Original Article

Hypoactive Sexual Desire Disorder, Sexual Distress and Quality of Life between Women with Surgical Menopause and Women with Natural Menopause

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Abstract

Objective: To investigate the differences in hypoactive sexual desire disorder, sexual distress, and quality of life between women with surgical menopause and women with natural menopause.
Study Design: Between-group research design
Place and Duration: The study was initiated in the year 2013 and was carried out for a period of 1 year in Departments of Gynecology and Obstetrics of 5 government hospitals, Lahore.
Methodology: Total 100 women, age ranging 40-65 years (50 with surgical menopause [M=50.28 years, SD=6.94] and 50 with natural menopause [M=45.46 years, SD=4.56] were recruited through purposive sampling strategy. Decreased sexual desire screener, female sexual distress scale-revised and Utian quality of life scale were the questionnaires employed in the research.
Results: T-test analysis revealed significant differences in hypoactive sexual desire disorder, sexual distress and 2 domains of quality of life i.e. sexual and emotional quality of life among women with surgical menopause and women with natural menopause.
Conclusion: Our study concludes that women with surgical menopause are more liable to experience hypoactive sexual desire disorder, sexual distress and disturbed the sexual and emotional quality of life as compared to women with natural menopause.
Key Words: hypoactive sexual desire disorder - sexual distress - quality of life - surgical menopause - natural menopause

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Introduction

Climacteric changes are an undeniable part of men and women's life. In Women, the cessation of menstrual cycle occurs which results in the termination of reproduction. Most women experience natural menopause; however, some women undergo surgical menopause. Natural menopause is defined as the termination of the menstrual life over a period of years, around the age of 50. It is a biological event that occurs as a normal and natural consequence of the aging process.[1] The average age of the natural menopausal transition varies from culture to culture; however, in Pakistan, it was reported to be 47 years.[2] Surgical menopause is the menopause induced through surgery that can be in the form of

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hysterectomy (surgical removal of the uterus) or oophorectomy (surgical removal of ovary), at any age. [1]

Previous research has suggested that women with natural or surgical menopause experience decreased sexual desire.[3-7] Clayton (2010) also acknowledged that menopause is associated with vaginal dryness and pain during intercourse that can lead to decreased sexual desire.[8] Moreover, hormonal fluctuations during menopause also influence levels of sexual desire.[3] Thus, the persistently low level of desire is when accompanied by marked distress or difficulties in a relationship in the absence of any other disorder, general medical condition or physiological effects of a substance than it is diagnosed as Hypoactive sexual desire disorder (HSDD).[8,9] Furthermore, decreased level of sexual desire also results in difficulties in a sexual relationship which causes marked sexual distress.[3] Sexual distress has a negative influence on one's mood and wellbeing. It may leads to depression and disturbed the quality of life.[9] Dennerstein et al. (2006) and Andrea & Suzanne (2009) also acknowledged that decreased sexual desire is further accompanied by disturbed quality of life; health care, disturbances in sleep patterns and mood problems. [9, 10] Moreover, Hubin et al. (2006) reported that Women with surgical menopause experience more decreased level of sexual desire and experience more sexual distress than women with natural menopause. They were found to be more dissatisfied with their life, and suffer marital dissatisfaction due to attaining menopause before time. [11]

The perception and attitude towards Menopause varies from culture to culture. In India, natural menopause is considered a positive event but surgical menopause is found to be associated with marked distress in sexual relationships. [12] Likewise, in Western culture, surgical menopause is associated with vasomotor symptoms (hot flashes and night sweats etc.) and urogenital problems (vaginal dryness, low libido etc.), therefore was seemed to be more distressing.[13] Nevertheless, there is a dearth of indigenous literature in Pakistan on the type of menopause and its impact on women's life.

Pakistan is a male dominant society, where men mostly express their desire and initiate sexual activity and women are bound to fulfill their men desire. Thus, sexual activity is considered wifely duty in rural as well as in some urban areas of Pakistan.[14] Hence, postmenopausal women, despite low desire tries to establish a sexual relationship with their husbands which is accompanied by distress and results in disgruntled life. [14]

In Pakistan, this issue is rarely reported and discussed in clinics.[15, 16] Women feel shy talking about it to their physicians.[15] It was found that 6% of the lower class, 26% of middle class, and 38% of upper class sought to obtain treatment for menopause-related signs and symptoms. [14] Neither the women discuss nor do physicians probe and address these problems to enhance their quality of life.[15, 16]

In the context of aforementioned circumstances, any study pertaining to the investigation of the mode of menopause (natural menopause and surgical menopause) and its impact on women sexual health status and life (hypoactive sexual desire disorder, sexual distress, and quality of life) would be highly beneficial in the Pakistani context. Hence this study will help to create general awareness about these women specific problem in this tabooed part of the world so that counseling and education could be provided to women in clinics and their problems could be better solved out.

Methodology

Hypotheses:

1. Women with surgical menopause are more likely to experience hypoactive sexual desire disorder than women with natural menopause.
2. Women with surgical menopause are more likely to experience sexual distress than women with natural menopause.
3. Women with surgical menopause are more likely to experience the disturbed quality of life than women with natural menopause.

The research design was used to compare the women with surgical menopause and women with natural menopause. Total 100 women age ranging 40-65 years (50 with surgical menopause [M=50.28 years, SD=6.94] and 50 with natural menopause [M=45.46 years, SD=4.56] were recruited from

different gynecological health departments in Lahore city, Pakistan. According to G-power analysis, the sample size was determined which came out to be 100 by keeping α=.05, with medium effect size (.15). The non-probability purposive sampling strategy was used. The data was collected from 5 government hospitals i.e. Sir Ganga Ram Hospital, Services Hospital, Government Maternity Hospital, Jinnah Hospital and Sheikh Zaid Hospital. The sample was drawn on the basis of the following inclusion and exclusion criteria.

Inclusion Criteria

a) Women with age range 40-65 years, with Natural or Surgical menopause that occurred 1 year before (No menses for at least 12 months and not more than 5 years) were included in the sample.

b) Women who were capable of understanding Urdu language were included.

Exclusion Criteria

a) Unmarried/ Divorced/separated/widowed postmenopausal women, physically disabled/ or any other severe physical illness, psychological illness.

b) Women with any infectious gynecological disease or with major life stress were not included in the sample.

Demographic form was developed by the researcher to get information regarding participant and her husband's age, education, occupation, marital status, relationship with husband, monthly income, type of menopause, timing of last menstrual period, decrease in sexual desire, associated distress, chronic illness, recent or current pregnancy, hormonal use, high-dose medicine, loss of partner, unwanted marriage, intimacy difficulty, any physical or psychological illness, disease or any life stressor.

It is a short diagnostic tool that was employed in the study to assess participant's level of sexual desire. It was developed by Clayton et al (2009) and was translated by the researcher into Urdu through MAPI guidelines to make it comprehendible for the sample. The following tool shows a diagnostic precision of 85.2%, sensibility 83.6 and specificity 87.8%. The reliability of this scale for the present study was calculated as Cronbach's alpha α=0.55[8]

Female Sexual Distress Scale-Revised (FSDS-R). It was used to assess female sexual distress. It was developed by Derogatis, Clayton, Agostino, Wunderlich, and Fu in 2008[17] and was also translated by the researcher into Urdu through MAPI guidelines. It has well-established reliability (>0.74) and validity (<.0001). The reliability of this scale for the present study was Cronbach's alpha α=.97[17].

Utian Quality of Life (U-QOL) scale. This 23-item tool was used to assess participant's quality of life. It was developed by Utian (2002) [18] and was translated by Tariq (2011) into Urdu. It is a menopause-specific scale that assesses four domains of quality of life which are health, occupational, emotional and sexual quality of life. Overall reliability value 0.91 and 0.54 with effect size 0.74 –0.82. The reliability of this scale for the present study was Cronbach's α=.71.

All the assessment measures were employed in the study after translation into the Urdu language according to standard translation procedure. The assessment measures were first translated by 5 bilingual educated people and then Back-translated by another 5 bilingual educated people.

Procedure: After formal permission from departmental research committee the permission was sought from the authors to use the tools in the present research. The permission to collect data was taken from the concerned authorities of gynecology departments. The researcher screened the participants and only those fulfilling the criteria were included in the study. Pilot study was carried out on 05 participants from each group and the researcher verbally administered the questionnaires on them in one to one setting. Any difficulty faced by the participants was taken into consideration and changes were applied according to their respective feedback (such as rephrasing of certain items of the questionnaire, the addition of some important questions and omission of irrelevant questions). During the main study, the purpose and nature of the study were explained to the participants. The consent was taken from the participants as an ethical obligation of the researcher and they were ensured of the confidentiality of their responses. They were allowed to leave the research questionnaire to incase where they could not continue it due to some personal reasons. It was made clear to them that the information was used only for education and research purposes. After

getting informed consent, the questionnaires were administered to the participants in sequence such as demographic questionnaire, decreased sexual desire screener,
female sexual distress scale and Utian quality of life scale. The participants were explained or guided where they found any difficulty. They were told that they were free to ask any question related to research. Confidentiality of data information and anonymity of participants was maintained. Data was entered, coded, analyzed and was presented genuinely.
During the data collection, 200 participants were approached, out of which 135 fulfilled criteria. 15 postmenopausal women rejected to fill the questionnaire due to several personal reasons. On 120 participants, 4 questionnaires were administered. During the administration, 11 participants left the questionnaires incomplete due to running short of time, not interested in the study, low mood and several other personal reasons. The incomplete questionnaires and 9 other questionnaires which depict the carelessness of the participants were discarded during data entry.

Results

Statistical Packages for Social Sciences (SPSS) was used to analyze the results. Descriptive statistics was used to analyze demographic characteristics. For comparison of 2 groups (women with natural menopause and women with surgical menopause), Independent Sample t-test was used. (Table I & II)

Table No. I. Mean, SD, Min. and Max. values of demographic variables.

Demographic Variables	M	SD	Min.	Max.
Age of participants	47.87	6.326	40	65
No. of children	4.84	2.014	0	11
Age of puberty	13.87	1.261	11	18
Age of menopause	43.47	6.519	6	60

Note. M=Mean, SD=Standard Deviation, Min.= Minimum values, Max=Maximum value

Descriptive statistics used to analyze demographic characteristics revealed the mean age of the sample M=50.28 years (SD=6.94) of women with surgical menopause and M=45.46 years (SD=4.56) of women with natural menopause, educated till primary, were housewives, living in a joint family system and had 4-6 no. of children.

Table III depicts that there was highly significant

Table No II: Frequencies and percentages of demographic variables.

Demographic variables	Natural menopause (n=50)		Surgical menopause (n=50)			
			Hysterectomy (n=25)		Oophorectomy (n=25)	
	f	%	*f*	%	*f*	%
Education						
Illiterate-Primary	37	74	14	56	18	72
Middle- Metric	7	14	8	32	5	20
F.A-M.A	6	12	3	12	2	8
Occupation						
House wife	48	96	24	96	24	96
Govt. Employee	1	2	0	0	0	0
Personal business	1	2	0	0	0	0
Family system						
Joint	31	62	17	68	14	56
Nuclear	19	38	7	28	11	44
Nature of marital relationship						
dissatisfactory	7	14	0	0	3	12
moderate	14	28	9	36	5	20
satisfactory	28	56	16	64	17	68
Duration of surgical menopause						
1 year	0	0	14	56	13	52
More than 1 year	0	0	11	44	12	48

Table No III: Difference in hypoactive sexual desire disorder, sexual distress and quality of life between women with surgical menopause and women with natural menopause (N=100).

Variables	Surgical menopause		Natural menopause				95%CI		Cohen's
	M	SD	M	SD	t(98)	P	LL	UL	d
HSDD	2.60	2.96	0.74	2.06	-3.64	.001	-2.87	-.84	0.73
SxD	18.84	16.14	10.26	12.04	-3.01	.001	-14.23	-2.92	0.60
QOL	64.78	13.34	72.02	15.86	2.47	.01	1.42	13.05	0.49
Health QOL	17.64	5.85	19.72	5.91	1.76	.08	-.25	4.41	0.35
Occupational QOL	24.16	5.14	24.74	5.26	0.56	.58	-1.48	2.64	0.11
Emotional QOL	15.06	4.54	17.30	5.82	2.14	.03	.16	4.31	0.42
Sexual QOL	7.92	3.38	10.26	3.70	3.30	.001	.93	3.74	0.66

Note.CI=confidence interval; LL=lower limit; UL=upper limit, HSDD= Hypoactive Sexual Desire Disorder, SxD= Sexual Distress QOL= Quality of Life, M=Mean, SD=Standard Deviation, t=t-value, p=significance level <.05.

difference in hypoactive sexual desire disorder and sexual distress among women with natural menopause and those with surgical menopause. Moreover, there was also significant difference observed in emotional quality of life and the highly significant difference was found in the sexual quality of life of women with natural menopause and surgical menopause. It refers that more women with surgical menopause experience more decreased sexual desire and accompanying sexual distress as compared to women with natural menopause. Furthermore, health, emotional and sexual quality of life seemed to be more disturbed in women who experienced surgical menopause.

Discussion

Menopause influences women's life in a different way depending on whether it is achieved naturally or induced through surgery. [19] Surgical menopause is medical intervention, therefore, is potentially more distressing. Moreover, the decline in sex hormones (estrogen, testosterone, and progesterone) is sudden and abrupt; therefore, the symptoms are more severe. [19] There is ample Western literature that emphasizes the differences in the two types of menopause and their consequences; nevertheless, there is an extreme paucity of empirical evidence in Pakistani culture. [2]

Therefore, the current study was designed to investigate the differences in hypoactive sexual desire disorder, sexual distress, and quality of life among women with surgical menopause and women with natural menopause. Our results show that there were highly significant differences in hypoactive sexual desire disorder between women with surgical menopause and natural menopause as it was hypothesized. Similar results were found by Dennerstein et al. (2006)[3] that Women who had removed their uterus (hysterectomy) or ovary (oophorectomy) through surgery were more prone to experience difficulties in the sexual relationship. Another study conducted by Leiblum et al. (2006) [4] comes up with similar findings i.e. women who undergo surgical menopause are 17% more prone to experience hypoactive sexual desire disorder than women who experience natural menopause. Omidvar et al. (2011) also came across with similar findings i.e. 70% of the postmenopausal married women in his study experienced decreased sexual activity and of them, 80% reported sexual desire disorder and sexual arousal disorder.[5] In Pakistani culture, as per demographic variables, the majority of the women included in the sample reported themselves to be housewives, belonging to the joint family system and having 4-6 numbers of children. Thus, in Pakistan, women are considered as the primary caregivers as they had to look after the needs of the children besides looking after other household chores. The women with the natural menopause reported that the sexual desire decreases with advancing age as they often find it difficult to maintain a cohesive relationship with their partner due to their limited ability to speak about sexuality and low openness. Furthermore, during data collection women with natural menopause also reported that their concerns shift more towards spirituality (prayers) and as body become weak with age and painful experiences during sexual activity resulted in significant decline in sexual desire. However, women with surgical menopause reported

that the decreased sexual desire was a significant stressor for them.

According to results, it was also observed that there was a significant difference in sexual distress experienced by women with surgical menopause as compared to women with natural menopause. Previous research support the present findings. Hubin, Sutter, and Reynaert (2010) conducted a research in which they reached the conclusion that the perceived negative impact of hysterectomy on body image, sometimes lead to anxiety and sexual distress. Of all surgical procedures, only hysterectomy and oophorectomy was found to have an impact on the glandular system, thus affecting sexual desire. [11] Another study was carried out by Leiblum et al. (2006) in which they inferred that hypoactive sexual desire disorder was found to be associated with emotional and sexual distress due to which mental and physical health are also affected. [4] During data collection, women with natural menopause also reported that they do not experience distress regarding rare indulgence in sexual activity; rather, they are more satisfied with their life and are more inclined towards religiosity. Surgical postmenopausal women reported sexual distress as it is affecting their relationship.

Furthermore, findings revealed that surgical post-menopausal women's quality of life was more disturbed than natural post-menopausal women's. Results can be further strengthened by describing them in the light of theoretical perspective. Nadeem and Khalid (2010) conducted a research in which the findings revealed that menopause is associated with hormonal changes that influence one's health and sexually related quality of life. [2] Another research by Andrea and Suzzane (2009) revealed that 6.6-12.5% women with hypoactive sexual desire disorder also showed marked impairment in health-related quality of life. [10]

Conclusion

Our study concludes that women with surgical menopause and more liable to experience hypoactive sexual desire disorder, sexual distress and disturbed sexual and emotional quality of life as compared to women with natural menopause.

Limitations and Suggestions: During the sample collection, some important facts were revealed such as most of the women reported that they had no information regarding sexual problems and therefore had never visited physicians to discuss their sexual difficulties. Therefore, it is recommended that further research is required in this area which should focus on women's sexual problems so that treatment plan could be devised of such problems which are highly underreported in Pakistan.

Future Implications: Physicians and doctors should incorporate sexual history in assessment and should recommend them to a qualified clinical psychologist if the disturbance in sexual life or sexual distress is diagnosed so that counseling guidelines could be provided.

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