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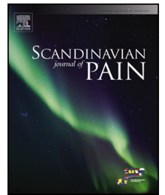

Original experimental

Living with genital pain: Sexual function, satisfaction, and help-seeking among women living in Sweden

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HIGHLIGHTS

- Many women suffer from genital pain, often associated with additional sexual problems.
- Sexual pain is not just sexual, but influences everyday life of women.
- Women who suffer from persistent sexual pain often fail to seek professional care.
- Women with sexual pain who seek care for their pain, report low treatment effects.

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ABSTRACT

Background and aims: Female genital pain is a debilitating problem that negatively affects several aspects of the life of women. Several studies present figures of prevalence indicating that the problem affects nearly 20% of young women. However, many women fail to consult health care and the estimated prevalence therefore remains insecure. Historically, genital pain was commonly viewed as either physiological or psychosexual. Although the current field of research and clinical expertise in general agree upon a biopsychosocial conceptualization, less is known about the manifestation of the problem in everyday life and the experience of seeking health care among afflicted women. The objectives of the present study was to examine genital pain in a general female population living in Sweden cross-sectionally in terms of prevalence, sexual function, sexual satisfaction and help seeking, and to identify possible predictors of genital pain among women.

Methods: The study was a population-based study using a postal questionnaire administered to 4052 women (age 18-–35). Of these 944 (response rate: 23%) took part in the study.

Results: Genital pain of six months duration was reported by 16.1% of the women. Women with pain more commonly reported fungal infections, other pain problems, sexual dysfunctions and symptoms of anxiety than pain-free women and in addition lower sexual satisfaction. There were no differences in sexual frequency. Pain was most commonly reported during sexual intercourse, but many women also experienced pain during non-sexual activities, with pain durations of several hours after the pain eliciting activity was interrupted. Of those reporting pain, 50% had sought care for their pain. The most common was to counsel a doctor and to receive topical treatment. However, the experienced effects of the treatments were on average low. In the explanatory model, fungal infections, and sexual dysfunctions were associated with genital pain.

Conclusions: The study had a low response rate, but still indicates that genital pain is common and negatively affects several aspects of women' life, not just sexual activities. Although many women report pro-longed pain experiences, many fail to consult health care and among those who seek care the effects of treatment are on average poor. There are strong associations between sexual dysfunctions (lack of sexual arousal, vaginal muscle tension hindering intercourse) and genital pain that, based on previous findings in this field of research, might be viewed in terms of circular maintaining processes.

Implications: Female genital pain is not just limited to the sexual context, but often negatively affects several situations in women' life. The size of the problem calls for immediate development of preventive interventions and treatment programs that focus on sexual education and to encourage a healthy sexuality among women and their partners. There is a need to identify methods in order to assemble evidence based interventions of female genital pain. Such methods are currently lacking, resulting in poor treatment options for women with pain.

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1. Introduction

Genital pain among women resulting in painful intercourse has been reported to be far more common than previously expected with prevalence figures for the general female population ranging between 10 and 13% [1]. Among women less than 30 years of age one of five reports chronic unexplained vulvar pain [2,3]. In clinical samples the corresponding numbers range between 34 and 72% [4,5]. Additionally, there are findings indicating that these conditions are increasing [1]. However, figures of prevalence especially based on clinical samples should be interpreted with caution since a large part of women with genital pain do not consult healthcare for their problem [2].

Within the psychological discipline and the DSM [6], pain during intercourse (dyspareunia) is categorized as a sexual dysfunction and thereby the only type of pain outside of the diagnostic category of 'pain disorder'. One criticism raised towards the DSM classification concerns the fact that the pain is defined primarily by the activity it is interfering with which isolates it from all other pain syndromes [7]. Thereby the condition of dyspareunia is primarily described as an intercourse problem. However, several studies demonstrate that women reporting painful intercourse, often experiences pain also in other situations, not involving sexual penetration (gynecological exam, touch, exercise, etc.)[8,9]. During the last decade arguments have been raised as to view dyspareunia as a pain disorder from a biopsychosocial perspective rather than as a sexual dysfunction [7,10]. The International Society for the Study of Vulvovaginal Disease, (ISSVD), defines female genital pain by its location and quality, occurring in the absence of relevant visible findings or a specific clinically identifiable, neurologic disorder. The pain might be provoked by sexual or nonsexual stimulation or by both [11]. These discrepancies regarding how genital/sexual pain should be viewed goes to show that there is a need of continued studies of the pain experience in genital pain and its consequences in everyday life of women.

Female genital pain and its sexual consequences has historically been an under-researched area, and were previously mostly studied from either a biomedical or a psychosexual perspective. Thereby, in comparison with other long-term pain conditions, knowledge on genital pain from a biopsychosocial perspective is scarce. There is a great lack of studies regarding the prevalence, etiology and assessment of women's genital pain conditions, resulting also in a lack of efficient treatment models. Although certain factors have been linked to genital pain, e.g. infections [12–14], pelvic floor muscle dysfunction [15], dyadic maladjustment [16], little is known of the relative role they play in the course of pain and to what degree such factors might explain the development of pain. In addition, in female genital pain, sexual function tends to be overly focused on intercourse and often fail to acknowledge other types of sexual behaviors, sexual dysfunctions and the woman' own perception of her sexual life. In sum, there is a continued need for studies especially in the general population examining the experience of genital pain among women, health-care consumption and predictive factors.

The aim of the present study was to examine female genital pain in terms of the pain experience and pain-related activities. In order to further illustrate patterns of health-care consumption experiences of seeking care and treatment were also included. Finally, the study sought to examine associations between pain, sexual dysfunctions, mental health and the woman' satisfaction with her sexual life.

2. Method

2.1. Design

This was a cross-sectional study, conducted as a postal survey.

2.2. Participants and setting

The initial sample consisted of 4252 women (age 18-–35) randomly chosen from the general population in two cities in the middle of Sweden. The sample was chosen using a random selection program conducted by SPAR (Statens Personadressregister) which is a company that administers data on all individuals living in Sweden. This is the standard procedure used in Sweden to create randomly chosen samples from the general population since it is efficient both in terms of time and resources. In addition a selection procedure can be saved and traced and replicated for follow-up analyses in further studies. Of the initial sample, 200 had to be excluded due to unknown addresses or because they had moved. Of the remaining 4052 women, 950 answered the questionnaire. A few cases were lost due to missing data, resulting in a final sample of 944 participants (response rate: 23%).

Postal surveys were administered to women of two middle-sized municipals in mid Sweden. The participants were groped into three age groups (18-–23, 24-–29, 30-–35 years). The size of each age group was weighed according to the size of the total number of women within in that specific age range in the general population of the two municipals. To give a valid representation of the study-population, the number of participants was also weighed in respect of the relative size of each of the two municipals.

2.3. Measures

Participants answered an extensive questionnaire including standardized self-reports inventories as well as specific items chosen to address the focus of the current study. Background variables included age, civil status, number of children, educational level, and occupational status.

Gynecological health: Gynecological health was measured with questions including experiences of abortion, contraceptive methods, and experiences of gynecological symptoms (e.g. infections; "*Have you been troubled by fungal infection/s?*").

Physical health: Included questions on common symptoms such as headache, aches in the body, uneasy stomach, distress/worry, sleeping difficulties) and how often these symptoms occur. The respondents also had to answer questions regarding the use of different types of medications (e.g. "*Do you use sleeping medication?*"). In addition questions on other types of pain conditions given and included pain in the last three months, pain duration and pain location.

Experiences of violence; was measured by questions regarding sexual, physical and psychological abuse (e.g. "Have you experienced any kind of sexual abuse, i.e. being forced to sex/had sex against your will").

Mental health: Mental health was measured with the *Hospital Anxiety and Depression Scale* (HADS) which is a standardized self-report inventory used to screen for anxiety and depression. The scale has shown to be reliable and gives a valid measure of the magnitude of the emotional disorder [17], also in Swedish normative data [18]. The scale has fourteen items whereof seven relate to anxiety and seven to depression. An analysis in the current sample gives a Cronbach's alpha at 0.82. In the statistical analysis HADS of the current data is treated as two separate variables following the division into the two subscales, anxiety and depression

Sexual function: Questions on sexual function included *sexual frequency* (non-penetrative sexual activity with a partner, penetrative sex with partner and sexual masturbation without a partner), e.g. "*How often do you have sexual intercourse with a partner*?" *Sexual satisfaction* was measured with a 10 point scale; ("*How satisfied are you with your sexual life during the last month?*"). *Sexual dysfunctions* included questions on other sexual problems such as; difficulties/inability to have an orgasm, lack/absence of desire,

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