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Sexual Complaints, Pelvic Floor Symptoms, and Sexual Distress in Women over Forty

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Abstract

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Introduction—The American Psychiatric Association recommends considering sexually related personal distress when assessing female sexual dysfunction. Currently, there is little data regarding the impact of sexual complaints on sexual distress.

Aim—To investigate the association between sexual complaints and perceived sexual distress in a population of ambulatory adult women.

Methods—Using the short forms of the Personal Experiences Questionnaire and Pelvic Organ Prolapse/Urinary Incontinence Sexual Function Questionnaire, we assessed sexual complaints among 305 women seeking outpatient gynecologic care. Depressive symptoms were quantified using the Center for Epidemiologic Studies Depression (CESD) score. Sexual distress was measured using the Female Sexual Distress Scale (FSDS). Using multivariable logistic regression, we compared sexual complaints between distressed and nondistressed women.

Main Outcome Measures—Sexual distress, defined by FSDS score ≥ 15 .

Results—FSDS scores were available for 292/305 participants. Seventy-six (26%) scores reflected distress. Distressed women were more likely to be younger (55.2 ± 1.0 years vs. 56.7 ± 0.8 years, $P = 0.017$); have higher CESD scores (16.6 vs. 9.5, $P = 0.001$); and report decreased arousal (56.8% vs. 25.1%, $P = 0.001$), infrequent orgasm (54% vs. 28.8%, $P = 0.001$), and dyspareunia (39.7% vs. 10.6%, $P = 0.001$). Women with sexual distress were also more likely to report sexual difficulty related to pelvic floor symptoms, including urinary incontinence with sexual activity (9% vs. 1.3%, $P = 0.005$), sexual avoidance due to vaginal prolapse (13.9% vs. 1%, $P = 0.001$), or sexual activity restriction due to fear of urinary incontinence (14.9% vs. 0.5%, $P = 0.001$). After multivariate analysis, sexual distress was significantly associated with dyspareunia (odds ratio [OR] 3.11, $P = 0.008$) and depression score (OR 1.05, $P = 0.006$), and inversely associated with feelings of arousal during sex (OR 0.19, $P = 0.001$).

Conclusion—Our results indicate that sexually related personal distress is significantly associated with dyspareunia, depressive symptoms, and decreased arousal during sexual activity. This contributes to our understanding of how sexual complaints may adversely affect women's quality of life.

Keywords

Sexual Distress; FSDS; SPEQ; PISQ

Introduction

The Diagnostic and Statistical Manual of Mental Disorders (DSM) IV-TR classifies female sexual disorder (FSD) into four broad categories: sexual desire disorders, female sexual arousal disorder, female orgasmic disorder, and sexual pain disorders [1,2]. Some studies estimate that 40–50% of women report at least one sexual complaint related to these aspects of sexual function [3]. However, not all sexual complaints lead to dissatisfaction or sexual distress.

Because the DSM-IV-TR defines female sexual disorder (FSD) as “disturbances in sexual desire and in the psycho-physiological changes that characterize the sexual response cycle and cause marked distress and interpersonal difficulty,” [1] both sexual function and sexually related personal distress should be considered when assessing FSD. However, until recently, most research on female sexual function has focused on sexual complaints but has not considered the quality-of-life impact of these complaints in relation to sexual distress [4].

The Female Sexual Distress Scale (FSDS) [5] is a potentially useful adjunct to other validated sexual function questionnaires because it allows an assessment of distress related to sexual function. Using the FSDS, one recent study of U.S. adult women found that 44% of women reported sexual complaints but only 12% reported “distress” with sexual function [6]. These data are helpful in creating a frame of reference regarding the impact of sexual complaints on quality of life. However, there has been little investigation of the sexual complaints that women find most bothersome or distressing. For example, low libido is the most common sexual complaint, but many women with low libido do not report personal distress related to this symptom [3]. Additionally, prior research suggests that women with pelvic floor symptoms, such as pelvic organ prolapse and incontinence, may be more likely to report sexual symptoms [7,8]. However, little is known about whether pelvic floor complaints, such as incontinence of urine during sexual activity, are sexually distressing [9].

Aims

Our study aims to investigate the association between reported sexual complaints and perceived level of sexual distress in women. In a population of adult women seeking ambulatory gynecologic care, we assessed sexual complaints, sexual interference from pelvic floor symptoms, and distress related to sexual function. Our goal was to investigate which sexual symptoms and problems were most likely to be associated with distress in this setting. We hypothesize that certain sexual complaints, especially those corresponding to DSM categories of sexual dysfunction, are positively associated with higher levels of perceived sexual distress in our population of women over 40 years.

Methods

Study Setting

This is a planned secondary analysis of a cross-sectional study of women with prior sexual experience seeking benign gynecologic or urogynecologic care at five outpatient sites in metropolitan Baltimore, MD [8]. The primary study was designed to investigate whether pelvic floor symptoms, such as urinary incontinence and pelvic organ prolapse, are associated with female sexual complaints. The study was funded by the National Institute of Health and approved by an Institutional Review Board.

Participants

Women over the age of 40 years who were scheduled for a gynecologic examination at one of these sites were eligible for this research. Women were excluded from the study if they were intentionally celibate at the time of the study, had never been sexually active, were pregnant, or could not complete questionnaires in English. Between January 1, 2006 and April 1, 2007, potentially eligible research subjects were approached for enrollment before their physical examination. Participants signed informed consent at the time of their visit, completed the research questionnaire at home afterward, and returned it by mail.

Outcome Measures/Instruments

The primary outcome considered in this analysis is sexual distress [1] assessed with the 12-item validated FSDS [5]. This questionnaire generates a numerical score, with a maximum possible score of 48 points. Higher scores suggest more sexual distress, and prior research suggests that an FSDS score of 15 or greater corresponds to clinically significant distress and difficulty [5]. Thus, in our research, we considered an FSDS score of 15 or greater to be evidence of sexual distress.

Independent Variables

To define sexual complaints, we used the short form Personal Experiences Questionnaire (SPEQ) [10], a 9-item sexual-function instrument that has been validated among perimenopausal women [10,11]. The SPEQ assesses the parameters of feelings for partner (“How much passionate love do you feel for your partner?” and “Are you satisfied with your partner(s) as a lover?”), sexual responsivity (“How enjoyable are sexual activities currently for you?” and “How often during sex activity do you feel aroused or excited” [heart beating fast/heavier breathing/vaginal wetness/flushing?]), sexual frequency (“During the last month, how often have you had sexual activities?”), libido (“During the last month, how often have you had sexual thoughts or fantasies?”), partner problems (“Does your partner(s) experience difficulty in sexual performance, ejaculation difficulties, or low arousal?”), dyspareunia (“Do you currently experience pain during intercourse?”), and orgasmic disorder (“Do you experience orgasm [climax] during sex activity?”). Answers for the SPEQ are graded from 1 to 6 (1 = “not at all”, 6 = “a great deal”) or 0 to 5 (0 = “never”, 5 = “several times a day”). Dichotomous variables were created using cutoffs close to the median value for each scale, taking into account the distribution of each answer within our study population. Specifically, for answers that were graded from 1 to 6 (1 = “not at all”, 6 = “a great deal”), we dichotomized into two groups with cutoffs ≤ 3 or >3 , and for answers graded from 0 to 5 (0 = “never”, 5 = “several times a day”), we dichotomized into two groups: “never” or “less than once a week” and “once or twice a week” or more.

We also assessed sexual complaints regarding the impact of pelvic floor symptoms, since the results from our primary study suggested that pelvic floor symptoms are significantly associated with reduced sexual arousal, infrequent orgasm, and dyspareunia [8]. This aspect of sexual function was assessed using the Pelvic Organ Prolapse/Urinary Incontinence Sexual Function Questionnaire (PISQ-12) [12], a condition-specific sexual function questionnaire. This 12-item validated instrument was specifically developed to assess sexual function in women with urinary incontinence and/or pelvic organ prolapse. We selected three questions from the PISQ-12 to assess sexual complaints specific to pelvic floor symptoms (“Do you avoid intercourse because of bulging in the vagina [either the bladder, rectum, or vagina falling out]?”), “Are you incontinent of urine [leak urine] with sexual activity?”, and “Does fear of incontinence [either stool or urine] restrict your sexual activity?”). We restricted inclusion to these three questions, as the other domains of sexual function addressed by the PISQ-12 are within the scope of the SPEQ. Questions for the PISQ have ordinal responses (“never,” “seldom,” “sometimes,” “usually,” “always”), and we dichotomized variables so that more frequent outcomes (“usually” or “always”) were compared with those less frequent (“never,” “seldom,” or “sometimes”). The rationale for this choice in dichotomization is that infrequent urinary incontinence is common and unlikely to be bothersome. Therefore, the convention is to divide populations into women with or without bothersome incontinence symptoms. This dichotomization scheme for the PISQ-12 has been used in prior studies [13].

Acknowledging the potential contribution of depression to sexual dysfunction, we included The Center for Epidemiologic Studies Depression scale (CESD) [14] as a measure of depressive symptoms. The maximum score for the scale is 60 points, with higher scores suggesting more depressive symptoms.

We also considered other characteristics of the population which might be associated with sexual distress. These included age, race, level of education, body mass index (BMI), hysterectomy status, number of pregnancies, self-assessed health, number of years with current partner, menopausal status, history of rape or sexual abuse, and marital status of our participants.

Statistical Analysis

Statistical analysis was performed using STATA version 9.2 (StataCorp LP, College Station, TX, USA). First, we used Pearson chi-square or one-way analysis of variance tests to compare general characteristics and measures of sexual complaints among women with and without sexual distress.

We then performed multivariate logistic regression to identify measures of sexual complaints associated with sexual distress. In fitting the model, we considered independent variables found to be statistically associated with sexual distress in univariate analyses. In the multivariate model, we focused on the four items that correspond to the four recognized types of female sexual dysfunction (arousal, orgasm, pain, and libido). After checking for collinearity, we performed stepwise logistic regression. Possible interactions and confounding were also considered in this process. A final model was fit to include statistically significant variables ($P \leq 0.05$). Sample size for our study was determined by the original study design [8].

Results

During enrollment of study participants, between January 1, 2006 and April 1, 2007, a total of 420 women were approached for participation, and 344 (82%) enrolled. Of the enrolled participants, 305 (89%) completed the questionnaire. Within this cohort of 305 women, 80 (27%) were seeking treatment of pelvic floor conditions, 69 (23%) came for treatment of other gynecologic complaints, and the remaining 152 (50%) were seeking annual gynecologic care [8]. Our analysis is limited to the 96% (292/305) of this cohort who specifically completed the FSDS portion of the questionnaire.

Seventy-six women (26%) were classified as reporting sexual distress. Information regarding general population characteristics and sexual distress is summarized in Table 1. Women with sexual distress were more likely than those without distress to be younger in age (55.2 ± 1.0 years vs. 56.7 ± 0.8 years, $P = 0.017$ had higher mean CESD scores [16.6 vs. 9.5 , $P = 0.001$]). Overall, 63% of our population was menopausal, and we found no significant association between menopausal status and sexual distress ($P = 0.814$). Additionally, 14% (24/175) of our study population who answered reported use of hormonal therapy.

Fifteen percent (14/80) of single and 31% (62/136) of married participants were sexually distressed. Regarding general partner status, 289/292 women answered the question, "Do you have a current sexual partner?" Of these respondents, 75.8% (219/289) of women answered "yes" to this question, with 84% (184/219) classifying their partnership as a marriage. With regard to sexual preference, 94.5% (276/292) of participants identified themselves as heterosexual, 1.7% (5/292) as "lesbian/gay," 0.7% (2/292) as "bisexual," and four women of the 292 (1.4%) declined to answer this question. Furthermore, 6.6% (19/288) of our population considered themselves a victim of rape and 11.1% (32/289) considered themselves a victim of sexual abuse. Sexually distressed women were more likely to report being a victim of sexual abuse vs. nondistressed women ($P = 0.001$).

Race, education, BMI, hysterectomy status, gravidity, and number of years spent with current partner did not differ significantly between women with and without sexual distress.

Table 2 describes relationships between different sexual complaints and sexual distress, as measured by the FSDS. Virtually all sexual complaints were significantly more common among women with distress. Compared to their nondistressed counterparts, sexually distressed women were more likely to report less enjoyment of sexual activity (73.3% vs.

28%, $P = 0.001$), decreased arousal (56.8% vs. 25.1%, $P = 0.001$), infrequent orgasm (54% vs. 28.8%, $P = 0.001$), dyspareunia (39.7% vs. 10.6%, $P = 0.001$), decreased frequency of sexual activity (76% vs. 57.7%, $P = 0.005$), decreased partner satisfaction (34.2% vs. 11.6%, $P = 0.001$), or less passionate love for one's partner (42.9% vs. 19.9%, $P = 0.001$). Sexually distressed participants were also more likely than those without distress to report urinary incontinence with sexual activity (9% vs. 1.3%, $P = 0.005$), avoidance of sexual activity due to vaginal bulge (13.9% vs. 1%, $P = 0.001$), or restriction of sexual activity due to fear of urinary incontinence (14.9% vs. 0.5%, $P = 0.001$). Presence of sexual thoughts in the last month and partner difficulty with sexual performance were not significantly related to higher FSDS scores. With respect to the four items that correspond to the recognized types of female sexual dysfunction (arousal, orgasm, pain, and libido), 192 of 292 participants (65.8%) reported at least one of these sexual complaints. Specifically, 88 (30.1%) reported one sexual complaint, 35 (12%) reported two sexual complaints, 57 (19.5%) reported three sexual complaints, and 12 (4.2%) reported four sexual complaints. The most frequent isolated complaints were dyspareunia and decreased libido. Furthermore, there was a significant association between presence of sexual distress and increasing number of complaints ($P = 0.001$).

Because women with sexual complaints often voiced multiple sexual problems, we used a multivariate model to investigate which sexual symptoms were most significantly associated with distress. This included the general descriptive variables age and CESD score. Regarding sexual complaints, we included statistically significant variables from our univariate analysis that best captured the defined types of sexual dysfunction: arousal, orgasm, dyspareunia, and libido. Our final model suggested that sexual distress is positively associated with dyspareunia (odds ratio [OR] 3.11, $P = 0.008$) and increasing CESD score (OR 1.05, $P = 0.006$), and inversely related to subjective feelings of arousal during sexual activity (OR 0.19, $P = 0.001$).

Prior research has suggested that age might modify the relationship between sexual complaints and sexual distress. Specifically, one study found that sexually related distress was more common in younger women, despite the observation that sexual complaints were more common in older women [4]. Therefore, we refit our multivariable model, with age as an interaction variable. However, after controlling for dyspareunia, problems with subjective arousal, and CESD score, age was not a significant predictor of distress. Additionally, age was not found to be a moderating variable when considering the relationship between sexual complaints and distress. In other words, younger women with complaints like dyspareunia and arousal problems were just as likely to be distressed as older women with these symptoms.

Discussion

Female sexual dysfunction appears to be prevalent [3] and can have adverse effects on a woman's quality of life [4]. The diagnosis of FSD should not be applied unless the patient expresses both sexual complaints and sexual distress related to those symptoms [1]. In this population, personal distress related to sexual function was reported by 26% of women. This result suggests that a substantial proportion of women seeking gynecologic care have clinically significant sexual complaints. This estimate of the prevalence of distress related to sexual function is somewhat higher than estimates from community populations. Using the FSDS definition, Shifren et al. identified sexually related personal distress in 22.8% of U.S. women over the age of 18 years [6]. Using this same definition, Dennerstein and colleagues found that 17% of female research volunteers aged 56–67 years were classified as having female sexual distress [9]. The prevalence estimate from our research population is somewhat higher and may be more typical for a population seeking gynecologic care.

We found that dyspareunia and subjective problems with arousal were the sexual problems most likely to be associated with clinically significant levels of sexual distress. The quality-of-life impact of dyspareunia has been previously recognized [15,16] but is not always considered in studies of female sexual function [6]. In that regard, a gynecologic population may be uniquely suited to explore the importance of dyspareunia as a sexual complaint. Our results suggest that dyspareunia, as a sexual complaint, should be considered in research on female sexual function and quality of life.

We found that decreased libido was not associated with sexual distress in this population. While decreased libido may prompt women to seek intervention [17], previous epidemiologic research has shown that many women with low libido do not report personal distress related to this symptom [3]. We speculate that partner interactions may mediate the level of distress experienced by women with low libido. Moreover, most recent studies assessing the relationship between decreased libido and sexual distress have done so by investigating hypoactive sexual desire disorder (HSDD), a DSM-IV diagnosis requiring decreased libido causing distress in the absence of other Axis I disorders [18]. Since our study does not assess HSDD, does not assume automatic presence of sexual distress due to decreased libido, and cannot guarantee the absence of Axis I disorders within its population, the associations found in previous studies assessing HSDD may differ from our findings.

Furthermore, we found no significant association between partner difficulty with sexual performance and female sexual distress. However, few studies have assessed this relationship, especially with a validated questionnaire like the FSQS. Our results are consistent with findings from other recent studies [19] that found no significant association between generalized measures of female sexual distress and their partner's difficulty with sexual performance.

Our final model also suggests a significant association between sexual distress and increasing CESD score (OR 1.05, $P = 0.006$). Current literature supports this association between depression and sexual distress [6,9]. Unfortunately, our study design does not permit us to investigate the nature of causation in this association.

We did not find that age impacted the relationship between sexual symptoms and sexual distress. This is somewhat contrary to results from other recent studies that suggest that younger women are more likely to be distressed by sexual complaints [6]. The fact that our results were not consistent with such a relationship may be attributable to our exclusion of women younger than 40 years.

Our study is novel in that it assesses the relationship among standard sexual complaints, pelvic floor symptoms, and sexual distress concomitantly. We found that sexual problems related to pelvic floor symptoms (loss of urine with sexual activity, for example) were associated with sexual distress, but these symptoms were not found to be independent predictors of distress in a multivariate model. However, sexual problems related to pelvic floor symptoms were uncommon in this population and our sample size may have been too small to detect this association.

Our study is not without limitations. First, most of our population was Caucasian, highly educated, and married. Since patients sought care from outpatient gynecologic sites affiliated with an academic institution, they may not be representative of all American women. These factors could influence the generalizability. Second, although we used validated instruments to assess sexual complaints, pelvic floor dysfunction, and sexual distress, the recall time for portions or entire questionnaires are different. For example, while certain questions within the SPEQ and all FSQS questions address symptoms experienced over the last month, the remainder of the SPEQ and the PISQ-12 does not

specify the recall period. These differences might affect temporal relationships if symptoms vary over time in severity or intensity. Third, since our study required participants to report information based on subjective recollection of past events, the results are subject to recall bias, as sexually distressed participants may have recalled the experiences that classified them as “distressed” differently as their nondistressed counterparts. However, selection of participants from a pool of women seeking “general” gynecologic care may have decreased the impact of this bias, as women were not specifically seeking care for sexual dysfunction. Fourth, we simplified the definitions of each sexual complaint and our outcome of sexual distress (FSDS score) by dichotomization of variables. The definitions used for dichotomizing sexual complaints are somewhat arbitrary and have not been validated. However, the cutoff used for dichotomization of FSDS score used was found to be both sensitive and specific in a mostly menopausal population of women during the validation process for this questionnaire [5]. Overall, our analysis is still subject to the inherent flaws that may occur when dichotomizing continuous variables, including potential for decreased power, loss of information, and decreased reliability. Additionally, because we used stepwise regression methods with a dichotomous dependent variable, it is possible that we overfit our statistical model, which may produce results that are spurious or only specific to this data set. Finally, as a secondary analysis of a cross-sectional study, our research is subject to the inherent limitations of this type of study design. For example, because “exposure” (sexual complaints) and “disease” (sexual distress) are measured at the same time, it is not possible to establish causality.

Conclusion

In conclusion, our results suggest that distress related to sexual function is relatively common among women seeking gynecologic care. In addition, our results suggest that dyspareunia and decreased sexual arousal are the complaints most strongly associated with sexual distress in this setting. Further research is needed to understand the interrelationships between multiple coexistent symptoms and the underlying factors leading to the development of multiple sexual complaints. Improved understanding of predictors of sexual distress could simplify the evaluation and enhance the management of sexual dysfunction in a clinical setting.

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Table 1

Characteristics of women with and without sexual distress according to FSDS* score

	FSDS < 15 (not distressed) (n = 216)	FSDS ≥ 15 (distressed) (n = 76)	P value
Age (years)	56.7 (±0.8)	55.2 (±1.0)	0.017 [†]
Race			0.368
Caucasian	168 (78.9%)	60 (81%)	
Black/African American	36 (16.9%)	12 (16.2%)	
Asian	8 (3.7%)	1 (1.4%)	
American Indian/Alaskan	1 (0.5%)	0	
Other	0	1 (1.4%)	
Education			0.211
College or higher	140 (65.4%)	43 (57.3%)	
No college	74 (34.6%)	32 (42.7%)	
CESD score [‡]	9.5 (+/-8.6)	16.6 (+/-12.2)	0.001 [†]
Body mass index	28.8 (+/-6.7)	29.0 (+/-7.4)	0.303
Prior hysterectomy			0.355
No	165 (76.4%)	54 (71.1%)	
Yes	51 (23.6%)	22 (28.9%)	
Number of pregnancies	2.6 (+/-1.9)	2.9 (+/-1.8)	0.337
Years with current partner	21.3 (+/-14.1)	22.6 (+/-13.1)	0.539
Menopausal			0.814
No	80 (37%)	27 (35.5%)	
Yes	136 (63%)	49 (64.5%)	
Victim of rape			0.090
No	203 (94.9%)	66 (89.2%)	
Yes	11 (5.1%)	8 (10.8%)	
Victim of sexual abuse			0.001*
No	199 (93%)	58 (77.3%)	
Yes	15 (7%)	17 (22.7%)	
Relationship status			0.003*
Single	80 (37%)	14 (18.4%)	
Married	136 (63%)	62 (81.6%)	

* Female Sexual Distress Scale (FSDS). Scale 0–48, Score > 15 has high predictive value for sexual distress.

[†] P value significant at <0.05. Statistical comparisons used Pearson chi-square for categorical data and one-way analysis of variance tests for continuous variables.

[‡] Center for Epidemiologic Studies Depression Scale (CESD). Scale 0–60, with higher scores suggesting more depressive symptoms.

Table 2

Evaluation of sexual complaints using the PISQ[§] [13] and PEQ[‡] [12] for women with and without sexual distress according to FSDS[†] [5] score

	FSDS < 15 (not distressed) (n = 216)	FSDS ≥ 15 (distressed) (n = 76)	P value
Enjoyment of sexual activities? ^{†‡}			0.000*
None to moderate	54 (28%)	55 (73.3%)	
Moderate to a great deal	139 (72%)	20 (26.7%)	
Arousal during sexual activity? ^{†‡}			0.001*
None to moderate	48 (25.1%)	42 (56.8%)	
Moderate to a great deal	143 (74.9%)	32 (43.2%)	
Orgasm during sexual activity? ^{†‡}			0.001*
None to moderate	55 (28.8%)	40 (54%)	
Moderate to a great deal	136 (71.2%)	34 (46%)	
Pain during intercourse? [¶]			0.001*
None to moderate	127 (89.4%)	38 (60.3%)	
Moderate to a great deal	15 (10.6%)	25 (39.7%)	
Sexual thoughts in last month? ^{**}			0.122
No	106 (51%)	46 (61.3%)	
Yes	102 (49%)	29 (38.7%)	
Frequency of sexual activity in last month? ^{**}			0.005*
None	120 (57.7%)	57 (76%)	
At least once a week	88 (42.3%)	18 (24%)	
Partner sex performance difficulty? [¶]			0.059
None to moderate	112 (76.7%)	39 (63.9%)	
Moderate to a great deal	34 (23.3%)	22 (36.1%)	
Amount of passionate love felt for partner? [¶]			0.001*
None to moderate	29 (19.9%)	27 (42.9%)	
Moderate to a great deal	117 (80.1%)	36 (57.1%)	
Satisfied with partner(s) as a lover? [¶]			0.001*
None to moderate	25 (11.6%)	26 (34.2%)	
Moderate to a great deal	191 (88.4%)	50 (65.8%)	
Avoid intercourse due to vaginal bulge? ^{‡‡}			0.001*
Never to Sometimes	202 (99%)	62 (86.1%)	
Usually or Always	2 (1%)	10 (13.9%)	
Urinary incontinence with sexual activity? ^{‡‡}			0.005*
Never to Sometimes	151 (98.7%)	60 (91%)	
Usually or Always	2 (1.3%)	6 (9%)	
Fear of incontinence restrict sexual activity? ^{‡‡}			0.001*
Never to Sometimes	203 (99.5%)	63 (85.1%)	
Usually or Always	1 (0.5%)	11 (14.9%)	

* *P*-value significant at ≤ 0.05 . Statistical comparisons used Pearson chi-square test.

[†] Female Sexual Distress Scale (FSDS). Scale 0–48, Score ≥ 15 has high predictive value for sexual distress.

[‡] Personal Experiences Questionnaire (PEQ): First nine questions in table. Ordinal responses dichotomized as above.

[§] Pelvic Organ Prolapse/Urinary Incontinence Sexual Function Questionnaire (PISQ): Last three questions in table (selected from 12 total). Ordinal responses dichotomized as above.

[¶] Dichotomized from scale: 1 (Not at all) to 5 (A great deal) and 6 (Not applicable). None to moderate: 1–3, Moderate to a great deal: >3 .

^{**} Dichotomized from choices 0 (Never), 1 ($<$ once a week), 2 (once/twice a week), 3 (several times a week), 4 (once/twice a day), 5 (several times a day). None: 0, Yes or At least once a week: >0 .

^{††} Dichotomized from scale: 1 (Not at all) to 6 (A great deal). None to moderate: 1–3, Moderate to a great deal: >3 .

^{‡‡} Dichotomized from scale: Never, Seldom, Sometimes, Usually, Always, Does not apply (not sexually active).