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COMPARISON OF CHARACTERISTICS OF SEXUAL DISORDERS IN INFERTILITY AND NON-INTERFERTILITY WOMEN

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ABSTRACT

Background: Sexuality is one of the basic human needs, and sexual dysfunctions (SDs) may occur, preventing couples from satisfying their sexual needs, leading to an unhappy relationship, anxiety, and stress. Currently in Vietnam, the issue of SDs evaluation has been addressed in some studies involving male subjects with a history of internal or surgical diseases, and research on SDs in women has just started to gain attention. There is a need to evaluate SDs in infertile couples, which serves as a basis for proper counseling, thereby creating favorable conditions for the success of assisted reproductive techniques in the future. **Objective:** Evaluating the characteristics of sexual dysfunction in infertile and non-infertile women and some related factors. **Methods:** The descriptive crosssectional study used the female sexual function indextoolkit to evaluate 55 wives in infertile couples whovisited the Thai Nguyen University of Medicine and Pharmacy Hospital for the first time, with the control group consisting of 51 women with normal fertility. **Results:** The infertile group was younger than the non-infertile group (30.0± 4.2 vs 32.1 ± 2.7). The infertile group had an average time of expecting a child of 2.1 ± 1.3 (1 - 8 years). The rate of gynecological inflammation history was higher in the infertile group (69.1%) compared to the non-

infertile group (43.1%), with a statistically significant difference (p = 0.01) The infertile group had lower female sexual function index scores (25.6 ± 5.2) and a higher rate of sexual disorders (67.3%) compared to the non-infertile group, which had FSFI scores of 27.9 ± 4.1 and a sexual disorder rate of 37.3%. The infertile group had a higher rate of disorders in specific domains than the non-infertile group. **Conclusion:** Wives in infertile couples have a high rate of sexual disorders, leading to reduced quality of life and the ability to get pregnant. Sexual health assessment should be added to the infertility management program.
Keywords: Infertility; Sexuality; Sexual disorders; Female sexual function index; Desire

SO SÁNH ĐẶC ĐIỂM RỐI LOẠN CHỨC NĂNG TÌNH DỤC Ở PHỤ NỮ VÔ SINH VÀ KHÔNG VÔ SINH

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TÓM TẮT

Đặt vấn đề: Tình dục là một trong những nhu cầu cơ bản của con người, và rối loạn tình dục có thể xảy ra, khiến các cặp vợ chồng không thể thỏa mãn nhu cầu tình dục, dẫn đến mối quan hệ không hạnh phúc, lo âu và căng thẳng. Hiện nay tại Việt Nam, việc đánh giá rối loạn chức năng tình dục đã được đề cập trong một số nghiên cứu chủ yếu ở nam giới có tiền sử bệnh nội khoa hoặc ngoại khoa, trong khi nghiên cứu về rối loạn tình dục ở phụ nữ mới bắt đầu được quan tâm. Việc

đánh giá rối loạn tình dục ở các cặp vợ chồng vô sinh là cần thiết, làm cơ sở cho tư vấn phù hợp, từ đó tạo điều kiện thuận lợi cho sự thành công của các kỹ thuật hỗ trợ sinh sản trong tương lai. **Mục tiêu:** Đánh giá đặc điểm rối loạn chức năng tình dục ở phụ nữ vô sinh và không vô sinh, cùng một số yếu tố liên quan. **Phương pháp:** Nghiên cứu mô tả cắt ngang sử dụng bộ công cụ Chỉ số chức năng tình dục nữ (FSFI) để đánh giá trên 55 người vợ trong các cặp vợ chồng vô sinh đến khám lần đầu tại Bệnh viện Trường Đại học Y Dược - Đại học Thái Nguyên, và nhóm chứng gồm 51 phụ nữ có khả năng sinh sản bình thường. **Kết quả:** Nhóm vô sinh có độ tuổi thấp hơn nhóm không vô sinh (30,0 ± 4,2 so với 32,1 ± 2,7). Thời gian mong con trung bình ở nhóm vô sinh là 2,1 ± 1,3 năm (1 - 8 năm). Tỷ lệ tiền sử viêm nhiễm phụ khoa ở nhóm vô sinh cao hơn (69,1% so với 43,1%, p = 0,01). Nhóm vô sinh có điểm FSFI thấp hơn và tỷ lệ rối loạn chức năng tình dục cao hơn so với nhóm không vô sinh (25,6 ± 5,2 so với 27,9 ± 4,1 và 67,3% so với 37,3%). Ngoài ra, nhóm vô sinh có tỷ lệ rối loạn ở các lĩnh vực chức năng tình dục cụ thể cao hơn. **Kết luận:** Phụ nữ ở các cặp vợ chồng vô sinh có tỷ lệ rối loạn chức năng tình dục cao, làm giảm chất lượng cuộc sống và khả năng có thai. Cần bổ sung đánh giá sức khỏe tình dục vào chương trình quản lý vô sinh.
Từ khóa: Vô sinh; Tình dục; Rối loạn chức năng tình dục; Chỉ số chức năng tình dục nữ; Ham muốn

INTRODUCTION

Sexuality is a basic human need, and sexual dysfunctions (SDs) can hinder its fulfillment, leading to stress, anxiety, and reduced relationship satisfaction. Beyond reproduction, sexual activity

also provides positive emotions, excitement, and pleasure. SDs are persistent or recurrent problems in the ability to respond sexually or to experience sexual pleasure, preventing individuals from engaging in sexual activity as they desire [1]. The prevalence of SDs increases among infertile individuals due to psychological stress from infertility and its treatment, as well as reduced intimacy when sexual activity becomes primarily goal-directed toward conception and is disrupted by medical interventions [2]. In women, the prevalence of SDs ranges from 6.9% to 77.3%, while in men it ranges from 6.7% to 53.6%. Most studies show that infertile women have significantly poorer sexual health compared to fertile women [3]. In a comparison between fertile and infertile women, author Mirblouk F reported desire disorders in 54.4% of fertile women and 69.8% of infertile women ($p = 0.006$), arousal disorders in 47.6% of fertile women and 63.8% of infertile women ($p = 0.005$), orgasm disorders in 13.6% of fertile women and 23.5% of infertile women ($p = 0.03$) [4]. When sexual activity is primarily for reproduction, it becomes scheduled rather than spontaneous, often accompanied by feelings of pressure, lacking concern for mutual arousal and satisfaction, and neglecting emotional and intimate interaction [5].

Although sexual dysfunction in infertile women has been of interest worldwide. In Vietnam, there have been many studies on sexual dysfunction in infertile wives and couples. A high rate of dysfunction has been recorded in this group of subjects. A recent survey of author Ngo Toan Anh and colleagues at the National Hospital of Obstetrics and Gynecology recorded the

rate of wives showing signs of anxiety, depression, and stress at 24.5%, 13.8%, and 8.8%, respectively. The rate of patients with sexual dysfunction accounts for a large proportion of 57.9% [6]. In addition, there is a research group of author Le Minh Tam at the Center for Reproductive Endocrinology and Infertility, Hue University of Medicine and Pharmacy Hospital [7,2]. However, there are still a few studies comparing the characteristics of sexual dysfunction between the infertile and non-infertile groups. Necessary for comprehensive consultation and treatment. Understanding the characteristics of sexual dysfunction helps obstetricians and gynecologists and reproductive support specialists develop appropriate consultation, screening and intervention programs, contributing to improving the effectiveness of infertility treatment and improving sexual health. Therefore, this study is conducted to evaluate the characteristics of sexual disorders in infertile and non-infertile women.

METHODS

Study Subjects

Inclusion criteria for the infertile women group: Women aged 18 - 49 years. Diagnosed with infertility (failure to achieve pregnancy after ≥ 12 months of regular unprotected intercourse). First-time visitors for infertility examination at Thai Nguyen University of Medicine and Pharmacy Hospital during the study period. Provided informed consent to participate.

Inclusion criteria for the Reproductive group: Women of reproductive age with normal fertility, attending routine health checkups at the same hospital,

currently not intending to have more children, and not undergoing treatment for any acute or chronic diseases. Provided informed consent to participate Exclusion Criteria.

History of mental illness or intellectual disability. Communication difficulties (language, hearing, or vision). Did not provide informed consent to participate in the study.

Study period: 2023 - 2024.

Study location: Thai Nguyen University of Medicine and Pharmacy Hospital.

Study Design: A cross-sectional comparative study.

Sample Size and Sampling Method

- Sample size: All eligible subjects meeting the selection criteria during the study period were included. The final sample consisted of 55 infertile women and 51 fertile women.

- A convenient sampling method was used: Infertile women were continuously recruited upon visitation for infertility consultations. Fertility women were recruited from those attending routine health checkups during the same period.

Research Variables

Collect data into the research form through the infertility examination records.

General characteristics: Age, body mass index, duration of marriage, economic status, housing condition.

Gynecological and obstetric characteristics: Menstruation, gynecological infections, gynecologic or obstetric surgery, history of miscarriage or abortion.

Mutual understanding between spouses refers to the degree to which partners share, empathize with, and understand each other's thoughts, emotions, needs,

and expectations within the marital relationship. Classification: Good: Frequent communication, mutual support, and strong emotional understanding. Average: Moderate level of communication and understanding, occasional conflicts Poor: Limited communication, lack of understanding, frequent conflicts.

For the infertile group: Time spent trying to conceive, classification of infertility, causes of infertility.

Sexual dysfunction indicators: FSFI total score, classification of sexual dysfunction (FSFI $\leq$ 26.55), and scores in each domain (desire, arousal, lubrication, orgasm, satisfaction, pain) according to established cutoffs.

Procedure

Wives of infertile couples, and non-infertile women who had been informed about the study and agreed to participate, were given assessment questionnaires upon their visit. They are instructed on how to answer and invited to a private room to fill out the form themselves. The questionnaires are anonymous and encrypted with a personal code.

Assessment of sexual dysfunction using a survey toolkit: Female Sexual Function Index (Female Sexual Function Index - FSFI) by directly guiding the research subjects to answer the questionnaire themselves. Rosen RC et al developed the original FSFI tool, which includes 19 items asking about 6 contents, including 2 items asking about sexual desire, 4 items asking about sexual arousal, 4 items asking about lubrication, and 3 items asking about each area of extreme pleasure, discomfort and pain during or after intercourse. Each item has 5 answer options with scores from 1 - 5 in increasing levels; some items have a score of 0 for

people who have not been sexually active in the past 4 weeks. The score of each domain content is calculated by adding the scores of each query attribute domain content item and multiplying by a clearly defined coefficient. The total FSFI score is the sum of the scores for the 6 domain contents, ranging from a minimum of 2 to a maximum of 36 [8,9].

Data Collection and Processing: Using the Independent Sample T Test to compare the mean values of general characteristics and sexual dysfunction characteristics between the two groups of infertile and non-infertile women, between the two subgroups with sexual dysfunction and no sexual dysfunction in the infertile women's group. Chi-square test was used to compare proportions between groups. The difference is statistically significant with $p < 0.05$.

Ethical Considerations: The study was approved by the ethics committee in biomedical research of Thai Nguyen University of Medicine and Pharmacy No. 774/ DHYD-HDDD dated July 19, 2024. All participants provided informed consent before participation.

RESULTS

The study collected data from 55 infertile women and 51 fertile women.

In the infertile group, the average duration of trying to conceive was 2.1 ± 1.3 (1 - 8) years; primary infertility accounted for 43.6%, and secondary infertility for 56.4%. The causes of infertility were attributed to the wife in 45.5% of cases, to the husband in 10.9%, to both partners in 9.1%, and unknown in 34.5%. Comparative results between the infertile and fertile women groups are presented in the following tables.

Table 1. General Characteristics of the study participants

Characteristic	Infertile (n = 55)	Fertile (n = 51)	*p*-value
Age (years)	30.0 ± 4.2	32.1 ± 2.7	< 0.001
Body Mass Index (kg/m²)	22.2 ± 2.0	22.4 ± 2.8	0.64
Duration of marriage (years)	5.5 ± 3.1	8.1 ± 3.1	< 0.001
Economic status			
Difficult	3 (5.5%)	3 (5.9%)	0.93
Adequate	49 (89.1%)	46 (90.2%)	
Well-off	3 (5.5%)	2 (3.9%)	
Housing			
Private house	23 (41.8%)	35 (68.6%)	0.01
Shared living	32 (58.2%)	16 (31.4%)	
Menstruation			
Regular	36 (65.5%)	36 (70.6%)	0.36
Irregular	19 (34.5%)	15 (29.4%)	
History of miscarriage or abortion			
Yes	22 (40.0%)	22 (43.1%)	0.45
No	33 (60.0%)	29 (56.9%)	
Gynecological infection			
Yes	38 (69.1%)	22 (43.1%)	0.01
No	17 (30.9%)	29 (56.9%)	
History of obstetric/gynecologic surgery			
Yes	25 (45.5%)	34 (66.7%)	0.02
No	30 (54.5%)	17 (33.3%)	

The infertile group had a lower mean age and a shorter duration of marriage compared to the fertile group ($p < 0.001$). Infertile women also had a significantly higher prevalence of gynecological infections (69.1% vs. 43.1%, $p = 0.01$). In contrast, fertile women reported a higher rate of prior obstetric/gynecologic surgery compared to infertile women (66.7% vs. 45.5%, $p = 0.02$).

Table 2. Characteristics of Sexual Dysfunction in Infertile and Fertile Women

Characteristic	Infertile (n = 55)	Fertile (n = 51)	*p*-value
Mutual understanding between spouses			
Good	28 (50.9%)	28 (54.9%)	0.70
Average	26 (47.3%)	21 (41.2%)	
Poor	1 (1.8%)	2 (3.9%)	
Sexual communication			
Yes	37 (67.3%)	36 (70.6%)	0.44
No	18 (32.7%)	15 (29.4%)	
FSFI total score	***25.6 ± 5.2***	***27.9 ± 4.1***	***0.01***
< 26.55	37 (67.3%)	19 (37.3%)	< 0.001
≥ 26.55	18 (32.7%)	32 (62.7%)	
Desire score	***3.6 ± 0.5***	***3.7 ± 1.0***	***0.55***
Dysfunction present	51 (92.7%)	39 (76.5%)	0.02
No dysfunction	4 (7.3%)	12 (23.5%)	
Arousal score	***4.0 ± 1.0***	***4.3 ± 0.8***	***0.11***
Dysfunction present	49 (89.1%)	40 (78.4%)	0.18
No dysfunction	6 (10.9%)	11 (21.6%)	
Lubrication score	***4.8 ± 1.1***	***5.3 ± 0.8***	***0.01***
Dysfunction present	45 (81.8%)	24 (47.1%)	< 0.001
No dysfunction	10 (18.2%)	27 (52.9%)	
Orgasm score	***4.4 ± 1.1***	***4.6 ± 0.9***	***0.32***
Dysfunction present	40 (72.7%)	30 (58.8%)	0.09
No dysfunction	15 (27.3%)	21 (41.2%)	
Satisfaction score	***4.3 ± 1.0***	***4.6 ± 1.2***	***0.25***
Dysfunction present	45 (81.8%)	36 (70.6%)	0.12
No dysfunction	10 (18.2%)	15 (29.4%)	
Pain score	***4.4 ± 1.6***	***5.3 ± 0.8***	***< 0.001***
Yes	33 (60.0%)	23 (45.1%)	0.09
No	22 (40.0%)	28 (54.9%)	

The infertile women group had a statistically significantly higher rate of sexual dysfunction

compared to the fertile group (67.3% vs. 37.3%, p = 0.00). In the comparison of specific sexual dysfunction characteristics, statistically significant differences were observed in desire disorders, lubrication disorders, and pain during intercourse among infertile women compared to fertile women. Other characteristics also showed higher rates of dysfunction; however, the differences were not statistically significant.

Table 3. Factors Associated with Sexual Dysfunction in Infertile Women

Factor	Dysfunction present (n = 37)	No dysfunction (n = 18)	p
Age	29.5 ± 4.5	31.1 ± 3.3	0.19
Body Mass Index (BMI)	21.8 ± 2.0	23.1 ± 1.8	0.02
Type of Infertility			
Primary	17 (45.9%)	7 (38.9%)	0.42
Secondary	20 (54.1%)	11 (61.1%)	
Duration of Marriage	5.1 ± 2.8	5.4 ± 3.1	0.64
Duration of Trying to Conceive	2.3 ± 1.4	1.7 ± 1.1	0.04
Gynecological infection			
Yes	29 (78.4%)	9 (50%)	0.03
No	8 (21.6%)	9 (50%)	
Sexual communication			
Yes	22 (59.5%)	15 (83.3%)	0.07
No	15 (40.5%)	3 (16.7%)	
Housing condition			
Private house	16 (43.2%)	7 (38.9%)	0.49
Shared living	21 (56.8%)	11 (61.1%)	

Age and duration of marriage between the two groups with and without dysfunction did not show significant differences. However, the group with dysfunction recorded a statistically significant lower BMI (p = 0.02) and a longer time to expect a child (p = 0.04). The rate of

gynecological infections was also significantly higher in this group (78.4% vs. 50%; p = 0.03). Meanwhile, factors such as type of infertility, level of sexual contact and housing conditions did not show statistically significant differences between the two groups.

DISCUSSION

The results of the study showed that infertile women tended to be younger and had a shorter marriage duration than the fertile group. This is consistent with the real clinical context, where many young couples proactively seek medical help earlier when having difficulty conceiving. The fact that the infertile group had fewer children or had never given birth is a natural characteristic of infertility, and suggests that factors that hinder fertility may appear early in married life [10]. There was no difference in economic status between the two groups, suggesting that economics may not be a direct factor influencing infertility in this population. However, a higher proportion of infertile women lived in large families, which may have led to increased psychological stress, affecting the quality of their married life and sexual function. Many previous studies have also noted a link between psychological stress and reduced fertility, with crowded living conditions or lack of privacy being potential risk factors. Depressive symptoms and anxiety in infertile women were associated with age, social concern, sexual concern and maternal relationship stress. Trait anxiety was also associated with financial stress [11]. The psychological pressure associated with infertility treatment - often prolonged, expensive, invasive, and prone to failure - can negatively impact female sexual

function. Moreover, sexual activity is frequently restricted to specific times in the menstrual cycle and primarily aimed at reproduction, transforming it from an intimate experience into an obligation. These psychological changes can adversely affect female sexual function [8].

Regarding obstetric and gynecological history, the fertile group had a higher rate of obstetric surgery, consistent with their experience of childbirth. In contrast, gynecological infections were noted as a factor associated with infertility, especially in cases of pelvic inflammatory disease, blocked fallopian tubes or persistent infection. This emphasizes the importance of early detection and treatment of gynecological diseases to limit complications leading to infertility. A study on infertile women infected with *Chlamydia trachomatis* recorded cervical inflammation, vaginitis, and fallopian tube obstruction rates of 80.67%, 75.63%, and 45.45%, respectively - factors that may hinder sperm transport in the female reproductive tract [12].

Studies on the prevalence of SDs among women in infertile couples seeking reproductive treatment have reported a wide range - from 17.5% to 87.5%. Ho Thi Thanh Tam reported an SDs prevalence of 43.8% among women in infertile couples [8]. In Ho Chi Minh City, the reported rate among reproductive-aged women was 34.2%. Risk factors for SDs included co-sleeping with children, lack of sexual communication with the husband, infrequent sexual activity (fewer than five times per month), the husband's sexual dysfunction, and cohabitation for more than five years [13]. When comparing specific types of SDs,

statistically significant differences were observed in desire disorder, lubrication disorder, and dyspareunia (pain during intercourse) between infertile and fertile women. Although other dysfunctions also showed higher prevalence in the infertile group, the differences were not statistically significant. A study by Phan Thi Bich Thuan et al. at the Hanoi Andrology and Infertility Hospital found the rates of desire disorder and arousal disorder to be 34% and 28.3%, respectively [14]. However, their assessment method differed from ours. Mirblouk F. also reported significant differences in sexual desire, satisfaction, and overall sexual function (26.33 ± 3.82 vs. 34.40 ± 5.13; $p = 0.011$) between fertile and infertile women [4].

Analysis within the infertile group showed that SDs was associated with body mass index (BMI), duration of infertility, and history of gynecologic infections. Jamali S. suggested that overweight and obesity alter sex hormone balance, adversely affecting both reproductive and sexual function. In addition, obese women may experience body dissatisfaction, resulting in lower self-confidence during sexual activity [15]. In our study, infertile women without SDs had significantly higher BMI compared to those with SDs, although the values were in the overweight-not obese-range.

Longer infertility duration was associated with a higher risk of SDs, possibly due to increased psychological stress from various sources. As infertility persists, hope for conception declines with age-related fertility reduction, coupled with numerous treatment attempts and failures. A history of frequent vaginitis (≥ 3 times) and current infections was also associated

with increased SDs risk. Women with ≥ 3 episodes of vaginitis had a 1.38 times higher risk of overall SDs and were particularly more likely to experience arousal disorder, anorgasmia, dissatisfaction, and pain during or after intercourse [8]. In Eastern cultures, sexuality remains a sensitive and often unspoken topic - even between spouses. Notably, women who reported having sexual communication had a 0.79 times lower risk of SDs, while those without such communication had a 1.27 times increased risk in multivariate analysis [8].

The limitation of this study is the small sample size, because the number of infertile couples visiting the Thai Nguyen University of Medicine and Pharmacy Hospital is limited. In the future, we hope to conduct a larger study with more diverse subjects.

CONCLUSION

The study showed that sexual dysfunction is significantly associated with infertility in women. Specifically, the mean FSFI score in the infertile group was 25.6 ± 5.2, which was significantly lower than that of the fertile group (27.9 ± 4.1, p = 0.01). The prevalence of sexual dysfunction among infertile women was 67.3%, significantly higher than in the fertile group (37.3%, p = 0.002). Among the domains of sexual function, infertile women had notably higher rates of dysfunction in desire, vaginal lubrication, and pain during intercourse compared to the control group. These findings emphasize the importance of screening and providing psycho-sexual support for infertile women, especially during the diagnosis and treatment of infertility.

RECOMMENDATIONS

Reproductive health care facilities should screen and intervene early for these disorders, combining psychological and sexological counseling to reduce stress and improve the quality of married life. In addition, BMI monitoring and nutritional management, as well as timely detection and treatment of gynecological infections, are necessary to limit risk factors affecting fertility. Prolonged gestation should also be considered as a risk indicator, and further research is needed on factors such as infertility type, level of sexual communication and housing conditions to have comprehensive intervention solutions.

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