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PERCEIVED SEXUAL DYSFUNCTION ADJUSTMENT STRATEGIES EMPLOYED BY LOCAL GOVERNMENT EMPLOYED MARRIED WOMEN IN KWARA STATE

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Abstract
This study investigated the Perceived Sexual Dysfunction Adjustment Strategies among Local Government Employed Married Women in Kwara State. Descriptive survey research design was adopted for the study. The simple random sampling technique was used to select 70 Local Government Employed Married Women from each of the 6 proportionate sample selected LGAs making total number of 420 participants. Self-developed instrument tag Sexual Dysfunction Patterns Questionnaire (SDPQ), was administered to the selected respondents. Frequency count and simple percentages were used for demographic data, mean and rank order were used for the for research questions, while Analysis Of Variance (ANOVA) statistical methods was used to test the three null hypotheses formulated for the study. The findings showed that there was no significant differences in the expression of respondents on hypothesis one that base on educational attainment (0.42<3.00 = p-value 0.661), while hypotheses two and three indicated that there is significant differences in the expression of respondents based on age (7.06<3.000= p-value 0.000) and religious affiliation (10.92<3.00 = p-value 0.001). Based on the findings, the researchers recommended that married women irrespective of their educational status should recognize the impact of sexual dysfunction on marriage and adopt appropriate strategies to combat sexual dysfunction.
Keywords: Perception, Sexual Dysfunction, Adjustment strategies, Married Women

Introduction
The institution of marriage is full of expectations between couple, most importantly on the issue of sexual compatibility. Many couples might not have known how compatible or otherwise they and their partners are sexually, especially when they have not had sex during courtship. Consequently, problem may crop up in marriage if one of the partners later found that the other could not perform to expectation sexually. Sexual satisfaction is very important because it is the most powerful marital gel a couple usually uses to make everything in marriage nicer and romantic. Therefore, sexual satisfaction is a strong determinant factor in the marital relationship because its role in marriage cannot be over emphasized. Study by Jalambadani et al. (2021) has established that sexual satisfaction is a pleasant feeling that one obtains through mixing mental and physical enjoyment of sexual intercourse. The existence of sexual satisfaction is capable of arising sexual intimacy and provides endurance and coping skills for the women (Rokach & Chan, 2023). Despite the important role plaid by sex in marital relationship, it can also be the source of catastrophe through experiences of unsatisfactory sexual relationship: lack of sexual desire, lack of sufficient sexual arousal (Ranjbar, 2023; UNFPA, 2022 Leman, 2005). Thus, spouses' understanding of their partners' sexual needs is imperative in order to avoid debilitating effects it might have on marriage stability. Oniye (2008) noted that many homes have broken as a result of the couple ignorance of each other sexual needs. It must be reiterated here that no marriage (even the best) is immune against sexual concerns but when sex evasion turns into a daily habit as a result of salient problem of sexual dysfunction, marriage can become an arctic zone. This is because a study (World Health Organisation, 2004) has reported that the issue of inadequate sexual desire or sexual dysfunction is one of the factors influencing marriage failure (Ranjbar et al., 2023). SD can afflict couple of any age, and its expression changes with the endocrinology of advancing years. Impact is often subtle. SD may express as seemingly unrelated emotional disturbances

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that degrade quality of life in family relationships, in the workplace, or both. For some, it is a minor short term problem. For others it is debilitating.

Sexual dysfunction according to the Kerskaw and Jha (2022), is any issues associated with sexual arousal concerns, poor orgasm, complain of pains from sex which causes interpersonal difficulty between spouses. American Psychiatric Association (2022), described it as loss of sexual interest, penetrative issues and sexual arousal problems. Osasona et al. (2019) noted that the prevalence of sexual dysfunction was about 48.7 percent while only 20.0% to 39.3% have erectile dysfunction. Omueri and Ayodele (2022) showed the overall prevalence of male sexual dysfunction was 60.5%. Kirkpatrick (2005) explained that sexual dysfunction encompasses disorders of the sexual response cycle or sex related pain. Disorders of desire include hypoactive sexual disorder and sexual aversion disorders. Disorders of arousal include male erectile disorder and female arousal disorder. Disorders of orgasm include premature ejaculation, female orgasmic disorder and male orgasmic disorder. Sexual pain disorders include vaginismus and dyspareunia. Kirkpatrick (2005) stressed that sometimes, sexual dysfunction could be accompanied by psycho-physiological changes, associated with marked distress and interpersonal difficulty.

Osundiya (2005) observed that almost 15-20% of men in Nigeria suffer one type of sexual dysfunction or the other. Also in a study carried out by Olushola et al. (2010) on sexual dysfunction among secondary school teachers in Ilorin was indicated that the prevalence of sexual dysfunction is high among female at the rate of 60% than their male counterpart at the rate of 25%. Olakunle explained further that the problem is more difficult to diagnose and treat in women than it is in men because of the intricacy of the female response cycle. Female sexual dysfunction is an impaired or inadequate ability of a woman to engage in, or enjoy satisfactory sexual intercourse and orgasm (Marthol & Hills, 2004). Fatigue was found to have the strongest positive relationship with sexual dysfunction in women. Demirkiran and colleagues (2006) reported that fatigue was significantly more common in women with SD than in men. Patterns of female sexual dysfunction are described in the Diagnostic and Statistical Manual of the American Psychiatric Association APA (2022), in relation to the desire, arousal, and orgasm axes described in the physiological models. According to DSM-IV-TR (2000), women may experience sexual difficulties in relation to problems in sexual desire, sexual arousal, and/or orgasmic experience; they also may experience sexual pain disorders, including dyspareunia and vaginismus. It must be noted that female sexual dysfunction cannot be easily determined and it varies among communities. However, available study of Goldstein (2000) showed that female sexual dysfunction is common and occurs in 30–50% of American women.

Nausbam (2003) reported in his large telephone survey in Australia, that 55% of women lacked interest in sex, 20% experienced pain during intercourse and 29% failed to have orgasm. In a probability sample of the US population by Dean (2006), 22% of women had low sexual desire, 14% had arousal problems, 7% had sexual pain and 26% were unable to achieve orgasm. In a large population survey of Iranian women, 35% had desire disorders, 30% arousal disorders, 27% pain disorders and 37% orgasmic disorders (Lauman et al., 2000). In Nigeria, Bengamin et al. (2010) in their study conducted to determine the prevalence of sexual dysfunction and their correlated among female patients of reproductive age concluded that 63%of women in Nigeria were sexually dysfunctional. Also, Nwagha et al. (2014) assessed the prevalence of sexual dysfunction among females in a university community in Enugu, Nigeria. The prevalence of female sexual dysfunction was 53.3%. The highest prevalence occurred in the 41-50 years age group.

Considering the devastating effects of sexual dysfunction, in this contemporary society that attaches more values to fertility/procreation and sexual satisfaction (a woman to be available for the partner every time), it may be more difficult for a woman with sexual dysfunction to coexist peacefully in the home. However, for the fear of domestic crises, separation and divorce, women usually adopt different kind of strategies to endure or adjust to the problem of sexual dysfunction (Nwagha et al., 2014). Adjustment strategies in this context, is the approach adopted by women with sexual dysfunction in addressing the conditions. It is coping strategies, behaviours, employed by an individual to handle the anticipated or experienced and stressful condition. Adjustment strategy is referred to as coping methods

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which include the appraisal of the difficult situation, ability and strategies to deal with it or handle it (Anshel, 2000). It is the perpetual cognitive, emotional and behavioural responses that one utilizes to manage, reduce, avoid or control the stress induced factor and its effects.

The study of Yahi (2004) identified some of the adjustment strategies usually employed by women with sexual dysfunction. These include resignation to fate, seeking support from friends and relatives, confrontational attitude, consulting family doctors, contacting spiritual heads and personal therapy. The findings indicated that all approaches employed by the wives are negatively associated with marital satisfaction except “consultation with family’s doctor/spiritual heads”. Sexual assertiveness was also found to be adopted by sexual dysfunction women (Sanchez et al., 2012; Ozogi et al., 2014). According to Tolman (2000), sexual assertiveness is necessary for healthy sexual relationships. Sexual assertiveness is important for attainment of sexual goals. A number of studies have shown that assertiveness positively correlates with sexual function including sexual satisfaction, sexual arouse ability, ability to reach orgasm and subjective sexual desire (Sanchez et al., 2012; Kiefer & Sanchez, 2007; Sanchez et al., 2006). To this end, this study aimed at investigating the perceived sexual dysfunction adjustment strategies of married women in Kwara State.

Research Questions

The following research questions were generated for the purpose of the study:

1. What are the Sexual Dysfunction adjustment strategies perceived by Local Government Employed Married Women in Kwara State?

Research Hypotheses

The following research hypotheses were formulated and tested at 0.05 level of significant:

1. There is no significant difference in the perceived sexual dysfunction adjustment strategies employed by Local Government Employed Married Women in Kwara State based on educational attainment.
2. There is no significant difference in the perceived Sexual Dysfunction adjustment strategies employed by Local Government Employed Married Women in Kwara State based on age.
3. There is no significant difference in the perceived Sexual Dysfunction adjustment strategies employed by Local Government Employed Married Women in Kwara State based on religious affiliation.

Methodology

The research design adopted for this study is the descriptive survey method since the study involves careful study and observation of the existing attributes of a particular event/situation. In selecting the sample for the study, a multi-stage sampling technique was employed. At stage 1, proportionate sampling technique was used to select six Local Government Areas across the three senatorial districts of Kwara State (Kwara South 3, Kwara Central 1 and Kwara North 2) respectively. At stage 2, simple random sampling technique was used to select 70 local government Employed married women from each of the 6 proportionate sample selected LGAs making total number of 420 participants. At stage 3, stratified sampling method was used to classify the respondents based on educational attainment, age and religious affiliation. A questionnaire tagged “Sexual Dysfunctional Adjustment Strategies Questionnaire (SDASQ)” was developed through extensive literature reviewed to collect data. The instrument was sub-divided into two major sections.

Section ‘A’ focused on background information about the respondents which consist of three item questions like educational attainment, age and religious affiliations. Section ‘B’ consist of 15 structured items with four likert type scale (Agree (SA) Agree (A), Disagree (D) and Strongly Disagree (SD)) focused on sexual dysfunction adjustment strategies employed by married women. Copies of the initial draft were given to five experts in the Department of Counsellor Education, University of Ilorin, to vet before the establishment of both face and content validity of the instrument. For the reliability of the instrument a test-retest reliability method was adopted. The instrument was administered twice with an interval of four weeks to the same set of respondents. The two sets of scores were correlated using Peason Product Moment Correlation Coefficient and the calculated r-value is 0.61, which indicated that

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the instrument is reliable. For the analyses of data, frequency count and simple percentages were used for demographic data, mean and rank order were used for research questions, while Analysis of Variance (ANOVA) statistical tools was used to test all the null hypotheses formulated.

Results

The results were based on the formulated hypotheses for study

Demographic Characteristics of Respondents

This section presents demographic characteristics of the respondents using frequency counts and percentages.

Table 1: Demographic characteristics of the respondents

SN	Variables		Frequency	Percentage %
1	Educational Attainment	Primary School	10	2.4
		Secondary School	52	12.4
		Tertiary	358	85.2
		Total	**420**	**100.0**
2	Age	18-30 years old	135	32.1
		31-40 years old	180	42.9
		41 years old and above	105	25.0
		Total	**420**	**100.0**
3	Religious Affiliation	ATR	19	4.5
		Christianity	180	21.2
		Islam	221	74.3
		Total	**420**	**100.0**

Table 1 presents the personal characteristics of the participants. The table shows that 420 married women participated in the study, out of which, 10 (2.4%) attained only primary school education, 52 (12.4%) were Secondary School certificate holders, while 358 (85.2%) of the respondents had tertiary educational qualification. This implies that the majority of married women who participated in this study were well educated. The age distribution of the respondents shows that 135 (32.1%) were between 18-30 years old of age, 180 (42.9%) were within the age bracket 31-40 years old, while 105 (25.0%) were 41 years old and above. This indicates that majority of the married women were within the average age of at least 35 years old. On the basis of religious affiliation, the table shows that 19 (4.5%) of the respondents were African Traditional Religion (ATR) adherents, 180 (21.2%) were Christians, while 221 (74.3%) were Islamic Religion affiliates. This means that majority (74.3%) of the participants are Muslims.

Research Question 1: What are the adjustment strategies being employed by married women in Kwara State?

Table 2: Mean and rank order of the sexual dysfunctional adjustment strategies employed by Local Government Employed Married Women in Kwara State

Item N	Women with sexual dysfunction adopt the following adjustment strategies:	Mean	Rank
6	seeking medical assistance	3.01	1st
4	seeking support from friends	2.99	2nd
13	using of sexual performance enhancement herbs	2.98	3rd
1	self-blame	2.96	4th
15	Praying for divine deliverance	2.95	5th
3	self-control	2.92	6th
9	mutual discussion with one's spouse	2.86	7th
7	consultation with clerics for spiritual assistance	2.79	8th
5	seeking support from relatives	2.74	9th
11	seeking sexual therapy	2.69	10th
2	resigning to fate	2.65	11th
12	involvement in physical exercise to boost libido	2.64	12th
10	trying other sexual partners (for clarification)	2.61	13th

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8	Planning for divorce	2.57	14th
14	allowing husband to marry another wife	2.25	15th

Table 2 presents the mean and rank order of the adjustment strategies employed by married women to cope with Sexual Dysfunction. The table shows that 14 out of the 15 items have mean scores that are above the benchmark mean of 2.50. This means that respondents perceptions supports majority of the adjustment strategies for Sexual Dysfunction. However, three major items took precedence over others. They are items 6 (with mean 3.01), 4 (with mean 2.99) and 13 (with mean 2.98) and were ranked 1st, 2nd and 3rd respectively. This indicates that married women in Kwara State adopt adjustment strategies of seeking medical assistance, seeking support from friends and using sexual performance enhancement herbs to cope with Sexual Dysfunction.

Hypotheses Testing

Three hypotheses were postulated in the course of the study. All hypotheses were tested using One-Way Analysis of Variance (ANOVA). All hypotheses were tested at 0.05 level of significance.

Hypothesis one: ***There is no significant difference in the perceived sexual dysfunction adjustment strategies being employed by Local Government Employed Married Women in Kwara State based on educational attainment***

Table 3: ANOVA showing difference in respondents' perception of Sexual Dysfunction adjustment strategies employed by Local Government Employed Married Women in Kwara State based on educational attainment

Source	Sum of Squares	df	Mean Squares	Cal. F	Crit. F	p-value
Between group	3.735	2	1.868	0.06	3.00	0.939
Within group	12320.862	417	29.546			
Total	12324.598	419				

Table 3 presents difference in respondents' perception of Sexual Dysfunction adjustment strategies being employed based on educational attainment. The table indicates that, under the degree of freedom (df) of 2 and 417, the calculated F-value of 0.06 is less than the critical F-value of 3.00, with a corresponding p-value of 0.939 which is greater than 0.05 level of significance. This shows that no significant difference exist, thus, the hypothesis is not rejected. Therefore, educational attainment has no significant influence on perceived Sexual Dysfunction adjustment strategies of by Local Government Employed Married Women in Kwara State.

Hypothesis Two: ***There is no significant difference in the perceived sexual dysfunction adjustment strategies being employed by Local Government Employed Married Women in Kwara State based on age.***

Table 4: ANOVA showing difference in respondents' perception of Sexual Dysfunction adjustment strategies employed by Local Government Employed Married Women in Kwara State based on age

Source	Sum of Squares	df	Mean Square	Cal. F	Crit. F	p-value
Between group	270.658	2	135.329	4.68 *	3.00	0.010
Within group	12053.940	417	28.906			
Total	12324.598	419				

* Sig. $p < 0.05$

Table 4 presents difference in respondents' perception of Sexual Dysfunction adjustment strategies being employed based on age. The table indicates that, under the degree of freedom (df) of 2 and 417, the calculated F-value of 4.68 is greater than the critical F-value of 3.00, with a corresponding p-value of 0.010 which is less than 0.05 level of significance. This shows that there is significant difference, thus, the hypothesis is rejected. Therefore, age has significant influence on married women perceived Sexual Dysfunction adjustment strategies being employed by Local Government Employed Married Women in Kwara State. In order to identify which of the sub-variables of age contributed to the difference noted in table 4, a Duncan Multiple Range Test (DMRT) is therefore performed.

Table 5: DMRT showing the sub-variable of age responsible for the difference in respondents' perception of Sexual Dysfunction adjustment strategies being employed by Local Government Employed Married Women in Kwara State

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Duncan Grouping	N	Mean	Age
Group1	135	42.76	18-30 years old
Group 2	105	41.25	41 years old & above
Group 3	180	40.94	31-40 years old

Table 5 represents DMRT of the sub-variable of age that influence the difference in respondents' perception of Sexual Dysfunction adjustment strategies being employed. The table shows that the mean of the three groups, that is, groups 1 (42.76), 2 (41.25) and 3 (40.94) differ significantly from one another. This is indicated by a significant difference of 1 and above. However, the mean score of group 1 is greater than that of group 2 and 3, hence, responsible for the difference noted in table 4. This implies that younger married women of between 18-30 years differ from others in their perception of Sexual Dysfunction adjustment strategies being employed. Their little experience as married women and about sexual problems could have contributed to the difference noted in table 4.

Hypothesis Three: ***There is no significant difference in the perceived sexual dysfunction adjustment strategies being employed by Local Government Employed Married Women in Kwara State based on religious affiliation***

Table 6: ANOVA showing difference in respondents' perception of Sexual Dysfunction adjustment strategies employed by Local Government Employed Married Women in Kwara State based on religious affiliation

Source	Sum of Squares	Df	Mean Squares	Cal. F	Crit. F	p-value
Between group	382.887	2	191.444	6.69 *	3.00	0.001
Within group	11941.710	417	28.637			
Total	12324.598	419				

* Sig. at $p < 0.05$

Table 6 presents difference in respondents' perception of Sexual Dysfunction adjustment strategies being employed based on religious affiliation. The table indicates that, under the degree of freedom (df) of 2 and 417, the calculated F-value of 6.69 is greater than the critical F-value of 3.00, with a corresponding p-value of 0.001 which is less than 0.05 level of significance. This shows that there is significant difference, thus, the hypothesis is rejected. Therefore, religion has significant influence on married women perceived Sexual Dysfunction adjustment strategies being employed by Local Government Employed Married Women in Kwara State. In order to identify which of the sub-variables of religion contributed to the difference noted in table 6, a Duncan Multiple Range Test (DMRT) is therefore carried out.

Table 7: DMRT showing the sub-variable of religion responsible for the difference in respondents' perceptions of Sexual Dysfunction adjustment strategies being employed by Local Government Employed Married Women in Kwara State

Duncan Grouping	N	Mean	Religion
Group 1	221	42.06	Islam
Group 2	108	40.76	Christianity
Group 3	19	37.95	ATR

Table 7 represents DMRT of the sub-variable of religion that influence the difference in respondents' perception of Sexual Dysfunction adjustment strategies being employed. The table shows that the mean of the three groups, that is, groups 1 (42.06), 2 (40.76) and 3 (37.95) different significantly from one another. This is indicated by a significant difference of 2 and above. However, the mean score of group 1 is significantly greater than that of group 2 and 3, hence, responsible for the difference noted in table 6. This implies that respondents from Islamic religion differ from others in their perception of Sexual Dysfunction adjustment strategies being employed. The reason might be because Islam is in support of seeking lawful and using appropriate solution to overcome the problem of sexual dysfunction in marriage.

Discussion of Findings

In order to adjust with these problems of Sexual Dysfunction among Local Government Employed Married Women in Kwara State adopted strategies of seeking medical assistance, seeking support from

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friends and using of sexual performance enhancement herbs to cope. This finding implies that the married women in Kwara State have positive adjustment strategies in coping with sexual dysfunction. The women believe in the efficacy of both orthodox and traditional medicine by seeking friend support in proffering solution to various kinds of Sexual Dysfunction they experienced. The reason for this finding might have resulted from the fact that married women have understood some likely consequences of sexual dysfunction in marriage (such as hatred and irritation, frequent conflict over sex, and inability to bear children); hence, they have taken appropriate steps to overcome the challenge. The findings of this study are in harmony with the finding of Yahi (2004) which identified seeking of support from friends and seeking medical assistance as adjustment strategies of women. The American Association of Sexuality Educators, Counsellors and Therapists (2015) noted women are also victim of sexual dysfunction and they usually engage in helping relationship with a medical experts who can help them understand their sexual problems and strategies to improve intimacy. Studies (Aschenbrenner, 2004; Kang et al., 2002) have similarly shown that there are various over-the-counter herbal products that heal female sexual dysfunction and restore hormone levels. However, they stressed that many of these products lack sufficient scientific studies required to support the manufacturer’s claims of efficacy and safety. Therefore, people should be cautioned about the potential side effects of herbal products.

The first hypothesis revealed that there was no significant difference in the perceived Sexual Dysfunction adjustment strategies being employed by Local Government Employed Married Women in Kwara State based on educational attainment. This also implies that respondents’ level of educational attainment has no influence on their perception of adjustment strategies employed by women in sexual dysfunction. The finding of this study is in line with the finding of Najafabady, Salmani and Abedi (2011), which revealed significant difference in the strategies employed by women in coping with sexual dysfunction based on educational attainment.

The second hypothesis revealed that there was significant difference in the perceived Sexual Dysfunction adjustment strategies being employed by Local Government Employed Married Women in Kwara State based on age. This implies that age difference of the respondents influenced their perception of adjustment strategies being employed in adapting to sexual dysfunction. This finding negates the finding of Xing-Li et al. (2016) which revealed that there was no significant influence on sexual dysfunction adjustment based on age groups.

The third hypothesis also revealed that significant difference exist in the perceived Sexual Dysfunction adjustment strategies being employed by Local Government Employed Married Women in Kwara State on the basis of religious affiliation. This implies that religion influenced respondents’ perceptions of adjustment strategies for sexual dysfunction. The study finding supports the finding of the National Youth Organization (2005) that found religion and spirituality as significant to the management of sexual dysfunction Iranian among women.

Conclusion

The study findings revealed that Local Government Employed Married Women in Kwara State adjust to problems of Sexual Dysfunction by seeking medical assistance, seeking support from friends and using of sexual performance enhancement herbs. The hypotheses tested revealed that there was no significant difference in the perceived sexual dysfunction and adjustment strategies among Local Government Employed Married Women in Kwara State based on educational attainment, while significant differences were found in the perceived sexual dysfunction adjustment strategies among Local Government Employed Married Women in Kwara State on age and religious affiliation.

Recommendations

Based on the findings of the study, it is recommended that:

1. Married women irrespective of their educational status should recognize the impact of sexual dysfunction on marriage and adopt appropriate adjustment strategies to combat it.
2. Women regardless of their age should endevour to organize seminars on a regular basis in their various communities to educate and enlighten themselves on the negatively impact sexual

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dysfunction may have on their marriage and appropriate adjustment strategies to combat the problems so that they achieve successful marital life.

3. Religious leaders should educate couples on sex related issues and how effectively they could adjust with problem of sexual dysfunction, thereby, achieving a stable and happy marital life.

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