General Health and Quality of Life in Patients With Sexual Dysfunctions

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Purpose: To study the general health and quality of life in patients with sexual dysfunctions.

Materials and Methods: One hundred and thirty-seven patients with diagnosis of a known sexual dysfunction (SD) were studied. A healthy group of 111 individuals matched for sex, education, and marital status were also selected as a control group. Both groups completed two rquestionnaires: General Health Questionnaire-28 (GHQ-28) and Personal Wellbeing Index–Adult (PWI-A). To analyze data, descriptive methods as well as student *t* test for independent groups were used.

Results: The mean scores for individuals suffering from SD were more than the control group in total GHQ scale and all its subscales. The mean scores in total PWI-A scale and most of its subscales for individuals suffering from SD were lower than the control group. Since the obtained *t* values (4.16 to 5.22) for all the comparisons done between the mean scores in GHQ for the two groups were higher than *t* value in the 't table' for df = 206 at $\alpha = 0.01$ (2.58), differences obtained were significant. Since obtained *t* values (-2.03 to 4.65) for total quality of life and health, achievements, personal relationship, safety, and feeling part of community dimensions were higher than *t* value in the 't table' for df = 206 at $\alpha = 0.05$ and $\alpha = 0.01$ (1.96 and 2.58, respectively), differences obtained except for standard of living and future security were significant.

Conclusion: Somatic, social, and mental measures for people having sexual dysfunctions (patient group) were lower than the control group.

Keywords: quality of life, sexual dysfunctions, health status, health surveys

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INTRODUCTION

Sexual problems are common in most of the populations and depending on cultural norms, they surface intermittently in the family practice setting.[1] Sexual dysfunction (SD) is an issue of growing interest. In a population-based study in Iran, of 2626 women interviewed, 31.5% (759) reported SD. The prevalence increased with age from 26% in women aged between 20 and 39 years to 39% in those >50 years (tested for trend $P < .001$).[2] In another population-based study in Iran, to explore the prevalence of and risk factors for erectile dysfunction (ED), a total of 2674 men aged between 20 and 70 years were interviewed.[3] Of the men interviewed, 18.8% (460) reported ED. The prevalence increased with age, from 6% in men aged between 20 to 39 years to 47% in those >60 years (tested for trend $P < .001$).

Research examining the occurrence

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of sexual problems in nonclinical populations tends to be restricted to highly selected populations,[4] such as healthy women in an outpatient gynecological clinic,[5] normal married couples,[6] young married couples with children,[7] and middle-aged men[8] and women with sexual dysfunction,[9] with sample size of 38 to 439 subjects.

A review of 23 "community samples" reported a frequency of 4% to 10% for difficulty in achieving orgasm in both men and women, 4% to 9% for erectile problems in men, and 36% to 38% for premature ejaculation in men.[7] Similarly, a large-scale international collaboration of multidisciplinary experts reported that 40% to 45% of adult women and 20% to 30% of adult men suffer from at least one form of SD. The following prevalence rates were also reported in women: low levels of sexual interest in 17% to 55%, lubrication difficulties in about 8% to 15%, orgasmic dysfunction in 25%, and vaginismus in approximately 6%. The prevalence of ED was reported to be 1% to 9% in men younger than 40 years, which rapidly increased with age to 20% to 40% in men in the age range of 60 to 69 years.[10]

It is difficult to obtain an accurate estimate of the prevalence of SD from the international literature because of the discrepancies existing in definitions and tools used in different studies. Only somatic dysfunctions are well-defined, while predominantly psychologically conditioned dysfunctions appear under a multiplicity of labels in various investigations. There is clinical evidence that sexual problems have a multifactorial etiology, including organic, social, and psychological components.[11] The impact of certain pathologies, such as depression and diabetes mellitus, on sexual function is well-known.[12,13] In men, ED is associated with age and is more prevalent in patients suffering from other medical problems.[14] Sexual dysfunctions often coexist with other problems, such as depression, lack of self-esteem, unsuccessful relationships, or just inadequate sexual experience. Nevertheless, very little is known about the relationship between sexual problems and the quality of life.[15]

MATERIALS AND METHODS

Target populations were all the people referring to Family Health Clinic in Tehran, with the complaint of a sexual problem. One hundred and thirty-seven patients without a history of other psychiatric disorders were selected for the study by consecutive sampling. They confirmed experiencing a SD through clinical interview by a psychologist, a psychiatrist, or a urologist on the basis of Diagnostic and Statistical Manual, 4th Edition, Text Revision (DSM-IV-RT). One hundred and eleven normal individuals were selected from general population as a control group matched for sex, education, and marital status without having history of sexual problems, to make comparisons possible.

To measure the study outcomes, following instruments were used: 1) Clinical interview on the basis of DSM-IV-TR; 2) General Health Questionnaire-28 (GHQ-28) developed originally by Goldberg[16] and translated into Persian by Taqhavi.[17] Taqhavi reported good psychometric measures (reliability and validity) for the test in Iranian population; 3) Personal Wellbeing Index-Adult (PWI-A), developed by Cummins,[18] is claimed to measure quality of life for adults. Its psychometric properties were confirmed in original articles. Naeinian and colleagues found good psychometric reliability and validity for this tool in Iranian population.[19] Both patient and control groups, who met inclusion criteria for the present study, were individually given the above-mentioned tools initially before starting the treatment.

RESULTS

The patient group consisted of 95 (69.30%) men and 42 (30.70%) women, with the mean age of 49.01(± 12.62) years, while in the control group, 75 (67%) of the participants were men and 36 (32.40%) were women, with the mean age of 40.86 (± 12.92) years. Single and married participants in the patient group were 14 (10.20%) and 123 (89.80%), and in the control group were 9 (8.10%) and 102 (91.90%), respectively.

Frequency distribution and percentages of common sexual problems among respondents

are shown in Table 1. Results show that the most common sexual problems were rapid ejaculation in men (27%), reduced sexual desire (21.90%) and vaginismus (15.30%) in women, and performance anxiety (6.6%) and premature erection in men (6.6%).

Descriptive measures, such as mean scores, standard deviations, maximum and minimum scores in GHQ-28 for patients and controls are given in Table 2. Data show that the mean scores for individuals suffering from SD (patient group) were more than the control group in total GHQ scale and all its subscales. As Table 3 shows, the mean scores in total PWI-A scale and most of its subscales for individuals suffering from SD (patient group) were lower than the control group.

Table 1. Frequency distribution and percentage of sexual problems

Diagnosis	Frequency	Percentage (%)
Masturbation	4	2.90
Reduced desire	30	21.90
Vaginismus	21	15.30
Rapid ejaculation	37	27.00
Homosexuality	2	1.50
Performance anxiety	9	6.60
Pain during intercourse	1	0.70
Lack of orgasm	4	2.90
Transvestitism	1	0.70
Premature erection	9	6.60
Lack of pleasure	4	2.90
Frigidity	1	0.70
Sexual aversion	2	1.50
More than one complaint	11	8.10
Unknown	1	0.70
Total	137	100.00

On the basis of data depicted in Table 4, since obtained *t* values (4.16 to 5.22) for all the comparisons done between the mean scores for the two groups were higher than *t* value in the 't table' for df = 206 at $\alpha = 0.01$ (2.58), differences obtained were significant. Therefore, general health measures in all studied dimensions were lower in patients suffering from SD in comparison with the control group.

According to Table 5, since obtained *t* values (-2.03 to 4.65) for total quality of life and health, achievements, personal relationship, safety, and feeling part of community dimensions were higher than *t* value in the 't table' for df = 206 at $\alpha = 0.05$ and $\alpha = 0.01$ (1.96 and 2.58, respectively), differences obtained except for standard of living and future security were significant. Therefore, total quality of life measure as well as quality of life measure in studied dimensions were lower in patients suffering from SD in comparison with the control group.

DISCUSSION

The most prevalent sexual problems in the studied sample were primary ejaculation, low libido, erection problems, and vaginismus, which were consistent with findings in previous studies.[7,10] It must be mentioned that apart from cultural and geographical factors in different countries, a proportion of general population in each country suffers from SD, of whom only a limited number seek help.

Results in this study also showed that somatic, social, and psychological measures of people

Table 2. Descriptive data in general health dimensions as measured by GHQ-28*

Dimensions	Group	Statistics				
		Mean	Standard deviation	Minimum	Maximum	N
Somatic dimension	Patient	7.54	4.15	1	19	97
	Control	5.36	3.42	0	15	111
Anxiety and sleepless	Patient	7.57	4.34	0	20	97
	Control	5.23	3.54	0	18	111
Social dysfunction	Patient	8.26	2.59	1	19	97
	Control	6.70	2.55	0	16	111
Depression	Patient	5.04	5.17	0	21	97
	Control	2.49	3.24	0	18	111
Total GHQ score	Patient	28.41	13.65	8	77	97
	Control	19.78	10.15	1	67	111

*GHQ-28 indicates General Health Questionnaire-28.

Table 3. Descriptive data in QOL dimensions as measured by PWI-A*

Dimensions	Group	Statistics				
		Mean	Standard deviation	Minimum	Maximum	N
Standard of living	Patient	6	2.13	0	10	137
	Control	4.49	2.42	0	10	111
Health	Patient	5.98	2.46	0	10	137
	Control	7.40	2.29	0	10	111
Achievements	Patient	5.93	2.15	0	10	137
	Control	6.82	2.60	0	10	111
personal relationships	Patient	6.60	2.17	0	10	137
	Control	7.49	1.99	1	10	111
Safety	Patient	6.65	2.57	0	10	137
	Control	7.31	2.48	0	10	111
Feeling part of your community	Patient	6.19	2.38	0	10	137
	Control	6.85	2.36	0	10	111
Future security	Patient	5.85	2.42	0	10	137
	Control	6.02	2.93	0	10	111
Total QOL score	Patient	43.19	12.69	0	69	137
	Control	48.37	13.02	3	70	111

*QOL indicates quality of life; and PWI-A, Personal Wellbeing Index-Adult.

Table 4. Comparison between patients and controls' mean scores in general health dimensions on the basis of student *t* test for independent groups.

Dimensions	Group	Statistics				
		Mean difference	Standard error difference	df	*t*	*P*
Somatic dimension	Patient	2.18	0.53	206	4.16	.000
	Control					
Anxiety and sleeplessness	Patient	2.34	0.55	206	4.28	.000
	Control					
Social dysfunction	Patient	1.56	0.36	206	4.38	.000
	Control					
Depression	Patient	2.60	0.59	206	4.32	.000
	Control					
Total GHQ* score	Patient	8.63	1.69	206	5.22	.000
	Control					

*GHQ-28 indicates General Health Questionnaire-28.

Table 5. Comparison between patients and controls' mean scores in QOL dimensions on the basis of student *t* test for independent groups*

Dimensions	Group	Statistics				
		Mean difference	Standard error difference	df	*t*	*P*
Standard of living	Patient	-0.49	0.29	246	-1.70	.09
	Control					
Health	Patient	-1.42	0.30	246	-4.65	.000
	Control					
Achievements	Patient	-0.89	0.31	246	-2.96	.003
	Control					
Personal relationships	Patient	-0.89	0.27	246	-3.32	.001
	Control					
Safety	Patient	-0.66	0.32	246	-2.03	.04
	Control					
Feeling part of your community	Patient	-0.66	0.30	246	-2.16	.03
	Control					
Future security	Patient	-0.17	0.34	246	-0.51	.61
	Control					
Total QOL score	Patient	-5.18	1.64	246	-3.16	.002
	Control					

*QOL indicates quality of life.

having SD were lower in comparison with general population. Depressive symptoms have been reported in individuals with SD in earlier studies.[15] Findings in the present study while confirm such previous results, also suggest that adverse effects of sexual problems go more beyond depression. This study also showed that quality of life for people having SD was lower than the control group. This finding is in accordance with the results observed in other countries.[15,20]

CONCLUSION

We concluded that low general health and quality of life in people with sexual dysfunction cannot be attributed to sexual problems.

CONFLICT OF INTEREST

None declared.

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