Araştırma Sunumu / Research Article

Factors Affecting The Recovery Time in Vaginismus / *Vajinismusda iyileşme süresine etki eden faktörler*

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Abstract

Aim: To examine the factors that had an impact on the treatment duration in patients presenting with a diagnosis of vaginismus. Method: This retrospective study included 62 patients who received cognitive behavioral therapy for vaginismus. Golombok Rusk Inventory of Sexual Satisfaction, Sexual Myths Scale tests and a socio-demographic questionnaire were applied to all patients. Those who responded to the treatment in the first 7 weeks were classified as 'early responders' and others as 'non-early responders' and factors that may affect the responses were investigated. Results: Thirty-two patients were early responders (52%) and 30 patients were late/no responders (48%). Concerns regarding the pain experienced by the spouse (OR:7.4, 95% CI: 1.02-54.2, p=0.048) and the idea that sexual intercourse should always be initiated by the male partner (OR:8.98, 05% CI:1.07-75.38, p=0.043) emerged as predictors of late/no response in multivariate analysis.Conclusion: Concern for female partners' pain during sexual intercourse among male partners, and the sexual myth of "sexual intercourse should always be initiated by the male partner" among female partners seems to effect treatment response. Prospective studies in different populations are needed in the future. Prospective studies in different populations are needed in the future.

Keywords: Vaginismus, Treatment response, Cognitive behavioral therapy.

Öz

Giriş: Vajinismus tanısı almış hastaların tedavi süresine etki eden faktörleri belirlemektir. Gereç ve Yöntem: Bu çalışmaya vajinismus için bilişsel davranışçı tedavi almış 62 hasta dahil edilmiştir. Tüm hastalara Golombok Rusk Inventory of Sexual Satisfaction, Sexual Myths Scale testleri uygulanmış ve bir sosyo-demografik soru formu verilmiştir. Tedaviye ilk 7 haftada yanıt verenler 'erken yanıt verenler', diğerleri ise 'geç yanıt veren ya da yanıt vermeyenler' olarak sınıflandırılmış, yanıt durumu üzerine etki edebilecek faktörler araştırılmıştır. Bulgular: Otuz iki hasta erken yanıt vermiş (52%), 30 hasta ise geç yanıt vermiş ya da yanıt vermemiştir (48%). Çok değişkenli analizde, eşin acı çekeceği endişesi (OR:7.4, 95% CI: 1.02-54.2, p=0.048) ve cinsel ilişkiyi her zaman erkek başlatmalıdır düşüncesi (OR:8.98, 05% CI:1.07-75.38, p=0.043) geç yanıt/yanıtsızlık için belirleyici olarak bulunmuştur. Sonuç: Erkek partnerin eşinin cinsel ilişki sırasında acı çekeceği endişesi ve kadın partnerin cinsel ilişkiyi her zaman erkek

başlatmalıdır şeklindeki düşüncesi tedavi yanıtını etkiliyor görünmektedir. Gelecekte değişik popülasyonlarda yapılacak prospektif çalışmalara ihtiyaç vardır.

Anahtar kelimeler: Vajinismus, Tedavi yanıtı, Bilişsel davranışçı terapi

1. Introduction

Vaginismus is the most prevalent sexual dysfunction disorder among females in Turkey (Yetkin, 1999). Main factors implicated in the high prevalence of this condition include cultural values, perceptions of sexuality, raising patterns in young girls, importance attributed to virginity, and lack of adequate knowledge on sexuality in both men and women (Dogan ve Ozkorumak, 2008; Dogan ve Saracoglu, 2009; Korkmaz ve diğerleri, 2008; Masters ve Johnson, 1970; Yasan ve Gurgen, 2004). Vaginismus represents a major health problem, as it may cause significant familial stress, relationship/communication problems, and infertility (Ozdel, Tumkaya, Levent, Atesci, ve Oguzhanoglu, 2013). Despite relative lack of incidence and prevalence studies, reported figures range between 5% and 17% (Hawton ve Catalan, 1990; Laumann, Gagnon, Michael, ve Michael, 1994; Reissing, Binik, ve Khalife, 1999) worldwide, and between 15% and 41% in Turkey (Dogan, 2006; Incesu, 2006; Leiblum ve Goldmeier, 2008). In a previous study by Öksüz et al. 42.9% of participating women reported pain during intercourse (Oksuz ve Malhan, 2006). Vaginismus can be defined as primary or secondary depending on the way it is seen. Primary vaginismus, also termed as "unconsummated marriage" occurs when vaginal penetration has never been achieved since the beginning of sexual life, while the secondary type of vaginismus is described as the occurrence of involuntary situational spasms in a woman who has previously been able to have penetrative sex. The latter type of vaginismus is more likely to be related with dyspareunia (Ozdel ve diğerleri, 2013). On the other hand, other authors classify vaginismus using a different approach based on its severity. Accordingly, type 1 patients can relieve perineal and levator spasms when reassured, while type 2 patients cannot achieve perineal relaxation, type 3 patients have elevation of buttocks in addition to levator spasm, and type 4 patients experience adduction and retreat in addition to above (Lamont, 1978). DSM IV criteria for vaginismus have been re-defined in DSM V as a "genito-pelvic pain disorder/penetration disorder" characterized by persistent or ongoing difficulties with one or more of the following for at least six months: marked difficulty, pain, fear, or anxiety during vaginal intercourse or penetration and marked tensing or tightening of the pelvic muscles (*American Psychiatric Association DSM-5 Diagnostic and statistical manual for mental disorders*, 2013). Although a variety of psychiatric therapies can be used to treat vaginismus, CBT is the most commonly preferred modality that yields good success rates. Also, other techniques such as the Eye Movement Desensitization and Reprocessing (EMDR) have been utilized (Ozdel ve diğerleri, 2013; Tastan ve Isik, 2015; F. Torun, 2010). Therapeutic success is determined by a multitude of factors, including but not limited to the belief in sexual myths, incorrect medical treatments, and use of erroneous traditional treatments (M. M. Ter Kuile ve Reissing, 2014). In this study, our objective was to examine the factors that had an impact on the treatment duration in patients presenting to our unit with a diagnosis of vaginismus.

2. Materials and Method

2.1. Research Model

A retrospective file search was performed for a total of 62 vaginismus patients attending to our psychiatric outpatient unit between 1999 and 2008.

2.2. Population and Sample

Power analysis was performed by using G Power (v3.1.7) program to determine the number of samples. The power of the study was xpressed as 1-β (β = type II error probability) and research should generally had 80% power. According to Cohen's effect size coefficients; assuming that the evaluations to be made between two independent groups will have a large effect size (d = 0.8), it was decided to take 30 people, considering that there should be at least 26 people in the groups and there may be losses in the working process.

2.3. Data Collection Tools

In our practice, Golombok Rusk Inventory of Sexual Satisfaction (GRISS), Sexual Myths Scale, and sociodemographic question form were routinely administered to all patients. GRISS is a likert-type scale that determines the personal sexual satisfaction level for heterosexual males and females (Rust ve Golombok, 1985), while the Sexual Myths Scale assesses whether the individual has any myths regarding sexuality (Zilbergeld, 1999). The Sexual Myth Scale was developed by Zilbergeld and is a scale previously used in other studies to investigate the common sexual myths in Turkey (Kayır, 1998; Fuat Torun, Torun ve Özaydın, 2011; Zilbergeld, 1999) Patients responding to treatment within 7 weeks were considered "early responders", while the remaining cases were categorized as "non-early responders", and factors determining an early or late/no response status were investigated. These periods were the subjective values determined by the authors. The authors adopted the methodology for CBT, taking into account the universal average duration of administration and the duration of cognitive change (Amick ve diğerleri, 2015). CBT, especially in female sexual dysfunctions, were reported to be around 8-12 weeks. We also made a distinction between the lower limit of 8 weeks and more (Moniek M Ter Kuile, Melles, Tuijnman-Raasveld, de Groot, ve van Lankveld, 2015). As a sign of healing, it was taken comfortably to provide a penile entrance and the woman was able to have sexual intercourse without suffering. Diagnoses were established by two independent clinicians based on clinical examination and DSM IV criteria. Patients who were found to have comorbid psychiatric conditions during this initial interview received appropriate therapy, while follow-up visits were scheduled for those with sub-clinical depression or anxiety. Although patients with a disease duration of less than 3 months were initially not included in the study, they were left to spontaneous recovery, and those with persistent disease were subsequently included. Patients were taken to the group or couple therapy without any special consideration. As a result of the increase in the number of patients due to inadequate working conditions during clinical practice, such a decision had been taken and intensive application had been tried to be overcome by group therapy method. 31 people in the group therapy and 31 in the couple therapy were included in the study. All patients received psychological training, and information was provided on the nature of the disease and CBT. Then, CBT based treatment was continued. For couple therapy, CBT sessions involved simultaneous participation of both spouses.

2.4. Statistical Analyzis

For statistical analyses, SPSS V 21 software pack was used. In univariate analyses, the frequency of factors with a potential effect on treatment response were compared with chi-square or Fisher's exact test as appropriate. In multivariate analyses, the independent predictors of late response were examined using a stepwise (forward selection) logistic regression analysis. A two-sided p value of less than 0.05 was considered statistically significant.

2.5. The Ethical Considerations of Research

A written consent form was obtained from all participants. The study was approved by the ethics committee of Inonu University Medical Faculty on 17.03.2009 and with number of 2009/04.

3. Results

A total of 62 female patients were included, with 32 patients in the early responders group (response within 7 weeks) and 30 patients in the late/no responders group. The table 1 shows the comparison of the two groups with respect to potential predictors of response in the univariate analysis. Previous use of another therapeutic method predicted a late/no response status. For significant or near-significant parameters, a multivariate analysis was performed in which concerns regarding the pain experienced by the spouse (OR:7.4, 95% CI: 1.02-54.2, p=0.048) and the idea that sexual intercourse should always be initiated by the male partner (OR:8.98, 05% CI:1.07-75.38, p=0.043) emerged as predictors of late/no response (Table2). In both groups, the general sexual mit belief levels were similar except for the two myths.

4. Discussion

Vaginismus is a known psychiatric disorder in which many sociocultural factors play a role in its etiology. As a matter of fact, vaginismus is a more common female sexual dysfunction compared to western countries in our country and countries in the Middle East (Yıldırım, 2017). Therefore, factors related to culture can be seen as factors affecting the course of treatment (Dağ, Dönmez, ve Kavlak, 2012). The clinicians have changed their couple treatment strategies as a group treatment in order to meet the intensive application demands. As we also encountered in clinical course and questioned many factors in our study such as; remaining naked in bed, touching to husband's penis, tear of hymen and fear of being in pain, false beliefs about masturbation, guiltiness about sexual intercourse are culture-specific and can arise from culture-related problems. Finally, there are publications supporting this in the literature (Rosario Fadul ve diğerleri, 2019). However, in our study in determining the duration of treatment in patients who respond early or late to treatment; factors appear to be inactive except for worry about the male partner's wife suffering during sexual intercourse and female partner thought of sexual intercourse should always be initiated by male. This can be explained either by the small number of patients or the fact that both groups are not compared with the non-vaginismus group. In logistic regression analysis, forward stepwise selection method was used, so in the final model there is only two factors left. Relatively small sample size of 62 patients might be the reason for borderline significance and large confidence intervals. This is one of the limitation of our study. Finally, it should be kept in mind that both two groups consisted of vaginismus patients. In our study, lack of healthy population control group is a limitation. There are many other factors that determine the duration of treatment like request of having child, wish to maintain marriage. However, data on these issues could not be reached in our clinical practice which is another limitation. In this study involving patients with vaginismus, concerns regarding the pain experienced by the female partner and the idea that sexual intercourse should always be initiated by the male partner were the two predictors of late/no response. Similar to many other studies from other countries, the mean age of our study participants was approximately 25 (Atmaca ve diğerleri, 2016) and more than half of the patients had a minimum education of 10 years (R. Fadul ve diğerleri, 2018). Also, in many studies, partners of vaginismus patients have also been included, with some studies reporting more passive personality traits in husbands of vaginismus patients (Farnam, Janghorbani, Merghati-Khoei, ve Raisi, 2014). Supportive of this notion, spouse concerns

regarding the pain during intercourse appeared to prolong the treatment process and thereby increase the effects of vaginismus in our study. To our knowledge, this has never been addressed previously in the published literature. However, in the study by Ter Kuile et al. in which therapist was directly involved as a facilitator in the treatment, catastrophic pain beliefs were a major determinant of poor disease course, with an approximate treatment duration of 12 weeks (M. M. Ter Kuile, Melles, Tuijnman-Raasveld, de Groot, ve van Lankveld, 2015). This observation regarding the spouse’s impact on treatment course is in close resemblance to our findings and is now considered an established phenomenon. Thus, provision of basic knowledge on anatomy, physiology, and pathophysiology of the disorder to the couples has a very significant therapeutic impact. In accordance with this, a similar course of training was provided to our patients and their spouses. Another important finding relates to the more frequent observation of the sexual myth “the sexual intercourse should always be initiated by the male partner” in those with a more prolonged course of recovery. The belief levels of both groups in sexual myths were the same but a difference was seen in two previously mentioned myths. The reverberations of this myth imply that these individuals had been heavily influenced by traditional/cultural/social misbeliefs and that the community in which the individual was brought up was judgmental of attitudes involving initiation of or enjoyment from sex. Prevalence of such myths in a community may indicate inadequacy of sexual education in schools with consequent lack of knowledge on sexuality. In this line of thinking, several studies have found reduced prevalence of sexual myths with increasing educational level (Evcili ve Golbasi, 2017). One of the most significant findings of our study relates to the fact that the duration of therapy was not significantly different between those who took couple therapy or group therapy. In our setting, group therapy was initially preferred as a means for circumventing the pressures of a very busy practice, and over the course of time, all patients were treated with group therapy based on the fact that it was deemed more motivating, feasible, and ergonomic. Although published studies referring to the duration of treatment are relatively scarce, our patients show improvement on average 7 weeks after the initiation of therapy. As both groups demonstrated similar duration of time to improvement, it may be proposed that the group therapy approach may be particularly suitable for busy practices, such as the state hospitals in our country. This gives the physicians the opportunity to treat more patients in a shorter period of time, leading to time, productivity, and cost savings both for the physicians and patients.

5. Conclusion

Among many factors that have been examined with regard to the impact on duration of therapy in patients with vaginismus, concern for spouse’s pain during sexual intercourse among male partners, and the sexual myth of “sexual intercourse should always be initiated by the male partner” among female partners emerged as factors associated with a more prolonged therapy course. The duration of therapy was similar irrespective of the therapeutic approach used in this study, i.e. couple therapy or group therapy. This latter finding suggests that group therapy in busy clinical practices may offer time, productivity, and cost savings. This study is expected to be a guide in vaginismus therapy especially for psychiatrists who work in hard conditions in state and training hospitals.

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Author contributions; Idea: EAM, RK, Design: EAM, Data Collection or Processing: EAM, Analysis / Interpretation: EAM, Literature Search: EAM, RK, Writer: EAM, RK, Critical Review: EAM, RK.

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Table 1. Univariate Analysis Of Predictors Of Treatment Response

	Early responders (n=32)	Late/no responders (n=30)	p
Age, y (mean ± SD)	24.6±3.5	24.6±3.5	0.954
Duration of education ≥ 10 years	22 (73.3%)	22 (68.8%)	0.783
Marriage ≥ 1 y	14 (46.7%)	21 (65.6%)	0.206
Employed	13 (43.3%)	7 (21.9%)	0.163
Previous trials of therapy	10 (33.3%)	20 (74.1%)	0.003**
Violence	4 (13.3%)	2 (6.5%)	0.425
Communication	9 (33.3%)	16 (51.6%)	0.192
Comorbid psychiatric diseases	5 (16.1)	4 (13.3)	0.758

Previous visit to a psychiatrist	15 (51.7%)	14 (45.2%)	0.796
Rural residency	2 (6.7%)	6 (18.8%)	0.258
Concerns for spouse's pain	4 (28.6%)	11 (64.7%)	0.073
Ability to stay naked in the bed	28 (93.3%)	25 (80.6%)	0.255
Can touch partner's penis	28 (96.6%)	24 (77.4%)	0.053
Partner can touch female genital organs	25 (87.3%)	24 (77.4%)	0.306
Flirt before marriage	22 (78.6%)	19 (65.5%)	0.379
Couples therapy	15 (50.0%)	16 (50.0%)	1.000
Intercourse should always be initiated by the male partner	6 (21.4%)	14 (46.7%)	0.056
Men should not expose their feelings	4 (14.3%)	4 (13.8%)	1.000
Masturbation during sexual intercourse is wrong	16 (59.3%)	17 (56.7%)	1.000
Sexual intercourse ≥ 1/week	18 (85.7%)	17 (65.4%)	0.179
Desire for sexual intercourse ≥ 1/week	21 (87.5%)	28 (96.6%)	0.318
Masturbation ≥ 1/week	3 (12.0%)	4 (14.3%)	1.000
Mostly prefers sex to be initiated by the spouse	3 (12.0%)	1 (37.9%)	0.060
Satisfied with the intercourse	18 (75.0%)	17 (73.9%)	1.000
Mostly agrees with the spouse's desire for sex	22 (88.0%)	22 (76.8%)	0.474

Feels guilt and aversion with sex	17 (68.0%)	21 (72.4%)	0.772
Pain	18 (90.8%)	21 (91.3%)	1.000
Satisfactory GRISS score	16 (61.5%)	21 (72.4%)	0.566
Can achieve orgasm	18 (69.2%)	20 (69.0%)	1.000
Considers the spouse as "trustworthy"	15 (93.8%)	20 (83.3%)	0.631

Not all patients answered all questions. Percentages refer to those who provided an answer for a specific question. **p<0.01

Table 2. Logistic Regression Analysis Results

	Beta	s.e.	p	Exp(β)	95% for Exp (β)
Concerns for spouse's pain	2.007	1.013	0.048*	7.441	1.022, 54.202
Mostly prefers sex to be initiated by the spouse	2.195	1.085	0.043*	8.983	1.071, 75.383

*p<0.05