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The online version of this article can be found at
http://ebcj.mums.ac.ir/article_13956.html

Evidence Based Care Journal 2019 09:58 originally published online 01 October 2019

DOI: 10.22038/ebcj.2019.38449.2009

Online ISSN: 2008-370X

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Evidence Based Care Journal

Short Report

OPEN ACCESS JOURNALS

The Effect of Motivational Interviewing-Based Counseling on Women's Sexual Satisfaction and Body Image

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Received: 24/02/2019
Accepted: 28/09/2019

Evidence Based Care Journal, 9 (3): 58-62

Abstract

It is a widespread recognition that breast cancer adversely affects the lives of many women the world over. Surgeries leading to breast loss (mastectomy) exert a negative impact on body image, sexual drives, and quality of life among women with breast cancer. The present study aimed to examine the effect of motivational interviewing-based counseling on sexual satisfaction and body image of women with mastectomy. This clinical trial was performed on 60 breast cancer patients (two groups of 30) admitted to Imam Khomeini Clinic in Hamedan, Iran. The patient in both groups completed the index of sexual satisfaction (Hudson) and a self-reported questionnaire entitled " Life After Mastectomy". Thereafter, they participated in five training sessions with a motivational interviewing (MI) approach on sexual disorders and body image for the subjects in the intervention group. In light of the results, a significant difference was found between the intervention group and the control group in terms of the mean sexual satisfaction and body image scores ($P<0.001$). It is recommended that the MI approach be used to improve sexual satisfaction and body image in patients with mastectomy.

Keywords: Body image, Counseling, Motivational interviewing, Sexual satisfaction

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Introduction

Statistics reveal that breast cancer is the second principle cause of cancer death and one of the most prevalent types of cancer among women throughout the world(1). However, the prevalence of breast cancer is on the rise among younger women under age 45, when compared to the past. However, this higher prevalence of breast cancer in this age group can be attributed to an early diagnosis of the disease (2). The incidence of breast cancer in Iranian women has been reported as 25% of all cancers in women(3). Cancer treatment is either topical (e.g., surgery and radiotherapy) or systemic (4). Previous studies indicated significantly higher rates of sexual dysfunctions and poor body image in women with experience of breast cancer, as compared to healthy and non-pregnant women (5).

Breast cancer can trigger depression and exert negative impact on women's body image, sexual and marital life (6). Physical changes affecting sexual function include fatigue, painful intercourse, vaginal dryness, lack or loss of sexual drive, and breast numbness following the diagnosis and treatment of breast cancer. Conversely, chemotherapy and radiotherapy can lead to several physical and psychological complications. In addition, hormone therapy results in sexual arousal disorder and inability to reach orgasm in women below 45 years (7).

Another treatment for breast cancer is a mastectomy which negatively affects the self-confidence and feminine identity of patients resulting in reduced sexual satisfaction and drive. Moreover, breast cancer patients are reported to experience body image disorder (8, 9). In a general sense, body image demonstrates the direct personal perception and self-assessment in terms of physical appearance, and body image disorder may occur due to negative thoughts and emotions related to one's body. In view of the fact that breasts are important for female beauty and an essential part of women's body image, any type of breast abnormality can adversely affect women's body image. Accordingly, designing a professional counseling program with an emphasis on sexual issues in breast cancer patients is of paramount importance (10). Motivational interviewing (MI) is a client-centered counseling style which directly increases clients' motivation by the elevation of intrinsic motivation. In addition, this approach is mostly applied to hopeless patients. Since the basis of MI is expressing empathy and supporting the client, and considering breast cancer patients' need of sympathy and emotional support, healthcare providers can significantly contribute to the sexual health and body image of patients using MI (11, 12).

Methods

This clinical trial with two intervention and control groups and a pretest-posttest design was performed on breast cancer patients undergoing a mastectomy with. Prior to sampling with a randomized block design, approval was obtained from the Ethics Committee and written consent was received from the Vice-chancellor for Research, Nursing and Midwifery School, Hamedan, Iran, and needed arrangments were made with the authorities of Imam Khomeini Clinic. The sample size was estimated at 60 participants in each group using the formula of comparing two proportions by considering 95% confidence interval, 90% test power, mean sexual desire score and standard deviation of 5 and 6, respectively, and 20% attrition (3).

Inclusion criteria entailed: 1) the second stage of breast cancer, 2) post-chemotherapy, 3) being married, 4) age of above 25 years, 5) absence of lumpectomy, 6) non-reporting addiction, 7) no underlying diseases, 8) residing in Hamedan, and 9) a sexual satisfaction score within the range of 30-70. On the other hand, exclusion criteria included 1)non-attendance in training sessions, 2) change of living place. 10 four-part blocks (two interventions and two controls) were placed next to each other in six different modes to carry out sampling with a randomized block design. Thereafter, the patients were allocated to their own group by blocks placed inside envelops provided to them. In addition, the participants were ensured of the confidentiality terms regarding their personal information.

All women were informed of the research objectives and the methods that would be used and written consent was obtained from all of them. Thereafter, subjects filled out the demographic characteristics questionnaire, the index of sexual satisfaction by Hudson, and body image inventory before the commencement of study. The questionnaire which is a self-report instrument consists of 25 items. The inventory contains 12 items with a positive load and 13 items with a negative load. The items are scored on a 5-points Likert scale ranging from "almost always" to "never" rated as 5-1, respectively. Furthermore, the items 4-8, 11, 13-15, 18, 20, 24, and 25 are answered reversely due to their negative

load. The score range is 0-100, and the questionnaire has two cut-off points of 30 and 70. In this regard, scores below 30 suggest sexual satisfaction, whereas scores above 30 are indicative of sexual dissatisfaction. Moreover, scores above 70 demonstrate serious sexual problems (13). The reliability and validity of the tool have been confirmed by Khamseh et al. (2015) (14).

The Life After Mastectomy (LAM) questionnaire,the validity and reliability of which have been assessed, is composed of 15 items on body image following a mastectomy (15), (8). In the current research, the validity of the tool was confirmed by 10 faculty members and its reliability was approved rendering the Cronbach's alpha of 0.85. The questionnaire has six alternatives ranging from "completely disagree" to "completely agree". However, six items (3, 5, 7, 10, 12, 13) are scored reversely. Upon the completion of Hudson questionnaire and receiving a score of 30-70, the subjects also filled out the LAM questionnaire and took part in training classes.

It is worthy to note that the participants in the intervention group were assigned into three groups of 10 who attended five weekly group sessions (one session per week). After the session, individual counseling was provided to clients separately for 45 minutes.

Group counseling sessions were held in five sessions in the following manner:

Session one (familiarization): clients were familiarized with sex physiology, increased sexual knowledge, and favorable body image.

Session two (emotions): clients received information on how to express their sexual feelings and practice and complete the dimensions of sexual emotion and body image.

Session three (positive and negative aspects of behavior and change): the session involved the reconstruction of irrational sexual attitudes and beliefs, recognition of unrealistic beliefs and expectations, and maladaptive sexual cognitions.

Session four (values): the clients were taught about communication skills of couples and practiced identification and prioritization of sexual values, as well as creating compassion-related skills and listening.

Session five (final vision): summary of previous session practices in the framework of vision practice and preparation to start a sexual behavior change program (16).

After the sessions, the subjects in the intervention and control groups filled out the Hudson and LAM questionnaires. It should be highlighted that ethical issues were adhered to by the provision of educational packages to the control group after the study. Data were analyzed in SPSS software (version 20) using statistical indexes and tables (to describe the results), Kolmogorov-Smirnov test (to evaluate the normality of data), and independent t-test (to assess the variables). Moreover, in order to avoid the phenomenon of returning to the average sexual satisfaction score, the variable was considered as a covariate, the effect of which was controlled using ANCOVA. Furthermore, P-value of less than 0.05 was considered statistically significant.

Results

Mean age of the subjects in the intervention and control groups was measured at 43.7±6.0 and 45.9±6.7 years, respectively. In addition, the mean number of children in the intervention and control groups was reported as 2.1±5.2 and 2.9±1.7, respectively. Regarding weight before disease, the mean weight of subjects in the intervention and control group was 70±10.2 and 69±16.2 kg, respectively, which increased to 72.12±6.4 and 73.9±12.1 kg, respectively (Table 1). Based on the results, the participants were homogeneous in terms of demographic characteristics (age, weight before and after disease, number of children), and no significant difference was found in this regard. Moreover, the results of the Kolmogorov-Smirnov test were indicative of normal data.

In addition, there was a significant difference in the mean sexual satisfaction score of the patients in the intervention group after the research, as compared to before the intervention ($P<0.001$). However, no significant change was observed in the mean sexual satisfaction score of the control group after the intervention ($P=0.12$). Therefore, one may conclude that sexual satisfaction score improved in the intervention group after the educational program. In addition, the covariance analysis test was applied to compare the groups due to the significance of statistical test results between the intervention and control before the intervention. After the intervention, there was a significant difference in the scores of the intervention group, compared to the control group ($P<.001$; Table 2).

Based on the obtained results, there was a significant increase in the mean body image score of the

Table 1. Comparison of demographic characteristics in study groups

Variable	Group		P-value Independent T-Test
	Intervention	Control	
	Mean±standard deviation	Mean±standard deviation	
Age (year)	43.7±6.0	45.9±6.7	P=0.20
Weight before disease (kg)	70±10.2	69±16.2	P=0.90
Weight after disease (kg)	72.6±12.4	79.3±12.1	P=0.32
Number of children	2.5±1.2	2.9±1.7	P=0.32

Table 2. Mean and standard deviation of sexual satisfaction and body image scores in the intervention and control groups

Sexual satisfaction score	Group		P-VALUE Independent T-Test ANCOVA Test
	Intervention	Control	
	Mean±standard deviation	Mean±standard deviation	
Before the intervention	44.6±8.7	38.6±6.6	P<0.001
After the intervention	31.2±8.3	42±11.1	P<0.001
P-value Intergroup Paired T-Test	P<0.001	P=0.01	
Body image score Before the intervention	53.8±12.2	54.6±12.6	P=0.81
After the intervention	40.8±8.7	53.6±12.2	P<0.001
P-value Intergroup Paired T-Test	P<0.001	P=0.33	

subjects in the intervention group after the program, in comparison with prior to intervention (P<0.001). Nonetheless, there was no significant difference in the mean body image score of the control group before and after the intervention (P=0.33). Moreover, a significant difference was found between the control and intervention groups after the intervention, when compared with prior to intervention (P<0.001; Table 2).

Implications for Practice

According to the results of the present study, the sexual satisfaction of participants significantly increased after MI sessions. Group counseling inspired women undergoing mastectomy to treat their disease since they realized that it was not just their problems and many other women deal with the same issue. This type of counseling promoted the subjects to release their innermost feelings and emotions and talk about their problems. Accordingly, the MI approach substantially increased sexual satisfaction in women with a mastectomy. Moreover, it exerts an effect on the sexual health-promoting behaviors in women and increased perception of sexual issues. It could also play a significant role in the control of unfavorable sexual desires, sexual satisfaction, and decrease of sexual problems in women with a mastectomy if correctly implemented at the appropriate time and during breast cancer treatments.

In addition, the MI approach affected the positive body image in women. In general, body image is of essential importance to women, especially in women with a mastectomy. Body image modification in women can enhance their sexual satisfaction and promote their psychological health. According to the results of the current research, group and individual MI sessions are suggested for women with mastectomy. Furthermore, it is recommended that face-to-face counseling and long-term follow-ups be used for these women to achieve more stable results.

Acknowledgments

This article was extracted from a Master thesis on midwifery with the Ethical Code of IR.UMSHA.REC.1395.219. It is noteworthy that the current study was supported by the Vice-

chancellor for Research and Technology, Hamedan University of Medical Sciences.

Conflicts of Interest
The authors declared that there is no conflict of interest.

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