Age as a Factor of Psychosexual Dysfunction and Marital Dissatisfaction among Heterosexual Married Individuals

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Abstract

This study was carried out to assess whether age will influence marital dissatisfaction and psychosexual dysfunction among heterosexual married individuals in Ado Ekiti metropolis. A total number of 453 [(male = 188, Female = 265) participants with age range between 23 and 65 years] participated in the study using purposive sampling method. These participants completed a questionnaire that consists of the Golombok Rust Invention of Sexual Satisfaction (GRISS) by Golombok and Rust (1986), Index of Marital Satisfaction (IMS) by Hudson (1982). The results of data analyses indicated that age did not influence marital satisfaction and psychosexual dysfunction among males and females. Recommendation was made in this study that a regular psycho-education in form of marriage seminars should be periodically sponsored by government and nongovernmental organisations for the elderly married people with a view to addressing various problems that are capable of reducing active sexual activities of the aged people.

Keywords: Age, Psychosexual dysfunction, Marital dissatisfaction, Heterosexual married individuals

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Introduction

Sexual intercourse tends to reduce in frequency the longer a couple stayed in marriage; unlike what they experienced when they were newly married. As couples get older, the frequency reduces. The decreased frequency however does not necessarily indicate that sex is no longer considered important or that the marriage is unsatisfactory (Blumstein and Schwartz 2000). However, it is argued that the reason for the decline may be as a result of biological/physical aging and decline in sexual drive. The reason may also be an indication that one or both partners are too tired or a result of intense domestic chores, fatigue or lack of private time to rest. Blumstein and Schwartz (2000) found that most people attributed the decline in frequency of sexual intercourse to lack of time or physical energy or to being accustomed to each other. In addition, other activities and interest engage them besides sex.

Most married couples do not seem to feel that declining frequency in sexual intimacy is a major problem of their overall relationship (Cupach & Comstock, 1990; Sprecher & Mckinnery, 1993). Sexual intercourse is only one erotic bond among many of the sexual intimacy variables in marriage enhanced by kisses, caresses, massage, curdling, intimate words and many others. Sexual intimacy involves sexual intercourse and it is most vital for marital satisfaction.

Ageing has also been considered as a factor of sexual intimacy and marital satisfaction. As people grow older, physical changes begin to occur as well as changes in emotional responses. However, sexual feelings and desires continue throughout the life cycle (Wenzell, 2013; Kingsberg, 2002). As older men and women's physical abilities change with age, their sexual responses changes as well. For example, 70 years old is seen as though, still sexual, but not sexual in the same manner as an 18 years old. As men and women continue to age, their sexuality tends to be more diffused, less genitally oriented, and less insistent (Jacoby, 1999). Also, men and women view aging differently. For example, at about fifty years, men generally fear the loss of their capacity but not the attractiveness; but women at that age generally fear the loss of their attractiveness but not their sexuality.

The place of culture in sexual expression and marital satisfaction has equally been explored. Sexual expression, in some culture (e.g. United

States), was viewed as the activity of the young and newly married. Ford and Beach (1951) discovered that there appear to be only two characteristics that women and men universally consider important in terms of sexual attractiveness: youthfulness and good health. But this view was not universally accepted based on some cross-cultural studies that show that sexual activities are not only accepted but expected among the aging in many countries. It is therefore important for old people to understand that slower responses are a normal function of aging and are unrelated to the ability to give and receive sexual pleasure (Mulligan, Retchin, Chinhilli, & Bettinger, 1988; Whitbourne, 1990). "The senior penis" can still give and take pleasure, even though it is not the same as was decades ago (Zilberggeld, 1999).

Another study on sexuality and aging in USA, sponsored by the American Association of Retired People and conducted by Modern Maturity in 1999 found that 45% of aged people were extremely satisfied with their sex lives. Most of the respondents declared that a satisfactory sexual relationship was an important factor to the quality of life, while poor health and lack of an available partner contributed, in part, to a decreased frequency of sex as age increases (Jacoby 1999). Age related changes in women include thinning of the pubic hair, shrinkage of the labia, thinning of the vagina mucosa and laxity of the perinea muscle. The thinning of vagina mucosa and the reduced lubrication may lead to dyspareunia and bleeding during intercourse. Orgasmic contractions may also become painful.

Ageism prevails in most Western societies where social attitudes and beliefs that consider sexual behaviours as inappropriate, repugnant or abnormal in old age will contribute to the curtailment of such behaviour. Older people have a difficult task in coming to term with the decline in physical attributes, sexual potency and attractiveness. They therefore adopt negative attitude towards their sexuality. Unfortunately however, because the society tends to desexualise the old, aging people may interpret their slower responses as sign of the end of their sexuality, but appropriate educational programme on sexuality may assist in dispelling the myths about the old people and sexual potency and build their confidence as well as encourage them to be more sexually active (Goldman & Caroll, 1990; Kellett, 1991).

Declines in self-rated marital quality appear to be a stable response to the first year or two of marriage (Markman, Benick, Floyd, Stanley & Clements, 1993; Markman, 1992). For some couples, this decline is dramatic because about one third of divorces occur within the first four years of marriage. Not surprisingly, the ways that spouses relate to each other influences marital satisfaction. Therefore, in the early stages of marriage, negative interactions appear to influence subsequent marital satisfaction, rather than the reverse. For example, dating couples' evaluations of their partners' communications were not related to initial relationship satisfaction, but did predict subsequent ratings of marital quality, a process Markman (1992) labelled a "sleeper effect." Similarly, it was found that interpersonal patterns (particularly conflict) were best predictors of changes in newly wedded couples' feelings about their relationship two years later, rather than vice versa, and these associations were stronger for wives than for husbands.

One study suggested that declines in marital quality might have physiological correlates. Among 19 married couples who had been selected on the basis of high or low scores on a measure of marital satisfaction, greater autonomic "linkage" at the initial assessment was associated with larger declines in marital satisfaction three years later (Gottman & Levenson, 1985).

Also, convergent evidence from psychosocial and immunological domains suggests that the links between marital discord and immunity could be stronger and could have more potent health consequences for older adults than younger adults. The number of relationships diminishes as people age, and the quality of close relationships becomes more salient. Consequently, troubled marital relationships could have a greater impact on older adults because of their smaller social network.

The prevalence of male erectile disorder has been said to increase with more than twice as many men aged 50-59 years were reporting problems with erection as against men aged 18-29. This finding was reported by Nicolosi, Moreiba, Shirai, Bin Mohd Tambi and Glasser (2003) in a study sponsored by Viagra Maker Pfizer in which, 2,400 men (600 each in four countries) found male erectile disorder to be a problem worldwide in response to a standardised questionnaire. That is, 34% of men in Japan, 22% in

Malaysia, 17% in Italy and 15% in Brazil were either never or only some time able to maintain an erection. Erectile difficulties increased with age, affecting 9% of men aged 40-44 years and 54% of those aged 65-70 years. Male erectile disorder are not exclusively the result of aging since other disease conditions, such as hypertension, diabetic mellitus, heart disease, and certain medications, such as cardiac drugs, anti-hypertensive drugs; cigarettes smoking, excessive alcohol consumption; suppression and expression of anger; and depression, are all contributing factors. (Feldman; Goldstein; Hatzicchristou; Krane; & Mclinlay; 1994).

However, the diagnosis of male erectile disorder is usually psychologically based. It has been observed that men who have erection while sleeping or masturbating obviously are physically able to have erection. This indicates that an erectile disorder during heterosexual intercourses has a psychological origin. The DSM-IV-TR states that male, erectile disorder is typically diagnosed only when the man or his partner is dissatisfied and distressed by the occurrence (Schwaitz; 2000).

The specific objective of this study is to find out the influence of age on psychosexual dysfunction and marital dissatisfaction among heterosexual married individuals.

Methods

Participants

Data were collected from heterosexually married individuals comprising people from different ethnic background residence in Ado-Ekiti metropolis, Nigeria. They are 453 participants who had been married for a minimum period of two years. They are made up of individuals not less than 23 years of age with the minimum academic qualification of Senior Secondary School Certificate (SSSC) who assumed to be able to read, write, and understand simple English Language.

The sample was based on the data of the registered statutory marriages in Ado-Ekiti Local Government Marriage Registry from year 2013 to 2016. They comprise of 188 males (41%), and 265 females (58.5%), with the maximum age of 65 and with the average age of 40 years. 401 (88.5%) are Yoruba; 30 (6.6%) are Igbo; 9 (2.0%) are Hausa and 13 (2.9%) are from other minority ethnic groups. Also, 405 (89.4%) are Christians; 43 (9.5%) are Muslims, while 5 (1.1%) are Traditional religious worshippers. Those

who had Senior Secondary School Certificate education are 23 (5.1%); NCE/OND are 143 (32.6%); HND/BSc and above are 244 (53.9%), while others with various professional qualifications are 43 (9.5%). Only 6 (1.3%) are those who did not indicate their level of education.

A total of 1,239 officially registered couples were obtained from the marriage registry Ado-Ekiti metropolis as at the time of the study.

To arrive at the minimum sample for the study, the Yamane (1967) formula was used. It is the formulae for obtaining the minimum sample size based on estimation of the study population. The formula is:

$$n = \frac{N}{1+(N(e)^2}$$

Where "n" is the sample size, "N" is the population size, and "e" is the level of precision. The commonly acceptable precision level (or statistically significant level) in the behavioural sciences is 0.05. Thus, 0.05 is used as the precision level in present study.

Therefore, for this study,

$$n = \frac{1,239}{1+1239(0.05)^2}$$

$$n = \frac{1239}{1+1239(0.0025)}$$

$$= \frac{1239}{1+3.0975}$$

$$= \frac{1239}{4 . 0975}$$

$$= 302.38$$

Appx. 302. Therefore, the minimum participants that can be used in the study is 302. However, 453 participants were sampled.

Instrument and Procedure

Each participant was administered a questionnaire that comprises two psychological instruments. The first is the Sexual Dysfunction Scale named Golombok Rust Inventory of Sexual Satisfaction (GRISS). It is a 28 items questionnaire developed by Golombok and Rust (1986) for the assessment of sexual dysfunction among heterosexual couples. The GRISS is used by relationship counsellor and clinics to identify and monitor sexual problems. It has been used in clinical trials of new treatment approaches and pharmacological products designed for the treatment of sexual dysfunction globally. It has two versions, one for male and one for the female partner.

The female version produces a total GRISS female score as well as subscales. The male version produces a total GRISS male score as well as subscales.

The 28 items on a simple sheet is used for the assessment of the existence and extent of severity of sexual dysfunction in heterosexual couples who are currently together in marriage. All the 28 questions are answered on a five point (Likert type) scale from "Never," "Hardly ever," "Occasionally," "Usually," and "Always." Option number one, "never" carries 1 mark; "hardly ever" caries 2 marks; "occasionally" carries 3 marks; "'usually" carries 4 marks, and "always" carries 5 marks.

It provides overall scores for men and women separately of the quality of sexual functioning within a relationship. For men, the subscale consists of impotence, premature ejaculation, infrequency, male dissatisfaction, male non-sensuality, and male avoidance of sexual activity. The women subscale consists of anorgasmia, vaginismus, non-communication, infrequency, female non-sensuality, female dissatisfaction, and female avoidance which represent the sexual profile of each participant. Each scale has both direct and reversed scoring method. For the men, the direct scoring was applicable for item numbers: 2, 3, 5, 6, 7, 9, 10, 11, 14, 17, 20, 22, 23, 24, 26, 27 and 28; for the women, the direct scoring was applicable for item numbers: 1, 3, 6, 7, 12, 13, 14, 16, 18, 20, 22, 23, 24, 25 and 28. Other items numbers are reverse scored for males and females as applicable.

Responses are summed up to give a total raw score ranging from 28 to 140 in the global scores. The total score and subscale score are transformed using a standard nine point scale, with scores higher than 49.00 indicate

sexual dysfunction. The reliability of the overall scale has been found to be 0.94 for men, 0.87 for women and that of the subscale, on average 0.74 (ranging between 0.61 and 0.83).

The second instrument is the Index of Marital Satisfaction (IMS) developed by Hudson (1982). Hudson provided original psychometric property for American samples while Anene (1994) provided the properties for Nigerian sample. It is a 25 item inventory, designed to measure the degree, severity or magnitude of the problems one spouse or partner perceives to be having in the marital relationship with his or her partner.

The focus is on current problems which have reduced marital satisfaction. IMS is administered individually or in groups. It has direct and reverse scoring methods. The direct scoring is by adding together the values of the numbers shaded in the relevant items, while the reverse scoring is by adding together the reversed value of the numbers shaded in the relevant item. The direct scoring was applicable for item numbers: 2, 4, 6, 7, 10, 12, 14, 15, 18, 22, 24 and 25 while reversed scoring was applicable for items numbers: 1, 3, 5, 8, 9, 11, 13, 16, 17, 19, 20, 21, and 23. The final scoring is by adding together the result of the direct scores and reverse scores to obtain the client's raw score. Then subtract 25 from the raw score to obtain the client's final score.

The norms for Nigerian samples are:

a. Young Adult M & F (n=25): 38.84
b. Middle age M & F (n=25): 27.65
c. Old age M & F (n=25): 15.36
d. Males only (n=80): 28.09
e. Females only (n=80): 31.28

It has the Cronbaach alpha internal consistency of .96. The concurrent validity coefficient of .48 was obtained by Anene (1994) by correlating IMS with Marital Stress Inventory (MSI) (Omoluabi, 1994).

The Nigerian norms or mean score was the basis for interpreting the scores of clients in this study. Scores higher than the norms indicate poor or problematic marital satisfaction while scores lower than the norms indicate normal or adequate marital satisfaction.

The questionnaires were administered to the participants in their places of work and business offices. Necessary rapport was established with the participants. The purpose and relevance of the study were succinctly discussed while the consent of those who were included in the study were sought. The willing participants were given the instrument together with necessary materials such as biro and pencil in an envelope. They were enjoined to feel free and be truthful in their responses. They were also assured of the confidentiality of their identity and their responses.

Copies of the questionnaire were distributed by personal contact and also retrieved by personal contact. A total of 800 questionnaires were administered, but only 690 were returned out of which only 453 were correctly responded to. 137 questionnaires were disqualified based on errors ranging from non-completion of items, incomplete pages and noncompliance with instructions given.

Table 1: Demographic Profile of Participants

Variable	Label	N	Percentage%	Grand Total
Sex	Male	188	41%	
Age	Female	265	58.5%	453
	Minimum (23)		Average	
	Maximum (65)	453	40	453
Ethnicity	Yoruba	401	88.5%	
	Igbo	30	6.6%	
	Hausa	9	2.0%	
	Others	13	2.9%	453
Religion	Christianity	405	89.4%	
	Islam	43	9.5%	
	Traditional	5	1.1%	453
Education	SSS	23	5.1%	
	NCE/OND	143	31.6%	
	HND/BSC	244	53.9%	
	OTHER	43	9.5%	
	Missing system	6	1.3%	453

Results

Table 2a: Independent t-test table showing the influence of age on psychosexual dysfunction and marital dissatisfaction among males

DV	Age	N	M	SD	df	t	P
Marital satisfaction	Above 40yrs	81	94.2346	18.49	186	-1.18	> .05
	Below 40yrs	107	97.2897	16.80			
Sexual dysfunction	Above 40yrs	81	56.0370	11.40	186	1.38	> .05
	Below 40yrs	107	53.7196	11.44			

From the table above, it showed that age did not influence psychosexual dysfunction [t(186)=1.38,p>.05] and marital dissatisfaction [t(186)=.18 ,p>.05] among males

Table 2b: Independent t-test table showing the influence of age on psychosexual dysfunction and marital dissatisfaction among females

DV	AGE	N	M	SD	df	T	P
Marital dissatisfaction	Above 40yrs	135	90.0889	18.55	263	-1.87	> . 05
	Below 40yrs	130	94.5462	20.34			
Sexual dysfunction	Above 40yrs	135	45.5185	10.05	263	.90	> . 05
	Below 40yrs	130	44.3615	10.94			

From the table above, it is revealed that age did not influence psychosexual dysfunction [t(263)=.90,p>.05] and marital dissatisfaction [t(263)=- 1.87, p>.05] among females.

Discussion

Results from the study indicated that age did not significantly influence psychosexual dysfunction as well as marital satisfaction among males and females. According to Zilberggeld (1999), older people have a difficult task in coming to term with the decline in physical attributes, sexual potency and attractiveness and consequently may therefore adopt negative attitudes towards their sexuality. But due to the enlightenment about sexual freedom and sexuality matters in most Western societies and which the modern technology has extended to the developing societies, the aged people may no longer suffer sexual inhibitions as in the past eras when technological

advancement in communication system was not as easily accessible as it is nowadays.

There are evidences from psychosexual and immunological domains which suggest that the links between marital discord and immunity could be stronger and could have more potent health consequences for older adults than younger adults. This according to Whitbourne (1990) suggests that the number of marital relationships diminish as people age. This implies that, age and stress may interact to promote immune down-regulation which may lead to depression in older adult than young adult (Mulligan *et. al.* 1988) and consequently impair psychosexual functioning; but the development in medical profession and the expansion of knowledge in the field of counselling and psychotherapy seem to have made it possible for people of different age to achieve both physical and mental balance, through which their sexual and marital lives could be improved.

Conclusion

This study has obviously been able to achieve its objectives based upon the research design and data collected for the purpose. Age was discovered not to have a significant influence on psychosexual dysfunction and marital dissatisfaction among males and females.

Recommendations

The following recommendation is therefore made for further studies. A regular psycho-education in form of marriage seminars should be sponsored by well-meaning governmental and non-governmental organisations with a view to addressing various problems that are capable of reducing active sexual life of the aged people and which may also destroy the marital homes and consequently producing children from broken homes with their attendant consequences of destroying the larger society.

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