Original Article

Comparison of Sexual Dysfunctions Among Employed Women and Housewives Attending's to Tabriz Counseling Crescent Center, Iran

Ahmad Esmaili[1] ***Leili Amirsardari[2]** Bahjat Ansary[3]

1- Department of Psychology, School of Literature, University of Maragheh, Maragheh, Iran
2- Young Researchers and Elite Club, Central Tehran Branch, Islamic Azad University, Tehran, Iran
3- Department of Psychology, Science and Research Branch, Islamic Azad University, West Azarbayjan, Urmia, Iran

l.amirsardari@yahoo.com

(Received: 27 Apr 2014; Revised: 11 Oct 2014; Accepted: 11 Dec 2014)

Abstract

Background and Purpose: Women with perfect physical, mental and emotional health are robust foundations of healthy family life combined with felicity. Suppress the innate and God-given needs, has undesirable consequences on intimacy and vitality of family members. Therefore, the aim of this study is evaluating and comparing sexual dysfunction of employed women and housewives. Finding the issue that whether there are differences between both groups, and if there is, which of these measures it includes. It is what the study is conducted to achieve.

Materials and Methods: The method of this study is descriptive-comparative, that in which 50 person from employed women were select and compared with 50 housewives based on the examination of female sexual function index (FSFI). MANOVA analyses were used for analysis data.

Results: The results of the analysis showed that measures of FSFI such as the desire, orgasm and sexual satisfaction have a significant difference with housewife's group.

Conclusion: On the basis of findings, it could be said that unlike employed women, housewives suffered from sexual dysfunctions and these disorders can lead to marital dissatisfaction in the life.

*[Ahmad Esmaili A, *Amirsardari L, Ansary B. **Comparison of Sexual Dysfunctions Among Employed Women and Housewives Attending's to Tabriz Counseling Crescent Center, Iran.** IJHS 2014; 2(4): 46-51] http://jhs.mazums.ac.ir*

***Key words*:** Sexual dysfunction, Sexual satisfaction, Employed women

1. Introduction

Identification and study the human sexuality behavior, considered as one of an important public health issues, especially for mental health. Sexual desires are accounted as innermost feelings and deepest heart wishes of human in giving meaning to the relationship. Sexual needs, not only in line with other human physiological needs as thirst, hunger and the need for air and sleep, but also considered in spiritual and mystical needs domain such as needs for beauty and perfection. Although, sex is a global and the international concept, but has no absolute and single interpretation (1). World Health Organization, recognized sexual health as an integration coordination between mind, emotion and body, which leads the social and intellectual aspects of human in the way of promoting character that leads to making relation and love. Hence, any disorder leading to imbalance and lack of sexual satisfaction, can be associated with sexual dysfunction. Sexual dysfunction is defined as a disorder of desire, arousal, orgasm, moisture and sexual pain that caused by multiple factors as anatomical, physiological, medical and psychological ones, which could cause severe discomfort and put effects on quality of life and interpersonal relationships (2). Sexual dysfunction may be caused by physical and psychological factors; in cases that there is a physical reason for sexual disorders, psychological factors may have a secondary role in complicating situations and can lead to difficulty with sexual response and dysfunctions of sexual response. Result about sexual dysfunction shows that sexual dysfunctions have a close relationship with social problems such as offenses, sexual abuse, and mental illness and divorce (3). Based on a national survey, 31.5% of women are with sexual dysfunction. Although this rate is lower than some other countries, but indicates a sexual dysfunction as widespread public health problem in Iranian women. Age, early marriage, wife's financial dependency, low education level, less physical activity and multiple births, are considered as a several risk factors that increase its incidence (4). Furthermore, nervousness, lower abdominal pain and back pain, disability in mental focus and even inability to perform daily activities as well as other consequences of the failure in satisfying the sexual instinct; while the optimal sexual performance is a factor for strengthening family and a basis for obtaining and stabilizing a stable culture (5). Perhaps, there were couples with sexual dysfunction who are unaware of their impact on marital life and its role in creating poor relation, low self-esteem and depression for own and their husbands (6). In a research conducted to evaluate the prevalence of female sexual dysfunction and its potential risks on 176 Turk women age group of 18-66, 49.9 of cases with sexual dysfunctions, the prevalence of female sexual dysfunction include disorders of desire, arousal, moisten vagina, orgasm, satisfaction and sexual pain disorders increase with age, and factors such as low education, unemployment status, chronic disease, multiple pregnancy and menopausal status were important risk factors (5). In a research which conducted by women with age group of 20-60 of all provinces of the country, results of sexual dysfunction prevalence separately achieved for sexual desire, lack of sexual arousal, not meeting the orgasm and pain during intercourse were 35, 30, 37 and 26 percent, respectively (4). In a study, aging considered as a risk factor of experience lower desire and not reaching orgasm, and lower education reported as risk factor of decreased desire, not reaching orgasm and pain during intercourse (7). Meanwhile, it seems that employed women, experienced sexual problems due to abundant problems and gets more into trouble. Two-career families are the largest group of non-traditional families.

In these families, both wife and husband have their own job and govern their common life from joint incomes. This pattern is completely inconsistent with traditional families, in which a husband charged as a home breadwinner and woman merely deals with housekeeping. Some researches show that family structure by employing wife and husband in some areas caused a gender roles become ambiguous. Also, some studies proposed contrary results (8). Sexual satisfaction and its importance on marriage stability (9). Researchers and practitioners in the marital problems considered the quality of the sexual bond of wife and husband as the most important detrimental for sexual satisfaction. In fact, the satisfaction from sexual connection helps to maintain a stable marriage. Some researchers in a study concluded that for employed women and their partners, the highest satisfaction achieved from satisfaction of friends and relatives networks, communication and financial issues, and the lowest gain from satisfaction of leisure time, sexual, personal and religious issues. Moreover in housewives and their husbands, the highest satisfactory is satisfaction from childrearing, sexuality, network of friends and relatives and the lowest from personal and religious issues (10). By considering that the cause of most psychological distress and marital discords is an sexual dissatisfaction, and many years of sexual neglecting in human left an uncompensated complications in social and marital relations and breakdown family foundations, measures of intercourse is necessary for the promotion of sexual health, and it seems that long-term neglect of sexual instinct in humans lead to sexual dysfunction and lack of sexual satisfaction of couples that cause to breakdown family foundations. So, the main aim of the current research is to compare the sexual dysfunction of employed women and housewives.

2. Materials and Methods

The current research design is a descriptive-comparative one based on the nature and intended purposes. The research population consisted of all employed and unemployed women. Regarding this issue, the sample selected from employed women and housewives that attended to counseling center's Red Crescent during 5 months as an available method. These patients were referred to our center with marital problems. Employed women must official workers in one of the organs of government and housewives should not work anywhere out of home. In regard of matching of groups tried to place women with marital problems in this study. First, a clinical interview was conducted by a psychologist, and then participations were asked to complete the female sexual function index questionnaire. Given that most patients were not present to provide demographic information and hence based on ethical issues, not willing to provide this information. Data collection tools include performance index questionnaire of women. This questionnaire measures female sexual function in 6 scales of tendency, mental arousal, moisture, orgasm, satisfaction and pain consisted of 2, 3, 4, 3, 3 and 3 questions, respectively, which has good validity and reliability, and in Iran, Validity of current questionnaire is 82% (11). Analysis stability was calculated by questions of stability analysis or internal consistency coefficient. Furthermore, with respect to maximum true positive and true negative, cut score of Persian version achieved 28 or lesser, that on this base, 0.82 of patients with sexual dysfunction and 0.82 of them healthy people that classified correctly. Cronbach's alpha coefficient for each domains and all scales were 0.70 and higher, that consistent (0.89); (0.74) and (0.80) (12-14). Provides data were analyzed using SPSS for Windows (version 13.5, SPSS Inc., Chicago, IL, USA) using MANOVA analysis of variance.

3. Results

Available sampling method was used for a select sample, in a way that the client who was attained to this center during 5 months were tested, and classification criteria is employed women and housewives. About the results we could say that, however, the research sample should be ones that attained to counseling center and faced with a shortage of samples, but in most researches, this sample size is adequate, and should be caution in generalizing the results.

Table 1 presents descriptive data related to sexual dysfunction of both employed women and housewives. As can be seen the mean of sexual function for employed women in all scales are higher than housewives.

The results of the analysis are presented in table 2. As can be observed, F value for all variables (desire, orgasm, satisfaction) is significant.

So, it could be said that housewives showed higher rates of sexual dysfunction such as the desire, orgasm, and sexual satisfaction than employed.

Table 1. Descriptive data related to sexual performance of employed women and housewives

Group	Sexual performance	Mean	Standard deviation
Housewives	Desire	5.70	1.99
	Arousal	10.30	5.31
	Orgasm	8.84	4.04
	Satisfaction	9.92	4.66
	Pain	7.92	4.72
	Moisture	11.06	5.24
Employed women	Desire	6.94	1.60
	Arousal	12.06	4.94
	Orgasm	10.64	3.65
	Satisfaction	12.28	4.19
	Pain	8.88	4.47
	Moisture	12.74	4.53

Table 2. Results of ANOVA for female sexual function scales of employed and unemployed women

Source	Scale	Sum of squares	df	Mean of squares	F	Significant level
Group	Desire	38.44	1	38.44	11.75	0.001
	Arousal	77.44	1	77.44	2.94	0.089
	Orgasm	81.00	1	81.00	5.46	0.022
	Satisfaction	139.24	1	139.24	9.38	0.009
	Pain	23.04	1	23.04	1.08	0.300
	Moisture	70.56	1	70.56	2.93	0.090
Error	Desire	321.32	98	3.27		
	Arousal	2579.32	98	26.32		
	Orgasm	145424	98	14.83		
	Satisfaction	1931.76	98	19.71		
	Pain	2078.96	98	21.21		
	Moisture	2352.44	98	24.004		
Total	Desire	4354.00	100			
	Arousal	15156.00	100			
	Orgasm	11022.00	100			
	Satisfaction	1439200	100			
	Pain	9158.00	100			
	Moisture	16584.00	100			

df: Degrees of freedom

4. Discussion

This study was conducted to compare the sexual dysfunction of employed women and housewives. It is an issue that can affect marital life and played a vital role in marital satisfaction. Results showed that there is a difference between employed women and housewives for sexual dysfunction scales. In a detailed investigation revealed that it includes the differences in the scales of desire, orgasm and sexual satisfaction. This difference is not shown for scales of arousal, pain and moisture. Higher grade of employed women for desired scale could be explained in a way that these individuals enjoy their marriage because of themselves employment and feel of financial security. Of course, this is a time when employed women were satisfied with their job and feel better for their husband and children (15). Also, employed women could have a better link with their husbands with having experience and interpersonal skills that can be gained from working. And these issues meant that they are not discouraged from desire, but more willingly turn to sexual relationships in marital life. This result is consistent with results of Mousavi (15), Goldenberg and Goldenberg (16), and inconsistent with results of Sadegh Moghadam et al. (10). In relation to the scale of orgasm, it is normal that individuals with dysfunction of desire have a problem in reaching orgasm during intercourse. Furthermore, the study results of investigating sexual dysfunction and psychological status in women showed that individuals with complaining lack of sexual desire attended to clinics that also with orgasm dysfunctions (17). In regard of sexual satisfaction scale, results indicate that there is a significant relationship between sexual satisfaction and dysfunction of sexual performance, so that 90% of women who were not satisfied with their sexual relationships have a one form of sexual dysfunctional performance. In this research, employed woman had a higher satisfaction than housewives, which also have a positive effect on other sexual performances and showed better performance in other scales. Overall, since a sexual dysfunction performance have undeniable role on quality of life and self-confidence in marital life of couples, inability to making a healthy and enjoyable relationship with partner, could have physical, mental and even social consequences for woman and her husband. According to results of various studies that reports higher prevalence of these disorders in women, especially housewives, these disorders should free from unreasonable prejudices and also considered practically and consistently with culture and admission of patients. Sex education, therefore, have a vital role in family health, reduce sexual violence in the family, attitudes toward sexuality, sexual pleasure, reduce incompatibility in family and achieving enjoyable experience for couples. So, family and individual health, followed by community health. Finally, researches have shown that people, who are satisfied with their jobs, have higher marital satisfaction. Accordingly, it is necessary to implement appropriate expertise that allows a woman to base appropriately their experience and interest having higher job satisfaction and also marital satisfaction and consequently have higher sexual satisfaction. However, current life events, such as marital relationship, impact on knowledge, attitudes, and beliefs of the person, and in this way affect our interpretations of events. In general, it is assumed that, interaction between cognitive and biological factors in determining desire, arousal and orgasm for individuals and couples should carefully studied. Due to the small sample size, generalizing results to community of employed and unemployed women should be carefully controlled. Also considering the fact that patients refused to give demographic

information and lack of early complaining of patients from sexual dysfunctions cause difficulties with results of demographic and other variables. Also, due to cultural factors, subjects were not simply giving more information. It is recommended that similar research is carried out in other cities with larger sample sizes. According to several studies reported a high prevalence of these disorders, these disorders should free from unreasonable prejudices and be considered practically and consistently with culture and admission of patients.

Acknowledgement

Thereby we sincerely thanks from employed colleagues in Tabriz Crescent Counseling Center in preparation for the implementation of this research.

References

1. Ouhadi B. Violations and sexual behaviors. Isfahan, Iran: Atropat Publiactions; 2001. p. 13-8. [In Persian]
2. Bernhard LA. Sexuality and sexual health care for women. Clin Obstet Gynecol 2002; 45(4): 1089-98.
3. Mehrabi F, Dadfar M. The role of psychological factors in sexual functional disorders. Iran J Psychiatry Clin Psychol 2003; 9(1): 4-11. [In Persian]
4. Safarinejad MR. Female sexual dysfunction in a population-based study in Iran: prevalence and associated risk factors. Int J Impot Res 2006; 18(4): 382-95.
5. Cayan S, Akbay E, Bozlu M, Canpolat B, Acar D, Ulusoy E. The prevalence of female sexual dysfunction and potential risk factors that may impair sexual function in Turkish women. Urol Int 2004; 72(1): 52-7.
6. Bolourian Z, Ganjloo J. Evaluating sexual dysfunction and some related factors in women attending Sabzevar Health Care Centers. J Reprod Fertil 2007; 8(2): 163-70.
7. Abdo CH, Oliveira WM, Jr., Moreira ED, Jr., Fittipaldi JA. Prevalence of sexual dysfunctions and correlated conditions in a sample of Brazilian women--results of the Brazilian study on sexual behavior (BSSB). Int J Impot Res 2004; 16(2): 160-6.
8. Long LL, Young ME. Counseling and therapy for couples. Boston, MA: Cengage Learning; 2006.
9. Crowe MJ. Indications for family, marital and psychosexual therapy. In: Falloon IRH, editor. Handbook of behavioral family therapy. New York, NY: The Guilforad Press; 1988. p. 51-77.
10. Sadegh Moghadam L, Askari F, Marouzi P, Shams H, Tahmasbi S. Comparison of marriage satisfaction in housewives and employed women and their husbands in Gonabad. Horizon Med Sci 2006; 12(2): 45-50.
11. Mohammadi Kh, Heydari M, Faghihzadeh S. The female sexual function index (FSFI): validation of the Iranian version. Payesh Health Monit 2008; 7(3): 269-78.
12. Rosen R, Brown C, Heiman J, Leiblum S, Meston C, Shabsigh R, et al. The Female Sexual Function Index (FSFI): a multidimensional self-report instrument for the assessment of female sexual function. J Sex Marital Ther 2000; 26(2): 191-208.
13. Meston CM. Validation of the Female Sexual Function Index (FSFI) in women with female orgasmic disorder and in women with hypoactive sexual desire disorder. J Sex Marital Ther 2003; 29(1): 39-46.
14. Wiegel M, Meston C, Rosen R. The female sexual function index (FSFI): cross-validation and development of clinical cutoff scores. J Sex Marital Ther 2005; 31(1): 1-20.
15. Mousavi AS. Marital satisfaction among employed and house-wife women. Women's Studies 2006; 4(2): 71-88. [In Persian]
16. Goldenberg H, Goldenberg I. Family therapy: an overview. 4th ed. Pacific Grove, CA: Brook/Cole; 2007.
17. Azar M, Iranpoor Ch, Noohi S. Sexual dysfunction relationship with psychiatric disorders in women. Iran J Psychiatry Clin Psychol 2003; 9(2): 22-9. [In Persian]