MENTAL HEALTH FACTORS THAT MAY CONTRIBUTE TO SEXUAL FUNCTIONING

A Thesis
by

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Submitted to the Graduate School of the
University of Texas-Pan American
In partial fulfillment of the requirements for the degree of

MASTER OF ARTS

August 2012

Major Subject: Clinical Psychology

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ABSTRACT

Cano, Monique M.T., Mental Health Factors That May Contribute to Sexual Functioning. Master of Arts (MA), August, 2012, 35 pp., 4 tables, references, 24 titles.

The present study investigated the relationship between mental health factors—depression, dysfunctional eating habits, and sexual abuse trauma—and sexual dysfunction. Sexual dysfunction was measured with The Sexual History Form (Nowinski & LoPiccolo, 1979 as cited in Davis, Yarber, Bauserman, Schreer, & Davis, 1998), a self report questionnaire. Depression was measured with the Center for Epidemiologic Studies Depression Scale (CES-D Scale) (Radloff, 1977). Dysfunctional eating habits were measured by the Eating Disorder Examination Questionnaire (EDE-Q 6.0) (Fairburn & Beglin, 2008). Sexual abuse trauma was measured by a subtest—the Sexual Experiences Short Form Version Victimization—of the Sexual Experiences Survey (Koss et al., 2006).

A regression analysis was utilized to determine which mental health factor(s) are significant in predicting sexual dysfunction. Depression and sexual abuse were significant factors for predicting sexual dysfunction in males.

DEDICATION

The completion of my Master's studies would not have been possible without the love and support of my family and friends. Thank you to all who have motivated me and supported me through this scholarly journey to accomplish this degree. Your love and patience helped me overcome the many milestones of graduate school. This thesis is also dedicated to my grandfather, B.Z.Cano, who had a passion for psychology and always encouraged me to reach for the stars.

ACKNOWLEDGMENTS

I will always be grateful to Dr. Russell Eisenman, chair of my thesis committee, for all of his mentoring and advice. He encouraged me to complete this process through his infinite patience and guidance. My thanks go to my thesis committee members: Dr. Darrin Rogers and Dr. Edna Alfaro. Their advice, input, and comments on my thesis helped to ensure the quality of my intellectual work.

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CHAPTER I

INTRODUCTION

Sex is one of the most fundamental human needs (Freedman, 2005) and because of this fact, it should be understood that a healthy sex life is essential to an individual's sense of well-being as well as a probable foundation for pleasure, contentment, and fulfillment; with this in mind, it can be asserted that healthy sexuality is beneficial for one's mental and physical health (Firestone, Firestone, & Catlett, 2006). Many elements such as a person's biological, social, and psychological well being—which work in conjunction with one another—affect one's ability to have a healthy sex life (Engel, 1977). The World Health Organization (2002) has taken these different elements into consideration and has defined sexual health as "a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity". (p. 5).

The psychological aspect of the sexual health equation has been a subject of enquiry for over one hundred years including notable research studies dating back to the eighteenth century (West, Vinikoor, & Zolnoun, 2004). Today, researchers focus on psychological factors that may negatively impact an individual's sexual health and potentially maintain sexual dysfunctions (Carvalho & Nobre, 2010; Derogatis & Meyer, 1979; McCabe et al., 2010; Nobre, 2009; Nobre & Pinto-Gouveia, 2008). These psychological processes can include interpersonal dimensions such as relationship satisfaction, psychopathological disorders such as anxiety, cognitive distortions of what sex should encompass, trauma experiences that are associated with sexual

abuse, etc (Firestone, Firestone, & Catlett, 2006; Laumann, Paik, & Rosen, 1999; Lewis et al., 2010; West, Vinikoor, & Zolnoun, 2004). Due to the extensiveness of the possible psychological processes that contribute to the factors affecting sexual health, it is important to try to narrow the possibilities to gain a greater understanding of the factors that may affect the etiologic nature and maintenance of sexual problems.

This greater understanding is also imperative considering the recent recognition of high prevalence rates of sexual dysfunctions in our society, with estimates ranging from 8-33% (DeRogatis, 2008; Heiman, 2002; Simons & Carey, 2001). With prevalence rates climbing (Laumann, Paik, & Rosen, 1999), predisposing psychological factors that contribute to the maintenance of sexual dysfunctions are crucial to study.

CHAPTER II

LITERATURE REVIEW

The Psychological Factors

Psychological disorders are considered to be one of the most common risk factors for sexual dysfunctions and are theorized to include maladaptive cognitions that have the potential to negatively affect sexual functioning (Barlow, 2008). Various psychological patterns—behaviors and cognitions—that are consistent with psychological disorders such as depression, dysfunctional eating habits, and the incidence of sexual abuse have been studied independently from one another when investigating the association that they each possess in conjunction with the etiology of sexual dysfunctions (Laurent & Simons, 2009; Leonard & Follette, 2002; Loeb et al., 2002; Wiederman, 1996). Due to the fact that each of these factors possess separate associations with sexual dysfunctionality, this study aims to investigate which predisposing factor(s) are significant predictor(s) of sexual dysfunctions within a Latino population.

Ethnic and Gender Considerations

Sexual Health within the Latino Population

Despite the fact that Latinos are the largest and fastest growing minority group in the United States, there is a limited amount of research on this specific population especially within the sexual health domain (Cardoza, Documét, Fryer, Gold, & Butler, 2012). In addition to the fact that Latinos are vastly underrepresented within the sexual health literature, it is important to note that Latino men and women tend to report less sexual dysfunctions as compared to both

majority and other minority populations (Lewis, 2004). Given these two important points, it is difficult to determine where Latinos lie on the sexual dysfunction spectrum in comparison to other populations. This study attempts to seek further understanding of the predisposing factor(s) associated with sexual dysfunctions within this ethnic population.

Gender Differences in Sexuality

Gender differences in sexuality have been widely studied within the sexual health literature (Eisenman & Dantzker, 2006; Gebal, Duyan, & Öztürk, 2008; Hendrick & Hendrick, 1995; Oliver & Hyde, 1993; Petersen & Hyde, 2010, 2011). What many recent empirical studies have noted is that the gender gap is not as large as researchers once thought (Eisenman & Dantzker, 2006; Oliver & Hyde, 1993; Petersen & Hyde, 2010, 2011). The results of three meta-analysis indicated that men and women are more similar than different in regards to sexuality (Oliver & Hyde, 1993; Petersen & Hyde, 2010, 2011) with the most recent study noting that these small gender differences are continuously decreasing through time (Petersen & Hyde, 2011). Furthermore, numerous studies have identified associations between mental health predictors and sexual dysfunction that affect both men and women in a similar—if not the same—fashion (Chen et al., 2005; Loeb et al., 2002; Mangweth et al., 2001). Due to the similarities between gender and sexuality that have been noted, the following literature review reports the associations between mental health predictors and sexual dysfunctions for both genders in an integrated manner.

Sexual Dysfunction

For the purpose of this study, sexual dysfunction is defined as a "disturbance in sexual desire and in the psychophysiological changes that characterize the sexual response cycle and cause marked distress and interpersonal difficulty" (American Psychiatric Association, 2000, p.

535); this definition is not limited to the sexual dysfunction disorders established within the DSM-IV-TR but encompasses any faulty sexual process that causes marked distress in an individual (e.g., sexual satisfaction).

Depression

For the purpose of this study, depression is defined as a state of mood that is characterized by feelings of melancholia, irritability, and a loss of pleasure in previously enjoyed things. There seems to be a recurrent trend in the literature asserting that there is a strong link between depression and sexual functioning (Rosen et al., 2004; Rizvi et al., 2009; Laurent & Simons, 2009; Dobkin, Leiblum, Rosen, Menza, & Marin, 2006; Bodenmann & Ledermann, 2007). Individuals who have depressive symptoms are significantly more likely to experience difficulties in regards to their sexual well being; these difficulties may manifest as a decreased frequency in sexual intercourse, reduction in sexual arousal and/or desire, diminished sexual satisfaction, inability to achieve orgasm, and prevalence of pain before and/or during sexual activity (Chivers, Pittini, Grigoriadis, Villegas, & Ross, 2011; Dell'Osso et al., 2009; Frohlich & Meston, 2002; ter Kuile, Weijenborg, & Spinhoven, 2010; Shindel, Eisenberg, Breyer, Sharlip, & Smith, 2011). For example, Frohlich and Meston (2002) found that—when compared to normative controls—participants who exhibited depressed symptomatology reported more sexual difficulties related to sexual desire, arousal and orgasm, more sexual pain concerns, and less sexual satisfaction. Likewise, Rizivi et al. (2009) discovered that—when compared to normative controls—participants who suffered from Major Depressive Disorder demonstrated lower sexual functioning; these scholars also asserted that mood disorders appear to be one of the strongest predictors of sexual dysfunctions.

Dysfunctional Eating Habits

For the purpose of this study, dysfunctional eating habits are defined as eating rituals that occur on a regular basis (at least twice a week) as characterized by binging, purging, and/or restricting food intake, to obtain a certain body mass and/or muscle mass usually due to a distorted body image; this definition also encompasses relevant eating disorder characteristics found in the Diagnostic and Statistical Manual of Mental Disorders IV-Text Revision as well. To date, the association between dysfunctional eating habits and sexual functioning has been studied modestly and with a lack of empirically based studies (Pinheiro et al., 2010). Although there is little research between these two variables, associations have been identified (Castellini et al., 2010; Mangweth et al., 2001; Don Morgan, Wiederman, & Pryor, 1995; Pinheiro et al., 2010; Rothschild, Fagan, Woodall, & Andersen, 1991; Wiederman, Pryor, & Don Morgan, 1996); when compared to normative controls, individuals who practice dysfunctional eating habits exhibit significantly poorer sexual functioning whether they have a thin or obese physique (Castellini et al., 2010; Pinheiro et al., 2010).

Individuals who exhibit behaviors that are characteristic of anorexia nervosa tend to have emaciated bodily features, sustain a considerably low body weight usually through a restriction of food intake, experience an intense drive for thinness usually due to a fear of fat, have a negatively distorted body image, and—in females—have amenorrhea (American Psychiatric Association, 2000). Due to the fact that anorexics have a distorted body image, an increased severity of dysfunctional eating habits may be associated with greater displeasure towards one's bodily appearance. According to Ghizzani and Montomoli (2000), the self-esteem of an individual who has anorexic characteristics is dependent on their body image: "losing weight is considered an achievement in self-discipline to be proud of, while weight gain is a terrible sign

of loss of control," (p. 80). A severely distorted body image may result in an exceedingly overt resiliency to lose weight which usually leads to emaciation (one of the physical characteristics anorexics exhibit). Due to the emaciating nature of anorexia, a loss of sexual interest and libido (Tuiten et al., 1993 as cited in Pinheiro et al., 2010) may be a consequence of hypogonadism thus making sexual functioning more difficult. For example, low lifetime BMI—which is indicative of an increased illness severity—has been found to be significantly associated with sexual relationships, low libido, and sexual anxiety (Pinheiro et al., 2010).

Individuals who exhibit behaviors that are characteristic of bulimia nervosa tend to binge eat (i.e., feeling a lack of control while eating an amount of food that is unquestionably larger than what one would usually eat in one sitting) and then proceed to compensate for that behavior by purging in order to prevent weight gain (American Psychiatric Association, 2000); also, while anorexics appear to be emaciated and are severely underweight, bulimics are usually average to slightly above average size (Wiederman, 1996). Like individuals with anorexic-like tendencies, bulimics also have a distorted body image that is overly concerned with body weight and shape. Conversely, bulimic individuals have been found to experience an earlier onset of sexual coitus and were more likely to engage in sexual behaviors when compared to anorexic individuals (Wiederman & Pryor, 1996; Wiederman, 1996). Despite this fact, bulimics still have a lower sexual functioning in comparison to individuals without disordered eating habits; for example bulimics have been found to be sexually dissatisfied, restricted, and not content with their interpersonal sexual relationships which indicative of the discomfort they have within themselves as sexual persons (Rothschild et al., 1991; Don Morgan, Wiederman, & Pryor, 1995).

Other dysfunctional eating habits such as restricting/eating certain types of foods to attain a specific physique and binge eating—without compensatory behaviors—and are also being

considered; like anorexia and bulimia, both of these other habits are also associated with a preoccupation with body shape and weight (American Psychiatric Association, 2000; Wilfley, Wilson,& Agras, 2003 as cited in Castellini, 2010). For example, male body builders tend to have a marked preoccupation with their body appearance much like that of anorexic and bulimic individuals but in a reversed focus (i.e., gaining muscle as opposed to losing fat); these individual's eating habits are determined by scheduled eating of high protein diets and not determined by hunger (Mangweth et al., 2001). In addition, individuals who exhibit behaviors that are characteristic of binge eating disorder tend to eat large amounts of food more rapidly than normal until feeling uncomfortably full; binge eaters tend to have concerns over body weight and shape and typically feel discussed or guilty for eating in excess (American Psychiatric Association, 2000).

These dysfunctional eating habits have also been linked to difficulties in sexual functioning. In a study conducted by Mangweth et al. (2001) body builders who practiced rigid eating habits reported a loss of sexual desire. Likewise, in a study conducted by Castellini et al. (2010) obese participants who had binge eating disorder characteristics were compared to other obese participants and normal weight participants in regards to sexual functioning. The binge eating disorder group was found to have a worse sexual functioning when compared to the other two groups; two clinical features—body image concerns and impulsivity—were prevalent in the BED group indicated an effect on sexual functioning. Body shape concerns were found to be a "significant determinant of different aspects of sexual dysfunction such as arousal, lubrication, and orgasm" (p. 3976); also, BED participants with high impulsivity—which is associated with a higher frequency of sexual intercourse—were also found to have a lower sexual satisfaction rate

proposing an association between disordered eating and impaired sexual functioning (Castellini, 2010).

Sexual Abuse

For the purpose of this study, sexual abuse is defined as any sexual activity—attempted or completed—that is forced upon a non-consenting individual. Unlike the factors described earlier, the experience of sexual abuse is associated with two different trends that affect post-abuse sexual functioning (Merrill, Guimond, Thomsen, & Milner, 2003; Najman, Dunne, Purdle, Boyle, & Coxeter, 2005; Rellini, 2008; Zwickl & Merriman, 2010); hypersexuality and hyposexuality. The hypersexuality or "oversexualization" phenomenon encompasses a higher prevalence of risky sexual behaviors such as being indiscriminately sexually active, having unprotected sex, having shortened sexual relationships, and having more liberal sexual attitudes (Najman et al., 2005; Rellini, 2008; Zwickl & Merriman, 2010). The hyposexuality or "undersexualization" phenomenon encompasses behaviors related to difficulties in sexual functioning such as sexual dissatisfaction, anorgasma, coital pain, and diminished sexual drive (Najman et al., 2005; Rellini, 2008; Zwickl & Merriman, 2010). Although sexual abuse may affect post-abuse sexual functioning in two different ways, this study aims to focus on the connection that sexual abuse has with hyposexual functioning (i.e., the more traditional DSM-IV-TR sexual dysfunctions).

Various studies have asserted that experience of sexual abuse plays a crucial role in the etiology and maintenance of sexual functioning specifically in regards to sexual dysfunctionality in both men and women; these scholars have established noteworthy findings that suggest that sexual disorders are significantly associated to sexual abuse-related factors (Beck, Elzevier, Pelger, Putter, & Voorham-van der Zalm 2009; Feinauer, 1989; Kinzl,Traweger, & Biebl, 1995;

Najman et al., 2005; Staples ,Rellini & Roberts, 2012; Swaby & Morgan, 2009;). For example, Swaby and Morgan (2009) found that sexual abuse impacts an individual's sexual functioning especially within the orgasm and sexual drive domains; abused persons had more difficulty achieving orgasm and indicated a decreased sexual drive. Likewise, Staples, Rellini, and Roberts (2011) found a significant interaction between severe sexual abuse histories and faulty orgasm functioning. Furthermore, Kinzl, Traweger, and Biebl (1995) found that sexual abuse victims reported sexual desire disorders and orgasm disorders more frequently than nonvictims. In addition, Feinauer (1989) documented that sexual abuse victims are less satisfied with their sexual relationships and many experience sexual arousal dysfunction and desire dysfunction; it was also reported that 36% of the participants "indicated that they needed sex therapy to resolve sexual issues related to their sexual abuse," (p. 306). Finally, Johnson and Shrier (1987) found that one fourth of their sexually abused male sample reported being sexually dysfunctional; for example, males experienced an inhibited libido, erectile failure, and premature ejaculation (as cited in Loeb et al., 2002).

CHAPTER III

METHODOLOGY

Participants

A total of 375 university students from the University of Texas – Pan American participated in this study; males (24%) and females (76%) over the age of 18. The majority of the participants were of Hispanic descent (93%) and in some form of romantic relationship (long term relationship = 23%; married = 26%; short term relationship = 4%; engaged = 2%). Participants were freshman (1%), sophomores (12%), juniors (36%), seniors (41%), and graduate students (5%). The majority of the participants were between 18-24-years-old (65%) and between 25-30-years-old (20%).

Despite the fact that college populations are not always considered suitable for clinical studies, the use of college students in this study could be justified for the following reasons: (a) collecting data on a non-clinical population can be argued to be more generalizable to other non-clinical populations, (b) the measures being used have been applied to college populations which allows this study to be consistent with previous and current research, (c) the vast majority of the college population under study consists of Latino minority students and because of this, the current study not only contributes to the scant literature on minority populations but may assist in further understanding of Latino sexuality.

Procedures

The researcher emailed various professors/instructors for permission and assistance in recruiting students from various undergraduate university courses during the Summer I session; informational flyers which explained the purpose of the research and the instructions for the online survey were attached to the emails sent to professors. The participants were recruited by means of in-class announcements, flyers, and messages in online forums such as Blackboard.

Data was collected during a six week period. Students who volunteered to participate were given a link to complete an online survey which could be taken at any time and on any computer. The informed consent form was the first page that appeared before the survey could be initiated by the participant. After reading the informed consent, the participant was asked if they would or would not like to participate in the survey; the participant was advised to print the informed consent form for their records. At the end of the survey, participants were issued a certificate of completion and were allowed to print the certificate to present to their instructor for credit to their selected course.

Measures

Sexual Dysfunction

Sexual dysfunction was measured by calculating the Global Sexual Functioning score from the Sexual History Form, a questionnaire used to measure the frequency of sexual activity; sexual function relating to desire, arousal, orgasm, and pain; and overall sexual satisfaction for men and women (Nowinski & LoPiccolo, 1979 as cited in Davis, Yarber, Bauserman, Schreer, & Davis, 1998). The GSF score has exceptional temporal reliability with previous research indicating a two week test-retest reliability of .92 (Creti, Fichten, Libman, Amsel, & Brender 1988 as cited in Davis et al., 1998). In the current study, one item was found to reduce the

Chronbach's alpha for both male and female GSF scores (item 7 = *How often do you masturbate (bring yourself to orgasm in private*). After the deletion of this item a higher Chronbach's alpha emerged for both male and female GSF scores (GSF $\alpha = .78$ for women and GSF $\alpha = .68$ for men); due to the fact that a higher alpha was found after the deletion of item 7, this item was removed from the GSF score. Although the alphas for the GSF scores may seem low—which may have the potential to reduce statistically significant findings between measures—researchers have noted that a cutoff value of .70 is adequate (Cortina, 1993; Schmitt, 1996) and that lower levels of alpha may still be fairly useful (Schmitt, 1996).

Depression

Depression was measured with the Center for Epidemiologic Studies Depression Scale (CES-D); this self-report questionnaire is formatted to measure depressive symptomatology in general populations by measuring an individual's current level of depressive symptoms (Radloff, 1977). The questionnaire contains 20 Likert scale items with responses ranging from 0 = *Rarely or none of the time (less than 1 day)* to 3 = *Most of all of the time (6-7 days).* The CES-D has been found to have high internal consistency (.85 in general populations and .90 in clinical populations) and moderate test-retest reliability (.67) over a four week time interval (Radloff, 1977). In the current study the CES-D was found to be highly reliable ($\alpha = .91$)

Dysfunctional Eating Habits

Dysfunctional eating habits were measured by the Eating Disorder Examination Questionnaire (EDE-Q), a 28 item survey (Fairburn & Beglin, 2008). This questionnaire was modified from an original investigator-based interview questionnaire to a self-report survey. It is designed to measure disordered eating and has four subscales relating to the cognitive features of eating disorders: Restraint, Eating Concern, Shape Concern, and Weight Concern. Items that

measure specific behavioral symptoms such as binge eating or precise purging behaviors are also included in the self-report questionnaire. The EDE-Q has been found to have high test-retest reliability over a two week time interval (≈.81 to .94), high internal consistency (≈ .70 to .93), and moderate construct validity (convergence with assessments of similar constructs ≈.40 to .79) (Berg, Peterson, Frazier, & Crow, 2012; Luce & Crowther, 1999).

Twenty-two items which make up the 'Global' score for the EDE-Q are being used for the analysis. In the current study, the EDE-Q Global score was found to be highly reliable (α = .94).

Sexual Abuse

Sexual abuse was measured by a subtest—the Sexual Experiences Short Form Version Victimization—of the Sexual Experiences Survey (Koss et al., 2006). This subtest of the questionnaire assesses victimization of unwanted sexual experiences (Koss et al., 2007). The SES has been vastly used within the literature and uses both item-level scoring and ordinal level scoring to facilitate the reporting of both incidence and prevalence rates (Koss et al., 2007). It has also demonstrated an acceptable internal consistency (α = .74 for women and α = .89 for men) and stable test-retest reliability with a mean item agreement of 93% (Koss & Gidycz, 1985). In the current study the SES was found to be highly reliable (α = .98 for women and α = .99 for men).

CHAPTER IV

RESULTS

A multiple regression analysis was used to assess whether depression, dysfunctional eating habits, and sexual abuse could be used to predict sexual dysfunction. Due to the fact that two of the scales used—Sexual History Form and Sexual Experiences Survey—are scored differently for males and females, separate analyses were conducted for each gender.

Assumption of Normality

The dependent variable and each independent variable were analyzed for normality by examining the histograms for each variable. The dependent variable for males—sexual dysfunction—had a slight positive skew of 1.536; the dependent variable for females—sexual dysfunction—had a slight positive skew of 1.163. The sexual abuse independent variable for males and females also had slight positive skews (males = 1.139 and females = .644). The depression independent variable had a slight positive skew of 1.263 and the dysfunctional eating habits independent variable had a slight positive skew of .616. Transformation of the slightly skewed variables was considered and calculated by using the square root of each variable. However, it has been noted that data transformations are capable of altering the fundamental nature of the data; this can create curvilinear associations and modify the measurement of a scale from ratio to ordinal thus, complicating the interpretation of the results (Osborne, 2002). The following results were calculated with and without square root transformations for all variables.

The pattern of significance in the results did not change and the R^2 values for the full models only changed by .013 for males and .002 for females. Due to the fact that a transformation can change the fundamental nature of the data (Osborne, 2002), the significance of the model did not change, and that a minimal difference was noted for the R^2 values after transforming the data, the original—untransformed—data was used for this analysis.

Results for Males

The regression model for males (see table 1) examined whether mental health factors (depression, dysfunctional eating habits, and sexual abuse) predicted sexual dysfunction. The results of the regression indicate that the three predictors explained 24.5% of the variance ($R^2 = .245$, $F(3, 77) = 8.311$, $p < .001$). It was found that depression significantly predicted sexual dysfunction ($\beta = .342$, $p < .001$) as did sexual abuse ($\beta = .327$, $p < .01$).

Results for Females

The regression model for females (see table 2) examined whether mental health factors (depression, dysfunctional eating habits, and sexual abuse) predicted sexual dysfunction. The results of the regression indicate no significant mental health predictors for sexual dysfunction ($R^2 = .016$, $F(3, 248) = 1.313$, $p = .271$).

The study intended to find significant mental health factors that predict sexual dysfunction. The results indicate that depression and sexual abuse are significant predictors for sexual dysfunction in males.

For correlations on all factors see tables 3 and 4.

Table 1

Predictors of Sexual Dysfunction

	Sexual Dysfunction (Males)			
Variable	B	SE_B	β	95% CI
Constant	.281***	.024		[.233, .329]
Depression	.005	.001	.342**	[.002, .008]
Dysfunctional Eating Habits	-.005	.012	-.047	[-.028, .018]
Sexual Abuse	.099	.031	.327**	[-.037, .162]
R^2	.245			
F	8.311***			

*p<.05. **p<.01. ***p<.001.

Table 2

Predictors of Sexual Dysfunction

	Sexual Dysfunction (Females)			
Variable	B	SE_B	β	95% CI
Constant	.413***	.021		[.372, .454]
Depression	.001	.001	.075	[-.001, .003]
Dysfunctional Eating Habits	.009	.008	.070	[-.007, .025]
Sexual Abuse	.009	.022	.029	[-.033, .052]
R^2	.016			
F	1.313			

*p<.05. **p<.01. ***p<.001.

Table 3

Descriptive Correlations for Males

	1	2	3	4
1. Sexual Dysfunction				
2. Depression	.381***			
3. Dysfunctiona Eating Habits	.176*	.396***		
4. Sexual Abuse	.375***	.177	.267**	
M	.370	13.690	1.410	3.090
SD	.150	9.890	1.270	8.540
N	88	92	90	82

*p<.05. **p<.01. ***p<.001.

Table 4

Descriptive Correlations for Females

	1	2	3	4
1. Sexual Dysfunction				
2. Depression	.100*			
3. Dysfunctiona Eating Habits	.092	.248***		
4. Sexual Abuse	.059	.289***	.126*	
M	.450	14.310	1.920	2.890
SD	.160	10.220	1.270	6.860
N	262	277	273	254

*p<.05. **p<.01. ***p<.001.

CHAPTER V

DISCUSSION

The present study expands existing knowledge on the predisposing factors of sexual dysfunction within a Latino population. The results indicated two significant mental health predictors—depression and sexual abuse—for sexual dysfunction in males and no significant mental health predictor(s) for sexual dysfunction in females.

Findings for Male Model

Depression and Sexual Dysfunction

Consistent with previous research on the associations between depression and sexual dysfunction (Rosen et al., 2004; Rizvi et al., 2009; Laurent & Simons, 2009; Dobkin et al., 2006; Bodenmann & Ledermann, 2007) the current study found that depression is significantly related to sexual dysfunction (Chivers et al., 2011; Dell'Osso et al., 2009; Frohlich & Meston, 2002; ter Kuile, Weijenborg, & Spinhoven, 2010; Shindel et al., 2011). The significance of the depression predictor in males—specifically in Latino males—could be explained by gender identity roles that are defined by cultural norms and stereotypes (Firestone, Firestone, & Catlett, 2006; Silverstein, Auerbach, & Levant, 2002). For Latino males, *machismo*, a type of hegemonic masculinity identity (i.e., the ideal and/or normative masculinity characterized by dominance, emotional control, pride, and a lack of vulnerability) plays a central function in male sexuality (Emslie, Ridge, Ziebland, &Hunt, 2006; Pavich, 1986; Richardson, 2010). In traditional Latino culture, males are encouraged to become sexually active from adolescence onward (Pavich,

1986) and to be regarded as 'macho' males may feel as if they need to have frequent sexual encounters in order to be considered as sexually functional (Nobre & Pinto-Gouveia, 2006; Richardson, 2010) whereas females do not; this coincides with the recurrent finding that males tend to be more permissive about sexual behaviors (Eisenman & Dantzker, 2006; Oliver & Hyde, 1993). Thus, this macho ideal has the ability to significantly influence a male's perception of what is considered sexually functional which in turn influences the manner in which they respond on a sexual functioning questionnaire. For example, "men who feel as though they must use their sexuality as an expression of their masculinity may feel unnecessary pressure to perform sexually" and have numerous sexual encounters (Zilbergeld, 1999 as cited in Peterson & Hyde, 2011, p. 163); this could potentially result in sexual anxiety and/or other sexual dysfunctions.

With this in mind, it is important to note that manifestations of sexual dysfunctions in males indicate vulnerabilities and a lowered emotional control—characteristics that are opposite from normative masculinity in Latinos—which could vastly impact a male's mental state. For example, if a male frequently finds himself not being able to sexually perform to the standards of his *machismo* identity, negative cognitive self-schemas have the potential to be developed (Nobre & Pinto-Gouveia, 2006). Additionally, a damaged sense of hegemonic masculinity (e.g., lowered emotional control, powerlessness) has been found to be significantly associated with depression in males (Emslie, Ridge, Ziebland, &Hunt, 2006). Thus, it can be concluded that gender identity could impact the relationship between sexual dysfunction and depression for males particularly in the Latino culture, a culture that has been found to have more conservative ideals—which in turn accounts for more traditional gender roles—when compared to other ethnicities (Eisenman & Dantzker, 2006).

Another explanation as to why depression was found to be a significant predictor could be due to the fact that the association between sexual functioning and depression has not been determined to be causal but complex and bidirectional (Laurent & Simons, 2009; Rosen et al., 2004); Laurent and Simmons (2009) have gone so far as to assert that all sexual disorders have been linked to depressive symptoms and disorders. For example, men who suffer from erectile dysfunction may develop depressive symptoms—such as dissatisfaction with their sex life, fatigue, and frustration—because they are unable to engage in sexual intercourse as frequently as they desire (Nicolosi, Moreira, Villa, & Glasser, 2004); likewise, men who suffer from depression may experience erectile dysfunction as the consequence of an anhedonic symptom of depression which may also be expressed as a decrease in libido or a decrease in sexual satisfaction (Rosen et al., 2004). Thus, the significance found in the current study could be due to the nature of this bidirectional relationship.

Sexual Abuse and Sexual Dysfunction

Consistent with previous research on the associations between sexual abuse and sexual dysfunction (Beck et al., 2009; Feinauer, 1989; Kinzl, Traweger, & Biebl, 1995; Kinzl, Mangweth, Traweger, & Biebl, 1996; Najman et al., 2005; Rellini & Roberts, 2011; Swaby & Morgan, 2009) the current study found that sexual abuse is significantly related to sexual dysfunction. The significance of the sexual abuse predictor in males may be explained by the fact that in comparison to females, men tend to report more pronounced effects of sexual abuse including greater difficulties with aggressive behaviors, thoughts and attempts of suicide, and drug abuse (Garnefski & Arends, 1998 as cited in Loeb et al., 2002).

Taking the *machismo* into consideration once more, the experience of sexual abuse for a male may challenge his sense of gender identity. Being sexually abused removes the power,

dominance, and emotional control associated with *machismo* (Emslie, Ridge, Ziebland, &Hunt, 2006; Pavich, 1986; Richardson, 2010) and in turn emasculates the male which may result in difficulties in sexual functioning (Myers, 1989).

Dysfunctional Eating Habits and Sexual Dysfunction

This study did not find a significant relationship between the predictor of dysfunctional eating habits and sexual dysfunction in men. However, a significant zero-order correlation was found between dysfunctional eating habits and sexual dysfunction. This association is consistent with other studies that have found a relationship between dysfunctional eating habits and sexual dysfunction (Castellini et al., 2010; Mangweth et al., 2001; Don Morgan, Wiederman, & Pryor, 1995; Pinheiro et al., 2010; Rothschild, Fagan, Woodall, & Andersen, 1991; Wiederman, Pryor, & Don Morgan, 1996). However, the correlation found in this study merely suggests that there is a direct relationship between dysfunctional eating habits and sexual dysfunction. When analyzed as a predictor to address the unique influence that dysfunctional eating habits have on sexual dysfunctions—while controlling for the two other predictors depression and sexual abuse—dysfunctional eating habits were not found to be significant.

Findings for Female Model

Interestingly, no mental health predictors of sexual dysfunction were found to be significant in Latino females. However, a significant zero-order correlation was identified between depression and sexual dysfunction. With this in mind, it is important to note that the correlation that was found between depression and sexual dysfunction is consistent with the associations that have been found in previous studies, (Chivers et al., 2011; Dell'Osso et al., 2009; Frohlich & Meston, 2002; ter Kuile, Weijenborg, & Spinhoven, 2010; Shindel et al., 2011). However, the relationship that was found simply suggests that there is a total correlation

between depression and sexual dysfunction. When analyzing depression as a predictor in this multiple regression model to address the unique influence that depression has on sexual dysfunctions, depression was not found to be significant. In addition, depression is significantly correlated with sexual abuse and dysfunctional eating habits. These zero-order correlations should be taken into consideration because the variables that correlate overlap and thus may have the potential to impact the influence of one or more predictor variables in the regression model.

Limitations and Future Directions

This study has a number of limitations. First, data was collected via an online questionnaire that could be taken at any time and on any computer during a six week period; this method of data collection poses risks as far as extraneous variables are concerned (Kaplan & Saccuzzo, 2005). For example, the environment chosen by a participant to take the survey may have affected the manner in which they responded to the questions; a participant taking the survey in a public location could have been more careless in answering questions due to outside distractions as opposed to a participant taking the survey in a more private location (Kaplan & Saccuzzo, 2005). Another limitation that could have jeopardized statistical significance is that three out of the four measures that were used—CESD, EDE-Q, and SHF—are clinical measures of mental health. Due to the fact that a non-clinical sample was utilized for this study, significant pathological scores were less likely to have been found thus impacting the results of the study. For example, there might not have been clear-cut relations between the predictor variables and the outcome variable due to a restricted range of scores i.e., little to no pathology. In addition, although significant findings have been found in previous studies for the predictor variables—depression, dysfunctional eating habits, and sexual abuse—in relation to sexual functioning within college populations, (Frohlich & Meston, 2002; Hunt & Kraus, 2009; Raciti

& Hendrick, 1992) it should be noted that the majority of these studies only focused on participants who exhibited pathology; college students who did not exhibit pathological symptoms were removed from analyses (Frohlich & Meston, 2002). Unlike previous studies conducted on college populations, this study did not solely focus on participants who were exhibiting pathological symptoms but on a non-clinical college population. This makes it more difficult to assess for variables such as depression, dysfunctional eating, and sexual dysfunction because participants are more likely to not have a pathological disorder thus resulting in a restricted range of scores.

Taking the findings of this study into consideration, future researchers should consider assessing different levels of conservatism within the Latino population (more traditional values vs. more liberal values) to examine how it may affect gender roles and in turn impact Latino sexual functioning. In addition, future researchers should also consider further exploration of the bidirectional relationship between depression and sexual functioning within the Latino population to address the consistencies or inconsistencies of the relationship when compared to other majority and minority populations. Lastly, scholars should take note of the significance that was found in this study between the sexual abuse predictor and sexual dysfunction in males due to the fact that there is a limited amount of research that focuses on how sexual abuse may impact sexual functioning in men (Kinzl et al., 1996) especially within a minority population. Future researchers should consider studying this association in greater detail in order to further understand how sexual abuse effects sexual functioning in males.

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BIOGRAPHICAL SKETCH

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