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DETERMINING SOME OF THE FACTORS RELATED TO SEXUAL FUNCTION AND SATISFACTION AMONG WOMEN IN AHVAZ

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ABSTRACT

Introduction: Recognition and investigation of sexuality is one of the most important problem of public health, especially mental health. In other words, sexual function and satisfaction have been one of the most basic aspects of human life and paying attention to it is an essential part of health care standards. Sexual function is also part of sexual health in women. The present study aimed to determine some of the factors related to sexual function and satisfaction in Ahvaz city. **Method:** This is a descriptive-analytic cross-sectional study. Random sampling method was available which was done on 685 eligible women referred to health centers in Ahvaz. **Findings:** There was a significant relationship between sexual function and satisfaction and all demographic characteristics and birth control methods. **Conclusion:** According to the findings of the present study that there is an relationship between demographic characteristics and birth control methods and sexual function and satisfaction, discovering and solving sexual dysfunctions have a significant impact on improving the quality of the marital relationship which is an important step in order to prevent family disputes and its consequences.

KEYWORDS: sexual function, sexual satisfaction, demographic characteristics, birth control methods.

INTRODUCTION

Sexual issues are the most important issues in a marital life and consistency and balance in the amount of sexuality in spouses are one of the major reasons of marital happiness and success.[1] In other words, sexual function and satisfaction have been one of the most basic aspects of human life and paying attention to it is an essential part of health care standards.[2,3] Sexual function is some part of human life and behavior, which have been so interwoven together that it seems impossible to speak of it as an independent phenomenon,[4] Sexual function is part of women's physical health.[5] In this regard, the World Health Organization defines sexual health as a coordination of mind, emotions, and body that leads to the completion of personality, communication, and love.[6] Therefore, any disorder leading to inconsistency and dissatisfaction with sex can cause sexual dysfunction.[7] Sexual activity is influenced by one's own, primary relationships, family, society, and culture, complexity of the environment, their sexual experience and their wife's experience, past relationships, mental health, depression, stress, chronic disease, medications, infertility, pregnancy, childbirth, recent medical problems and hormonal status.[8] Organic diseases affect sexual activity and satisfaction. Depression, stress, chronic disease, medications, infertility, pregnancy, birth, one's social problems are of factors involved in sexual satisfaction. Contraceptive methods also have different effect on women's sexual satisfaction. Birth control methods also have different effect on women's sexual satisfaction.[10, 9] Research shows that the incidence of migraine headaches, premenstrual syndrome, and chronic arthritis decrease in women who experience sexual satisfaction in their marital life. In fact, sexual satisfaction not only brings warmth and passion for couples but also protects them against many diseases.[11] Some researchers believe that the main cause of 80% of marital disputes is sexual dissatisfaction between spouses.[12] Researchers have reported that approximately 30-20% of men and 20-15% of women in America, because of their sexual dissatisfaction, has sexual relations outside the family. 40% of betrayals and secret sexual relationships of Iranian couples is due to sexual dissatisfaction.[13] About 80-60% of women suffered from various forms of sexual disorders.[14] Results of a study conducted in Malaysia on

163 married women aged 18-65 showed that the prevalence of sexual dysfunction had been 25.8%.[15] In another study conducted on 504 Korean women aged 18-25, the prevalence of sexual dysfunction was reported 43.1%.[16] Various demographic studies in Iran have reported the prevalence of such disputes 25-63%.[17] Although sexuality is inherent and involuntary, sexual behaviors and attitudes are learnable. Therefore, similar sexual activities can have different meanings for different people and even they can change for one person over time. Since social attitude toward sexual health has changed in the recent decade, a person is able to have more healthy sexual relationships.[18] Due to the negative effects of female sexual disorders and their complications on family and society, prevention and treatment of such problems is the duty of health care workers, especially doctors and midwives. They have to be aware of such problems and their influencing factors in a community in where they are serving to be able to take a considerable action to reduce these problems applying appropriate measures. Given that a limited number of studies have been conducted in this regard in our society, this study aimed to determine some of the factors related to sexual function and satisfaction in women in Ahvaz.

METHOD

This study was a descriptive-analytic cross-sectional study conducted on 685 eligible women referred to health centers in Ahvaz. Inclusion criteria were being married, being 18-45 years old, being literate, monogamous, and passing at least one year from the time of their marriage. Exclusion criteria were suffering from any known medical and psychological diseases, having any critical incident in the last 6 months, pregnancy, experiencing sexual harassment before marriage, addiction to drugs and alcohol in couples, consuming sedation, and infertility. Random sampling method was available. Data collecting tools in this study was a questionnaire including three parts: A) Demographic characteristics, including age, the number of years after marriage, number of children, age of the youngest child, age of husband and birth control method, B) sexual function questionnaire[1] and C) Larson sexual satisfaction questionnaire.[2] To provide the scientific credibility (reliability) of the demographic characteristics questionnaire, content validity was used. In this way that after studying the latest books and articles, the questionnaire and checklist were provided and they were given to 10 members of the Faculty of Ahvaz Nursing and Midwifery to be studied and after carrying out the necessary reforms, the final version was drafted under their supervision. Sexual function questionnaire has 19 questions that assess sexual function in six independent areas of sexual desire, sexual excitement, vaginal moisture, orgasm, sexual satisfaction, and sexual pain. In terms of scoring, according to the questionnaire designer, scores of each area were obtained by summing the scores of the questions of each area and multiplying them by the factor of a number (since in this questionnaire, number of questions of areas are not equal, in order to homogenize the areas, at first the sores obtained from the questions of each area were summed and then were multiplied by the factor number). The scores considered for the questions are 1. sexual desire[1-5] and 2. sexual excitement, 3. vaginal moisture, 4. orgasm, 5. Pain (0-5) and 6. Sexual satisfaction (0 or 1-5). 0 shows that the person did not have any sexual activity during last four weeks. Summing the scores of all areas provides the total score. Therefore, higher score shows better sexual function. Accordingly, the maximum score for each area is 6 and for the total scale will be 36. The minimum score will also be 1.2 for sexual desire area, 0 for sexual excitement, vaginal moisture, orgasm and pain, 0.8 for sexual satisfaction and 2 for the total scale. The total score of 26.55 or less than it shows sexual dysfunction.[19] In Iran, first Mohammadi confirmed the reliability and validity of the Persian version of this questionnaire in 1383 and then Fakhri confirmed it in 1391. The reliability of the total scale and subscale was obtained through Cronbach's alpha coefficient. To measure the validity of the instruments, index structure of principal component analysis using varimax rotation and subsequent confirmatory factor analysis were used. To recognize the validity, analysis of variance between groups was done. Generally, test-retest reliability coefficient was high for each area of the questionnaire (0.73-0.86) and internal stability was within an acceptable range (0.72-0.90). This study showed that this questionnaire is a reliable and valid instrument with good psychometric characteristics that can be used for a fast, accurate, and primary screening of women's unknown sexual health in clinics and sexual counseling centers.[20, 21] Sexual satisfaction questionnaire has 25 questions and to answer each question 5 items, based on the Likert scale (never, rarely, sometimes, often, or always), are included and each question is given from 1 to 5. Thus, in questions 1, 2, 3, 10, 12, 13, 16, 17, 19, 21, 22, 23, the "never" is given 1, "rarely" 2, "sometimes" 3, "the often " 4 and "always" 5. However, in other questions, "always" is given 1, "rarely" 2, "sometimes" 3, "often" 4 and "never" 5. To analyze the data, scores between 25 to 125 was considered as a scale. According to the obtained scores, classification of the variable is dependent on the levels of sexual dissatisfaction (less than 50), low satisfaction (50-75), moderate satisfaction (75-100) and high satisfaction (more than 100).[22, 23] Validity and reliability of the Larson sexual satisfaction questionnaire firs was confirmed by Moshkbid Haghighi and Shams Mofarrah in 1380 and again in 1390 by Asadzade was assess. To determine the validity of this questionnaire, content validity and to determine the reliability, test-retest method were used and due to the correlation of 98%, its reliability was confirmed.[24] Questionnaires were completed by the subjects after providing coordination with the relevant authorities and taking oral and written consent letter from research units in a private setting. In order to confidentiality of information, the name of the subjects was not mentioned on the questionnaires. Subjects were allowed to leave the study

whenever they were not inclined any more to carry on their participation in the research. The researcher was present to respond to questions the subjects might have about the questionnaire. Collected data were analyzed using statistical software SPSS (version 22) and descriptive statistics and chi square methods.

Findings

Results mentioned in Table 1 showed there had been a significant relationship between all demographic characteristics and birth control methods and sexual function (P<0.05). However, there was a negative relationship between age and sexual function and growing older led to lower satisfactory sexual function and more sexual dysfunction. There was a negative relationship between sexual function and length of marriage so that by increasing the years after marriage, satisfactory sexual function decreased. The results also showed that there had been a negative relationship between the number of children and sexual function and couples without any children had the highest frequency of satisfactory sexual function. And also, there was a negative relationship between age of the youngest child and age of husband and sexual function. There was less satisfactory sexual function and more sexual dysfunction in those subjects who used ampoule as a birth control method rather than other methods. The highest frequency of satisfactory sexual function and the lowest sexual dysfunction were related to those subjects who used condoms or no birth control method.

Table 1: Distribution of frequency and percentage of female sexual function in terms of demographic characteristics

Demographic characteristics		Sexual function		N
		Sexual dysfunction Number (percent)	Without sexual dysfunction Number (percent)	
Age	19-29	67(39)	105(61)	<0.001
	30-39	220(58.7)	155(41.3)	
	40-49	102(73.9)	36(26.1)	
The number of years after marriage	1-10	171(44.6)	312(55.4)	<0.001
	11-20	169(68.7)	77(31.3)	
	21-30	49(87.5)	7(12.5)	
The number of children	Without children	39(38.6)	62(61.4)	<0.001
	One child	103(43.8)	132(56.2)	
	Two children	141(64.1)	79(35.9)	
	Three children	79(78.2)	22(21.8)	
	Four children	27(96.4)	1(3.6)	
The age of the youngest child	1-18	221(54.3)	186(45.7)	<0.001
	9-16	112(72.3)	43(27.7)	
	17-24	17(77.3)	5(22.7)	
The age of the spouse	20-30	25(30.9)	56(69.1)	<0.001
	31-40	167(51.1)	160(48.9)	
	41-50	172(69.4)	76(30.6)	
	51-60	25(86.2)	4(13.8)	
Birth control methods	Tablet	104(55.9)	82(44.1)	<0.001
	Ampule	11(91.7)	1(8.3)	
	IUD	58(70.7)	24(29.3)	
	Condom	131(48.3)	140(51.7)	
	No birth control	34(48.6)	36(51.4)	
	Vasectomy	51(79.7)	13(20.3)	

The results mentioned in Table 2 show that there is a significant relationship between all demographic characteristics and birth control methods and sexual satisfaction (P<0.05). There was negative relationship between age and sexual satisfaction and by increasing age sexual satisfaction decreased. It is noteworthy to mention that due to this fact that there were few cases with no sexual satisfaction, no sexual satisfaction was merged with little sexual satisfaction. There was also a negative relationship between length of marriage and sexual satisfaction so that by increasing the number of years after marriage, sexual satisfaction decreased. The

results also showed that there had been a negative relationship between number of children and sexual satisfaction and people without children had the most sexual satisfaction. And also there was a negative relationship between age of the youngest child and age of husband and sexual satisfaction. There was the lowest sexual satisfaction in using vasectomy and the most sexual satisfaction in using condom (Table 2).

Table 2- Distribution of frequency and percentage of female sexual satisfaction in terms of demographic characteristics.

Demographic Characteristics		Sexual satisfaction			P-value
		A little and little Number (percent)	Moderate Number (percent)	High Number (percent)	
Age	19-29	9(5.3)	57(33.1)	106(61.6)	<0.001
	30-39	42(11.2)	169(52.3)	137(36.5)	
	40-49	24(17.4)	77(55.8)	37(26.8)	
The number of years after marriage	1-10	26(6.8)	163(42.6)	194(50.7)	<0.001
	11-20	34(13.8)	136(55.3)	76(30.9)	
	21-30	15(26.8)	31(55.4)	10(17.9)	
The number of children	Without children	8(7.9)	30(29.7)	63(62.4)	<0.001
	One child	17(7.2)	99(42.1)	119(506)	
	Two children	24(10.9)	119(54.1)	77(35)	
	Three children	17(16.8)	63(62.4)	21(20.8)	
	Four children	9(32.1)	9(67.9)	0(0)	
The age of the youngest child	1-18	33(8.1)	201(49.4)	173(42.5)	<0.001
	9-16	29(18.7)	88(56.8)	38(24.5)	
	17-24	5(22.7)	11(50)	6(27.3)	
The age of spouse	20-30	5(6.2)	23(28.4)	53(65.4)	<0.001
	31-40	24(7.3)	150(45.9)	153(46.8)	
	41-50	39(15.7)	140(56.5)	69(27.8)	
	51-60	7(24.1)	17(58.6)	5(17.2)	
Birth control methods	Tablet	18(9.7)	89(47.8)	79(42.5)	<0.001
	Ampule	2(16.7)	8(66.7)	2(16.7)	
	IUD	15(18.3)	47(57.3)	20(24.4)	
	Condom	18(6.6)	122(45)	131(48.3)	
	No birth control	6(8.6)	29(41.4)	35(50)	
	Vasectomy	16(25)	35(54.7)	13(3.20)	

DISCUSSION

The results of this study showed that there had been more satisfactory sexual function and sexual satisfaction in people aged 19-29 and less satisfactory sexual function and sexual satisfaction in people aged 40-49 (P<0.05). Similarly, a study conducted in California indicated that growing older led to increasing sexual dysfunction.[25] And also Addis et al. concluded that younger women had been more sexually active and had had more sexual satisfaction.[26] The results of this study showed that there had been a significant relationship between length of marriage and sexual function and satisfaction so that by increasing the number of years after marriage, satisfactory sexual function and sexual satisfaction had decreased (p<0.05). boloriyan et al. found a significant relationship between the length of married life and sexual dysfunction so that by increasing the length of married life, fewer sexual problems were reported which is not consistent with the present study.[27] However, Halford believes that sexual satisfaction decreases over time among the majority of couples.[28] Probably, by increasing the length of married life, the problems of life as well as mental problems get more evident and a false sense of dissatisfaction creates in couples. The researcher believes that sexual satisfaction, because of the strong feeling in couples, is in highest level in the first years after marriage, but gradually by increasing age it loses its importance over time. Of course, this does not mean that sexual satisfaction decreases over time, but it should stay stable during life if it is not influenced with other factors such as marital disputes, diseases, or mental problems. According to the results of this study, sexual function and satisfaction are related to the number of children so that by increasing the number of children, satisfactory sexual function and satisfaction decrease (P<0.05). In the study conducted by Safarinejad and colleagues, the number of pregnancies had a significant relationship with sexual function.[29] Witting et al found that nulliparous women because of painful intercourse, had had less sexual satisfaction compared to women who had had children, regardless of the number of children.[30] This finding is consistent with this study. In fact, it can be concluded that the frequency of sexual activity is one of

the important predicative factors of sexual satisfaction in couples.[31] The frequency of sexual activity decreases over time, which can be because of pregnancy, declining attractiveness of a person based on the sexual partner's opinion due to having delivery, taking care of children and mental conflicts etc. It seems that by decreasing the frequency of sexual activity over years after marriage, sexual satisfaction decreases.[32] According to this study, age of the youngest child is related to sexual function and satisfaction so that by increasing age of the child, the satisfactory sexual function and sexual satisfaction decreases ($P<0.05$). in fact, it can be concluded that by increasing age of children, related responsibilities and age of parents increase thus satisfactory sexual function and satisfaction decrease. In the present study, age of husband is significantly related to sexual satisfaction in women so that by increasing age of husband, the satisfactory sexual function and sexual satisfaction decrease ($P<0.05$). Ramezani et al. concluded that a big age gap between couples leads to non-identical sexual needs and thus sexual dysfunction.[33] Arrno et al. also concluded that the most sexual satisfaction is for those women who marry men 5-6 years olde.r than themselves.[34] It seems that age gap can be an important factor in agreement in various fields as well as in sexuality issues between couples. Therefore, no age gap between couples can be one of the effective factor to have satisfactory sexual function. A man and a woman with smaller age gap can understand each other better and they have similar needs and interests thus they can have more agreement in their life as well as their sexual issues. Studies have shown that increasing age gap places threats family more. The best age gap is 0 to 10 years. At the threshold of 20, half of the families take action to be divorces.[35] In this study, there was a significant relationship between birth control method and sexual function and agreement ($P<0.05$). In other word, in terms of birth control method, satisfactory sexual function and the amount of sexual satisfaction in women differed. Those people who used condom and those who had not used any birth control method reported the most satisfactory sexual function and sexual satisfaction. A study conducted by Hoseini et al. did not prove any significant relationship between birth control method and sexual function.[36] While in a study conducted by Aslan and colleagues, there was a significant relationship between birth control method and sexual function.[37]

CONCLUSION

According to the findings of the present study that there is a relationship between demographic characteristics and birth control method and sexual function and satisfaction, discovering and removing sexual dysfunctions have a significant effect on improving the quality of marital relationship which itself is an important action to prevent from family disputes and their consequences. Given that married people have different sexual behaviors and patterns, training couples, increasing their sexual knowledge, modifying their beliefs and attitudes can lead to cognitive changes. Finally, sexual health meaning taking care of female sexual health, identifying the concerns and helping them to improve their sexual function should be considered as fundamental issues of a healthy family.

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