ORIGINAL RESEARCH

Prevalence and Risk Factors of Sexual Dysfunction in Postpartum Australian Women

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ABSTRACT

Introduction. Female sexual dysfunction is highly prevalent and reportedly has adverse impacts on quality of life. Although it is prevalent after childbirth, women rarely seek advice or treatment from health care professionals.

Aim. The aim of this study was to assess the sexual functioning of Australian women during the first year after childbirth.

Methods. Postpartum women who had given birth during the previous 12 months were invited to participate in this cross-sectional study. A multidimensional online questionnaire was designed for this study. This questionnaire included a background section, the Female Sexual Function Index, the Patient Health Questionnaire (PHQ-8), and the Relationship Assessment Scale. Responses from 325 women were analyzed.

Results. Almost two-thirds of women (64.3%) reported that they had experienced sexual dysfunction during the first year after childbirth, and almost three-quarters reported they experienced sexual dissatisfaction (70.5 %). The most prevalent types of sexual dysfunction reported by the affected women were sexual desire disorder (81.2%), orgasmic problems (53.5%), and sexual arousal disorder (52.3%). The following were significant risk factors for sexual dysfunction: fortnightly or less frequent sexual activity, not being the initiator of sexual activity with a partner, late resumption of postnatal sexual activity (at 9 or more weeks), the first 5 months after childbirth, primiparity, depression, and relationship dissatisfaction.

Conclusion. Sexual satisfaction is important for maintaining quality of life for postpartum women. Health care providers and postpartum women need to be encouraged to include sexual problems in their discussions. **Khajehei M, Doherty M, Tilley PJM, and Sauer K. Prevalence and risk factors of sexual dysfunction in postpartum Australian women. J Sex Med 2015;12:1415–1426.**

Key Words. Childbirth; Sexual Dysfunction; Postpartum Depression; Relationship Satisfaction; Quality of Life

Introduction

The World Association for Sexual Health [1] and the World Health Organization stated that sexual health is ". . . a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity . . ." [2]. Sexual activity is an integral part of everyone's life, and its impairment may have a substantial impact on quality of life [3].

Maintaining meaningful sexual activity after childbirth has been shown to be a key factor in the quality of a couple's relationship [4]. During and after pregnancy, many factors can affect sexual function in women and can result in changes to their sexual practice, sexual behaviors, and interpersonal relationships. Factors that have been reported include the following: hormonal and physiological changes, physical factors, health issues, and psychological and neurological changes [5,6]. In addition, cultural and ethical issues, reli-

gious beliefs, social norms, and myths and fears, as well as the changing structure of women's roles, have been reported to influence the sexual life of women during and after pregnancy [7,8] and their quality of life [9].

Female sexual dysfunction has been described and widely accepted as an impairment of normal sexual function in women [10]. Sexual dysfunction is specified by the American Psychiatric Association as "a disturbance in the processes that characterize the sexual response cycle or by pain associated with sexual intercourse" [11].

The prevalence of sexual dysfunction among women after childbirth has been reported to vary worldwide from 5% to 35% after caesarean section to 40% to 80% after normal vaginal delivery with an episiotomy [12]. Despite this high prevalence of sexual dysfunction, only a small proportion of women with sexual dysfunction refer to health care professionals to seek advice or treatment for their sexual problems [13–15].

There has been increasing recent interest in assessing the sexual functioning of women after childbirth [16–18]. An integrated search of the literature identified preliminary reports on sexual function in postpartum Australian women [19,20]; however, there is a lack of up-to-date data.

Aims

The present study was conducted to measure the prevalence of sexual dysfunction after childbirth among Australian women while addressing the limitations of previous studies. In addition, this study investigated which factors contributed to the sexual dysfunction of the participants.

Method

Study Design

This study was undertaken as a cross-sectional investigation. Postpartum women who had given birth during the previous 12 months were invited (as described below) to complete the multi-section online questionnaire.

Ethics

The Human Research Ethics Committee at Curtin University (approval HR171/2011) approved the study protocol. Women provided passive consent by completing and submitting the online questionnaire.

Participants

Based on previous reports by Brown and Lumley [19,20], which showed that 26% of postpartum women in Australia reported sexual dysfunction, the following formula was used. It was then calculated that 295 postpartum women were required to complete the online questionnaire, so that the study would be adequately powered:

$$n = \frac{Z^2 P(1-P)}{E^2 R}$$

$Z = 1.96$; E = error (precising) = 0.05; P = prevalence of sexual problems = 26% or 0.26 [19,20].

The following inclusion criteria were applied: (i) aged between 16 and 40; (ii) gave birth to a live baby at week 37 or later in pregnancy; (iii) gave birth 0 to 12 months ago; (iv) had a regular sexual partner; (v) not pregnant at the time of the study; and (vi) an Australian resident. The exclusion criteria were as follows: (i) clinically diagnosed with a psychiatric illness; (ii) taking antipsychotic medicine; and (iii) identifying as Aboriginal or Torres Strait Islander. At the beginning of the questionnaire, relevant questions were included that allowed the inclusion and exclusion criteria to be applied.

Recruitment Process

Participation in this anonymous study was voluntary. Australian women who had given birth during the past year were recruited through a variety of venues to complete the online questionnaire. For example, the invitation letter was posted on selected Facebook pages. The 123 Submit and Dream submission programs were also used to place the link to the questionnaire on various search engines; advertisements containing a brief description of the research and the link to the study website were printed in community newspapers; flyers were distributed in public places to women who had babies younger than 1 year old; and invitation e-mails were sent to mothers whose babies were in selected childcare centers. Snowball sampling technique was also used, and women passed the website's link to other women. The questionnaire was available online from May to August 2012, and during this time frame, the required number of participants was acquired.

Main Outcome Measures

A multidimensional questionnaire was designed and made available, which redirected participants to SurveyMonkey. The questionnaire included an initial section of 37 questions, including 6 questions about demographics, 10 related to obstetric and