

Internet-Based Guided Self-Help for Vaginal Penetration Difficulties: Results of a Randomized Controlled Pilot Trial



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ABSTRACT

Introduction: Difficulties with vaginal penetration can severely affect a woman's desire to have sexual intercourse, her sexual and general well-being, or her partnership. However, treatment opportunities for vaginismus are scarce.

Aim: To evaluate the efficacy of an internet-based guided self-help intervention for vaginismus in a randomized controlled pilot trial.

Methods: Seventy-seven women with vaginismus (primary inclusion criterion = no intercourse \geq 6 months) were randomly assigned to an intervention group (IG) and a waitlist control group (WCG). The intervention consisted of 10 sessions involving psychoeducation, relaxation exercises, sensate focus, and gradual exposure with dilators. Participants received written feedback on completed sessions from an eCoach.

Main Outcome Measures: The primary outcome was successful sexual intercourse. Secondary outcomes were non-intercourse penetration, fear of coitus, sexual functioning, and dyadic coping. Self-reported assessments were scheduled at baseline, 10 weeks, and 6 months.

Results: More participants (10 of 40, 34.48%) in the IG had intercourse compared with those in the WCG (6 of 37, 20.69%) at least once at 10 weeks or 6 months (odds ratio = 2.02). The difference was not significant ($\chi^2_1 = 1.38$, $P = .38$), but in the IG, there was a significant increase in intercourse penetration from baseline to 6 months ($d = 0.65$). No such increase was found in the WCG ($d = 0.21$). There were significant between-group effects concerning non-intercourse penetration (self-insertion of a finger or dilator or insertion by the partner) in favor of the IG. Fear of coitus and dyadic coping significantly decreased in the IG. Overall satisfaction with the training was high.

Conclusion: This randomized controlled trial showed promising effects of an internet-based intervention by increasing participants' ability to have intercourse and non-intercourse penetration while experiencing high treatment satisfaction. The WCG also showed improvement, although participants had vaginismus for an average duration of 6 years. Internet-based interventions could be a treatment modality to complement other methods in stepped care for vaginal penetration difficulties. **Zarski A-C, Berking M, Fackiner C, et al. Internet-Based Guided Self-Help for Vaginal Penetration Difficulties: Results of a Randomized Controlled Pilot Trial. J Sex Med 2017;14:238–254.**

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Key Words: Vaginismus; Genito-Pelvic Pain/Penetration Disorder; Sexual Dysfunction Disorder; Female Sexual Functioning; Internet Intervention; Randomized Controlled Trial

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INTRODUCTION

The recurrent or persistent difficulty or even impossibility of vaginal penetration, despite women's expressed wish for it, poses a considerable burden for the women concerned.^{1,2} These vaginal penetration problems range from the insertion of a tampon, at least one finger, or a speculum during gynecologic examinations to that of a penis during sexual intercourse. One of the primary characteristics of vaginal penetration difficulties is the fear of penetration or of the pain associated with penetration accompanied by avoidance behavior. These difficulties can be

present lifelong beginning with the first sexual contact or acquired after a period of normal sexual function.³

In the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (DSM-IV-TR), vaginal penetration difficulties were referred to as *vaginismus* and defined as a vaginal muscle spasm that interferes with sexual intercourse.³ This definition is the one used in the present study. In the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5), vaginal penetration difficulties are part of the new diagnosis of genito-pelvic pain/penetration disorder, which combines the revised definition of vaginismus with dyspareunia.^{4–8} Diagnostic criteria of genito-pelvic pain/penetration disorder are persistent or recurrent difficulties with (i) vaginal penetration during intercourse, (ii) genito-pelvic pain during vaginal intercourse or penetration attempts, (iii) fear of and anxiety about pain or vaginal penetration, or (iv) tightness of the pelvic floor muscles during attempted vaginal penetration.⁸

Because of the definitional problems and changing diagnostic criteria, epidemiologic incidence or prevalence estimates for vaginal penetration difficulties, previously referred to as *vaginismus*, are scarce. Reported prevalence rates in the literature vary from 5.0% to 81.0% in clinical samples^{9–12} and from 0.4% to 6.8% in non-clinical samples.^{13–18}

Vaginismus has been associated with a wide range of consequences such as low overall sexual functioning, decreased sexual behaviors, and low sexual satisfaction.^{19–22} It can negatively affect women's self-image and self-worth, especially with regard to their sexuality.^{20,23} These consequences also affect social relationships in general and relationships to partners in particular. Women report feelings of guilt for not being able to have sexual intercourse,²⁴ are afraid to lose their partner, or might struggle to have long-term relationships.²⁵ Vaginismus also can become a major strain if women want to have children.^{26,27} For all these reasons, women affected by vaginismus report impairment in quality of life and well-being.²⁸

Anxiety and negative cognitions about sexual stimuli, pain, and penetration are considered the most important etiologic and maintaining factors in vaginismus.^{4,25,29–35} They are believed to become conditioned responses to sexual situations, similar to those of anxiety disorders. Recent findings have strengthened this assumption by showing that achieving intercourse is mediated by the decrease of catastrophic pain penetration cognitions.³⁶ Therefore, a fear-avoidance model is well suited to explain the maintenance of vaginismus.^{37,38}

Research on other etiologic factors of vaginismus is scarce and has not yielded any conclusive evidence.²² Some studies have indicated that feelings of disgust^{25,39–41} and fear of losing control and failure in sexual situations^{25,40} could play an important role in vaginismus. Borg et al⁴² also found that strong conservative values and strict sexual standards are involved in the development and maintenance of vaginismus.

Other factors assumed to be associated with vaginismus are negative body and genital images²⁵ and negative sexual

experiences (eg, painful gynecologic examinations and sexual abuse).^{7,20} In the existing literature, the influence of partner-related variables on vaginismus has been assumed but not confirmed empirically (eg, with regard to male sexual dysfunctions).^{34,43,44} However, relationship quality has not been found to differ between couples with and without vaginismus in most studies.^{26,45} In addition to the influence of relationship quality, there is an effect of everyday stress on sexual problems.⁴⁶ Thus, the stress management skills of partners in a dyadic relationship seem to be closely linked to sexual functioning.

If vaginismus is conceptualized as a conditioned fear response, then exposure to feared stimuli is essential if women are to overcome their anxiety and negative cognitions and begin to engage in sexual behavior, including intercourse. Major cognitive-behavioral components of treatment for vaginismus include (i) psycho-education, (ii) gradual exposure with insertion of a finger, dilator, or tampon in the vagina, (iii) cognitive restructuring, (iv) relaxation and pelvic floor muscle exercises, (v) self-exploration, and (vi) sensate focus exercises with the partner.⁴⁷

However, only few interventions for vaginismus have been empirically tested thus far and even fewer studies have applied a randomized controlled trial (RCT) design.^{48–50} To the best of our knowledge, only two RCTs have been conducted thus far. Ter Kuile et al³⁵ evaluated the efficacy of therapist-guided vaginal-penetration exercises in an RCT of 70 women with vaginismus. Ter Kuile et al found that women in the intervention group were more likely to have sexual intercourse and show decreased coital fear and pain compared with the control group at 6 weeks after the intervention and 3-month follow-up. Van Lankveld et al⁵¹ evaluated the efficacy of cognitive-behavioral group therapy and bibliotherapy for women with lifelong vaginismus compared with a waitlist control group (N = 117). The bibliotherapy was a 3-month program guided by biweekly telephone contacts. The results showed that women in the two treatment conditions reported more successful intercourse at post-treatment assessment than the control group. Another RCT on cognitive-behavioral bibliotherapy for mixed sexual dysfunctions also included women with vaginismus (n = 29 of 199). The results showed a significant decrease in symptoms for women with vaginismus in the treatment group compared with the waitlist control condition. All the findings indicate that guided self-help treatment for women with vaginismus might be a promising treatment modality.

Integrating guided self-help interventions in the treatment of vaginismus offers the possibility to overcome barriers in health care that concern not only vaginismus but also sexual dysfunction disorders in general. One major limitation of traditional health care is the small number of evidence-based treatments and specialists that address the specific needs of women with vaginismus.⁴⁸ Furthermore, usage is limited because of stigma and shame.⁵² In the context of face-to-face therapy, feelings of shame can prevent not only patients but also therapists from addressing the issue of sexual problems.⁵²

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