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Observational placement at a pelvic floor clinic: a reflective report

Physiotherapy appeals to me because of the diversity of its applications, and the significant impact that it can have on people's lives. In general, I find myself attracted to areas of practice that are holistic, functional and have an effect on quality of life (QoL). For these reasons, I chose to complete a literature review and a proposal for a research module in women's health, an area that, following a brief lecture, I wanted to know more about. In order to increase my knowledge and gain a depth of understanding that simply reviewing the evidence would not give me, I decided that I would benefit from observing a women's health physiotherapist and member of Pelvic, Obstetric and Gynaecological Physiotherapy (POGP) in action. I was lucky enough to be able to contact a local physiotherapist, a pelvic floor specialist at a district general hospital, who allowed me to watch her at work in her diverse clinic.

I observed a number of patient assessments, which included evaluations of women suffering from pelvic organ prolapse, hypersensitivity and weak pelvic floor muscles (PFMs). All of the women I saw had experienced reduced QoL because of either pain or continence issues. This was measured using validated tools during the first assessment.

The relationship between the physiotherapist and her patients in this environment was of particular interest to me. Having worked in the community for the past 8 years, I have frequently noticed the importance of therapeutic interactions. Good communication, a supportive attitude, and a professional but personal relationship have an impact on all areas of physiotherapy treatment. Patients feel that they are being listened to and understood, and as such, come to a broader appreciation of the purpose of their treatment, which increases their compliance with home exercise programmes.

The benefits of positive therapeutic relationships in women's health physiotherapy described above are based on my own anecdotal observations. However, improved compliance and the significant impact of interaction, as opposed to intervention without communication, has been backed up by a number of studies in other areas (Sluijs *et al.* 1993; Campbell *et al.* 2001; Linde *et al.* 2011). Because of this, interaction is recognized as being a factor that must be controlled for when planning research (Hicks 2004).

I very much enjoyed watching the skilled way in which the physiotherapist built her relationship with her patients from their initial assessment onwards. She was understanding and sensitive, but also frank and professional. This allowed patients to respond to questions and treatment without embarrassment, and meant that they appeared to feel comfortable about asking questions themselves.

The physiotherapist empowered the women whom she saw. One of the ways she did this was, when possible, by asking her patients to insert any vaginal devices themselves. This approach has the benefit of allowing women to take ownership of their treatment, and to assume responsibility for their own participation in the exercise programme. It also has the added advantage of ensuring that patients can raise any queries with the physiotherapist during the clinic, as opposed to having problems at home when trying to use the devices there for the first time.

Patients are also treated in a sitting position, where possible and appropriate, rather than in a supine position. This is because lying down may have connotations of submission and powerlessness. To ensure that there is absolutely no underlying suggestion of this, patients are encouraged to take more control of their treatment, including the position that they adopt. This has the added benefit of reducing disassociation, which may be the result of a previous negative experience, a coping mechanism that women with chronic pelvic girdle pain are significantly more likely to use (Walker *et al.* 1992). There are times when treatment may call for a patient to lie in supine, of course; for example, in order to work their PFMs without the influence of gravity. However, an awareness of the issues surrounding this underpins women's health physiotherapy.

The physiotherapist also discussed her concerns about the use of pornography by younger adults, and the unrealistic expectations this creates. Young women have been referred to her for vaginismus triggered by anxiety and the trauma

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caused by their previous sexual experiences. I wonder what impact this will have on these individuals as they age?

As a student, I found it particularly notable that the physiotherapist was often able to pre-empt a woman's description of her symptoms during the subjective assessment. I was also fascinated to witness the patient's response to this. The subjective assessment prompted the physiotherapist to ask questions, and the answers helped her to diagnose and treat the woman's issues. The physiotherapist gave her patients confidence by telling them that she had seen people suffering from their problems before, and she was able to allow patients to speak about their issues freely. I should also point out that appropriate questioning allows clinicians to stick to appointment times!

Biofeedback was used to direct treatment during treatment sessions. It gives women a visual tool to help them respond to the physiotherapist's directions. Given that some evidence suggests that around half of women who are taught to do PFM exercises (PFMEs) are unable to complete these effectively, biofeedback quite simply allows physiotherapists and patients to know when they are performing their exercises correctly, and eliminates the need for repeated invasive physical examinations.

Women's health technology is advancing, and other devices intended to help women perform PFMEs are now available, such as the Elvie exercise tracker (Chiaro, London, UK; see pp. 80–82). This allows women to complete their PFM training using an app on their mobile phone. The Elvie device is an attractively designed "pebble", in stark contrast to the Pelvic Toner (Kegel8 Savantini Ltd, Kingston upon Hull, UK), which although available on prescription, is a lot less user-friendly and looks somewhat like a torture device! However, beautiful as Elvie appears, it costs £149 (Elvie 2016), which would price some people out of being able to use it, I imagine.

It seemed to me that PFM problems were only a small part of the issues with which the women whom I saw in the clinic were dealing. Muscles can usually be trained, but when these are part of an area that is considered intimate and possibly rarely discussed, it may not be their physiology that holds patients back so much as their own feelings and beliefs about their pelvic floor.

As a student physiotherapist who has had two children, the morning I spent with the physiotherapist was very enlightening, both clinically and in terms of the amount of detail I learned. If I assume that most women are like me, then I have identified a huge gap in our knowledge of how to perform PFMEs (e.g. the correct holding time, and numbers of sets and repetitions). Would better public awareness help to reduce problems further? Pelvic floor muscle training could potentially be brought into many areas of therapy. If nothing else, better awareness may allow a more-open discussion about the problems associated with the PFMs, and help to reduce the severe under-reporting of these issues (CSP 2014).

I would very much like to spend more time with clinicians working in this area, and in particular, I want to gain a better understanding of related men's health problems. I also intend to apply to attend the 2016 POGP Conference because I feel that a good understanding of the pelvic floor could potentially be of benefit in whichever area I begin my physiotherapy career.

Many thanks to my local POGP physiotherapist for giving up her precious time to allow me to visit her clinic, and also for answering all my questions with patience.

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