Original Article

Estimates of Sexual Functioning in Married Men and Women

Tehreem Arshad

ABSTRACT

OBJECTIVE: To have estimation of sexual functioning in married men and women in Lahore, Pakistan.
METHODOLOGY: This is a cross sectional design study, Community Sample was drawn from lower, middle and upper union councils of Data Ganj Bukhsh Town, Lahore to ensure representation of all socioeconomic statuses. Sample of 300 married participants including both genders who could read and understand Urdu language, with age range of 25 to 60 years were included after approval. All individuals who had some serious psychiatric or physical disorder which could have co-occurred with the sexual dysfunctions were excluded from the study. Data was analyzed by SPSS. Sexual Functioning Questionnaire was used to assess the overall sexual functioning of the participants.
RESULTS: The results of the study suggested that participants had adequate sexual functioning (41% men, 32% women). In exploration of the problems faced by individuals in their sexual life, most of the participants had reported difficulties in experiencing interest (49% men, 48% women) and having sexual desire (55% men, 45% women) during the sexual activity.
CONCLUSION: It is concluded that most of the participants had adequate overall sexual functioning but also have some sexual concerns like lack of interest and desire to take part in sexual activities.

KEY WORDS: Sexual functioning, Married Men & Women, Sexual problems

This article may be cited as: Arshad T. Estimates of Sexual Functioning in Married Men and Women. J Liaquat Uni Med Health Sci. 2018;17(04):235-40. doi: 10.22442/jlumhs.181740584

INTRODUCTION

Human beings are complex individuals having various contributory factors of the overall well-being and better quality of life where the significance of healthy and fulfilling sexual life could never be reprimanded. Multiple researches have shown a robust of high-quality association among sexual functioning and health related quality of life making sexual dysfunction a greater concern[2,3]. Not only this, sexual dysfunctions are also related with mental health of individuals making it an integral concern for social scientists and mental health professionals[4]. Sexual dysfunctions are characterized by disturbance in sexual preference and in psycho-physiological adjustments that symbolize the sexual reactions in a cycle and are a source of marked misery and various interpersonal troubles[4]. It manifests variedly in the individuals due to an altogether one of a kind reproductive mechanism. The most common sexual dysfunctions in men encompass: erectile disorder, premature ejaculation, ejaculatory incompetence and retarded ejaculation; while, the women experiences sexual dysfunctions like sexual arousal ailment, orgasmic disorder, vaginismus and painful intercourse. In a broader context, sexual dysfunctions are categorized into 4 classes: Sexual desire disease, sexual arousal disorder, issues of orgasm and issues of sexual pain[5].

To better understand the sexual dysfunction, normal functioning of sexual response cycle must be understood. For Kaplan, desire is the vital element because of its demonstration as the cognitive need during the human sexual response cycle. Pleasure and orgasm are defined as often physiological components. The segment of pleasure consists of preliminary vasocongestion of the genitals, ensuing in erection in the male and vaginal lubrication inside the female. The orgasm segment is marked via pelvic muscle contractions in ladies and men, and ejaculation in adult males. In Kaplan's version, those 3 additives are impartial and no longer absolutely sequential.

Sexual dysfunction can happen at any stage of sexual response cycle. Sexual Aversion refers to lack of desire in sexual activity which also includes disgust, fear and avoidance of sexual activity. According to American Psychiatric Association, premature ejaculation is defined as a recurrent or persistent ejaculation occurring before or immediately after penetration that is interfering with the couple's sexual satisfaction[6]. Orgasmic disorder is absence of sexual satisfaction; it's a persistent, recurrent delay in or absence of orgasm following a normal sexual excitement. This dysfunction is prevalent in 5 to 10 percent of women. Erectile dysfunction is a persistent inability to sustain an erection essential for the completion of sexual activity in men[4]. Moreover, some females reported lack of vaginal lubrication, decreased clitoral and labial sensation; decreased clitoral and labial engorgement; lack of vaginal

lengthening, dilation, and arousal[6].

Despite the increasing prevalence of sexual dysfunction, associated factors have not been studied thoroughly yet. Many theorists have tried to find possible explanations. The most common psychological factors and reasons of female sexual arousal disorder are guilt feelings, unexpressed or concealed anger towards her partner, having history of sexual trauma or abuse, anxiety towards sexual activity, lack of sexual stimulation by the partner. It is also investigated that 15 - 36 % of cases suffer sexual pain disorder (Priapism) of painful erection that will not subside Overall, it has been found that there are many causes of developing sexual disorders like biological, emotional, psychological, interpersonal, and social factors, can contribute in developing sexual dysfunctions[5,7].

Sexual disorders are common in society but rarely diagnosed or treated which makes the prevalence study a cornerstone for understanding epidemiological factors. Almost 8 % to 33% of USA individuals of adulthood are affected by such disorders[2]. One of a research showed that one third of men (34%) and two-fifths of women (41 %) reported having a current sexual problem[6]. The most common problems were erectile dysfunction and premature ejaculation in men; in women the most widely reported problems were vaginal dryness and infrequent orgasm[8]. It was found that 34 out of 80 women had sexual dysfunction[9]. Moreover, Montorsi F 2005[10] found prevalence rate of premature ejaculation which was approximately 30% across all age groups. The point to ponder is that it is nearly impossible to generalize these findings in the context of Pakistani culture due to paucity of literature related to sexual problems of married individuals[11].

While current pharmacological advances, even in narrow minded collectivistic society of Pakistan, have generated expanded public interest and demand for clinical services especially regarding erectile dysfunction or experiencing orgasms, epidemiologic data on sexual disorder are extraordinarily scant for each women and men even in developed countries[1]. However, the situation is worse in developing countries like Pakistan where this particular area of human's wellbeing and quality of life seemed as taboo. This makes it necessary for mental health professionals and social researchers to take some productive steps. One such step could be exploring the prevalence of sexual problems faced by the community that could further leads to epidemiological evidences and interventions. Moreover, Pakistan is a traditionalistic society with conservative cultural insight making people hesitant to express or discuss their personal problems like sexual and gynecological problems. Thus, exploring of such issues by asking purposive questions would built insight in Pakistani and could further make them comfortable to share their sexual issues and problems with concerned health professionals as well. This prevalence study will further contribute in identifying the most prevalent sexual disorder which will also be guided for the appropriate treatment options. Further, it will provide a guideline to the mental and sexual health professionals in planning and devising intervention strategies because sexual dysfunctions are comorbid with life satisfaction and overall well-being[12]. Awareness campaigns and media help make it easier for the researcher to share the contributory findings at public forums in simpler yet taboo-free language to connect this issue with community's better health and functioning. Hence, the research questions were: 1) How much each sexual dysfunctions namely interest, desire, masturbation, satisfaction related issues are prevalent in our community? 2), which of the sexual dysfunction is the most prevalent amongst our general population?

METHODOLOGY

The cross-sectional research design was employed, and the study was carried out following the Ethical guidelines of American Psychological Association and it was duly approved by Institutional Review Board of Centre for Clinical Psychology, University of the Punjab. Using the proportionate stratified random sampling, representative proportion of sample was selected from various towns of Lahore city having 10 union councils of Lower Socio-economic status, 6 Middle socio-economic statuses and 2 from upper socio-economic statuses[13]. Keeping in view the proportions, 56 % of sample was taken from lower socio- economic status. The 33 % sample was taken from Middle socio-economic status. Almost 15% sample from upper socio-economic status was collected. A sample of *N*=300 comprised of 150 men & 150 women with an age range from 25 to 60 years was employed. The inclusion criteria were that the participant should be married with an age range from 25 to 60 years and were able to read and understand Urdu language so that they can comprehend the statement of problems. All individuals who had some other comorbid physical and or psychological conditions like Major Depressive Disorder, Generalized Anxiety Disorder, AIDS, Hepatitis, etc. which was duly diagnosed by mental health practitioner and general physician. Such conditions could have co-occurred with the sexual dysfunctions, hence, were excluded from the study.

Sexual Functioning Questionnaire (SFQ, Syrjala, 2004) was used to assess the overall sexual

functioning as well as the specific dimensions of sexual functioning like Interest, Desire, Arousal, Orgasm, Satisfaction, Activity, Relationship, Masturbation, and Problems[1]. The list of problems that may arise in sexual functioning is gender specific, having 25 items each so that each item reflects the viewpoint of particular gender in an appropriate manner. For women, the problems could be related to vaginal dryness during sexual activity, vaginal tightness, pain during intercourse, anxiety about sexual performance, vaginal bleeding, hypersensitivity of skin, sharp pain in vagina, or other problems with sexuality. However, for men, the list of problems could be difficulty getting erection, losing an erection during sexual activity, delayed ejaculation, anxiety about sexual performance, pain during intercourse or other problems related to sexuality.

Originally, the scale was in English language, however, it has been adapted and validated by Munir A 2013[14] with regards to our culture. Hence, to make it comprehendible by our community, Urdu version of SFQ was used. The formal permissions were taken from the main researchers in order to use it in this research.

Demographic Information Sheet–Related Condition was used to assess the socio-demographic variables of an individual that could have a related effect on their sexual functioning which includes personal characteristics like gender, education, age, profession, residential area, religious inclination; and familial characters like family system, number of siblings, nature of relationship with parents and spouse as well as their subjective ratings for physical and psychological health. This information was evaluated in descriptive manner.

Procedure

Following the official procedures of permissions from committees and authors of measures, a pilot study was conducted with a sample of ten participants to find out the understanding of questionnaires. Following that, in main study, the data was collected from selected UCs of each socioeconomic class (i.e. Lower, Middle and Upper) in their home setting. Keeping in view the ethical considerations of informed consent, confidentiality keeping and giving the right to withdraw, questionnaires were self-administered by the respondents in one-to-one setting. The researcher found that male participants were not much open to respond about their sexual matters to a female researcher. So, two male research assistants were hired and trained them in order to collect data from men of the respective town and community. It was also observed that upper class responded more cooperatively, this may be due to their understanding towards the research.

RESULTS

Using the Statistical Package for Social Sciences (SPSS), descriptive analyses were carried out to find the estimates of sexual functioning of the participants.

It was shown in the results that almost 3.9 % men and 1.3 % women has the score in the range of 1 – 25 which shows that they have poor sexual functioning because this score lie below the mean (31.6) and standard deviation (40.56) of the sample. Almost 10.5 % men and 9.5 % women have the score in the range 26 – 50 which also shows lower scores and had poor sexual functioning. It is also evident that almost 41.3 % men and 31.9 % women have the score in the range 51 – 75 which also reveals their adequate sexual functioning. Almost 10.1 % men and 23.5 % women has the score in the range 76 – 100 which also reveals their better sexual functioning. It was also revealed from the results that 31.9 % data was missed. A large number of participants (20%) did not even reply to some of the questions of the questionnaire showing their resistance and defensiveness (Table I).

It was found out that most of the men (75%) have low scores on all the subscales of SFQ indicating lack of interest, less desire to perform sexual activity, unable to achieve orgasm, poor satisfaction and lesser sexual activities despite having sexual relationship (Table II). In relationship subscale, the scores are scattered and somewhat inclined above the mean scores i.e. 11.4. It is noteworthy, that despite having optimum overall sexual functioning, men does not experience phases of sexual response cycle at its peak. Even, in the subscale of listed problems in sexual functioning, no significant results were reported.

In case of women in Table III, it is showed that more than 75 % women (approx.) lack sexual interest and desire, unable to experience sexual arousal and orgasm, and lacks sexual satisfaction despite having sexual activities with sexual relationships indicated by the mean score in Table III. Moreover, 76 % women had the score in the range of 0 – 5 in masturbation subscale indicating that women lack the desire to engage in masturbation and does not aroused by it. Amongst the problems faced, it was found that most common problems experiences were vaginal dryness, vaginal tightness and vaginal bleeding during sexual activity.

It has been found that significant gender differences could be observed in the subscale of interest where men have significant interest related sexual dysfunctions as compared to women and overall women experiences 25% high level of sexual functioning as compared to men.

TABLE I: FREQUENCIES AND PERCENTAGES OF THE TOTAL SCORE ON SEXUAL FUNCTIONING QUESTIONNAIRE (n= 300)

	Men (n =150)		Women (n =150)	
SFQ Total Score	*f*	*%*	*f*	*%*
1 - 25	6	3.9	2	1.3
26 – 50	15	10.5	15	9.5
51 – 75	59	41.3	49	31.9
76 – 100	17	10.1	35	23.5
101 – 125	1	0 .7	4	2.6
126 – 150	2	1.3	0	0
Missing System	47	31.9	47	31.9

DISCUSSION

The results of the present study showed that majority of the participants had adequate overall sexual functioning. But most of the men and women had difficulties in experiencing sexual interest and desire phases during the sexual activity. Majority of the men and women were unsatisfied with their sexual contacts and relationships. These results were consistent with the empirical findings of Laumann[2]. It has been researched that 43% American women have sexual concerns lowering their sexual functioning. It has been observed during study that most of the women were not easy in discussing their personal sexual matters and problems due to shyness, embarrassment and strictness. It is also vital that scientific awareness be created in the general public so that women as well as men feel secure to disclose an discuss their sexual

TABLE II: PERCENTAGES OF THE MEN'S SCORE OF SUBSCALES OF SEXUAL FUNCTIONING QUESTIONNAIRE (n = 150)

	Scores of Subscales in Percentages					
SFQ Subscales	*0-5*	*6 – 10*	*11- 15*	*16- 20*	*21-25*	*Missing value*
Interest	49	40.4	9.3	0	0	1.3
Desire	54.6	34.3	2.6	0	0	9.1
Arousal	35.6	34.2	18.5	2	0	9.7
Orgasm	16.4	53.3	23	0	0	7.3
Satisfaction	56	36.2	0	0	0	7.8
Activity	28.2	40.2	17.7	0.7	0	13.2
Relationship	2.0	14.4	23	23	33	4.6
Masturbation	76.2	13.2	0.7	0	0	9.9
Problems	23.7	48.1	10.5	4.9	2	10.8

TABLE III: PERCENTAGES OF THE WOMEN'S SCORE OF SUBSCALES OF SEXUAL FUNCTIONING QUESTIONNAIRE (n =150)

SFQ Subscales	Scores of Subscales in Percentages						*M*	*SD*
	0-5	*6 – 10*	*11- 15*	*16- 20*	*21-25*	*Missing value*		
Interest	47	40	7	2	0	3	23.5	62.9
Desire	44	34	5	1	3	2	27.3	93.9
Arousal	36	41	20	4	2	5	32.4	66.1
Orgasm	16	57	22	1	0	3	18.0	48.8
Satisfaction	56	39	2	0	0	3	26.1	94.4
Activity	35	37	18	3	2	5	77.9	175.7
Relationship	0	2	14	23	36	25	11.4	9.6
Masturbation	76	14	2	1	0	7	16.1	47.7
Problems	24	48	11	5	2	11	21.6	62.2

Note: SFQ Sexual Functioning Questionnaire.

TABLE IV: INDEPENDENT SAMPLE T –TEST OF GENDER DIFFERENCES BETWEEN MEN (n=150) AND WOMEN (n=150) FOR SEXUAL FUNCTIONING AND ITS SUBSCALES

	Gender								
	Men		Women						
	M	SD	M	SD	UL	LL	t	p<	Cohen's d
Interest	40.09	101.7	20.70	49.87	37.61	1.16	2/09	.04*	.24
Desire	31.96	79.62	22.13	63.34	26.21	-6.55	1.18	.34	.14
Arousal	43.01	106.18	25.48	70.10	38.01	-2.97	1.68	.09	.19
Orgasm	29.80	75.51	21.29	45.52	22.68	-5.65	1.18	.23	.14
Satisfaction	22.71	50.24	16.54	30.47	15.60	-3.27	1.29	.20	.15
Activity	37.85	102.72	33.58	121.63	29.85	-21.30	.33	.74	.04
Relationship	26.54	11.77	30.59	21.51	.59	-8.71	-1.71	.08	.23
Masturbation	29.17	79.32	20.13	58.34	24.86	-6.78	1.13	.26	.13
Problems	41.68	103.92	44.51	141.47	25.40	-31.07	-.20	.84	.02
SFQ total	92.66	51.89	165.01	293.7	-14.73	-129.94	-2.47	.02*	.34
*Note: df = 299, *p<.05*									

concerns which would ultimately lead to timely clinical help. The role of clinician within the discipline of sexuality is quiet vivacious because they have to be efficient in diagnosing sexual dysfunctions with the provision of psycho-education so that women look forward to treatment options and possibilities[15]. In the context of traditionalistic society of Pakistan, this gets more crucial because women are not allowed to discuss sexual and gynecological matters openly making it a taboo for them.

It was also explored that participants of this study had problems in their interest and desires towards sexual activity. The findings were also correlated with the Kaplan who found that most of women patients don't have the desire to be aroused by their partners even. They felt difficulties in their desires. And following this she proposed that sex response cycle consists of four phases: Desire, arousal, orgasm, resolution. So all the phases played important role in the sexual activity and if one have difficulty at any phase must experience some sexual problem which may lead to sexual disorders[6]. According to DSM-IV if the person experience any problem in their sexual cycle or experience pain during sexual intercourse then it may leads to sexual dysfunctions in the extreme situation[5]. Waldinger MD 2007[16] suggested the severity of the dysfunction could also be expressed by different degrees of distress and interpersonal difficulty, so in the present research cultural constraints and gender disadvantages also led women to such sexual problems. According to Meston CM 2007[15] these attitudes regarding human sexuality develops over a period of time which afflicts the sexual development of an individual as well with regards to cultural practices. This gets more vigorous for women because they internalize and in a traditionalistic society of Pakistan women are reinforced to be passive. Not only this, it develops negative attitude towards sexuality in the head and heart of women making them vulnerable of experiencing sexual issues[17]. Similarly, with regards to lack of sexual interest and desire, anxiety problems regarding sexual performance was found to be associated as well. These problems are also sexuality -centered with regards to gender in collectivistic cultures. It may be stated that men experience less sexual problems because they are more open, dominant and have independent life, they could avail many opportunities of the environment, didn't require permissions as women need from their husbands and can fulfill their desires by visiting prostitutes, watching pornographic movies to fulfill their desires[18].

CONCLUSION

Conclusively, it can be said that most of the participants had adequate overall sexual functioning but also have some sexual concerns like lack of interest and desire to take part in sexual activities. In our culture, sexual activities are considered as a taboo and is mainly related to child rearing practices. Many of the participants find it difficult to express their

dysfunctions and issues to researcher as well, reflecting the shyness and awkwardness of the participants. This prevalence study will provide a guideline to the mental and sexual health professionals in planning and devising intervention strategies because sexual dysfunctions are comorbid with life satisfaction and overall well-being.

REFERENCES

1. Syrjala KL, Schroeder TC, Abrams J, Atkins T, Brown WS, Sanders J, et al. Sexual functioning measurement and outcomes in cancer survivors and matched controls. The Journal of Sex Research 2000; 37(3): 213-225. doi: 10.1080/00224490009552042
2. Laumann EO, Paik A, Rosen RC. Sexual dysfunction in the United States: prevalence and predictors. JAMA 1999; 281(6): 537-44.
3. Leiblum S. Persistent Genital Arousal Disorder. In Leiblum S, editor. Principles and Practice of Sex Therapy. New York: Guilford Press; 2005. pp. 54-83.
4. Seidman SN, Roose SP. Sexual dysfunction and depression. Current psychiatry reports, 2001; 3 (3): 202-8.
5. American Psychiatric Association. Diagnostic and statistical manual of mental disorders 4th ed, Text Revision (DSM-IV TR). Washington DC; 2000.
6. Kaplan HS, editor. Sexual Aversion, Sexual Phobias, and Panic Disorders. New York: Brunner Mazel; 1987.
7. Dunn KM, Croft P R, Hackett GI. Sexual problems: a study of the prevalence and need for health care in the general population. Fam Pract 1998; 15(6): 519- 24. doi:10.1093/ fampra/15.6.519
8. Basirnia A, Izadian ES, Arbabi M, Bayay Z, Vahdat SV, Noorbala AA, et al. Systematic review of prevalence of sexual disorders in Iran. Iran J Psychaitry 2007; 2: 151-56.
9. Grover S, Shah R, Dutt A, Avasth A. Prevalence and pattern of sexual dysfunction in married females receiving antidepressants: An exploratory study. J Pharmacol Pharmacother 2012; 3(3): 259 -65. doi: 10.4103/0976-500X.99430.
10. Montorsi F. Prevalence of premature ejaculation: A global and regional perspective. J Sex Med 2005; 2(Suppl 2): 96–102. doi:10.1111/j.1743-6109. 2005. 20369.x
11. Shah F, Sultan A, Dar SI. Depression and prevalence of sexual dysfunction. Pak J Med Res 2004; 43(3): 104-7.
12. Penedo FJ, Dahn JR. Exercise and well-being: A review of mental and physical health benefits associated with physical activity. Curr Opin psychiatry 2005; 18(2): 189-93.
13. Gravetter F J, Forzano LAB. Research Methods for Behavioral Sciences. 4th ed; Australia: Wadsworth / Thomson Learning, Inc; 2003.
14. Munir A, Mohsin H. Difference between anxiety and depression with respect to marital adjustment and sexual functioning. World Appl Sci J 2013; 28 (12): 2147-51.
15. Meston CM, Bradford A. Sexual dysfunctions in women. Annual Review of Clinical Psychology. Annual Review 2007; 3:233 – 256.
16. Waldinger MD, Zwinderman AH, Olivier B, Schweitzer DH. The majority of men with lifelong premature ejaculation prefer daily drug treatment: An observation study in a consecutive group of Dutch men. J Sex Med 2007; 4: 1028-37.
17. Nobre PJ, Pinto-Gouveia J. Dysfunctional sexual beliefs as vulnerability factors to sexual dysfunction. *J Sex Res 2006; 43*(1): 68-75.
18. Evans A, Riley S, Shankar A. Technologies of sexiness: Theorizing women's engagement in the sexualization of culture. Feminism & Psychology 2010; 20(1), 114-131.

AUTHOR AFFILIATION:

Ms. Tehreem Arshad
Assistant Professor, Centre for Clinical Psychology
University of the Punjab, Lahore, Punjab-Pakistan.
E-mail: tehreem.ccpsy@pu.edu.pk