The Impairment of Sexual Function Is Less Distressing for Menopausal than for Premenopausal Women

Marta Berra, MD, Francesca De Musso, MD, Carlotta Matteucci, MD, Valentina Martelli, MD, Anna Myriam Perrone, MD, Carla Pelusi, MD, Giuseppe Pelusi, MD, and Maria Cristina Meriggiola, MD, PhD

Center for Sexual Health, Department of Obstetrics and Gynecology, University of Bologna, S. Orsola Hospital, Bologna

[Correction added after online publication 14-Jan-2010: Dr. Martelli has been added to the author listing.]

DOI: 10.1111/j.1743-6109.2009.01666.x

ABSTRACT

Introduction. Menopause requires psychological and physical adjustments because of the occurring significant hormonal changes. Sexuality is one of the aspects that undergoes the most profound modifications. Preliminary data suggest that sometimes women do not regard sexual changes as problematic and often readjust their life and relationship according to their new physical status.

Aim. The aim of our study was to evaluate sexual function and the way women feel by comparing healthy postmenopausal and premenopausal women.

Methods. One hundred menopausal (M) and 100 premenopausal (pM) healthy women were asked to complete anonymous questionnaires to assess sexual function and stress related to sexual activity.

Main Outcome Measures. Female Sexual Function Index (FSFI), Female Sexual Distress Scale (FSDS) were completed by M and pM women.

Results. Medium FSFI score was 20.5 ± 9.6 and 26.4 ± 7.7 ($P < 0.0005$) and medium FSDS score was 12.1 ± 11.7 (95% CI 9.7–14.4) and 11.3 ± 10.2 ($P = 0.917$) for M and pM women, respectively. Twenty-five of the 69 M women and 20 of the 31 pM women with a pathological score in the FSFI questionnaire scored higher than 15 in the FSDS ($P < 0.0005$). The overall prevalence of sexual dysfunction was 20% and 25% ($P = 0.5$) in the M and pM women.

Conclusions. Our data confirm that menopause is associated with changes in sexual function that may be compatible with sexual dysfunction. However, personal distress caused by these changes in sexual life appears to be lower among menopausal women (36.2%) as compared with premenopausal women (64.5%). These data suggest that medical treatment for sexual health in menopause must be highly personalized and carefully prescribed. **Berra M, De Musso F, Matteucci C, Martelli V, Perrone AM, Pelusi C, Pelusi G, and Meriggiola MC. The impairment of sexual function is less distressing for menopausal than for premenopausal women. J Sex Med 2010;7:1209–1215.**

Key Words. Menopause; Sexual Function; Personal Distress

Introduction

Sexual response in women is adversely affected both by aging and menopause [1,2]. Aging has a powerful impact on the quality of relationships and sexual function [3]. Menopause is a complex period of transition that determines physical and anatomical changes as well as psychological adjustments. After the ceasing of cyclical ovarian function, women face a severe decrease in circulating estrogen levels [4]. On the other hand, aging is related to a progressive reduction of androgens: testosterone decreases throughout life after a woman reaches 20 years old; by the time women enter the climacteric period testosterone is about 70% lower then it was at the end of the teen years [4]. These two hormonal components highly affect sexual dynamics in terms of desire, arousal, lubrication, orgasm, and pain related to sexual activity [5,6]. At the same time, emotional and relational factors play a crucial role in sexual function, especially in this period of life when women face a profound change in their social role, traditionally related to reproductive function. In older women an array of physical problems may contribute to the loss of sexual interest: urinary incontinence,

depression, dementia, arthritis, stroke, and breast cancer are major determinants [7,8].

Therefore, what must be taken into serious consideration is the real role that sexuality plays in "the second half" of life. Almost all research conducted in the field shows a concrete worsening in sexual function during menopause [9–16], but only a few researchers have considered how much this effectively concerns and affects the well-being of women. It is fundamental to understand whether these changes in sexual life really worsen the quality of life of menopausal women and whether they feel it is matter of concern. Indeed, it has been recently stressed that an essential condition for the definition of sexual dysfunction is that the woman perceives it with personal distress [17,18].

Sexuality is an important determinant of health and overall quality of life in adulthood, but its relevance becomes less predictable in older women [2].

Aims

The aim of our study was to evaluate sexual function in premenopausal (pM) and menopausal (M) women and to determine whether the presence of sexual problems could cause personal distress in these groups of women.

Methods

Population

One hundred M and 100 pM women were asked to voluntarily complete the questionnaires. Women were selected among those coming for cervical cancer screening between September 2005 and June 2006.

Only healthy women were included in the study. They had to declare to have no major illness such as oncologic disease, cardiovascular disease, and overt diabetes under any therapy other than diet-controlled, psychiatric illness and to have never been treated for sexual problems. While performing the pap stream we could exclude from the study women suffering from lower genital pathologies such as clinically relevant infections, vaginal stenosis, or genital mutilations. Inclusion criteria for spontaneous M women were absence of menstrual period for at least 12 months, follicle stimulating hormone (FSH) higher than 40 IU/L [19], no previous bilateral annessiectomy, and no present known oncologic disease. Inclusion criteria for pM women were regular menstrual cycles (at least five periods in the past 6 months), not assuming any steroid hormones, no current pregnancies, or not breast feeding.

Women were reassured that the questionnaires would be anonymous. The Ethic Committee of S. Orsola Hospital-University of Bologna approved the present study and women signed a written consent form.

Women were asked to complete two questionnaires validated to evaluate sexual function and sexual distress related to sexual activity.

The Female Sexual Function Index (FSFI) is a multidimensional self-report questionnaire for assessing sexual function in women; it consists of 19 items that assess sexual desire, arousal, lubrication, orgasm, satisfaction, and pain. A final score, obtained by adding the six domain scores, equal or lower than 26.5 is suggestive of an alteration in sexual function. Each domain is considered dysfunctional when the correspondent score is equal or lower than 4.3. The factor structure and internal consistency have been examined and found to be satisfactory. Discriminant validity testing confirmed the ability to discriminate between women with and without sexual complaints [20–22]. The Female Sexual Distress Scale (FSDS) is a 12-item self-report assessment questionnaire to assess sexuality-related personal distress. A final score higher than 15 is indicative of a high level of distress related to sexual life. The consistency and test–retest reliability coefficients were satisfactory. The scale showed a high degree of discriminative ability in distinguishing between sexually dysfunctional and sexually functional women and proved to be sensitive for treatment response [23,24]. A score of 15 or higher indicates sexual distress.

A sexual problem of desire, arousal, or orgasm was considered distressing if associated with personal distress (FSDS score of 15 or higher) in accordance with American Psychiatric Association guidelines [25].

A list of questions of demographic information, medical conditions, and marital status were presented before the two questionnaires.

Main Outcomes Measures

Statistical Analysis

All continuous distributed data are expressed in terms of mean ± standard deviation and 95% CI of the mean. Grouping variables are expressed as proportions or percentages.

The Kolmogorov Smirnov test was used to check the data distribution normality. The Levene test was used to check the homogeneity of variances.