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The quality of life of women with postpartum sexual dysfunctions, how is it?

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During the study it was showed reasons, forming mechanisms, clinical displays of sexual dysfunctions in women. Also role of caesarian section in their origin was established. The directions of complex and adequate sexual health correction was defined.
Keywords: *sexual dysfunctions, cesarean section, quality of life, women.*

Якість життя жінок із сексуальними дисфункціями після пологів, яка вона?
О.Ю. Гурженко

Протягом дослідження показано причини, механізми формування, клінічні прояви сексуальних дисфункцій у жінок. Встановлено роль кесарева розтину в їхньому виникненні. Визначено напрямки комплексної та адекватної корекції статевого здоров'я.
Ключові слова: *сексуальні дисфункції, кесарів розтин, якість життя, жінки.*

Качество жизни женщин с сексуальными дисфункциями после родов, каково оно?
Е.Ю. Гурженко

На протяжении исследования показаны причины, механизмы формирования, клинические проявления сексуальных дисфункций у женщин Установлена роль кесарева сечения в их возникновении. Определены направления комплексной и адекватной коррекции полового здоровья.
Ключевые слова: *сексуальные дисфункции, кесарево сечение, качество жизни, женщины.*

Studies of sexual dysfunctions and long-term complications after childbirth are quite numerous, but ambiguous and largely determined by the characteristics of the female population and the difference in methodological approaches.

In Ukraine, there are some studies of the estimation of the economic and social costs of sexual health treatment for women with distant complications after caesarean section, as well as the impact of hormonal and mental disorders on women's quality of life. Sexual disorders in this category of women limit social contacts, which affects all spheres of their life.

MATERIALS AND METHODS

The study is based on the results of an analysis of 192 women. Patients were asked to fill out a specially designed questionnaire to obtain anamnestic, clinical, laboratory data. All surveyed women gave their voluntary consent to the examination.

The control group consisted of 74 women (38.5%) who gave birth through the natural birth canal. The initial examination of women in the control group allowed us to identify 31 women (16.1%) with normal sexual health (group Ia) (mean age 28.7 ± 2.8 years). Another 43 women (22.5%) complained of sexual health disorders, there were no complications of gynecological and somatic status (10 women with pelvic inflammatory diseases), which led to consider this group of subjects as a comparison (group Ib) (average age 32.3±2.9 years).

The main group consisted of 118 women (61.5%) who had abnormal births by cesarean section. Preliminary analysis of sexual health required the division of surveyed women into those who did not have sexual disorders (group IIa) 32 women (16.6%) (mean age 35.6±3.7 years) and women with sexual disorders after cesarean section (group IIb) 86 women (44.8%) (mean age 36.8±3.9 years).

The mean age of the women was 30.1±2.2 years. There were 37.5% (n=72) women aged 18–25 years, 33.9% (n=65) women aged 26–35 years, 28.6% (n=55) women aged 36–45 years. 138 women (71.8%) sought medical help from a gynecologist, but neither patients nor doctors paid attention to the sexual dysfunctions at the initial examination, which required analysis to determine the causes of their development and resumption of sexual intercourse.

It was established that the changes in sexual function are often registered in women after cesarean section, which leads to violation or impossibility of sexual intercourse, the quality of life of women was deteriorated. 36-Item Short-Form Health Survey (SF-36) was used in patients for comprehensively assess the long-term complications of caesarean section and the effectiveness of treatment of sexual dysfunction. Currently, SF-36 is the most commonly used and common test of group comparisons, it allows to assess the course of the disease and the rate of physical and mental recovery [1]. The 70 points are considered to be the norm.

The formation of depressive disorders in women after childbirth is noted by other authors [2, 3, 4]. These non-psychotic mental disorders can be leading in the clinic of sexual dysfunction and they are difficult to be treated. Severe depressive disorders are more common in women who have already had depressive episodes and had a negative impact on the psycho-emotional state during pregnancy and after childbirth, which determines the vector of marital development [2, 5, 6].

The early detection of the disease is the important condition for the effectiveness of treatment. That's why we studied the anamnesis to determine the period of time from the first signs of the disease to the visit of doctor for medical help. Only 17 patients (8.8%) came to the doctor in the first month of the disease. It was noteworthy that 93 women (48.4%) sought medical help only 7 or more months after the first symptoms of the disease. However, women who complained of postpartum sexual dysfunction after the caesarean section were more likely to see a doctor in the first 6 months of the pathology appearance (43 women; 50.0%) than women with sexual dysfunction after childbirth per vias naturales (11 women; 25.6%).

There were identified two main reasons of late treatment:

1) the gradient course of the disease, when the intensity of symptoms increases gradually;

2) intimate nature of the disease and shyness of patients.

During analyzing the factors that prompted patients to seek specialized medical care, it was found that the main reason was the inability to have sexual intercourse due to gynecological (pelvic inflammatory diseases, pain during intercourse, vaginal dryness) and psychological («sexual coldness») factors.

Table 1

Distribution of patients depending on the period from the first signs of the disease to the first visit to the doctor

Time from the appearance of the first symptoms before a visit to the doctor	Women after childbirth through the natural birth canal				Women after cesarean section				Total, n=192	
	Group Ia, n=31		Group Ib, n=43		Group IIa, n=32		Group IIb, n=86			
	n	%	n	%	n	%	n	%	n	%
More than 1 month	-	-	2	4.6	3	9.4	12	13.9	17	8.8
From 2 to 3 months	-	-	3	6.9	5	15.6	13	15.1	21	10.9
From 4 to 6 months	-	-	6	13.9	6	18.7	18	20.9	30	15.6
From 7 to 9 months	-	-	10	23.2	8	25.0	24	27.9	42	21.8
From 10 to 12 months	-	-	12	27.9	4	12.5	12	13.9	28	14.5
Less than 24 months	-	-	8	18.6	4	12.5	3	3.5	15	7.8
More than 24 months	-	-	2	4.6	2	6.2	4	4.6	8	4.2
Total	31	100	43	100	32	100	86	100	192	100

Table 2

Marital status of women with sexual dysfunctions

Marital status	Women after uncomplicated childbirth				Women after cesarean section				Total, n=192	
	Group Ia, n=31		Group Ib, n=43		Group IIa, n=32		Group IIb, n=86			
	n	%	n	%	n	%	n	%	n	%
Married	25	80.6	30	69.8	20	62.5	49	56.9	124	64.6
Unmarried	2	6.5	4	9.3	5	15.6	12	13.9	23	11.9
Divorced	4	12.9	9	20.9	7	21.9	25	29.2	45	23.5
Total	31	100	43	100	32	100	86	100	192	100

Table 3

Distribution of patients depending on family relationships

Family relationships	Women after childbirth through the natural birth canal				Women after cesarean section				Total, n=192	
	Group Ia, n=31		Group Ib, n=43		Group IIa, n=32		Group IIb, n=86			
	n	%	n	%	n	%	n	%	n	%
Calm and friendly	21	67.7	12	27.9	12	37.5	12	13.9	48	25.0
Uneven	6	19.3	6	13.9	5	15.6	8	9.3	25	13.0
Formally calm	2	6.5	8	18.6	9	28.2	16	18.6	40	20.8
Conflicts that disrupt family unity	2	6.5	17	39.6	6	18.7	50	58.2	79	41.2
Total	31	100	43	100	32	100	86	100	192	100

The occurrence of such complications in women has a negative social and marital significance. Sexual dysfunction can cause disruption of interpersonal and sexual relations in the family, cause marital maladaptation, which can lead to divorce, loss of sexual partner. This fact was confirmed by the results of the analysis of family relations. The marital status of patients is shown in table 1.

The data in Table 1 suggest that sexual dysfunction, especially after caesarean section, may be a risk factor for marital maladaptation and divorce of already established couples, as there is a tendency to increase the number of divorced women in group Ib and to a greater extent in group IIb.

According to our data, family relationships were of varying degrees in 35.4% of cases (68 women out of 192). The analysis of marital status showed a negative dynamics of married life in relation to the anamnesis. Divorce cases were 2.2 times more common in women of group IIb than in group Ia, the distant sexual disorders after cesarean section were combined with depressed psychoemotional state of women.

Such situation became a factor of marital maladaptation and subsequent conflict and maladaptive marital situations that caused divorce. Thus, only 37.5% of women in group IIa and 13.9% of women in group IIb had a calm and friendly marital relationship (67.7% in sexually healthy women), and 18.7% and 58.1% respectively were in conflict (in sexually healthy women only 6.4%) (Table 2).

From the anamnesis of women there were established the peculiarities of the conditions of their upbringing, society, life and cultural level, the presence and causality of stress factors, bad habit. The term and beginning of sexual intercourse, the number of sexual partners were established too. The analysis of sexual life showed that about half of women (n=98; 51.8%) had their debut in sexual life at the age of 16-25 years, for 74 women (38.5%) it was from 20 to 25 years and for 20 women (10.4%) it was at the age of 26-30 years. The age characteristics of the beginning of sexual (marital) life were usually determined by a list of social factors.

The average onset of sexual life was 23 years.

After studying of the anamnesis data, there were established the causes and preconditions of sexual disorders, their connection with gynecological diseases, the nature and duration of the clinical course of disorders, the frequency of combination of different types of disorders, the peculiarities of their course in women with complicated

Table 4

Indicators of quality of life of surveyed women with sexual dysfunctions

SF-36 scale indicator «Quality of life»	Group of surveyed women			
	Women after childbirth per vias naturales		Women after cesarean section	
	Group Ia, n=31	Group Ib, n=43	Group IIa, n=32	Group IIb, n=86
Physical functioning (PF)	92.7±0.4	95,0±0.4	60.0±1.6*#	55.0±1.2*#
Role-Physical Functioning (RP)	88.6±1.4	81.5±1.9	57.1±0.8*#	34.4±0.8*#^
BodilyPain (BP)	79.4±0.3	82.9±1.4	52.7±0.6*#	36.2±0.9*#^
General health (GH)	85.7±0.8	90.4±0.8	63.4±0.4#	52.7±1.0*#^
Vitality (VT)	72.7±0.8	74.5±0.8	58.5±0.8#	51.8±0.6*#
Social functioning (SF)	79.5±1.1	91.2±0.8	57.1±0.4*#	53.1±0.4*#
Role Emotional (RE)	90.9±1.0	69.9±2.0	66.6±1.3*	45.7±1.1*#^
Mental Health (MH)	76.7±0.3	77.6±0.3	60.0±0.5*#	58.0±0.2*#
Physical component (PH)	54.2±0.2	55.6±0.4	41.5±0.3*#	36.0±0.4*#
Mental component (MH)	51.8±0.2	50.1±0.3	44.9±0.3*#	42.5±0.3*#

Note: * – significantly to group Ia (P<0.05); # – significant to group Ib (P<0.05); ^ – significantly to group IIa (P<0.05).

childbirth, after cesarean section and after gynecological diseases therapy and preventive measures. The effectiveness was evaluated.

RESULTS

The quality of women life is associated to personality traits, social adaptation, and the severity of sexual disorders. Single women over the age of 35 suffered more, that significantly affected their quality of life. The need for sexual dysfunctions treatment significantly worsened the mood: 17 (39.5%) women after childbirth per vias naturales worried a lot about the treatment, 46 (55.4%) women with a history of cesarean section complained of psychological discomfort during the treatment.

The nature of psycho-emotional disorders was multifactorial and was determined by sexual health, gynecological status and relationship with a partner. Patients had problems in social and marital adaptation and needed complex and adequate gynecological and psychological care.

The results of the survey showed a decrease in the quality of life of patients with long-term complications after caesarean section in the anamnesis. The mean integral of the physical component of health (PH) in women without sexual dysfunction was 41.5±0.3 points (P<0.05) and 36.0±0.4 (P<0.05) points in women with sexual health disorders; the mental component of health (MH) was 44.9±0.3 points (P<0.05) and 42.5±0.3 points (P<0.05), respectively. That is, the quality of life at the physical and mental level was lower in the range of 20–30% (Table 4).

Examined women with physiological childbirth (groups Ia and Ib) in the history of the studied SF-36 scale indicators did not have a significant difference, while women after cesarean section (group IIa) had significantly worse physical and social functioning (PF, RP, VT, SF).

Patients with cesarean section in the anamnesis complained of discomfort in the external genitalia and painful sexual intercourse (BP, GH), noted psycho-emotional disorders (MH). The examined women of the main group with sexual dysfunctions (group IIb) showed a low level of physical and mental health in all indicators. The significant worsening of health at the level of RP, BP, GH and RE was found in women of group IIa.

The obtained data confirmed our opinion about the psychogenic nature of sexual disorders in women after childbirth, as one of the factors of sexual dysfunction in women with distant complications after cesarean section. It should be noted that sexual disorders, according to respondents, were combined with a state of frustration, low self-esteem, depression, that was the basis of anxiety and depression and a significant factor that negatively affected the quality of life. At the same time, patients of all observation groups expressed a desire to have more sexual intercourse, which on their opinion would improve the quality of life and vital activity.

CONCLUSION

Thus, the results of the study allowed to establish the causes, mechanisms of formation, clinical manifestations of sexual dysfunction in women. The role of cesarean section in their occurrence were established. The areas for complex and adequate correction of sexual health were identified. Sexual adaptation in women with sexual dysfunctions was dominant regardless of the nature of childbirth, sexual intercourse, their sexual scenario. The stimulating factor of female sexuality can be not only external stimuli, correction of hormonal and gynecological status, but also a set of measures aimed at improving the psycho-emotional relationship with a partner.

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