



Communal motivation in couples coping with vulvodynia: Sexual distress mediates associations with pain, depression, and anxiety

Amy Muise^{a,*}, Sophie Bergeron^b, Emily A. Impett^c, Isabelle Delisle^d, Natalie O. Rosen^{d,e}

^a Department of Psychology, York University, Canada

^b Department of Psychology, Université de Montréal, Canada

^c Department of Psychology, University of Toronto Mississauga, Canada

^d Department of Obstetrics & Gynaecology, IWK Health Centre, Canada

^e Department of Psychology & Neuroscience, Dalhousie University, Canada

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ABSTRACT

Objective: To examine the role of a novel motivational perspective—sexual communal motivation—in women's pain during intercourse and both partners' distress in couples coping with vulvodynia, a prevalent gynecological pain condition. Our goal was to test whether sexual communal strength (i.e., motivation to meet a partner's sexual needs) and unmitigated sexual communion (i.e., prioritization of a partner's sexual needs in neglect of one's own needs) were indirectly associated with pain, depression, and anxiety via sexual distress.

Methods: Couples ($N = 101$) completed daily surveys about their sexual communal motivation, sexual distress, anxiety, depression, and women reported on their pain during intercourse. Using multilevel modeling, we examined how daily fluctuations in sexual communal motivation were directly and indirectly (via sexual distress) associated with pain and psychological distress.

Results: On days when women with vulvodynia reported higher sexual communal strength, they reported less pain and anxiety, and on days when they reported higher unmitigated sexual communion, they reported more pain, more anxiety, and both partners reported more depressive symptoms. Daily associations between women's unmitigated sexual communion and greater pain, depression and anxiety were mediated by sexual distress.

Conclusions: Being motivated to meet a partner's sexual needs was associated with less pain and anxiety for women with vulvodynia, but when this motivation excluded a focus on one's own needs, there were detrimental consequences for women's pain and both partners' depressive symptoms. Interventions for improving women's pain and the psychological well-being of affected couples should target motivational factors and sexual distress.

1. Introduction

Vulvodynia is a prevalent gynecological pain condition, affecting 8% of women [1]. The most common subtype of vulvodynia is provoked vestibulodynia (PVD), which is characterized by recurrent pain localized in the vulvar vestibule and experienced in sexual and non-sexual contexts [2]. Vulvodynia has consequences for couples' sexual activity and romantic relationship—both of which are central to couples' overall health and well-being [3,4]. Women with vulvodynia are four times more likely to report depression and anxiety than women without vulvodynia, and depression and anxiety disorders are more common following a diagnosis of vulvodynia than preceding it [5]. Often, affected women report feeling stigmatized by health care providers and inadequate as sexual partners, contributing to their distress [6]. In one study, male partners also report more depressive symptoms

compared to age-matched controls [7], although other studies have found no such differences [8,9]. Still, a recent qualitative study underscored that male partners experience significant distress in their relationship as a consequence of vulvodynia [10].

Women with vulvodynia cope with the pain for many years. In a population-based sample, the average pain duration was > 12 years [1] and over two-thirds of affected women receive no diagnosis or treatment [11]. Yet, > 85% of couples report engaging in painful vaginal intercourse [1], underscoring the importance of considering their motivation for doing so. Motivation plays a key role in pain maintenance and psychological adjustment [12,13]. In a study of individuals with chronic pain, both achievement goals for persisting with painful activities and pain-avoidance goals were associated with greater pain severity and disability [14]. Motivational factors also play an important role in the experience of pain and distress for couples coping with

* Corresponding author at: Department of Psychology, York University, Behavioural Science Building Room 244, 4700 Keele St, Toronto, Ontario, M3J 1P3, Canada.
E-mail address: muiseamy@yorku.ca (A. Muise).

vulvodynia [15–17]; when affected women engage in sex for avoidance goals (i.e., to avoid conflict) they report greater depressive symptoms and more pain, whereas when they pursue sex for approach goals (i.e., to enhance intimacy) both partners report fewer depressive symptoms [15,16].

Theories of communal motivation have focused on when and for whom being motivated to be responsive to a partner's needs is beneficial. People high in *communal strength*—those who are highly motivated to meet a partner's needs [18,19]—tend to report more satisfaction when making sacrifices for a romantic partner [20]. Whereas people high in *unmitigated communion*—those who provide care to others that involves self-neglect [21,22]—tend to experience poorer health and well-being [22,23]. In couples where one partner experiences chronic pain, being motivated to help that partner for autonomous reasons (i.e., inherent enjoyment), in line with communal strength, as opposed to controlled reasons (i.e., internal obligation), was associated with greater subjective well-being and less distress for both partners [24,25]. In contrast, women with rheumatoid arthritis who reported higher (relative to lower) unmitigated communion were more psychologically distressed [26], and, among patients recovering from their first coronary event, those higher in unmitigated communion had spouses who reported more anxiety and depression [22].

In vulvodynia, where there is interference to the couples' sexual relationship, the motivation to meet a partner's *sexual* needs is important. *Sexual communal strength*—the extent to which people are motivated to be responsive to their partner's sexual needs [27]—and *unmitigated sexual communion*—the motivation to meet a partner's sexual needs to the exclusion of a person's own needs [23]—are shown to be relevant for couples' coping with vulvodynia [23]. In qualitative studies, women who report pain during intercourse indicated that satisfying their partner's sexual needs was a key reason for continuing to have intercourse [28], and tended to prioritize their partner's sexual needs over their own [29,30]. The partners of women with vulvodynia might feel pressure to focus on the woman's needs given her pain, while setting aside their own sexual needs, which might account for partners' greater distress [10].

One reason people higher in unmitigated communion report greater psychological distress is because when managing an illness or stressor, they feel more distress about the specific health issue [31]. Among women recently diagnosed with breast cancer, those higher in unmitigated communion reported greater psychological distress, and this was accounted for by distress specifically related to their health issue—body image [32]. In contrast, people higher in communion (a construct similar to communal strength) tend to more effectively cope with health issues because they are comfortable receiving support from others and in turn, report greater well-being and less psychological distress compared to people higher in unmitigated communion [33,34]. In the context of vulvodynia, both members of affected couples report significantly higher sexual distress compared to pain-free controls [35–38], and this sexual distress, in turn, exacerbates women's pain. For example, women with vulvodynia who report more negative thoughts about sex (i.e., negative body and genital image) also report greater pain intensity [37]. Understanding the role of couples' sexual distress as an explanatory mechanism in the association between sexual communal motivation, pain and psychological distress is important for improving treatments for vulvodynia; targeting sexual distress could yield benefits for psychological well-being and women's pain.

In the current study—a two-month daily experience study of couples coping with vulvodynia—our key aim was to test the direct and indirect (via sexual distress) associations between daily fluctuations in sexual communal motivation and women's pain during intercourse, and both partners' depression and anxiety. We predicted that on days when women with vulvodynia and partners reported higher sexual communal strength, they would report lower sexual distress, and in turn, women would report less pain and both partners would report less psychological distress. In contrast, on days when women with vulvodynia and

partners reported higher unmitigated sexual communion, they would report greater sexual distress, and in turn, women would experience more pain, and both partners would report more psychological distress.

2. Method

2.1. Participants

Women with vulvodynia and their partners ($N = 153$ couples) were recruited in two North American cities through advertisements (105; 69%), participation in our prior research studies (29; 19%), physician referrals (16; 10%), and word of mouth (3; 2%). For women, the inclusion criteria were: [1] a diagnosis of PVD based on: reports of pain during vaginal intercourse which was subjectively distressing, had lasted for at least six months, and occurred on 80% of intercourse attempts, pain limited to pressure to the vestibule, pain during the diagnostic gynecological examination at a minimum of four on a self-reported scale ranging from 0 (*not pain at all*) to 10 (*worst pain imaginable*); [2] see their partner in-person at least four times per week; and [3] engaged in sexual activity with their partner a minimum of once per month in the previous three months. Exclusion criteria for women were: active vulvo-vaginal infection, pregnancy, age < 18 or > 45 years, and had started menopause (self-reported). The only inclusion criterion specific to partners was age of 18 or older.

Of 153 interested couples, 49 (32%) were ineligible: 12 (8%) did not receive a diagnosis of PVD, 25 (16%) women or partners withdrew before starting the daily surveys, 9 (6%) couples ended their relationship during the eligibility process, and 3 (2%) were ineligible for other reasons (e.g., pain location criteria). Of the 49 ineligible couples, we have demographic information (age, relationship duration, sexual frequency and pain duration) for 34 couples, who did not differ significantly on any of these variables compared to the eligible couples. Of the 104 eligible couples, three couples were excluded because they did not report engaging in sexual activity during the study. The final sample size included 101 women diagnosed with PVD and their partners ($n = 99$ men; 2 women) (see Table 1 for participant demographics).

2.2. Procedure

The current study used data collected from an ongoing study. One paper has been published focusing on sexual functioning, sexual satisfaction, and relationship satisfaction [23]. The current paper, however, focuses on associations between sexual communal motivation and women's pain during intercourse, which has been shown to be unrelated to sexual and relationship functioning in vulvodynia [39], as well as both partners' symptoms of anxiety and depression, which are broader indices of couples' psychological adjustment. Women were screened for eligibility using a structured interview and gynecological examination (if not referred directly from a physician). The gynecological exam involved a well-validated “cotton swab test” [2]. Study participation had the benefit of expediting a gynecological appointment. Eligible couples attended a laboratory session where they provided informed consent and completed online questionnaires. Participants then completed daily online surveys for eight consecutive weeks. They were instructed to begin the daily surveys that evening and to complete them each evening (reflecting on the previous 24 h) independently from their partner. Daily measures included an item asking whether or not the participant had engaged in sexual activities in the preceding 24 h. If the participant answered yes, they completed measures of sexual communal strength, unmitigated sexual communion, and sexual distress. If they indicated that vaginal intercourse occurred, women reported on their experience of pain (i.e., intensity and unpleasantness). Each day participants also completed measures of depressive symptoms and anxiety. After completing the study, participants received psychoeducational information and references to local health professionals with expertise in vulvodynia. Women received \$20

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