



# International Organization of Physical Therapists in Women's Health

A sub-group of WCPT



## PRESIDENT'S MESSAGE



We have a wonderful artist that is busy working up the design for our new website which will be easier to read and fun to navigate. There will be no interruption between sites so you will always be able to access information. By the next newsletter we should have it up and running.

I recently went to one of our national meetings, Combined Sections Meeting of the American Physical Therapy Association and handed out flyers to many US colleagues who showed interest in the Portugal meeting. Please make you reservations early for the October meeting and sign up on the web site when the Pay Pal link is provided. Thank you to our committee for their hard work at setting up such a wonderful conference. We have an auspicious faculty for the conference that represents many regions of the world. I am looking forward to this updated conference and networking with all of you.

Speaking of conferences it is not too early to think about WCPT Congress in Amsterdam:  
**World Physical Therapy 2011 20-23 June 2011, Amsterdam, Netherlands.**

In 2011 the Royal Dutch Society for Physical Therapy (KNGF) will host the congress in Amsterdam. The venue is the Amsterdam RAI Exhibition and Congress Center, which is well situated and easily accessible from all directions. It has its own train station and is

*(Continued on page 2)*

### WHAT'S INSIDE...

President's Message.....	1-2
Secretary's Report.....	3
Treasurer's Report.....	4
Report on Pelvic Partnership Conference.....	5
International Continence Society Conference Cairo 2008.....	6
The Aix-Lyon-Strasbourg Pelvic Pain Diagnostics and Procedures Meeting... 7-8	
German Physiotherapists visit Bradford, UK .....	9
New Zealand Society of Physiotherapists Special Interest Group Report .....	10
Feature Article No. 1.....	11-15
Feature Article No. 2.....	16-23
Abstracts .....	24
IOPTWH Conference 2009.....	25
Continuing Education.....	26
IOPTWH Contact List.....	27

*(Continued from page 1)*

less than 10 minutes from Schiphol Airport by rail. Also please consider submitting a poster, or presentation for the Congress.

This month we have a piece from Candice Schachter PT, PhD adjunct Professor at the School of Physical Therapy at the University of Saskatchewan, Canada. Many of you know her work on exploring how health professionals can practice in ways that are sensitive to adult women survivors of child sexual abuse. Many of us see these women in our practice and Dr. Schachter offers her research on how we can improve the way we practice with these clients.

I look forward to your contact with ideas, suggestions and volunteerism.

With warm regards,

**Rebecca Stephenson**  
**IOPTWH President**  
**rgspt@comcast.net**



From Left to Right: Jill Boissonnault former President IOPTWH, Marilyn Moffat President WCPT, & Rebecca Stephenson President IOPTWH at the WCPT booth at the Combined Sections Meeting of the American Physical Therapy Association in Las Vegas, Nevada Feb 2009.

## SECRETARY'S REPORT

As I write this report on 1<sup>st</sup> March it really feels like spring is nearly with us here in the UK after what has been, in our terms, a hard winter.

### IOPTWH Conference

Since my last report I have continued to liaise with Fátima Sancho in Portugal on plans for our October conference, full details of which can be found at [www.ioptwh.org](http://www.ioptwh.org) We hope to see you there!

### New member elect

I was delighted to receive an application for membership from Jovita Daniel on behalf of the Nigerian Society of Physiotherapy in Women's Health. The group will remain a member elect until our next general meeting in Amsterdam in 2011. The Italian group for Rehabilitation of the Pelvic Floor has also expressed its interest in joining.

### Conference in Croatia

As previously mentioned, fellow IOPTWH executive committee member Darija Šćepanovič and I have been invited to participate in the first international congress of physiotherapists organized by the University of Applied Health Studies, Zagreb. Entitled "Physiotherapy - Skill and Creativity" it will be held in Zadar, Croatia from 1<sup>st</sup> - 4<sup>th</sup> April 2009. Further details can be found at <http://www.zvu.hr/kongresphysio/eng/index.html>

### Listservs

I use this opportunity to announce five additions to the listservs which members can access via our website. This means you can now post, and reply to, messages on urinary incontinence, pelvic pain, obstetric back pain, breast, osteoporosis, anorectal dysfunction, research and billing. If you wish to subscribe please email me at [gill.brook@lineone.net](mailto:gill.brook@lineone.net) stating your country of residence, confirming you are a member of your national women's health physiotherapy / physical therapy group, and telling me which listservs you wish to access.

**Gill Brook**

**IOPTWH secretary**

## **IOPTWH TREASURER'S REPORT**

### **Fall 2008**

May I remind those countries who have not yet paid, that dues are payable by the end of March 2009.

Expenditure has been on the website, newsletter and card services.

Income and expenditure since 1<sup>st</sup> October 2008 are as follows:

Income:

i) from dues	£2,603.40
ii) from Bank interest	£37.08

Expenditure:	£1,999.12
--------------	-----------

Funds at March 2009:	£14,582.88
----------------------	------------

**Ros Thomas**  
**IOPTWH Treasurer**

## REPORT ON PELVIC PARTNERSHIP CONFERENCE

Tara Towers Hotel, Dublin. October '08

Pelvic Partnership is a national UK based charity providing much needed support and positive information for sufferers of pregnancy related Pelvic Girdle Pain (PGP.) They are also the flagship body providing education and training in best practice for members of the multidisciplinary team involved in treating women with PGP.

In October 2008, Pelvic Partnership ran their third multidisciplinary conference in association with the Mount Carmel Hospital. A diverse group of practitioners were present at the conference including Physiotherapists, Midwives, Obstetricians, Pilates Instructors and Osteopaths, as well as patients who have benefited directly from the work of Pelvic Partnership.

The day included a variety of talks from members of the multidisciplinary team. Malcolm Griffiths, a Consultant Obstetrician, spoke on the clinical presentation and the role of obstetric management of PGP. Ideally a spontaneous onset of labour, followed by a normal vaginal delivery in a comfortable birth position remains the best option for most women with PGP. He conceded that both physiotherapists and informed midwives have more to contribute in the management of women with PGP.

Maeve Whelan (SMISCP) spoke on the important role of manual therapy as best practice in treating women with PGP. The use of clinically reliable diagnostic tests to identify asymmetry within the pelvic girdle, alongside the use of manual therapy to treat the dysfunction forms the baseline for actively reducing pain and improving motor control. Maeve also provided a thorough and dynamic practical demonstration as part of her presentation, thus strongly promoting the skills of the specialist physiotherapist. Well done Maeve for once again raising our profile and voice within the multidisciplinary team.

The day also included many case histories, and research presentations. What was particularly evident was the use of colourful narrative and quotes from women who have experienced PGP directly, intricately describing the impact of PGP on their quality of life, both personally and in their role within the family.

Pelvic partnership also provide a telephone helpline service to sufferers and Celia Kitzinger (Professor of Sociology) spoke on the social skills involved in providing positive information and support to women.

Pelvic Partnership also produce publications for use by both the general public as well as guidelines for health professionals on the management of pregnancy – related PGP. Further information on future courses/ conferences and publications can be found on their website at [www.pelvicpartnership.org.uk](http://www.pelvicpartnership.org.uk). Thanks are due to Clare Farrell and the physiotherapy staff at Mount Carmel Hospital for organising the conference.

**Debbie Fallows**  
**Chartered Physiotherapists in Women's Health - Ireland**



## INTERNATIONAL CONTINENCE SOCIETY CONFERENCE CAIRO 2008

Cairo, Egypt was the lively and historic setting for the 38<sup>th</sup> annual conference of the International Continence Society (ICS). A city at the crossroads of Europe, Asia and Africa symbolised the mix of healthcare professionals and nationalities that came together to define the state of the art in continence promotion.

The conference commenced for physiotherapists with a “Physiotherapy Round Table”, a whole afternoon devoted to physiotherapy issues pertinent to this speciality. We were fortunate to hear presentations from many well-known physiotherapists whose work has gained great respect for our profession in the field of continence promotion.

Ruth Lovegrove Jones reported on her PhD research in measuring ultrasound parameters in women with and without stress urinary incontinence. In acknowledging some of the help she received along the way she mentioned our own Maeve Whelan. We heard some of the insights gained by Julia Herbert from a group of women who had sustained third and fourth degree tears during delivery, and this highlighted how profound the challenges can be, even for women considered minimally symptomatic. The subject of pelvic organ prolapse and pelvic floor rehabilitation is a hot topic in research at present, and we heard a couple of presentations on whether, and at what point, physiotherapy intervention might be of value in this condition. We were also given insight into the challenges in representing the physiotherapy profession on the ICS committee.

The next couple of days comprised various workshops, and the biggest challenge here was deciding which parallel sessions not to attend. For myself, a day gaining more knowledge of pelvic floor function and dysfunction in men and innovation in the treatment of male urinary incontinence was invaluable and will enhance my work with this patient group. A workshop on chronic pelvic pain syndromes showed that multidisciplinary health care professionals are beginning to see the common themes between conditions as diverse as chronic prostatitis, painful bladder syndrome, fibromyalgia, migraine, chronic fatigue syndrome and others. This is a link that many physiotherapists have made in our clinical practice. Some research has been done supporting the efficacy of manual therapy techniques in patients with chronic pelvic pain, thus strengthening our role with this challenging group of patients.

The use of ultrasound to assess and measure pelvic floor function and levator avulsion was a topic that was revisited several times during oral presentations. Hans Peter Dietz has done work that aims to define this problem; its relationship to pelvic organ prolapse, and those presentations will certainly have a bearing on how I assess patients in the future both manually and the use of rehabilitative ultrasound imaging (RUSI).

Attending the ICS annual conference was a career highlight and I would like to thank the MMUH physiotherapy department for making this possible for me.

**Patricia Malone**  
**Chartered Physiotherapists in Women's Health - Ireland**

## **The Aux-Lyon-Strasbourg Pelvic Pain Diagnostics and Procedures Meeting: January 8<sup>th</sup> & 9<sup>th</sup> 2009**

Well, how hard can it be –a conference in Aix-en-Provence, South of France in January?! It wasn't hard at all but strangely enough for this or any other time of year the snow brought the area to a stand-still. Apparently the heavens opened on the Tuesday evening and 15cms of snow landed in the Marseille/Aux area, as a result there was complete disruption to the local airports and motorways. The Conference started on Thursday, many speakers didn't make it at all and delegates were delayed by a day in most cases although a few did get there for the start, I was not one of them. So my report is based on the second days proceedings, the presentations from the website and some good networking with colleagues at the dinner on the evening of day one.

The Conference is a Multidisciplinary meeting set up by a group of doctors in the Aix-Lyon-Strasbourg area. They are pioneers in the area of pelvic and perineal pain and have taught their medical colleagues world wide their surgical procedures. The doctors, physiotherapists and osteopaths working in this field have respect for the role their colleagues play in this hugely debilitating condition, I found it very encouraging to hear from the many attending physicians, surgeons and anaesthetists the vital role of the physiotherapist on the team.

I will mention in brief under the various headings what took place. The anaesthetist spoke of the various ways to visualise access to the pudendal nerve when attempting to inject with anaesthetic. The latest is ultrasound guided as the patient lies prone Dr. Peng described how the nerve can be visualised and he highlighted how it is far less expensive than MRI for the same procedure and easily accessible too.

The pelvic floor muscles can be injected with anaesthetic, any of the muscles can be accessed externally, it is not necessary to access internally and this can be done in the consulting rooms setting.

There were presentations on Botulinum Toxin A. It is being successfully used in treatment of chronic pelvic pain. The correct muscle can be located with anaesthetic to confirm before the Botulinum is injected. This will last a few months and would need to be repeated once the effect has worn off.

Pudendal nerve entrapment cannot be definitively diagnosed by any medical procedure including nerve blocks, electrophysiological studies or MRI scans. Patients will only be selected for surgery when every other approach has been exhausted.

The surgeons described the techniques they do to decompress the pudendal nerve, the most common being the trans-ischiorectal approach. There can be no doubt that those who are at this confer-

ence (please view [www.perineology.com/files/Peng-pelvic-pain.pdf](http://www.perineology.com/files/Peng-pelvic-pain.pdf)) do so extremely well and with very good results. They do however choose their patients extremely well and those they feel are suffering primarily from a myofascial disorder would sooner be referred for conservative treatment. When they refer for physiotherapy they are often disappointed to hear back from patients that despite clear instructions to teach pelvic floor release, these patients have been instructed in pelvic floor muscle strengthening.

It was a pity that Physical Therapist Elizabeth Rummer who was in Dublin to teach us myofascial release techniques for Pudendal Neuralgia in November got stuck in Paris and could not get to Aix because of the bad weather, she had to head back to California without presenting her talk. Two French physiotherapists spoke on their down-training techniques for Vulvodynia using palpation, verbal cues and electrotherapy and biofeedback therapy.

I enjoyed the talk by Dr. Stanley Antolak, Urologist and formerly of the Mayo Clinic on Interstitial Cystitis and Pudendal Neuralgia. He talked of the frequency of existence of Pudendal Neuralgia with Interstitial Cystitis. He spoke of Maigne Syndrome and Middle Cluneal Neuropathy being the difficult presentations to treat and appealed for the help of physiotherapists in these cases. Maigne Syndrome is where there is involvement at the Thoracolumbar junction and specific restrictions will be picked up over the suprapubic, and lateral iliac regions. These patients can have symptoms consistent with Interstitial Cystitis.

Mark Conway an eminent surgeon from New Hampshire spoke on Ilioinguinal Neuralgia, another relatively common neuralgia that is tied in with the thoracolumbar area (T12-L1) as well as the Psoas muscle, referring to the anterolateral abdominal wall. This is not just a postsurgical presentation but can present de Novo.

I found it interesting that two of the main presenters spoke on the existence of Thoracolumbar involvement when speaking of Chronic Pelvic Pain. It begs the question of whether we should include routine Thoracolumbar clearing in some of our patient groups.

So as we reached the end of the day the snow had started to melt around us and one day later the ground was dry again with the sun shining. Our thanks to surgeon Dr. Eric Baurant, the main host and organiser of a great conference that was dealt a cruel blow by the ill-timed weather.

**Maeve Whelan**  
**Chartered Physiotherapists in Women's Health –Ireland**





## German Physiotherapists visit Bradford, UK

On 16<sup>th</sup> January 2009 three German physiotherapists met with British colleagues at Bradford Royal Infirmary for a working visit. Astrid Landmesser, Almut Köwing and Louise de Nijs-Renken have been teaching digital assessment and biofeedback of the pelvic floor for many years and wanted to compare their competencies with those of their British colleagues. Besides, since the use of Real Time Ultrasound (RTUS) by physiotherapists is not yet very common in Germany, they wished to get some experience on diagnosis and treatment with such equipment.

Following an invitation from Gill Brook we had a very interesting and informative day with Dianne Naylor and Stephanie Knight, women's health physiotherapists in clinical practice who also teach at postgraduate level. We exchanged views on assessment and treatment, showed our various approaches (for instance digital assessment in the upright position as occasionally performed in Germany), discussed anatomy, topography and pathology etc. For us, German physiotherapists, it was good to experience that our level of pelvic floor assessment was similar to the British way.

As mentioned before, we only recently became acquainted with RT Ultrasound. After a workshop at ICS Rotterdam, several presentations and a RUSI course in Hamburg, it was good to get some practice in using different probes and reading images. Besides, since we all had full bladders, we had the opportunity to compare RTUS measurements of bladder filling with the actual contents of the bladder which, in our inexperienced hands, wasn't all that accurate yet.

We thank Gill and Bob Brook for putting us up in their warm and friendly home, Dianne Naylor and Stephanie Knight for sharing their knowledge and being good company, and, last but not least, our German Women's Health Association for their financial support.

### **Louise de Nijs-Renken German Physiotherapy Association**



From left to right: Louise de Nijs-Renken, Stephanie Knight, Astrid Landmesser, Almut Köwing, Dianne Naylor, & Gill Brook

## New Zealand Society of Physiotherapists - Continance & Women's Health Special Interest Group Report

Last year's highlight was undoubtedly the Jill Boissonnault Seminar in August. This two and a half day course was held in Auckland, and was designed to provide the physical therapist with an overview of the obstetric population and teach management skills for treatment of musculo-skeletal dysfunction commonly seen in the childbearing year. The course proved to be an effective way of giving women's health physiotherapists exposure to a presenter of international standing. A maximum of 30 participants allowed for individual attention during the practical sessions. Feedback showed that 100% of participants declared that their course needs were met. Comments included:

- Very well presented, thorough knowledge, went over and over the mechanics;
- Jill was great, generous with time and knowledge, good amount of time for practical work with lots of feedback and 1:1 help;
- The cardboard sacrum was brilliant;
- The whole course was very well presented;
- Absolutely fantastic course, great getting background information on maternal physiology; very well paced, followed lines of thought;
- Presented information, then went over again and reinforced points before moving;
- Good balance of theoretical and practical;
- Osteopathic teaching and techniques very well taught.

There was a 'magic moment' on the last day during a geographical line up as participants from more isolated parts of the country excitedly exchanged contact details with their closest neighbours for further interchange and the sharing of knowledge and experience.

Now 6 months later course participants express delight at the way they have been able to incorporate new learning from the course into clinical practice, with good outcomes.

**Ruth Broom**  
**IOPTWH Chief Delegate**  
**New Zealand**



Jill Boissonnault with 2 course participants

## **FEATURE ARTICLE No. 1**

### **The Hamlin Fistula Hospital in Ethiopia**

The elderly cook has had a stroke, there is a patient with paraplegia, the aide who speaks a little English is in mourning, therefore not working just now and patients are in the physiotherapy department waiting to see you – but no-one speaks any English. Welcome to Ethiopia!

Perhaps some physiotherapists reading this might understand my consternation on being presented on my first day in Ethiopia with conditions which I last treated over 22 years ago and the feeling of helplessness on walking into the physiotherapy department which had at least 12 patients in it – all dressed the same and not one spoke English.

#### The hospital

The Fistula Hospital in Addis Ababa is a charity hospital dedicated to the treatment and rehabilitation of women in Ethiopia who have suffered tragic and humiliating injuries during childbirth. Gynaecologists Reg and Catherine Hamlin came to Addis from Australia in the late 1950s and were so moved by the plight of these women that they raised sufficient funds to build their own hospital dedicated to the treatment of fistula patients. Catherine Hamlin is now in her mid eighties and still operates and travels the world continuing to fund raise. Reg died some years ago.

#### Cause of fistulae in Ethiopia

Ethiopia is five times the area of the UK and villages are situated high in the mountains where the ground is fertile, but roads and major towns can be a few days walk away. Women are encouraged to marry very young and therefore become pregnant when little more than children themselves. Because the pelvis is not fully developed, obstructed labour is very common and, with no easy access to medical help, this can lead to stillbirth and internal trauma which can result in fistulae of both bladder and bowel. Permanently soaking in their own urine and faeces, these young women can be outcast by their family and village and often abandoned by their husband.

When they arrive in the hospital, they have often been traveling for days, walking for many miles to catch a bus or carried in by family members. Some have appalling contractures of hips, knees and ankles as they have spent many months lying in a hut trying to stop the flow of urine - in some cases even tying their legs together. Some have foot drop, many are just too weak to walk.

#### The developing hospital

The main hospital operates on about 1200 women each year and has now opened 4 centers in other parts of Ethiopia with another planned for the near future. Success rate for repairing the hole in the bladder is apparently around 95%, but sadly some patients have such severe damage that there is virtually no bladder left to repair. These women run a high risk of kidney failure.

Continued on Page 12...

Professor Gordon Williams, consultant urologist from the Hammersmith Hospital in London, has supported the hospital for many years by teaching the staff to carry out ileal conduits on such patients, thus prolonging their life expectancy. These women are still unable to return to their villages because of the problems of infection and the difficulty of acceptance of a stoma, and all it entails, by the family. Many remain in the hospital working as nurse aides, and now, with the opening of new hospitals, some of them can work in hospitals near their own village.

### Why me?

When I stopped working for the National Health Service in the United Kingdom in 2002, I did not feel ready to give up physiotherapy completely. I had worked for 22 years in the developing specialty of women's health and for 10 years before that had taught antenatal classes for the National Childbirth Trust. I read about the problems of vesico-vaginal fistulae caused by obstructed labour in developing countries and the work being done in Ethiopia in the Fistula Hospital. I made contact with the hospital to see if I could be of any help as my experience in women's health seemed appropriate. In 2003, over three visits, I spent 10 weeks working at the hospital and since then have visited about twice a year.

### Physiotherapy

The physiotherapy department was initially staffed by 2 aides – patients who have not been cured and will never be well enough to return home. They had been taught some techniques from visiting physiotherapists. Azeb Befekadu Tessema, one of the Ethiopian qualified nurses, had just started a two year course in physiotherapy when I first went. Now she is running the department, and recently a second physiotherapist has been employed.

The role of physiotherapy is first to help rehabilitate the women until they are fit enough for surgery. After surgery many are still incontinent even though the hole in the bladder has been successfully closed, so assessment and treatment of the pelvic floor and bladder function is an important part of the work. At present there is no specific data on the number of patients still wet on discharge.

The first thing you become aware of on entering the hospital is the smell. Then you see the patients, all dressed in thick blue cotton gowns, some sitting quietly on their own, some in small groups. All who have not been operated on leak large amounts of urine, so are constantly wet or standing in a puddle, or leaving trails of urine wherever they go. Those who have had surgery are lying in a huge Nightingale ward where they remain in bed for two weeks. They have a catheter draining into a kidney dish between their legs, which they regularly empty into a plastic bucket placed between the beds.

My role initially was to support the physiotherapy aides and help them to set up effective treatment programmes for the patients. Whenever possible I worked with the ward aides teaching simple principles of patient handling and bladder function.

Continued on Page 13...

When I first arrived I was quite overwhelmed by the number of patients with a variety of mobility problems arriving together in quite a small department. All tended to appear in the department first thing in the morning and expected to spend most of the day there, having first washed their urine soaked feet and put on a huge cloth nappy.

By introducing a warm up class to music followed by a circuit with appropriate stations suitable - with modification - for everyone, individual treatment sessions and games in the afternoon, the day was broken up, enthusiasm increased, and the sessions became more effective. The department had parallel bars and some modern exercise bikes. Since 2003 the introduction of an ultrasound machine, gym balls, mats, wobble boards and a variety of small pieces of equipment has improved the range of possibilities for rehabilitation work. Before surgery the patient must be fit enough to walk and cope with going home and, although it can sometimes take many months, this is usually achieved.

Women are discharged soon after their catheter has been removed. For post operative patients suffering from incontinence group work has been introduced. After an individual assessment and instruction, the group has proved helpful in giving maximum input to patients before discharge.

Dr Andrew Browning, an Australian gynaecologist working in one of the new hospitals, has recently been undertaking trials with a urethral plug for women still wet after surgery. Azeb is now assessing patients and fitting plugs with some success.

The work is a challenge both professionally and emotionally as many of these patients are very young and their future can be bleak. In spite of their injuries there is fun and laughter in the department, especially if I try to speak their language and inevitably find I am being corrected in one of the other 80 languages spoken in Ethiopia. The courage and determination shown by the women is humbling. It is very moving to see the joy on the face of a cured patient who can go back to her village where she will remarry, and hopefully she will have a successful pregnancy in the future, going to her local hospital for safe delivery, as instructed by the doctors at the Fistula Hospital.

#### The future

It took time, but I have been accepted. As for introducing change – this will only happen slowly. Recently Professor Williams was appointed Medical Director of the hospital. He is working with the staff to update procedures and practice in all areas. With his support I am sure Azeb will be able to work with other disciplines to develop an effective service for patients with incontinence after surgery.

In 2008 I was delighted to bring Azeb to the UK where she had a week in Bradford Royal Infirmary with Gill Brook and a week with Diane Stark at the Southern General Hospital in Glasgow. I hope that having links with these departments will give all involved opportunities to work together in the future.

I hope to continue to visit and support Azeb in all aspects of developing the physiotherapy service. I have learned far more in my retirement than I ever did during my working life. Catherine Hamlin is an inspiration to all who meet her and I consider myself very privileged to have been able to be involved in her hospital.

**Lesley Cochrane**  
**Retired Women's Health Physiotherapist**  
**Aberdeen, Scotland, United Kingdom**

Continued on Page 14...

## **A visit to women's health physiotherapists in the United Kingdom**

*Extracts from a report by Azeb Befekadu Tessema, physiotherapist, Hamlin Fistula Hospital, Addis Ababa, Ethiopia edited by Gill Brook*

The whole experience was exciting and very helpful for the development of my career. During an enjoyable stay with Lesley and Bruce Cochrane in Aberdeen, I spent time with a continence advisor, including the opportunity to use a bladder scanner which we are planning to buy for the hospital. I also met a Pilates teacher who discussed the basics of core stability and I participated in a Pilates session with her. I believe this will help me to revise our patient group exercise both in the main hospital and the other centres.

Next, I spent a week with Gill Brook, women's health physiotherapist, and her team at Bradford Royal Infirmary, staying with her and her husband Bob. I do thank them and appreciate their kindness and care. During my time in Bradford I discussed our hospital and what the physiotherapy department is doing so we could plan the activities for the rest of the week. Gill explained the different assessment forms they are using. The quality of life questionnaire has good information that shows how much women's incontinence affects their daily living. I think this is something we need to adopt. I was able to observe Gill with patients, and see the biofeedback machine. We also treated a woman and baby on the maternity ward. Over the days I observed different various interesting cases including faecal urgency, and mixed incontinence. I spent an afternoon learning about moving and handling patients, which I believe will improve our way of working. I also had an opportunity to learn about clinical audit, and to talk to a woman who is in charge of training physiotherapy and nurse assistants. I spent time with nurses on a gynaecology ward discussing catheter management, and with physiotherapists from the neurology team, watching them assess and treat patients. Apart from work, I also went out for a curry, and visited the art gallery and market in Leeds before flying back to Scotland.

After a day visiting Edinburgh, Lesley took me to Glasgow where I spent a week with Diane Stark and the women's health physiotherapists at the Southern General Hospital. I learnt about the POPPY trial they are leading, looking at pelvic floor muscle exercises for pelvic organ prolapse. We also discussed the use of electrical stimulation. It was motivating to discuss with Diane the work they are doing. She is also keen to help me to undertake clinical audit in both the women's health work and the rehabilitation in our hospital. Together we wrote the basic outline for a clinical audit on the effectiveness of pelvic floor exercise for patients following fistula surgery

I participated in a postnatal Pilates class, and spent time with the urogynaecology nurses, observing urodynamic studies, and discussing catheter care and bladder training. I also watched an ante-natal class, and attended a meeting organized by Scottish continence forum, on the management of patients with overactive bladder.

During my stay in the UK I had a wonderful time, learning many new ideas. I am very grateful to Lesley who organized this trip for me with the fistula hospital. Lesley wants me to have a connection with physiotherapists who are currently engaged in research activity. I believe this trip open the door for that. Both Diane and Gill showed a special interest to help the Addis Ababa Fistula Hospital (AAFH) physiotherapy department in many ways. I strongly believe the whole experience will add and improve our department's performance. I am very grateful to the AAFH founder, chief executive officer, medical director, and management committee for believing in me and sending me for this training.

For further information about the Addis Ababa Fistula Hospital please visit  
<http://www.fistulafoundation.org>.

Continued on Page 15...



A young women newly admitted to hospital



The same women following surgery and rehabilitation



From Left to Right: Lesley and Azeb

## FEATURE ARTICLE No. 2

### **Sensitive Practice: Fine-tuning Patient-Centered Care for Adult Survivors of Childhood Violence**

by C.L. Schachter, PT, PhD, G.C. Lasiuk, RN, PhD, & C.A. Stalker, PhD, RSW

The *Handbook on Sensitive Practice: Lessons from Adult Survivors of Childhood Sexual Abuse* (2<sup>nd</sup> edition, 2009)<sup>10</sup> presents information that will help health care practitioners to practice in a manner that is sensitive to the needs of adult survivors of childhood sexual abuse and other types of interpersonal violence. This second edition is the product of a collaborative research project that included over 400 women and men survivors, practitioners from more than ten health disciplines, and counselors who work with survivors. The *Handbook* is intended for health care practitioners and students of all health disciplines who have no specialized training in mental health; it is not meant to encourage clinicians to step outside their scope of practice, but rather to help them to 'fine-tune' patient-centered care for those patients who have experienced violence as children. In this article, we introduce the *Handbook on Sensitive Practice*, briefly offer the rationale for its use, highlight some of the feelings and behaviours that survivors bring to the health care encounter, and introduce the Principles of Sensitive Practice. We present our perspective on effective responses to disclosures of abuse and ways to use task-specific inquiry and disclosure to enhance treatment. Lastly we discuss working with patients who become distressed during treatment. While the *Handbook* reflects experiences of both women and men survivors, for this article we have selected quotes from women survivors who participated in the research (in *italics*) to illustrate some of the information being presented.

As many as one third of women and 14% of men are survivors of childhood sexual abuse<sup>4,5,6</sup>. Childhood adversity – including sexual, physical, and emotional abuse – is associated with a greater risk of a wide variety of health problems, such as chronic pelvic pain, intractable low back pain, chronic headaches, as well as difficulties with pregnancy and childbirth (See Banyard et al 2009<sup>1</sup> for a range of information about trauma and physical health). This means that all physical therapists who work with adults – whether they know it or not – encounter adult survivors of interpersonal violence in their practices. Survivors are health care consumers of every age who seek all types of health services, and our hope is that the principles and guidelines of Sensitive Practice will become "routine procedures" in all health care encounters and that all health care consumers will benefit from them.

Childhood sexual abuse is a violation of body, boundaries and trust<sup>2</sup> and is typically experienced as traumatic.<sup>7</sup> Examinations and treatment can be distressing for survivors, because they may be reminiscent of the original trauma. The clinician's focus on the patient's body, the patient's lack of control in the clinical environment, the patient having to undress, and feelings of pain, vulnerability and powerlessness are examples of common experiences in the health care environment and may be extremely difficult for survivors because they mirror aspects of past abuse. While most clinicians automatically assume that touch involved in pelvic, rectal and breast exams may be difficult, this research had shown that other components of a health care encounter can also be distressing for survivors of interpersonal violence. Examples include interactions with support staff, aspects of the physical environment, clinicians' time pressures, issues related to clothing, to name a few. Thus, it is not possible to make a complete list of problematic situations. *The Handbook on Sensitive Practice* has been developed to address common difficulties that survivors experience and to help health care practitioners be more understanding of and responsive to the specific needs of adult survivors of violence with the goal of maximizing the benefits of consultation and treatment.

(Continued on page 17)



### **What survivors bring to the health care encounter**

In our research, many survivors told us that their responses to health care encounters are affected by their distrust of authority figures (which include the physical therapist), fear and anxiety, discomfort with persons who are the same gender as their abuser(s), ambivalence about their bodies, and conditioning to be passive. When they exist, these things make it difficult for survivors to seek assistance from health care practitioners and interfere with their ability to participate in their treatment.

*[In the clinic waiting room, I felt] nervous, apprehensive, not exactly knowing what was going to happen ... as far as clothing was concerned or ... touch, just not knowing.* <sup>9 p.252</sup>

Examinations and treatment may 'trigger' or precipitate flashbacks, a specific memory or overwhelming emotion such as fear, grief or anger. Some survivors dissociate, that is, they experience a disruption in the usual state of consciousness during treatment (see the Handbook for further description). All of these feelings and behaviours leave survivors feeling unsafe and often have a negative effect on the effectiveness of the treatment they receive.

*And the goop that they put on me for the ultrasound gave me flashbacks, nightmares, insomnia; I just couldn't deal with it.* <sup>9 p.257</sup>

### **The Principles of Sensitive Practice**

*I now am beginning to understand that my physical wellness is really very connected to my emotional state, and if I'm not comfortable, if I'm feeling unsafe, then I'm not going to progress as quickly as a physiotherapist would want me to.* <sup>9 p.251</sup>

The primary goal of Sensitive Practice is to facilitate feelings of safety for the client. The nine themes outlined below were identified by virtually all participants as important to facilitating their sense of safety during interactions with health care practitioners. These themes are so critical to survivors' feelings of safety that we term them the *Principles of Sensitive Practice*. Through the course of our research, we have come to conceptualize safety as a protective umbrella, with the principles of Sensitive Practice being the spokes that hold the umbrella open. When the umbrella is open, *an individual feels safe*, and can participate in the examination or treatment at hand. While most of the principles are components of patient-centred care, they take on even greater significance within the context of childhood sexual abuse and other interpersonal violence.

The physical therapist's deliberate and ongoing attention to the principles (highlighted in bold in this section) can help to address the difficulties related to past abuse that survivors may experience during healthcare encounters. For example, abuse disrespects and disregards the child's autonomy and boundaries; hence, the physical therapist's active demonstration of **respect for the patient** and **attention to the survivor's boundaries** is very important. The lack of control experienced when a child is abused needs to be countered by conscious **sharing of control** during treatment. While this must apply to all components of treatment, seeking *ongoing* verbal consent stands out as crucial, beginning with the first contact. One woman explained the importance of consent, saying "being a survivor, I have to be in charge, I guess, and if I'm not in charge... it's an awful feeling...I want that person out of here..." <sup>9 p.255</sup>

Time pressures can leave survivors feeling like a 'number' in a similar way that they were objectified during abuse. Thus **taking time** to connect with the patient and putting ongoing effort into maintaining **rapport** are essential. **Sharing information** both addresses fears about the physical therapist's actions and provides the opportunity for survivors to be *heard* as persons with valuable information to contribute their her health care. A woman explained that this was absolutely essential for her because "...the element of surprise is just really, really difficult to deal with...[and if] there's a preparation...[it reduces] that fear of the unknown, and [it reduces] the likelihood then that I will be triggered by something that is done...into remembering something that

(Continued on page 18)

is abusive for me.”<sup>9,p255</sup>

**Fostering a mutual learning process** stresses that survivors may be learning about caring for their bodies while at the same time, the clinician is learning about working more sensitively with survivors, a process that is dependent on mutual respect and cooperation. The final two principles speak to the importance of the clinician learning more about the long-term effects of interpersonal violence. The research participants told us that it is important that clinicians **understand that healing from childhood sexual abuse is not a linear process** and that the survivor's ability to participate in and tolerate treatment may vary unpredictably over time. As one woman said, *“Parts of my body at different times might be untouchable. It's gonna change, depending on what I'm dealing with. So, you're not going to be able to make a list and count on that every time kinda thing: it's gonna be a check-in every session.”*<sup>9,p255</sup> As a result, clinicians must indeed ‘check in every session’, invite the patient to verbalize discomfort, monitor body language that suggests decreased comfort and be willing to change treatment if the patient cannot tolerate a certain approach, whether temporarily or permanently. The final principle emphasizes the importance of clinicians **demonstrating their awareness about interpersonal violence** through their actions and using aids such as posters and brochures (e.g. from a local sexual assault center).

The guidelines for Sensitive Practice address components of practice that range from interactions with administrative staff to referral to other health care practitioners. In this article, we will attempt to highlight some of the aspects of practice that evoked the most attention of survivors and clinicians who participated in the study. We encourage readers to reflect on all aspects of their own practice, and seek new ways to facilitate the survivor's feeling of safety.

The first appointment can be crucial for survivors—many spoke about feeling so unsafe that they could not return for further appointments. In all health care settings, steps must be taken to ensure that the first moments of an encounter set a tone consistent with Sensitive Practice. By introducing oneself, explaining the nature of the appointment, and asking patients how they wish to be addressed, practitioners convey respect for their clients and begin to build a positive relationship with them. Further, before beginning any examination, the physical therapist must ask clients about their expectations for care. Doing so establishes a relationship that involves two-way sharing of information and control. It also creates an opportunity for the clinician to gain quick insight into patients' potential apprehensions, which can help to avoid triggering negative reactions. In long-term health care relationships, the periodic revisiting of roles and responsibilities allows for renegotiation and communicates genuine compassion and concern. For survivors, these simple actions can have a tremendously positive impact on their care because they demonstrate that the clinician is taking many conscious steps towards facilitating the survivor's feelings of safety.

The issue of disclosure is one that quickly arises when we focus on working with survivors of childhood sexual abuse. We approach disclosure in a number of ways. First, is the question of whether the clinician should inquire about past abuse. The research evidence connecting health and childhood adversity is so strong that we believe the clinician should inquire about childhood violence as a routine part of the health history, and leave the decision about whether or not to disclose up to the patient.

*I think it's important that [health care practitioners] ask questions about abuse as part of a medical history, particularly of women, and I think that anyone dealing with women's pain who doesn't ask questions about violence in a woman's life is not doing their job. I feel that very, very strongly.*<sup>9p.93</sup>

(Continued on page 19)

By routinely asking about past violence and abuse, practitioners open the door for individuals to disclose if they choose to do so. In asking the question, practitioners: (a) demonstrate that they have an understanding of the relationship between interpersonal violence and health; (b) break the harmful silence surrounding abuse and violence; (c) signal that they recognize interpersonal violence as a health issue; and (d) validate their patients' experiences. Asking about a history of abuse can also lead to improvements in health care and may help avoid or reduce retraumatization, which often occurs in health care settings.

*Surely [practitioners] realize that it's a part of who I am and it needs to be acknowledged, and it does have an impact in terms of how I need to be treated.*

Some survivors choose to disclose when asked, some may disclose at a later time once they firmly trust the physical therapist, and others may never disclose, for a variety of reasons. For those who choose to disclose, the clinician and patient can engage in a dialogue about the implications for their work together.

There will certainly be instances in which the patient does not disclose past abuse, even when asked. To understand how past abuse affects current health care, we recommend that clinicians use what we term *task-specific inquiry* to ask about patients' preferences for or potential difficulties with a specific examination, procedure, treatment or other aspects of the health care encounter. This provides an opportunity for patients to disclose information that is directly pertinent to the present situation without any reference to past interpersonal violence. Task-specific inquiry should be used during an initial meeting with a patient, before any new examination or procedure, and any time body language suggests that the patient may be uncomfortable or experiencing difficulty.

*We send out signals ... to people that we have been abused ... I was sending signals out, and I don't think the people were listening really and picking up on them ... [I would] cringe and move and I often said "What are you doing?"*<sup>9p.252</sup>

Task-specific inquiry should not be reserved exclusively for examinations involving touch. While touch is problematic for many survivors, other health care interventions and actions (such as standing behind a client during an examination, taking a pulse or blood pressure, or immersing a painful swollen hand in ice water) can also provoke discomfort and trigger distressing reactions. Regardless of other factors, task specific inquiry should also be done intermittently during interactions as an ongoing invitation to offer feedback or to identify problems.

Task-specific inquiry involves a combination of closed- and open-ended questions that offer patients an opportunity to share anything that they consider relevant. A closed-ended inquiry might be, "Have you ever had difficulty with examinations/procedures like this one?" If the individual answers in the affirmative, then an open-ended question – such as "What can I do to make this easier for you?" – can help to minimize the patient's discomfort. Before the examination begins, the physical therapist can extend a broad invitation to share relevant information (e.g., "Is there anything else I should know before we begin?").

*Asking if [the individual] has any issues or any concerns or are they uncomfortable, either physically or emotionally, is a really good way to start.*

The clinician's response to the task-specific disclosure is also crucial. Problem-solving with the patient provides the opportunity to identify possible solutions and demonstrate the physical therapist's willingness to share information and control; ignoring patient's difficulties and task-specific disclosure can undermine feelings of safety and trust.

*(Continued on page 20)*

*[It] would be even better ... if every time you went into a [practitioner's] office, they gave you a little survey ... asking you ..., "Do you have a problem with getting undressed, or being touched?" It would be great if they did that, 'cause then they'd have an idea of what kind of person they're dealing with when that person walks in that door. They're prepared – that person's prepared, because they think, or they'll know that the doctor or the physiotherapist has an idea of what they're going to be dealing with. That if this person says, "Mm, I don't feel comfortable with that," they're going to know. They're going to understand ... And I think that would be fantastic, if they did that. So then both parties would be aware of things.*<sup>11p.93</sup>

As with disclosure of past abuse, practitioners also need to be aware that, although they should make task-specific inquiries prior to any examination, some individuals may not be able to talk about their difficulties until they develop a rapport with their physical therapist. Further, the ability or willingness to talk about task-specific difficulties may be a function of the survivor's stage of healing; certain components of an exam may be well tolerated at some times and problematic at others.

### **Dealing with difficult situations**

Despite ongoing efforts to help the survivor to feel safe, (ongoing information sharing and informed consent, task-specific inquiry, repeated invitations to provide feedback, joint problems solving et cetera), it is sometimes impossible to avoid difficult situations in which the patient appears very upset or distraught and the clinician is unsure of what has happened and what to do. In such instances, reference to the "SAVE the Situation" model may be helpful. The model uses "SAVE" as an acronym for the following four steps: **S**top, **A**ppreciate, **V**alidate and **E**xplore. The "SAVE" approach can be effective in any difficult situation and is not reserved exclusively for work with survivors.

The acronym **SAVE** is a guide for responding effectively and compassionately in a variety of emotionally charged situations.

- **S**top - Stop what you are doing and focus your full attention to the present situation.
- **A**ppreciate - Try to appreciate and understand the person's situation by using the helping skills of empathy and immediacy. Empathy involves imagining the other person's experience (thoughts, feelings, body sensations) and communicating an understanding of that experience. Immediacy is verbalizing one's observations and responses in the moment, using present tense language. For example, 'Your fists are clenched and you look angry. What is happening for you?' or 'You seem upset' or 'I doubt there is anything that I can say that will make this easier. Is it okay with you if I sit here with you for a few minutes? If the person is unable or unwilling to answer, the HP can shift the focus to actions that s/he can do to assist the client, for example, 'How can I help you?'
- **V**alidate - Validate the other person's experience. For example, "Given what you have just told me, it makes sense that you feel angry."
- **E**xplore - Explore the next step. For example, "Who can I call to come and stay with you?" or 'This has been difficult for both of us. I am not sure where to go from here. Can I check with you tomorrow to see how you are doing and how you would like to proceed?'

### **If a survivor has been triggered**

SAVE can be used as the first steps when a survivor is triggered by some aspect of the healthcare encounter. The following ideas may assist the clinician working with a patient who has been triggered.

*(Continued on page 21)*

- Follow the SAVE protocol;
- Orient clients to the present by reminding them where they are and what was happening when they began to have trouble staying present;
- Encourage slow, rhythmic “4-6 breathing” (inhale to the count of four and exhale to the count of six) and (if possible) sitting up and placing their feet on the floor;
- Remind individuals to keep their eyes open and to look around the room;
- Encourage patients to notice physical sensations (e.g., the feeling of their back on the chair and their feet touching the floor, or the sensation of the air on their face).

*As clients become more oriented and responsive:*

- Do not touch them;
- Offer verbal reassurance in a calm voice;
- Avoid asking complicated questions or giving complex instructions; instead, ask simple questions to try to connect with the person (e.g., “Are you with me?”, “Are you following me?”, “Do you have ways of staying present?”);
- Offer them a glass of water;
- Allow them the necessary time and space to regain their equilibrium (a quiet room may be helpful);
- Normalize the experience. If the patient has disclosed abuse prior to this incident, let her know that health care interventions commonly trigger flashbacks or emotional responses, but do not ask for details of past abuse that may have contributed to being triggered. If the patient has not disclosed abuse, frame the normalizing comments in terms of anxiety that many people feel when seeing health care practitioners;
- Ask what the clients need right now (e.g. do they want your company or would they rather be alone);
- Offer continuity of care (i.e., if time constraints prevent you from staying with upset clients as long as you would like, explain this and ask if someone else can help, such as another staff member or a friend whom you could call).
- Ask whether the client feels able to continue the examination or treatment.

Being triggered can be a frightening or bewildering experience. Some clients may benefit from talking about the experience. Thus, clinicians can inquire about whether the patient has someone to offer support and whether they would like to contact that person now (e.g., “A new exam like the one we were doing today can be scary for many people and can bring about very strong emotions, as you just experienced. Sometimes it helps to talk about what happened. Do you have anyone you can process this with? Would you like to call this person to be with you now?”). If the patient would like to explore what has happened but does not have a support person or counsellor, the clinician can ask if she would like a referral to a counsellor or other community resource. If the individual is unaware of resources such as telephone help lines, the clinician can provide this information. Referral can be useful for some survivors, however, it is important to realize that offering a referral too quickly can be taken as a message that the clinician wants to avoid or ignore the incident.

The next time the practitioner sees the client it is important to mention the experience to ensure that they are feeling better and to reaffirm the message that the event does not alter the esteem in which they are held. This is a useful time to problem-solve with clients to identify what to avoid or modify in the future to prevent further triggering, keeping in mind that they may or may not be able to identify the trigger for a par-

*(Continued on page 22)*

ticular incident. This is also a good time to learn from the individuals what techniques they use to stay present and grounded, including any reminders or instructions that the clinician can give them. As time progresses, if the survivor has repeated difficulty, a consultation with a mental health practitioner may enable the patient to develop additional strategies for coping with triggers.

A person who has been triggered or has dissociated may not retain or recall important information shared by the clinician. Thus, it is helpful for practitioners to repeat all instructions and write down instructions and recommendations in clear language. Individuals who have repeated experiences of dissociation during treatment may benefit from the use of a notebook to write information, instructions, and suggestions. Under such circumstances, the physical therapist and client can share the responsibility for ensuring that essential information is recorded before the end of the interaction.

Practitioners may need to seek the support of a colleague or counsellor to talk about *their own reactions* to disclosures of childhood sexual abuse or other difficult situations with patients. Obtaining this support can and must be done without breaching confidentiality. Seeking support is not a sign of weakness; rather, it is indicative of taking professional responsibilities seriously. Practitioners who have personal histories of childhood sexual abuse may be especially empathic towards other survivors, particularly if they have worked through and resolved their own wounds. However, practitioners who have unresolved abuse issues may face great challenges when working with other survivors.<sup>2,7</sup> It is recommended that individuals work through and come to terms with their own history of childhood sexual abuse to avoid confusing their own difficulties with those of their patients.

All forms of violence and abuse can leave an individual feeling disempowered and disconnected from others. Healing from abuse involves re-empowerment and reconnection with self and others.<sup>7</sup> Because the harm of abuse occurs in the context of relationships and because it affects individuals' ability to relate with others, healing can only occur in relationships. Relationships with caring others provide the substrate – the nutrient medium – for healing the parts of the self that were damaged by past trauma. Physical therapists can be allies in that process by offering effective and sensitive health care in the context of genuine human connection. They can also facilitate reconnection by helping survivors learn about their bodies and how they function in health and illness.

*Handbook on Sensitive Practice for Health Care Practitioners: Lessons from Adult Survivors of Childhood Sexual Abuse* is available free of charge in English ([http://www.phac-aspc.gc.ca/ncfv-cnivf/pdfs/nfntsx-handbook\\_e.pdf](http://www.phac-aspc.gc.ca/ncfv-cnivf/pdfs/nfntsx-handbook_e.pdf)) and French ([http://www.phac-aspc.gc.ca/ncfv-cnivf/pdfs/nfntsx-handbook\\_f.pdf](http://www.phac-aspc.gc.ca/ncfv-cnivf/pdfs/nfntsx-handbook_f.pdf)) from the Public Health Agency of Canada's National Clearinghouse on Family Violence.

## References

1. Banyard V.L., Edwards, V.J., Kendall-Tackett, K.A. (Eds) (2009). *Trauma and Physical Health*. London: Routledge.
2. Blume ES. (1990) *Secret survivors*. New York: Ballantine Books.
3. Bohn, D.D. & Holz, K.A. (1996). Sequelae of abuse: Health effects of childhood sexual abuse, domestic battering, and rape. *Journal of Nurse-Midwifery*, 41(6), 442-456.
4. Bolen, R. & Scannapieco, M. (1999) Prevalence of child sexual abuse: A corrective meta-analysis. *Social Service Review*, 73(3), 281-313.
5. Briere, J., & Elliott, D.M. (2003). Prevalence and psychological sequelae of self-reported childhood physical and sexual abuse in a general population sample of men and women. *Child Abuse and Neglect*, 27(10), 1205-22.

(Continued on page 23)

6. Finkelhor, D. (1994). Current information on the scope and nature of child sexual abuse. *The Future of Children*, 4(2), 31-53.
7. Herman, J. (1992). *Trauma and recovery*. New York: Basic Books.
8. Monahan, K., & Forgash, C. (2000). Enhancing the health care experiences of adult female survivors of childhood sexual abuse. *Women & Health*, 30(4), 27-41.
9. Schachter, C.L., Stalker, C.A., & Teram, E. (1999). Toward sensitive practice: Issues for physical therapists working with survivors of childhood sexual abuse. *Physical Therapy*, 79(3), 248-261.
10. Schachter, C.L., Stalker, C.A., Teram, E., Lasiuk, G.C., Danilkewich, A. 2009. *Handbook on Sensitive Practice for Health Care Practitioners: Lessons from Adult Survivors of Childhood Sexual Abuse*. Public Health Agency of Canada: Ottawa, Canada.
11. Teram, E., Schachter, C.L., & Stalker, C.A. (1999). Opening the doors to disclosure: Childhood sexual abuse survivors reflect on telling physical therapists about their trauma. *Physiotherapy*, 85(2), 88-97.

## ABSTRACTS

### **Introducing aromatherapy as a form of pain management into a delivery suite**

K. R. Pollard. *Journal of the Association of Chartered Physiotherapists in Women's Health*, Autumn 2008, **103**, 12–16.

#### **Abstract**

This paper describes the implementation and audit of aromatherapy in the delivery suite of a busy consultant-led maternity unit. Aromatherapy was introduced with the aims of reducing the need for more invasive and expensive forms of pain management, and maximizing mothers' positive experiences of labour. An audit carried out in the inaugural year of the implementation appears to support the use of this therapeutic intervention.

### **The benefits of pelvic floor muscle training in people with multiple sclerosis and lower urinary tract dysfunction**

D. McLurg, A. Lowe-Strong & R. G. Ashe. *Journal of the Association of Chartered Physiotherapists in Women's Health*, Autumn 2008, **103**, 21–28.

#### **Abstract**

The aim of this study was to determine whether pelvic floor muscle (PFM) training (PFMT) improves lower urinary tract function in people with multiple sclerosis (MS). Thirty-seven subjects (11 males and 26 females) with a definite diagnosis of MS were recruited from neurological outpatient departments and MS charities throughout Northern Ireland. The participants received individualized PFMT combined with electromyography (EMG) biofeedback for 9 weeks. These individuals served as the control group in a double-blind randomised controlled trial (RCT) of the effects of neuromuscular electrical stimulation on bladder dysfunction in people with MS. The outcome measures included: digital and EMG biofeedback assessment of the PFMs; the number of leakage episodes (bladder diary); the amount of leakage (pad test); uroflowmetry; the International Prostate Symptom Score; and a Visual Analogue Scale relating to the problems associated with the symptoms. The results of the RCT demonstrated that improvement in the strength and endurance of these muscles was possible, and a significant reduction in symptoms was evident. A 9-week PFMT programme improved the function of the PFMs, reduced the symptoms associated with lower urinary tract dysfunction and increased quality of life in people with MS.

---

#### **ACKNOWLEDGEMENT**

These Abstracts were published in the Journal for the Association of Chartered Physiotherapists in Women's Health, thanks goes to Ros Thomas for gaining permission to publish.



## IOPTWH Conference 2009

### The Portuguese Association of Physiotherapists

Dear Colleagues all over the world

The Portuguese Association of Physiotherapists through its interest group of Physiotherapy in Women's Health will be hosting the next IOPTWH Conference in Lisbon-Oeiras, in October. Though a small country and a small interest group we will try to do our best to make your stay worthwhile.

This year we are celebrating our 25<sup>th</sup> anniversary and have a number of physiotherapists working in women's health, and doing a great job. We are still new to some aspects of the specialty. We started 25 years ago with pre natal education, and later with post natal education. Ten years ago we started with incontinence education and then breast surgery rehabilitation. Since 2007, we have had a partnership with a recognized High School in Health Science and run a Post Graduation in Physiotherapy in Women's Health which has been very successful.

Since the very beginning, one of our main goals has been to have an updated and high standard of education. We are grateful for all the help we have received from our colleagues all over the world and those that have contributed to our growth.

We have always believed that we learn more and enhance our knowledge if we are able to enjoy the exchange and sharing of experiences and expertise.

I hope to see you all in Portugal this year and I am sure you will enjoy your stay as much as we shall enjoy you coming.

See you in October 2009.

#### Fátima Sancho

**President of the Portuguese Interest Group of Physiotherapy in Women's Health**



Portuguese Association of Physiotherapists in Women's Health Logo



Oeiras, Portugal

## CONTINUING EDUCATION

### IOPTWH CONFERENCE

**Date:** October 9-10, 2009

**Where:** Oerias, Portugal

**More Information:** [www.ioptwh.org](http://www.ioptwh.org)



### INTERNATIONAL CONTINENCE SOCIETY

#### ANNUAL MEETING

39<sup>TH</sup> Annual Meeting

Date: September 29<sup>th</sup> to October 30<sup>th</sup>, 2009

Where: San Francisco, USA

More Information: [www.icsoffice.org](http://www.icsoffice.org)

#### COURSES

**5th Pan-Arab Continence Society (PACS) Congress**

Date: December 18th, 2008

Where: Jordan

More Information: [www.icsoffice.org](http://www.icsoffice.org)

### AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

#### 2<sup>ND</sup> CONTINENCE & WOMENS HEALTH CONFERENCE

Date: October 3-5, 2009

Where: Sydney, Australia

More Information: [www.physiotherapy.asn.au](http://www.physiotherapy.asn.au)



## IOPTWH CONTACT LIST

WWW.IOPTWH.ORG

### EXECUTIVE COMMITTEE

#### **PRESIDENT**

*REBECCA STEPHENSON*  
rgspt@comcast.net

#### **VICE-PRESIDENT**

*MEENA SRAN*  
msran@cw.bc.ca

#### **SECRETARY**

*GILL BROOK*  
Gill.brook@lineone.net

#### **TREASURER**

*ROS THOMAS*  
ros.thomas@virgin.net

#### **MEMBER AT LARGE**

*DARIJA ŠĆEPANOVIĆ*  
darija.scepanovic@vsz.uni-lj.si

### COMMITTEE CHAIRS

#### **PRACTICE**

*RUTH BROOM*  
ruthieb@paradise.net.nz

#### **RESEARCH & EDUCATION**

*DARIJA ŠĆEPANOVIĆ*  
darija.scepanovic@vsz.uni-lj.si

#### **PROGRAM**

*GILL BROOK*  
Gill.brook@lineone.net

#### **PUBLICATION & INFORMATION**

*ROS THOMAS*  
ros.thomas@virgin.net

#### **NEWSLETTER EDITOR & WEB PAGE**

**COORDINATOR**  
*SIMONE GRUENIG*  
simonegruenig@hotmail.com

### FALL 2009 NEWSLETTER

**Deadline for Submission: September 13, 2009**

**Publication Date: September 30, 2009**

I am always looking for member contributions (or if you know of anyone that I can contact that would also be helpful):

- ⇒ Book Reviews.
- ⇒ Articles.
- ⇒ Highlights from courses and conferences.
- ⇒ Interesting member profiles.

There is no minimum length and it can be in any format.