*Journal of Caring Sciences, 2015*, *4(2), 143-153*
doi:*10.15171/jcs.2015.015*
*http:// journals.tbzmed.ac.ir/ JCS*

# Sexual Dysfunction and Help Seeking Behaviors in Newly Married Men in Sari City: a Descriptive Study

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**ARTICLE INFO**

***Article Type:***
Original Article

***Article History:***
Received: 13 Jul. 2014
Accepted: 7 Sep. 2014
ePublished: 1 Jun. 2015

***Keywords:***
Sexual function
Dysfunction
Help-seeking behaviors
Newly married men

**ABSTRACT**

***Introduction:*** Sexual dysfunction is a major concern for people's general health. The aim of this study was to determine the status of sexual function and help-seeking behaviors in newly married men.

***Methods:*** This descriptive study was conducted on 363 newly married men. Simple random sampling was used according to premarital counseling offices in the health center of Sari city. Data collection instruments included personal and social characteristics, Arizona Sexual Experience Scale (ASEX), and help-seeking behaviors questionnaires. In order to determine the relationship between characteristics and sexual function, general linear model and also between socio-demographic characteristics and receiving or lack of receiving help, multivariate logistic regression test were used.

***Results:*** The mean of sexual function score was 21.3 (2.7) out of possible 5-30, and 26% of men suffered sexual dysfunction. The highest prevalence (27.2%) of dysfunction was in the dimension of sexual stimulation, and the lowest (15.7%) in maintaining erection. For the treatment of sexual dysfunction, only 32% men had sought help, and 40% of them had visited specialists. The most frequent reasons for not seeking help were feeling uncomfortable with doctor, and their belief that doctor is not able to do much. 65% of men desired to be treated.

***Conclusion:*** The results demonstrated relatively high prevalence of sexual dysfunction among men, and unfortunately, most of them did not seek help for their sexual problem. Since Sexual dysfunction can leave damaging effects on the quality of life and marital relationship, interventions to deal with these challenges and screening to identify such problems appear necessary.

## Introduction

Sexual health means physical, emotional, mental and social welfare in sexual relationships.[1] The World Health Organization describes sexual function as different styles in which an individual (male or female) is unable to participate in a sexual relationship in the way he or she wishes.[2]

Sexual dysfunction is an important concern for people's general health, and it is affected by several factors such as emotional problems, stressors, marital status, health, poor lifestyle, and low education level.[3]

Sexual dysfunction leaves damaging effects on mental health, self-esteem, and quality of life, and can lead to emotional distress, communication problems, and infertility.[3-6]

Moreover, sexual dysfunction is closely associated with family and social relationships such as a damaging husband and wife relationship, reducing marital

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This Project was approved and funded by the Tabriz University of Medical Sciences, International Branch Aras (Project number: 91231).

satisfaction, crime, rape, mental disorders, divorce.[7] and quality of life.[6] In many cases, the unspoken and hidden sexual problems may emerge with symptoms and complications such as physical problems, depression, and marital dissatisfaction, and progress to the limit of severe family dysfunction and divorce.[8] Sexual dysfunction has been reported as one of the influential factors in divorce.[7] According to existing statistics, divorce rate in the first year of marriage has grown by 90% from 2004 to date. In 2012, 14.1% of divorces were marriages lasting under one year, and had grown by 7% in comparison with the previous year.[9]

Worldwide prevalence of sexual dysfunction in men has been reported from 10% to 25%.[3,10] The few studies conducted in Iran indicate the high prevalence of sexual dysfunction.[11] In Iran, studies have been conducted on sexual dysfunction in men with infertility problem,[12] diabetes,[13] epilepsy,[14] heart disease,[15] chronic hepatitis,[16] hemodialysis patients,[17] and referred patients to urology clinic.[18] However, according to investigations conducted by the researcher, only one study has been conducted on a small sample size (61 men) of healthy men attending in a family health clinic,[19] but the sexual function of newly married couples has not been studied.

Despite high prevalence of sexual dysfunction, this problem has been frequently overlooked by primary healthcare systems.[3] In some cultures, due to a sinful perspective on sexual matters and a series of cultural issues, people cannot comfortably talk about their sexual problems.[11] Help-seeking behaviors are defined as behaviors in which an individual actively seeks help from others. The contact with others to receive help involves advice and guidance, information, treatment and support to solve a problem or a distressing experience. Identifying help-seeking models and help-seeking obstacles among people with sexual dysfunction are important and increase access to treatment and improve their quality of life.[20,21]

There are few studies on help-seeking behaviors for treatment among men and women.[22,23] According to a study in England, people with sexual dysfunction sought little help, and this was associated with elements such as severity of dysfunction, and lack of knowledge and information about the availability of counseling and treatment.[24] According to a study in Britain, people that sought help for sexual dysfunction, often consulted general practitioners, and reported lack of time and resources.[25] In Iran, only one study [26] has been conducted on help-seeking behaviors for sexual dysfunction, and the participants surveyed in this study were women.

Because of the vital role of sexual dysfunction in mental health[7] and quality of life[6] and also lack of studies on sexual function and help-seeking behaviors in newly married men, it was decided to conduct a study aims at determining the level of sexual dysfunction and help-seeking behaviors in newly married men in Sari city during 2012-2013.

## Materials and methods

This was a descriptive study, conducted on 363 newly married men with minimum of 3 months (because of common transient problems in early marriage) and maximum of one year elapsed since sexual relationship with their sexual partner. Sample size was estimated 363 according to Vahdaninia study,[26] taking into account 5% error, accuracy of 0.05, and 38% prevalence for the subdomain of orgasm disorder.

For the purpose of sampling, based on premarital counseling registry offices, addresses and contact numbers of all those who had attended premarital in counseling centers during the past year from the beginning of the project were obtained. Then, by using simple random sampling technique, 363 men were contacted and if they met study inclusion criteria, they were invited to attend in the premarital counseling center on a

 

pre determined day, when informed written consents were obtained from them and self-report data collection tools were completed. Iranian nationality, over 18 years of age, junior high school education and higher, living with spouse, first marriage, absence of any physical problems due to diabetes, heart diseases, chronic disease, hormonal problems, cancer, pelvic surgery or other limb and organ surgeries, absence of known mental illnesses such as current depression or depression in the last 3 months, no adverse event in the last 3 months, and willingness to take part in the study.

Those participants who did not wish to attend in the premarital counseling center, but they were willingness to take part in the study, the researcher visited them at their homes.

Data collection instruments included personal and social characteristics, Arizona Sexual Experience Scale (ASEX), and help-seeking behaviors questionnaires.

personal and social characteristics questionnaire included age, age at marriage, duration of marriage, education level, occupation, type of residence, living with family (living with the wife's or husband's family), adequacy of monthly income for living expenses, body mass index and exercise.

Arizona Sexual Experience Scale (ASEX): This questionnaire was designed by one of the professors of psychiatry at the Arizona University. It contains only 5 items and can be used to screen for sexual dysfunction at the level of primary health care. These 5 items are concerned with sexual drive, arousal, vaginal lubrication, maintaining an erection, ability to reach orgasm, and satisfaction with orgasm, and are scored according to 6-option Likert scale, so that extremely easy scores 1, very easy 2, occasionally high 3, occasionally poor 4, very poor or very difficult 5, and never 6. Scores in excess of 18, or if score of one of the questions is 5 or 6, the person is considered to have sexual dysfunction.[27] In the previous studies in Iran, internal reliability of this scale has been determined with Cronbach's alpha 0.7 or greater.[28] The results of a study on accuracy of ASEX in identifying sexual dysfunction showed that sensitivity and specificity of this tool is 80.8% and 88.1%, respectively; therefore, this instrument was found to be highly accurate in identifying sexual dysfunction.[29]

Help-seeking behaviors questionnaire was designed by two psychologists and one psychiatrist, [3, 4] and in Iran was used by Vahvaninia et al.[26] This questionnaire contains 5 items. Participants reporting at least one sexual problem are asked whether they have received any help from available sources such as: care providers, specialists, GPs, psychiatrists and others.

So, participants with negative answers are asked to recite reasons for not receiving help.

To determine the validity of these questionnaires, content and face validities were used. In the present study, using pretest-posttest, reliability was confirmed from repeatability and internal consistency dimensions. ICC (95% Confidence Interval) and Cronbach's alpha were found for sexual function questionnaire: 0.86 (0.72 to 0.93) and 0.84 respectively and ICC (95% Confidence Interval) for help-seeking behaviors were 0.91 (0.81 to 0.95).

Data were analyzed using the Statistical Package for Social Sciences SPSS (version 13.0, Chicago, IL, USA).

To describe personal-social characteristics, sexual function, and help-seeking behaviors, descriptive statistics including mean (standard deviation) and frequency (percentage) were used. Also, to assess the relationship between personal-social characteristics and sexual function, one-way ANOVA test and independent t-test were used, and then to assess adjusted relationships, variables with $P<0.05$ entered general linear model. To determine the relationship between personal-social characteristics and receiving or lack of receiving help, and raw and adjusted relationships, univariate and multivariate logistic regression tests were used.

## Results

Almost half of the men were in the over 28 years old, with mean age 25.6 (4.0) years. About three fourth of men (%73) had been married for 10 months. About half of the participants lived (%48) in their own private houses. More than half of the men (%53) revealed that they did not exercise, and about half of them did exercise irregularly. One third of these men (34%) were manual workers. More than half of the men (54%) had university education. More than half (54%) considered their monthly income about sufficient for living expenses. Close to three fourth of men (72%) did not live with the family. BMI in nearly half of men (45%) was in the range 25-29.9.

The mean of sexual function score was 21.3(2.7) out of possible 5-30, 26% of men suffered sexual dysfunction, with the highest prevalence (27.2%) in arousal dimension, and the lowest (15.7%) in maintaining an erection (Table 1). Only 32% of men had sought help for the treatment of sexual dysfunction, and 40% of them had visited specialists. The main reasons for not receiving help were uncomfortable feeling with doctor, and their belief that doctor is not able to do much, but 65% of men desired to be treated (Table 2).

According to one-way ANOVA analysis and independent t-test, sexual function was found significantly related to age, the type of residence, occupation, exercise, adequacy of monthly income for living expenses, living with family, and BMI ($P<0.05$). According to multivariate general linear model, the variables of residence type , adequacy of monthly income for living expenses, and living with family, with adjustment of other variables, predicted overall score of sexual function ($P<0.05$), and were able to predict 39.4% of sexual function variance in newly married men (Table 3).

Based on the univariate logistic regression, significant relationships were found between receiving help and adequacy of monthly income, exercise, and BMI ($P<0.05$). Also, according to multivariate logistic regression with adjusted other variables, exercise and BMI predicted receiving help ($P<0.05$) (Table 4).

## Discussion

The present study addressed sexual dysfunction and help-seeking behaviors in newly married men. About one fourth of the men (26%) suffered sexual dysfunction, and the most dysfunction was in the dimensions of arousal, orgasm, sexual desire, satisfaction with orgasm, and maintaining an erection, respectively.

In the present study, nearly a quarter of men had sexual dysfunction. Considering that sexual function in sick or infertile men has been studied in Iran, comparing the results of present study with these studies will not be helpful. Thus, the prevalence of dysfunction is compared to the findings of

**Table 1.** Mean (SD) score and the frequency of sexual dysfunction and its dimensions in newly married men (n= 363)

| Variables | Mean (SD)** | N (%)* |
|---|---|---|
| Sexual function | 21.3 (2.7) | 93 (25.6) |
| Dimensions of sexual function | | |
| Sexual desire | 4.4 (0.9) | 76 (20.7) |
| Arousal | 4.2 (0.7) | 89 (23.4) |
| Maintaining an erection | 4.2 (0.7) | 61(15.7) |
| Orgasm | 4.2 (1.0) | 84 (23.0) |
| Satisfaction with orgasm | 4.2 (1.0) | 67(17.2) |

Available overall score ranged 5-30, and scores for each dimension ranged 1-6. Lower scores indicated more favorable conditions.

**Table 2**. Help seeking behaviors in men with Sexual dysfunction

| Variables | N (%)* |
|---|---|
| **Receive help** (n=110) | |
| Yes | 35 (32.1) |
| No | 74 (67.9) |
| **From whom did you receive help?** (n=35) | |
| Specialists | 14 (40) |
| Care providers | 4 (11.4) |
| Psychiatrist | 10 (28.6) |
| Others | 7 (20.0) |
| **Reasons for not receiving help** (n=70) | |
| I feel uncomfortable talking to doctors | 34 (48.6) |
| Doctor cannot do much | 18 (25.7) |
| It will be resolved by itself | 11(15.7) |
| I don't think it is a medical problem | 7 (10.0) |
| **Do you wish to be treated now?** (n=108) | |
| Yes | 70 (64.8) |
| No | 19 (17.6) |
| I'm not sure | 19 (17.6) |

* Number (percent), Because the variables are not answered, valid percent reported.

**Table 3**. The relationship between sexual function with personal-social characteristics in newly married men were based on the general linear model variables (n=363)

| | N** | Unadjusted | | Adjusted | |
|---|---|---|---|---|---|
| | | β (CI 95%)* | P | β (CI 95%)* | P |
| **Age** (Reference: more than 28 years) | 178 | -1.6 (-3.3, 0.02) | 0.053 | -1.5 (-3.2, 0.1) | 0.06 |
| Less than 24 | 72 | 0.4 (-0.9, 1.9) | 0.516 | -0.2 (-1.7, 1.1) | 0.69 |
| 25 to 27 | 113 | | | | |
| **Type of residence** (Reference: Family house) | 38 | 2.2 (0.1, 4.4) | 0.040 | 2.8 (0.3, 5.3) | 0.025 |
| Personal | 168 | 3.6 (1.5, 5.8) | 0.001 | 3.9 (1.4, 6.4) | 0.002 |
| Rented house | 157 | | | | |
| **Occupation** (Reference: other) | 67 | 2.5 (-0.7, 5.9) | 0.130 | 1.4 (-1.8, 4.7) | 0.37 |
| Unemployed | 15 | 3.6 (1.8, 5.4) | <0.001 | 1.6 (-0.2, 3.6) | 0.09 |
| Workers | 21 | 1.8 (-0.7, 3.8) | 0.059 | 1.4 (-0.6, 3.5) | 0.17 |
| Employee | 84 | 0.3 (-1.5, 2.3) | 0.706 | 0.2 (-1.8, 2.1) | 0.90 |
| Shopkeeper | 76 | | | | |
| **Sufficiency of income for expenses** (Reference: Absolutely not) | 96 | -1.9 (-3.8, -0.1) | 0.039 | -0.3 (-2.4, 1.7) | 0.72 |
| Completely | 198 | -2.2 (-3.7, -0.7) | 0.003 | -1.9 (-3.4, -0.3) | 0.015 |
| To some extent | 96 | | | | |
| **Living with family** (Reference: No) | 260 | 4.1 (2.8, 5.4) | <0.001 | 2.7 (1.8, 3.6) | <0.001 |
| Yes | 103 | | | | |
| **Exercise** (Reference: No) | 187 | -1.3 (-2.6, -0.1) | 0.034 | -0.5 (-1.9, 0.8) | 0.20 |
| Yes | 176 | | | | |
| **Body Mass Index** (Reference: 30 and higher) | 115 | -1.7 (-3.5, -0.3) | 0.040 | -1.0 (-2.7, 0.6) | 0.18 |
| 18.5 to 24.9 | 81 | -1.0 (-2.4, 0.4) | 0.142 | -0.2 (-1.7, 1.1) | 0.59 |
| 25 to 29.9 | 164 | | | | |
| Adjusted $R^2$= 39.4 | | | | | |

* (95% confidence interval) , ** Number

**Table 4.** The relationship between demographic characteristics with receiving or not receiving help in newly married men based on logistic regression

| Variables | N** | Unadjusted OR (CI 95%)* | P | Adjusted OR (CI 95%)* | P |
|---|---|---|---|---|---|
| **Sufficiency of income for expenses** (Reference: Absolutely not) | 39 | | | | |
| Completely | 19 | 2.7 (0.6, 12.0) | 0.019 | 3.9 (1.2, 12.7) | 0.171 |
| To some extent | 52 | 1.9 (0.6, 6.1) | 0.847 | 1.1 (0.4, 2.8) | 0.261 |
| **Exercise** (Reference: No) | 64 | | | | |
| Yes | 46 | 3.8 (1.4, 10.4) | 0.002 | 3.7 (1.6, 8.7) | 0.008 |
| **Body Mass Index** (Reference: 30 and higher) | 33 | | | | |
| 18.5 to 24.9 | 23 | 16 (3.5, 72.4) | <0.001 | 16.2(4.2, 61.1) | <0.001 |
| 25 to 29.9 | 54 | 1.3 (0.4, 4.4) | 0.771 | 1.1 (0.3, 3.5) | 0.590 |

*95% (confidence interval) ** Number( Odds ratio)

studies in other countries. In an international study conducted on sexual behaviors and attitudes in 20 countries, 43% of men reported at least one sexual problem.[30] In a study conducted on 3350 men in urban populations of Asian countries (except Japan), over 20% of men complained about at least one sexual problem,[31] which concurs with the results of present study. The prevalence of sexual dysfunction may depend on biological, medical, psychological, cultural-social, economic, racial, health status among countries and interpersonal relationships.[32-36]

In this study, the most important dysfunctions in men included premature ejaculation (24%), and inability to maintain erection (17%). In Moreira Junior et al., study,[35] dysfunctions were premature ejaculation, inability to reach orgasm, maintaining erection, and lack of sexual drive, respectively. In Nicolosi et al.,[31] study, the most common sexual dysfunctions among Asian men were premature ejaculation (20%) and erectile dysfunction (15%), which agrees with the findings of present study.

Perhaps, the similarity in present study and study conducted on urban populations in Asian countries, both in terms of prevalence and type of dysfunction is due to similar biological, cultural, social, and economic status. In a study in Brazil, premature ejaculation (33.3%) was the most common sexual problem in men.[35] In Reza khniha et al., study,[18] premature ejaculation, erectile dysfunction, and sexual desire, respectively, were the most frequent dysfunctions in sick men presenting to urology clinic. With global prevalence of almost 30%, premature ejaculation is probably the most common sexual dysfunction in men, [37] and the results of all above studies confirm this claim. Thus, in routine men's visits, questions should be asked about this problem and appropriate treatment should be administered.

In all societies and religions, sexual desire is a taboo, wrapped in a mist of superstition, and talking about it is accompanied by a sense of shame, embarrassment, fear and guilt. Perhaps, differences in culture, ethnicity, religion, and race, in expressing and dealing with sexual desire, in any country and even in different regions in Iran are possible reasons for diversity in reports.

In the present study, the problem of sexual dysfunction was significantly greater in men living in rented accommodations and inadequate incomes for living expenses.

Addis found a positive and significant relationship between high level of income and increased sexual activity, and satisfaction with sexual activity.[38] In a study by Laumann, people's social status factors such as social, economic, and cultural positions were reported as influential factors in sexual function.[3] In a study by Bayrami et al., sexual dysfunction was

 

associated with dissatisfaction with family income.[39] Reduced household income was generally associated with increased mean risk for increased sexual dysfunction.

Possible reason for this finding could be mental preoccupations with providing for family livelihood causes psychological pressures on the individual, and leads to emotional and mental disintegration of spouses, which can manifest itself as dissatisfaction and poor sexual function.

In the present study, only one third of men (%32) had sought help for the treatment of their sexual dysfunction. In Moreira Junior et al.,[35] study 41.3%, and in GSSAB[32] study 77.8% of men had not sought any help for the treatment of their sexual dysfunction, which somewhat agrees with the findings of present study. In Vahdaninia et al.,[26] study, 64.2% of women had sought medical help for the treatment of this dysfunction. In a study conducted in Brazil, the majority of men had received help from healthcare specialists.[37] Help-seeking is reported differently in different studies, and people's seeking treatment for sexual dysfunction depends on the knowledge of counseling and treatment for these dysfunctions.

In present study, about 40% of men had visited specialists for treatment of their sexual dysfunction and 28.6% had visited psychiatrists. In a study in China, conducted on 2577 men aged 25-70 years with erectile dysfunction, the most common counseling source for receiving information about sexual dysfunction was the doctors (54%).[21] In Moreira Junior et al.,[35] study, 21.2% received counseling from GPs, and in GSSAB[32] study, 42.3% received help from sexual partner, 18% from GPs, and 2%-12% sought psychological help (psychiatrist, psychologist, and marriage counselors) for treatment of their sexual dysfunction, which disagree with the results of present study. These differences can probably be attributed to cultural differences.

In the present study, the reasons given for not seeking help were "I feel uncomfortable talking to doctors" by almost half men (%49), "doctors are not able to do much" (26%) and, "it will be resolved by itself" (16%). In Moreira Junior et al.,[35] study, the most important reasons for not receiving help were "It does not bother me", "I don't think it is serious, or expect it will resolve on its own", "I feel uncomfortable talking to doctors", "I don't think it is a medical problem, or doctors cannot do much", and "I don't have access to medical care" respectively, which somewhat agree with the present study. In Europe and other countries, doctors rarely ask about their patients' sexual health, even if they are so willingness.[30,35] Unwillingness to start conversation about sexual health can impede establishment of patient-doctor relationship, and this may be due to embarrassment, lack of knowledge, or indirect presentation of disease;[40] furthermore, because of lack of proper training about sexual dysfunction, doctors have difficulties in management and treatment of these problems.[41]

Exercise and normal BMI were among predictors of seeking help. Physical activity plays an important role as a disease prevention and controls behavior and promotes health in people and groups.[41] Therefore, perhaps the reason for receiving help for sexual dysfunction in those who exercise and those with normal BMI can be attributed to the fact that these people attach greater importance to preventive behaviors.

## Conclusion

In this study, sexual dysfunction was relatively common, and most men had not sought help for their sexual problems. The most frequent reasons given for not seeking help were feeling uncomfortable with care, and their belief that doctors are not able to do much. Since sexual dysfunction have

destructive effects on the quality of life and marital relationships, and increases the likelihood of a divorce, it seems necessary to provide related services to sexual problems, and screen for sexual problems in men in appropriate centers, and to provide help where there is a dysfunction.

## Acknowledgments

This study was approved by Tabriz University of Medical Sciences (code No: 91231). We would like to express our sincere gratitude to all personnel at premarital counseling centers in Sari. We send our deep appreciation to all participants in this study.

## Ethical issues

None to be declared.

## Conflict of interest

The authors declare no conflict of interest in this study.

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