 minutes of somatocognitive therapy for a period of 12 weeks. After treatment, the women in the therapy group had a 41 % higher VAS score and 63 % better respiration score than the women who only received guidance (1). At follow-up a year after the start of therapy, this progress had continued, and the therapy group now had a 53 % better score for pain and an 86 % better score for respiration (8). Their scores for anxiety, depression and mastery (measured by GHQ-30) had also improved. A continued improvement after completion of the therapy can be explained by the fact that the women had now gained new experiences and methods for mastering bodily and cognitive challenges in everyday life, methods that they themselves could apply, independently of the therapist (1, 4).

Recommendations

In a commentary from the *American Journal of Obstetrics and Gynecology* it is argued that a standardised Mensendieck test can be used to evaluate candidates for somatocognitive treatment, and that a somatocognitive approach can be used on patients with long-term urogenital and muscular and skeletal disorders. We recommend Norwegian gynaecological departments to develop therapy programmes for patients with long-term pelvic pain which include a somatocognitive approach to movement analysis and therapy. Where such programmes are not available, the patient can be referred on.

Somatocognitive therapy has proved highly effective for treating chronic pelvic pain in women. The approach has yielded promising results in pilot studies, also for long-term back pain, chest pain, neck and shoulder pain, generalised pain disorder, irritable bowel syndrome and pain in the vulva/vestibulum. We believe it is important that Norwegian gynaecologists are aware of somatocognitive treatment, and that the treatment be tested at more gynaecological departments.

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