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Sexuality of Chinese women around menopause

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ABSTRACT

Objective: To study the sexual activities and prevalence of sexual dysfunctions in midlife Chinese women and their correlations with demographic factors, sexual dissatisfaction and interpersonal difficulty.
Study design: This is a cross-sectional survey of a convenience sample of women aged 40–60, who requested gynecological checkup or attend social activities at Women's Club.
Main outcome measures: Sexual activities, sexual dysfunctions, sexual dissatisfaction, demographic factors and interpersonal difficulty were assessed by self-administered questionnaire.
Results: Among 371 eligible subjects, 22.4% and 39.6% women had low intimacy and coitus frequency (0 to <12 acts in one year), respectively. The odds ratios for low coital frequency in the natural menopausal and surgical menopausal subgroups were 3.00 and 5.09, respectively (95% confidence interval: 1.73–5.19 and 1.77–14.69, respectively). Overall, 77.2% women had at least one type of sexual dysfunctions; this proportion was highest in the surgically menopausal subgroup (88.9%) followed by the naturally menopausal subgroup (79.3%), the perimenopausal subgroup (78.2%) and the premenopausal subgroup (72.2%) ($p = 0.003$). No lubrication (42.9%) was the commonest sexual dysfunction and predominantly affected naturally and surgically menopaused women ($p = 0.001$). Sexual dysfunction was the major contributor to sexual dissatisfaction (0.80), followed by interpersonal difficulty (0.2). Arousal disorder was the pivot of interaction between sexual dissatisfaction, menopausal status and low coital frequency.
Conclusions: Chinese women had fewer intimate contacts and less coitus when menopause progressed. No lubrication was the commonest sexual dysfunction and predominantly affected menopaused women. Our model showed that sexual dysfunction is the main contributor to sexual dissatisfaction.

1. Introduction

Women develop physical and psychological changes when they transit through menopause. Perimenopausal symptoms like vasomotor symptoms and mood changes usually subside a few years after menopause [1–3]. Nonetheless, sexual problems worsen with menopause [4–7]. Longitudinal study showed significant decrease in desire, arousal, orgasm and frequency of sexual activities; and increase in vaginal dryness or dyspareunia during menopause transition [6]. Postmenopausal women were 2.3 times more likely to experience sexual dysfunction than premenopausal women [7]. Studies on postmenopausal women showed prevalence of sexual dysfunctions from 68% to 86.5% [8,9]. These earlier studies recorded high prevalence because they were conducted before the adaptation of the Diagnostic and Statistical Manual of Mental Disorder 4th edition (DSM-IV) [10], which included marked distress and interpersonal difficulty in the diagnostic criteria. These new criteria avert over-treatment and medicalization of sexual problems. Disappointingly, standard clinical tools for assessing distress or interpersonal difficulty are lacking thus clinicians can only make subjective decision based on their judgment on their patients' conditions. Different psychometric instruments have been adopted in research to measure distress. The prevalence of distress among women with sexual dysfunctions was between 14% and 67% [11–13]. One recent study showed that fewer menopausal women (36.2%) were distressed by sexual dysfunction than premenopausal women (64.5%) [14].

Another major factor that determines health seeking behavior is sexual dissatisfaction but it has not been included as a diagnostic criterion in the DSM-IV. Sexual satisfaction has been described as "the individual's subjective evaluation of the positive and negative subsequent affective response to this evaluation" [15]. Compared to sexual dysfunction, it is more difficult to define sexual satisfaction because this term is poorly conceptualized [16]. Sexual satisfaction relies on good communication [17,18], relationship satisfaction, love for partner and devotion to the relationship [19,20]. Little is known about sexual dissatisfaction in the context of sexual dysfunction.

Female sexuality is a multifaceted construct. The clinical relevance of symptoms is determined by biological, psychological and

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socioeconomic factors. In midlife, additional partner-related factors such as his health, his age, feelings toward him and length of the relationship also influence sexuality. Besides, women's cultural values and health beliefs also affect their sexual activities and how they uphold sexual relationships. Therefore, the prevalence of female sexual dysfunctions is unique to each ethnic group. Sexuality has been widely studied in Caucasians but little is known about Chinese women. Sex used to be a taboo in Chinese culture and people seldom share their feelings about sex. As the society becomes more open, more midlife women start to discuss sexual problems with their healthcare providers in the past few years. This opens an opportunity to investigate their sexuality such as sexual activities, the prevalence of various sexual dysfunctions and their correlations with demographic factors, sexual dissatisfaction and interpersonal difficulties.

2. Materials and methods

2.1. Study design and sample selection

This is a cross-sectional survey of a convenience sample of midlife Chinese women aged 40–60, who visited the Women's Health Service and Women's Club of the Family Planning Association of Hong Kong from December 2007 to December 2009. All women were informed about the research, its purpose and the content of the anonymous, self-administered questionnaire. Written informed consent was obtained. The study was approved by the Ethics Panel of the Family Planning Association of Hong Kong.

2.2. Outcomes measured

Basic demographic data such as age, relationship status, obstetric history, menopausal status, health conditions, life stress and sexual activities were collected. Outcome variables including sexual dysfunctions, sexual dissatisfaction and interpersonal difficulty were assessed by questions designed by the investigators. The variables are defined as follows:

2.2.1. Menopausal status

Premenopausal subgroup included women with regular menstruation and no menopausal symptoms. Natural menopausal subgroup included women who had ceased menstruation for at least one year. Those in transition were categorized into the perimenopausal subgroup.

2.2.2. Sexual dysfunctions

Sexual dysfunctions are defined according to DSM-IV and assessed by five statements using a 5-point scale (0–4). Participants were instructed to assign 0 to any intermittent symptom or symptom that persisted for less than three months in the past one year. For symptom that persisted for at least three months within the past one year, they should grade the severity of the symptom using a scale of 1–4 with 4 meaning "It always happens".

2.2.3. Sexual dissatisfaction and interpersonal difficulty

Respondents were asked to use a 5-point scale (0 = never, 4 = always) to rate their agreement with "I am dissatisfied with our sexual intercourse." Higher score indicated higher dissatisfaction. Interpersonal difficulty was measured by three statements using a 4-point Likert scale (1 = totally disagree, 2 = somewhat disagree, 3 = somewhat agree, 4 = totally agree).

2.2.4. Sexual activities

Sexual intimacy included hold hands, kisses, hugs and caresses. Coitus meant vaginal penetrative sex.

2.2.5. Health conditions

Past medical history was assessed by self-reported open questions. Weight of 1 was assigned to each medical disease, gynecological disease and psychiatric disease. History of one or more sexually transmissible infections was given weight of 1. The total number of diseases was counted and summated.

2.2.6. Life stress

Socioeconomic stressors such as family problems, marital problems, financial problems, job-related problems and problems in their family of origin were counted and summated.

2.3. Statistical analysis and sample size

The Statistical Package for Social Science (Windows version 16.0; SPSS Inc, Chicago, IL, US) was used for statistical analysis. Descriptive statistics on demographic factors and primary outcome variables were presented. Chi-square or Kruskal Wallis tests were used to analyze categorical and continuous variables in bivariate contingency tables, respectively. Internal consistency of the questionnaire was examined with Cronbach's coefficient alpha and a value of 0.7 indicated acceptable reliability of the statements. Loglinear model was used to analyze the inter-relationships of sexual dissatisfaction, sexual dysfunctions (including four different domains and overall sexual dysfunctions), interpersonal difficulty, coital frequency and menopausal status because there was no clear distinction between the response and explanatory variables. Four of them were dichotomized variables and menopausal status was a trichotomized variable. Therefore the minimum sample size required was $(2 \times 2 \times 2 \times 2 \times 3) \times 5$, i.e. 240. Overall and individual domains of sexual dysfunction (desire, arousal, orgasm and pain) were analyzed individually in separated loglinear models. Among the three sexual activities, only coitus frequency was used in the analysis because it can be clearly defined. All tests were two-tailed, with $p < 0.05$ being statistically significant.

3. Results

3.1. Participants' characteristics

Four hundred and seven questionnaires were received and 36 were discarded because these respondents did not have a stable partner. Among the 371 eligible subjects, 366 were married and 5 were in cohabitation. Majority of respondents had median parity of 2 and no history of miscarriage or abortion. In this cohort, 31.5% ($n = 117$) were premenopausal, 33.7% ($n = 125$) were perimenopausal, 29.9% ($n = 111$) had natural menopause and 4.9% ($n = 18$) had surgical menopause. The details of other demographic factors in the cohort and its four menopausal subgroups are listed in Table 1. The four subgroups were similar except for age and history of gynecological diseases.

Among different types of stressors reported, 15.1% were family problems, 8.9% were financial stress, 5.9% were job stress, 4.9% were stress from their family-of-origin and 4.3% were marital problems.

The odds ratios for natural menopausal and surgical menopausal women to have low coitus frequency (0 to <12/year) were 3.00 and 5.09 respectively (95% confidence interval: 1.73–5.19 and 1.77–14.69, respectively) when compared to premenopausal women. Coitus frequency in the perimenopausal subgroup was insignificantly different from the premenopausal subgroup. The differences in the frequency of sexual intimacy among different menopausal subgroups did not correlate with life stress, sexually transmissible infections, medical diseases, gynecological diseases and psychiatric diseases.

Among the 147 respondents who had low coitus frequency, 72 experienced personal distress, 76 said their partners were