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Sexual Problems During Pregnancy and After Delivery Among Women With and Without Anxiety and Depressive Disorders Prior to Pregnancy: A Prospective-Longitudinal Study

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ABSTRACT

Introduction: Few prospective-longitudinal studies have examined the course of sexual problems during pregnancy and after delivery in women with and without anxiety and depressive disorders prior to pregnancy as well as with and without maternal birth injuries.

Aims: To prospectively investigate associations of anxiety and depressive disorders prior to pregnancy and maternal birth injuries with sexual problems during the peripartum period.

Methods: The Maternal Anxiety in Relation to Infant Development Study is a prospective-longitudinal study of 306 women enrolled during early pregnancy and repeatedly assessed in seven waves during the peripartum period. Anxiety and depressive disorders prior to pregnancy were assessed in early pregnancy (T1) using the Composite International Diagnostic Interview for Women. Maternal birth injuries were assessed by questionnaire shortly after delivery (T4). Sexual problems during pregnancy (T2) as well as 4 months (T6) and 16 months (T7) postpartum were measured using the German version of the Massachusetts General Hospital Sexual Function Questionnaire.

Main Outcome Measures: Impairment of sexual interest, arousal, orgasm, lubrication, and overall sexual satisfaction at T2, T6, and T7.

Results: Rates of sexual problems generally increased from T2 to T6 and decreased from T6 to T7. Compared with women without anxiety and depressive disorders, those with comorbid anxiety and depressive disorders prior to pregnancy more often specified impairment of overall sexual satisfaction at T2 (odds ratio [OR] = 2.0) and T7 (OR = 2.1). In contrast, sexual problems were not pronounced in those with pure anxiety or pure depressive disorders, and women with pure anxiety disorders often reported even less impairment of sexual interest at T7 (OR = 0.5). Compared with women without birth injury, those with vaginal birth injury more often reported impairment of sexual interest (OR = 1.8) and lubrication (OR = 2.3) at T6.

Conclusion: Findings suggest that especially women with comorbid anxiety and depression and vaginal birth injury are at increased risk for sexual problems during pregnancy and after delivery and thus might benefit from targeted early interventions.

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INTRODUCTION

During pregnancy and after delivery, (expectant) mothers experience a wide variety of hormonal, physical, and social changes that can affect their overall well-being, partnership, and sexuality.[1–5] A series of studies have examined changes in sexual functioning across the peripartum period and consistently found that sexual problems in women increased during pregnancy, remained relatively high within the first months after delivery, and decreased thereafter[6–11] (for comprehensive review, see Yeniel and Petri[12]).

Moreover, sexual problems during pregnancy and after delivery have been shown to be particularly pronounced in depressed women.[13–19] For example, depressive symptomatology during pregnancy has been associated with lower sexual functioning, desire, arousal, lubrication, orgasm, and satisfaction and more pain during intercourse.[15] Similarly, postpartum depressive symptomatology has been related to lower postpartum sexual functioning, arousal, orgasm, and satisfaction.[16]

Considerably fewer studies have examined the role of anxiety for sexual problems during pregnancy and after delivery.[17,20] Faisal-Cury et al[17] found that postpartum anxiety and depressive symptoms (anxiety and depression were not assessed separately) were associated with a decrease of sexual activity after delivery, whereas Wenzel at al[20] found that women with vs without postpartum anxiety disorder did not differ in postpartum sexual desire, arousal, activity, and orgasm.

In addition, there is evidence for postpartum sexual problems being especially pronounced in women with vaginal birth injuries.[21–23] For instance, perineal trauma has been associated with pain during intercourse,[22] and vaginal delivery has been related to lower sexual functioning compared with planned cesarean section.[21]

In general, most prior research has focused on anxiety or depressive symptoms instead of disorders and not distinguished pure from comorbid anxiety and depressive disorders, although doing so is necessary to specify the role of both conditions for sexual problems during pregnancy and after delivery. Moreover, no previous study has examined strictly prospective associations of anxiety and depressive disorders prior to with sexual problems during pregnancy and after delivery. Such research promises to considerably improve our knowledge of the role of anxiety and depressive disorders as risk factors for sexual problems during pregnancy and after delivery. As suggested by previous evidence, pure depressive and comorbid anxiety and depressive disorders, but not pure anxiety disorders, prior to pregnancy may be risk factors for sexual problems during pregnancy and after delivery. In addition, maternal vaginal birth injuries may increase the risk for postpartum sexual problems and such associations may be more pronounced in women with anxiety and depressive disorders prior to pregnancy who might be particularly afraid of pain during intercourse and, hence, experience a vicious cycle of symptom escalation (eg, anxiety can lead to lower sexual interest and lubrication, promoting pain and anxiety).

AIMS

This prospective-longitudinal study of expectant mothers examined the role of anxiety and depressive disorders prior to pregnancy and maternal birth injuries for changes in sexual functioning across the peripartum period. The authors hypothesized that pure depressive and comorbid anxiety and depressive disorders, but not pure anxiety disorders, prior to pregnancy would be associated with sexual problems during pregnancy and after delivery. They also hypothesized that women with vaginal birth injuries, but not those with injuries from cesarean section, would be at increased risk for postpartum sexual problems (compared with women without birth injuries) and that such associations would be more pronounced in women with anxiety and depressive disorders prior to pregnancy.

METHODS

Sample and Procedures

The Maternal Anxiety in Relation to Infant Development (MARI) Study is a prospective-longitudinal study of expectant mothers sampled from the community in gynecologic outpatient settings in the area of Dresden, Germany (from January 2009 through September 2012). Pregnant women (n = 533) were recruited by personal contact in gynecologic outpatient settings after pregnancy was confirmed by a gynecologist and screened for inclusion and exclusion criteria.[24] Finally, 306 women were enrolled in the study and completed up to seven assessments: weeks 10 to 12 of gestation (T1, baseline), weeks 22 to 24 of gestation (T2), weeks 35 to 37 of gestation (T3), 10 days postpartum (T4), 2 months postpartum (T5), 4 months postpartum (T6), and 16 months postpartum (T7). Two hundred seventy-four women remained through T7 (retention rate = 89.5%). Informed consent was obtained from all subjects. The MARI Study was carried out in accordance with the Declaration Helsinki of 1975 (as revised in 2013) and was approved by the ethics committee of the Medical Faculty of the Technische Universität Dresden (Dresden, Germany; number EK 94042007). Only anonymized data were used. Additional information on the methods and design of the MARI Study has been published elsewhere.[24,25]

Assessment of Anxiety and Depressive Disorders

Maternal anxiety and depressive disorders were assessed at each wave using the Composite International Diagnostic Interview for Women,[26] a modified version of the World Health Organization's Composite International Diagnostic Interview[27] that has been shown to have excellent psychometric properties.[28,29] All diagnostic assessments were conducted by clinically trained and supervised assessors. Based on lifetime diagnostic information reported at baseline (T1), participants were allocated to one of the following initial diagnostic groups: no anxiety nor depressive disorder prior to pregnancy (no AD; n = 109), pure depressive disorder(s) prior to pregnancy (pure D; n = 48), pure anxiety disorder(s) prior to pregnancy (pure A; n = 84), and comorbid anxiety and depressive disorders prior to pregnancy (comorbid AD; n = 65). Diagnoses with onset no more than 4 weeks before baseline (approximately the time when the pregnancy was confirmed by a pregnancy test or a gynecologist) were not included as lifetime disorders prior to pregnancy.[23]

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