

Self-Perception of Sexual Dysfunction of Adult Brazilian Women of Reproductive Age: A Cross-Sectional Study

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Introduction: Sexual dysfunction (SD) comprises disorders in sexual desire, arousal, orgasm, and lubrication. The importance of self-perceived SD relies on its relation to personal values, sex education, and partnership. We aimed to analyze the association between self-perceived SD and the Female Sexual Function Index (FSFI) in adult women of reproductive age and the correlation between age and sexual function.

Material and Methods: This analytical cross-sectional study included 285 women aged 18 to 49 years, sexually active for at least four weeks, cisgender and heterosexual, and with Internet access. Women were divided into control (CG, control group; without SD) or study group (SG, study group; with SD) and responded to a self-applicable online survey containing a sociodemographic characterization, an interview about SD knowledge, and the FSFI test. The Chi-square test of independence (χ^2) analyzed the association between self-perceived SD and FSFI-assessed SD. Pearson's correlation coefficient investigated the correlation between age and FSFI.

Results: Included women had a mean age of 29.57 years \pm 7.11 years. Self-perceived SD showed a moderate association (Cramer's $V = 0.590$) with the FSFI score ($\chi^2 [2] = 91.500$; $p < 0.001$). A weak, negative, and significant correlation was observed between age and the FSFI desire domain ($r = -0.120$; $p = 0.030$; $r^2 = 1.440$).

Conclusion: Women with self-perceived SD were 68% more likely to present FSFI-assessed SD. Regarding the FSFI desire domain, sexual function decreased with age.

Keywords: sexual dysfunction, physiological, sexuality, women

Introduction

Human sexuality is multifactorial and depends on the integration of psychological, biological, relational, and socio-cultural factors.¹ According to the World Health Organization, healthy sexuality comprises quality of life, anatomical-physiological, personal, and social well-being, and the absence of sexual dysfunction (SD).²

SD is a health problem related to disorders in sexual desire, arousal, orgasm, and lubrication that impair the physical and emotional well-being of women during reproductive age (from 10 to 49 years), women may experience different phases (pregnancy, childbirth, postpartum, and puerperium) that result in biological, psychological, and social changes, possibly affecting sexual function (SF).³⁻⁵ Moreover, some factors are associated with SD, such as perineal trauma during vaginal delivery, breastfeeding, mood swings, fears, changes in body self-image, lack of support from the partner, and urinary incontinence.^{6,7} Sexual dysfunction is also prevalent among women with depression⁸ and there is an interrelationship between the presence of female sexual dysfunction and the male partnership.⁹ Dysorgasmia, decreased

desire and sexual satisfaction, and onset or increased dyspareunia are the main SD.¹⁰ The prevalence of SD in Brazilian women ranges from 49.0% to 58.3%.^{11,12}

The biopsychosocial paradigm also recognizes the multifactorial (physical, psychological, and social) etiology of SD.¹³ Social norms related to SF may restrict the access of women to body self-knowledge and awareness about sexual responses and changes in the sexual cycle.¹⁴ Moreover, identifying SD depends on the personal values, desires, and sex education of women and partners, making self-perceived SD an important factor.¹⁵ Understanding the relationship between self-perception and the actual presence of sexual dysfunction can contribute to advancing research on the subject and developing more effective sexual education approaches for Brazilian women. This understanding can help mitigate the sexual vulnerabilities to which they are commonly subjected.

Among the available instruments, the Female Sexual Function Index (FSFI) is a validated questionnaire that assesses SF. It is concise and self-applicable, containing six domains: desire, arousal, lubrication, orgasm, satisfaction, and pain.^{16,17}

Therefore, this study aimed to analyze the association between self-perceived SD and FSFI and the correlation between age and SF in adult women of reproductive age.

Materials and Methods

Study Design

This analytical cross-sectional study was conducted between August 2021 and July 2022 using an online survey applied to Brazilian women, following the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) guidelines.¹⁸ The study was submitted and approved by the research ethics committee of the Faculdade de Ciências da Saúde do Trairi (registry no. 47466121.8.0000.5568; 4,847,000). All participants signed an informed consent form. This study complies with the Declaration of Helsinki.

Population and Sample

The sample size was calculated using the site openepi.com, considering the population of Brazilian women aged 18 years or older (109,298,000 women), the expected frequency of SD (37.20%), a 95% confidence interval (95% CI) and an expected effect of 0.28.^{19,20} Considering an ideal sample of 101 participants, the final sample was 285 adult women of reproductive age.

Inclusion criteria were women (a) aged between 18 and 49 years; (b) sexually active (with or without partnership) for at least four weeks; (c) cisgender and heterosexual; (d) with access to the Internet.²¹

Data Collection and Instruments

The study was conducted using an online survey (Google Forms[®]), which included the informed consent form. Initially, the women responded to the sociodemographic characterization developed by the researchers (age, schooling, social class, profession, religion, marital status, use of a contraceptive method, number of pregnancies, number of deliveries [vaginal and c-section], number of abortions, SD knowledge, smoking, alcohol consumption, and physical exercises practice). The form's link was shared through social media, messaging apps, and via the communication department of the Federal University of Rio Grande do Norte. The assessment report was provided to the volunteers via email. Those experiencing sexual dysfunctions and desiring support could contact the research team for initial guidance and referral to specialized professionals.

Then, the women responded with “(0) no” or “(1) yes” to the following question: “Do you know or have heard about some type of dysfunction (problem) related to female sexuality?”. After the question, the main SD were described in accessible language for the women to answer the following question: “Knowing the concepts of the main SD, do you think you have any of them? (You can check more than one option)”.²² The available options were (0) No, (1) Hypoactive desire; (2) Sexual aversion or phobia; (3) Sexual arousal dysfunction; (4) Anorgasmia; (5) Dysorgasmia; (6) Dyspareunia; (7) Vaginismus; (8) I cannot identify; (9) I do not want to answer that question. Analytically, self-

perceived SD was categorized as “no” (women who did not identify any SD), “yes” (women who indicated one or more SD), and “I cannot identify”.

Last, the women responded to the Portuguese version of the FSFI to assess SF in the last four weeks.¹⁶ This questionnaire contained 19 questions from six domains: desire, arousal, lubrication, orgasm, satisfaction, and pain. The psychometric properties met the criteria of internal consistency, reliability, and validity.^{16,22} The answers ranged from 0 to 5 points regarding function. The final score ranged from 2 to 36; higher values indicated good SF. Scores ≤ 26.55 indicated SD.¹⁵ The selection of this cutoff point was based on previous studies involving Brazilian women.^{23,24} From this cutoff point, women were divided into control (CG; without SD) or study group (SG; with SD).⁶

Data Analysis

Sample characterization was performed by measures of central tendency (mean) and dispersion (standard deviation) or frequencies (absolute and relative), depending on the type of variable. The Chi-square test of independence (χ^2) analyzed the association between self-perceived SD and FSFI-assessed SD. Pearson's correlation coefficient (r^2) analyzed the correlation between age and FSFI scores (total and by domain), classified as 0 = absent; 0.1 to 0.3 = weak; 0.4 to 0.6 = moderate; 0.7 to 0.9 = strong; 1 = perfect. The values were presented in percentages. Results were reported using the significance level (p) set at $p < 0.05$, 95% CI, coefficient of determination (r^2), and Cramer's V effect size, which estimated the strength of the associations.¹⁶ This same criterion defined the odds ratio (OR) and the strength of the correlations and associations.²⁵ Data storage and processing were performed in the Statistical Package for Social Science for Windows, SPSS, version 20.0. The research stages are depicted in [Figure 1](#).

Results

This study included 285 women with a mean age of 29.57 ± 7.11 years. The sociodemographic characteristics related to sexual and gynecological health and life habits are shown in [Table 1](#).

Of all participants, 27 (9.5%) did not identify any SD. The remaining 258 women (90.5%) showed a moderate association (Cramer's V = 0.590) between the self-perceived SD and the FSFI score ($\chi^2 [2] = 91.500$; $p < 0.001$).

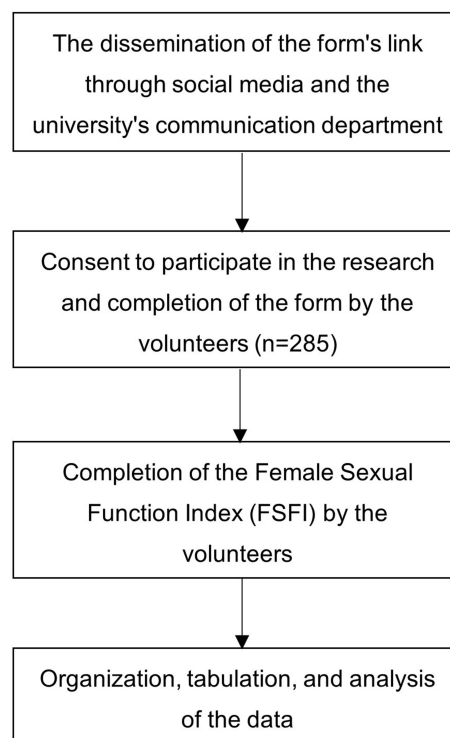


Figure 1 Flowchart of the research procedures.

Table 1 Sociodemographic Characteristics, Sexual and Gynecological Health, and Life Habits of the Participants

Variables	Women (n = 285)	
	n	%
SCHOOLING		
Elementary school	1	0.4
Middle school	4	1.4
High school	42	14.7
Incomplete higher education	59	20.7
Complete higher education	179	62.8
SOCIAL CLASS	n	%
A (\$3507.38)	2	0.7
B (from \$1753.69 to \$3507.38)	25	8.8
C (from \$701.48 to \$1753.69)	74	26.0
D (from \$350.74 to \$701.48)	78	27.4
E (\$350.74)	59	20.7
Did not answer	47	16.5
PROFESSION	n	%
Housewife	5	1.8
Health professional	139	48.8
Education professional	21	7.4
Commercial career	3	1.1
Autonomous	14	4.9
Student	43	15.1
Others	45	15.8
No profession	7	2.5
Refrained from answering	8	2.8
RELIGION	n	%
Catholic	199	69.8
Protestant	35	12.3
Spiritist	8	2.8
Jehovah's witness	2	0.7
Other	9	3.2
Atheist	1	0.4
No religion	31	10.9

(Continued)

Table I (Continued).

Variables	Women (n = 285)	
	n	%
MARITAL STATUS		
Partner	255	89.5
No partner	30	10.5
USE OF A CONTRACEPTIVE METHOD	n	%
Yes	163	57.2
No	122	42.8
NUMBER OF PREGNANCIES	n	%
0	149	52.3
1	46	16.1
2	20	7.0
3 or more	8	2.8
NUMBER OF VAGINAL DELIVERIES	n	%
0	238	83.5
1	37	13.0
2	9	3.2
3 or more	1	0.4
NUMBER OF C-SECTIONS	n	%
0	189	66.3
1	60	21.1
2	29	10.2
3 or more	7	2.5
NUMBER OF ABORTIONS	n	%
0	238	83.5
1	37	13.0
2	9	3.2
3 or more	1	0.4
SD KNOWLEDGE	n	%
Yes	182	63.9
No	103	36.1
SMOKING	n	%
Yes	17	6.0
No	268	94.0

(Continued)

Table 1 (Continued).

Variables	Women (n = 285)	
	n	%
ALCOHOL CONSUMPTION		
Yes	81	31.9
No	91	28.4
Rarely	113	39.6
PHYSICAL EXERCISES PRACTICE		
Yes	162	56.8
No	123	43.2

Abbreviation: SD, sexual disfunction.

Thereby, women who self-perceived the SD were 68% more likely to present FSFI-assessed SD (OR = 0.320; 95% CI = 0.013 to 0.078) (Table 2).

A weak, negative, and significant correlation was observed between age and the FSFI desire domain with a weak effect size ($r^2 = 1.44$). Table 3 presents a detailed analysis.

Table 2 Association Between Self-Perceived SD and FSFI-Assessed SD

		FSFI Score			χ^2 (df)	Cramer's V (p)
		CG % (n)	SG % (n)	Total % (n)		
Self-perceived SD	No	38.0 (98)	2.3 (6)	40.3 (104)	91.500 (1)	0.560 (<0.001)
	Yes	20.5 (53)	39.1 (101)	59.7 (154)		
	Total	41.5 (107)	58.5 (151)	100 (258)		

Abbreviations: CG, Control group (no sexual dysfunction); SG, Study Group (sexual dysfunction); χ^2 , Chi-square; df, degrees of freedom; p, significance level ($p < 0.05$); SD, sexual dysfunction; FSFI, Female Sexual Function Index; Cramer's V, effect size.

Table 3 Correlation Between Age and FSFI Domains

	Age			
	r	p	r^2	95% CI
Desire	-0.120	0.030	1.4400	-0.230 to 0.030
Arousal	-0.100	0.090	1.0000	-0.230 to 0.010
Lubrication	-0.005	0.920	0.0020	-0.130 to 0.110
Orgasm	0.002	0.970	0.0004	-0.130 to 0.120
Satisfaction	-0.100	0.060	1.0000	-0.230 to 0.015
Pain	-0.070	0.220	0.4900	-0.200 to 0.050
Total score	-0.080	0.170	0.6400	-0.200 to 0.040

Notes: p, significance level ($p < 0.05$); 95% CI, confidence interval; r, Pearson's correlation coefficient; r^2 , effect size; %, percentage.

Discussion

This study aimed to analyze the association between self-perceived SD and FSFI and the correlation between age and SF in adult women of reproductive age. Self-perceived SD and FSFI were moderately associated, and older ages correlated with lower sexual desire. However, the effect size of this correlation was weak.

Women with self-perceived SD were 68% more likely to present FSFI-assessed SD. Contrarily, Song et al identified that the prevalence of self-perceived SD was lower than the FSFI-assessed SD, which was not perceived or caused discomfort.²⁶ This contrast found by Song et al is possibly due to the lack of SD knowledge.²⁶

Most women (63.9%) reported SD knowledge and were from the health area (professionals or students), presenting high schooling. Therefore, these aspects suggest that socioeconomic factors (ie, profession and schooling) facilitated access to information, enabling the self-perceived SD (confirmed by FSFI). This self-perception may stimulate women to confirm the SD and seek treatment.

Regarding the FSFI desire domain, older ages were correlated to worse SF, corroborating other studies.^{11,26} This result may be due to the progressive decrease in hormone levels, leading to altered SF (including in desire).²⁷ Decreased steroid hormones (testosterone, estradiol, and progesterone) alter the release of hormones that modulate sexual desire, such as dopamine, norepinephrine, alpha-melanocyte-stimulating hormone, and oxytocin.²⁸ However, sexual desire is also influenced by psychosocial and cultural factors, possibly justifying the weak effect size found in our study.²⁹ Having a job and a monogamous and long-term relationship were also related to a low sexual desire in older women compared to those younger who have a sexual partner but have no formal relationship (marriage).³⁰

To our knowledge, this was the first study to analyze the association between self-perceived SD and FSFI and the correlation between age and SF in Brazilian women of reproductive age. A validated and widely used instrument was applied to assess SF and SD with proper sample size and data analysis. In addition, an internationally recognized guideline was consulted for study planning, data collection, and analysis. This study hypothesized that most women with FSFI-assessed SD would not self-perceive SD due to sociocultural characteristics prevalent in Brazil (chauvinism, stigmas involving women SF, poor or lack of sex education, and low-quality information). However, the results were contrary, probably due to socioeconomic characteristics.

These findings highlight the importance of health guidance about SF for women. Access to reliable information and sex education may enable women to identify SD, seek specialized professionals to assess it using validated questionnaires, and properly treat it. The self-perception of sexual dysfunction can be addressed within themes related to female sexual education. Body self-awareness and the conditions (physical and/or emotional) that can lead to alterations in sexual function can be extensively discussed by specialized professionals in schools, healthcare settings, and within families. Given the country's persistent culture of chauvinism and misogyny, women might normalize sexual dysfunctions, considering them as commonplace. Hence, the significance of this study and others aimed at deepening knowledge in this specific field. Finally, the correlation between older age and decreased sexual desire may be justified by biopsychosocial factors. However, the weak effect size indicates the need for further studies to understand this correlation better.

Some strategies were adopted to reduce study limitations. This study was widely disseminated via social media to reach more women in different regions of the country; still, most women lived in Northeast Brazil. In addition, due to the COVID-19 pandemic, the survey was online and self-applicable, minimizing embarrassment in responding to the questions and increasing study reliability. Also, the negative aspect (ie, difficulty in comprehending the questions) was mitigated by presenting clear questions and explaining or replacing technical or difficult-to-understand terms. However, the lack of Internet access may have excluded women from other socioeconomic strata, interfering with the results. It's also worth noting that, due to the cross-sectional design of this study, establishing cause-and-effect relationships is not feasible. Therefore, other studies involving this theme must be developed, considering a diverse sample and longitudinal follow-up of the women to establish cause-and-effect correlations.

Conclusion

Heterosexual, cisgender women who self-perceived SD were 68% more likely to present FSFI-assessed SD. A decrease in sexual function with age was also observed regarding the FSFI desire domain.

Abbreviations

SD, sexual dysfunction; SF, sexual function; FSFI, Female Sexual Function Index; STROBE, Strengthening the Reporting of Observational Studies in Epidemiology; OR, odds ratio.

Disclosure

The authors report no conflicts of interest in this work.

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