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Do women's relationship satisfaction and sexual functioning vary as a function of their male partners' premature ejaculation symptoms?

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Do women's relationship satisfaction and sexual functioning vary as a function of their male partners' premature ejaculation symptoms?

The present study investigated how women's sexual functioning and relationship satisfaction are associated with their partner's premature ejaculation (PE) symptoms, and whether prevalence rates of PE differ when women report on their male partners compared to male self-report. The sample comprised of responses from 1,779 Finnish women (mean age 33.3 years) and a control group of 1,024 Finnish men. Women who reported that their male partners had symptoms of PE were less satisfied with their relationships, and reported lower levels of arousal, orgasm, satisfaction, lubrication, and pain, but not desire. Effect sizes of these associations were small. Men and women report similar base rates of PE, suggesting that on a population level prevalence estimates are remarkably similar irrespective of whether men report on PE symptoms themselves, or women report on their partners.

Keywords: premature ejaculation, sexual dysfunction, relationship satisfaction, female sexual functioning

Introduction

Being able to enjoy and feel pleasure from one's sex life is important for psychological functioning and relationship satisfaction (Althof, 2009). Sexual dysfunctions are associated with decreased sexual satisfaction, lower levels of sexual well-being and decreased relationship satisfaction and quality (Althof, 2009; Sjögren Fugl-Meyer & Fugl-Meyer, 2002; Virtanen, 2002). Premature ejaculation (PE) is considered the most common male sexual complaint and impacts both the man's and his partner's life. (Althof, 2009; Hartmann, Schedlowski & Krüger, 2005). Most studies report a prevalence of 20% to 30% in the general population (de Carufel, 2017; Jern, 2009), but prevalence rates vary widely between studies depending on the definition of the disorder. In studies where PE has been defined with an intra-vaginal ejaculation latency time (IELT) of less than one minute, prevalence rates around 1.5% or less have been reported (Jern, 2009).

PE has been shown to significantly and negatively impact a man's quality of life, psychological functioning and sexual relationship (Rosen & Althof, 2008). Men with PE report lower levels of emotional well-being and higher levels of distress than men without PE (Rowland, Patrick, Rothman, and Gagnon 2007). PE has also been shown to be associated with sexual difficulties in female partners of men. Sjögren Fugl-Meyer and Fugl-Meyer (2002) found in a large, population-based sample in Sweden that 48% of women reported experiencing at least one sexual dysfunction (*i.e.*, distressing difficulties related to sexual desire, subjective or objective arousal, orgasm, and pain), and further, that 54% of women who reported suffering from low sexual interest also reported that their male partner suffered from PE. Several studies have reported associations between symptoms of PE in the male partner and increased occurrences of sexual dysfunctions in their female partners (Canat et al., 2018;

Graziottin and Althof, 2011; Hobbs, Symonds, Abraham, May and Morris, 2008; Kontula, 2009; Verze, 2018).

PE has also been found to be associated with decreased relationship satisfaction and distress in female partners, but these findings have been equivocal. Rosen and Althof (2008) examined the consequences of PE regarding sexual relationship and quality of life through a literature review. High levels of personal distress, such as anxiety, stress, low sexual satisfaction, as well as a negative impact on quality of life and relationship was reported by female partners of men with PE. Patrick et al. (2005), Rowland et al. (2007), Graziottin and Althof (2011), Limoncin et al. (2013) and Giuliano et al. (2008) showed that female partners of men with PE had significantly lower satisfaction with sexual intercourse, higher personal distress, higher sexual distress and more interpersonal difficulty compared to partners of men without PE. On the other hand, Rosen, Heiman, Long, Fisher, and Sand, (2016) found in a sample of 1,009 couples that female partners of men with PE did not report lower sexual or relationship satisfaction than partners of men without PE. Byers and Grenier (2003) also found that having more characteristics of PE was related to lower sexual satisfaction, but not to relationship satisfaction.

Findings regarding how female partners estimate the PE in their partners compared with how men estimate PE in themselves are also equivocal. Sjögren Fugl-Meyer and Fugl-Meyer (2002) found that women's reports of their male partner's sexual dysfunctions were generally fairly close to the rates reported by the male sample. Likewise, Rowland, Patrick, Rothman, and Gagnon (2007) found that PE from men suffering from PE and from their female partners correlated significantly. By contrast, Byers and Grenier (2003) found that men's and women's reports on the man's ejaculatory functioning were only moderately correlated, with men reporting higher

levels of problems than women. Similar results have been reported by Kontula (2009) and Kempeneers, Andrienne, Cuddy and Blairy (2018).

Aims and hypotheses of the present study

The present study aimed to fill the knowledge gaps regarding how PE is associated with different domains of female sexual functioning, relationship satisfaction, and additionally, whether PE symptoms reported by female partners differ from self-reported symptoms by males in a population-based sample.

Based on earlier research, the hypotheses for the present study were:

- (1) Higher levels of PE symptoms in male partners of women predicts lower relationship satisfaction scores and lower scores on variables measuring female sexual functioning when self-reported by women.
- (2) The prevalence rate of PE does not differ when comparing self-reports from men to self-reports from women reporting on their male partners.

Materials and methods

Participants

The sample comprised of responses from 1,779 female twins and sisters of twins who had participated in the second wave of a large-scale longitudinal Finnish population-based study: the Genetics of Sex and Aggression study conducted in 2006 and 2013. The original data collection was carried out in 2006 and targeted all Finnish-speaking twins aged 18-33 years and their over-18-year-old siblings living in Finland at the same time (for a detailed description of this sample, see Johansson et al., 2013). All participants in the data collection were identified from the Finnish Central Population Registry. A total of 7,680 female twins and 3,983 sisters were contacted by mail and

asked if they were interested in completing a sexuality-related questionnaire. A total of 6,200 women completed the questionnaire either by mail or online through a secure web page, resulting in a response rate of 53% for the first data collection. In 2013, women in the first data collection who had declared an interest in participating in future studies were contacted again by mail and asked if they were interested in participating in a follow-up study. Of these 5,197 women, 2,173 participated by completing an online questionnaire through a secure web page, resulting in a response rate of 42% for the second data collection. These women constituted the sample of the present study. Since the mean age of the participants was relatively low at the second time point ($M = 33.2$, $SD = 5.0$), confounding effects of hormonal changes relating to menopause were avoided (the average age of menopause is 51 years; te Velde et al. 1998). An ethical research permit was obtained for both data collections from the Ethics Committee of Åbo Akademi University, in accordance with the Helsinki Declaration. The purpose of the study was clearly described, and the voluntary and anonymous nature of the participation emphasized. Written informed consent was obtained from all participants at both time points.

From the total sample of 2,173 participants, 320 women without a steady male sexual partner, and 74 participants with missing data were excluded, resulting in a final sample of 1,779 women. To control for dependence between members of the same family, only one individual from each family was randomly included in the internal consistency analyses.

To test hypothesis 2, a population-based sample with responses from 1,024 Finnish men (mean age 32.9 years, $SD = 4.9$ years) was also included the study. Participants were taken from the Genetics of Sexuality and Aggression (GSA) sample collected in 2006 (Johansson et al., 2013). In the 2006 data collection, 2,559 men

indicated willingness to participate in follow-up studies. In 2012, these participants were invited to participate in an online follow-up survey. Altogether 1,173 men responded, resulting in a response rate of 46% for the 2012 data collection. Of these, 1,024 gave informed consent and participated in the study.

Measures

All data were gathered using self-report questionnaires.

Relationship satisfaction

Relationship satisfaction was measured using The Perceived Relationship Quality Components scale (PRQC; Fletcher, Simpson, & Thomas, 2000a). The scale has been shown to have good internal consistency and predictive validity in previous studies (Fletcher et al., 2000a; Fletcher, Simpson, & Thomas, 2000b). The PRQC consists of six questions (e.g., “How satisfied are you with your relationship?”) with response alternatives on a 7-point Likert scale with the anchors “not at all” and “extremely”. Higher scores indicate increased relationship satisfaction. The items on the scale were added up to create a composite variable. In the present study, the internal consistency of this measure was good (Cronbach's $\alpha = 0.894$).

Relationship duration

Relationship duration was measured with one question “For how long have you been in your present relationship?” The question was scored on a scale ranging from 1 to 6, where 1 = less than a month, 2 = more than a month but less than six months, 3 = 7-12 months, 4 = 1-3 years, 5 = 4-10 years, 6 = more than 10 years.

Female sexual function

Female sexual function was measured by The Female Sexual Function Index (FSFI; Rosen et al., 2000). The FSFI has repeatedly demonstrated good validity and reliability in different settings and samples (Rosen et al., 2000; Wiegel et al., 2005; Witting et al., 2008) and is the most commonly used tool for assessing sexual function in women. The FSFI includes 19 items, which assess female sexual function over the past 4 weeks in six subdomains (desire, subjective arousal, lubrication, orgasm, sexual satisfaction and intercourse-related pain). For the present study questions assessing female sexual function in a lifelong perspective were created. The same 19 items as in FSFI were used, so that for each item there was one question assessing the function over the past 4 weeks and one question assessing the lifelong function. Due to a technical error in the data collection phase, one pain-related question was omitted from the data collection (item 18: ‘Life-long, how often did you experience discomfort or pain following vaginal penetration?’). Consequently, this item was excluded from all subsequent analyses in the present study (*i.e.*, the sexual pain factor was measured by two items, instead of three). Despite this, the composite variable measuring sexual pain had good reliability ($\alpha = .852$).

In the present study, only the questions assessing life-long female sexual function (FSF) were used in the analyses. The questions are scored on a Likert-type scale ranging from 1 to 5 for some of the items, with lower scores indicating increased sexual function, and from 1 to 6 for some of the items with the supplementary option ‘no sexual activity/did not attempt intercourse’ (see Rosen et al., 2000, for a complete listing of FSFI items and response options). Four women reported that they had not had a partnered sexual experience and were therefore excluded from statistical analyses. The

items of each subscale were calculated in line with the FSFI scoring system (Rosen et al., 2000) and added up to create a composite variable.

The internal consistency was excellent for lubrication ($\alpha = .904$) and orgasm ($\alpha = .922$), good for subjective arousal ($\alpha = .870$) and sexual satisfaction ($\alpha = .866$). For the subdomain of sexual desire, however, Cronbach's α was questionable ($\alpha = .688$). However, the composite variable for sexual desire only consisted of two items which might explain the low level of internal consistency.

Premature ejaculation

Premature ejaculation was measured using the Checklist for Early Ejaculation Symptoms questionnaire (CHEES; Jern, Piha & Santtila, 2013). This tool was developed empirically from three existing screening tools for PE and was found to have good validity (Jern et al., 2013). The male participants responded to the five original items of CHEES, while the items were modified for female participants in order to correspond to their partners' symptoms of PE (e.g., the original question 'Do you ejaculate from very little stimulation?' was phrased as 'Does your partner ejaculate from very little stimulation?'). The five items used in the present study were responded to on a Likert-type scale ranging from 1 to 5. Higher scores are indicative of more pronounced PE symptoms. The items on the scale were added up to create a composite variable. In the present study, the internal consistency of this measure was acceptable in the female sample (Cronbach's $\alpha = .791$). In the male sample the internal consistency was good (Cronbach's $\alpha = .824$).

Statistical analyses

Descriptive statistics were computed using IBM SPSS Statistics (v. 24) software package. The hypotheses were tested using a Student's t-test and a series of generalized

estimating equation (GEE) regression models. The GEE procedure allows for controlling for between-subjects dependence, which was necessary because the data consisted of genetically related individuals. Age and relationship duration were included as covariates in the GEE models.

[Table 1 here]

Results

Descriptive statistics are presented in Table 1. As can be seen in Table 2, hypothesis 1 (that higher levels of PE symptoms in male partners of women would predict lower relationship satisfaction scores and higher scores on variables measuring female sexual dysfunctions) was supported for all variables except sexual desire. The analysis revealed an association between more pronounced PE symptoms in the male as reported by women and lower relationship satisfaction after age and relationship duration were controlled for ($\eta^2_{\text{partial}} = .054$)¹

Regarding the different subscales of the FSFI clear differences were found. The analysis revealed negative associations between the partner's PE symptoms reported by women and the female arousal ($\eta^2_{\text{partial}} = .019$), orgasm ($\eta^2_{\text{partial}} = .012$), and satisfaction ($\eta^2_{\text{partial}} = .027$). Smaller, but still statistically significant, negative association were found for pain ($\eta^2_{\text{partial}} = .004$) and lubrication ($\eta^2_{\text{partial}} = .002$). The analysis revealed no association between the partner's PE symptoms reported by women and the female desire measured by FSFI after age and relationship duration were controlled for ($\eta^2_{\text{partial}} = .000$). The results indicate that female partners who report more pronounced PE

¹ Note. As the GEE procedure in SPSS does not have an option to calculate effect size, effect size was estimated using the univariate General Linear Model procedure, using one randomly selected individual from each family to control for any between-subjects dependence due to genetic relatedness.

symptoms in their male partners tend to report lower sexual function on all subdomains except sexual desire.

An independent sample t-test was conducted to test hypothesis 2 (i.e., that the prevalence rate of PE does not differ when comparing self-reports from men to self-reports from women reporting on their male partners). The results showed that the prevalence rate of PE differs slightly when women reported on their male partners ($M = 9.560$, $SE = 0.098$) compared to when men self-report. ($M = 10.010$, $SE = 0.130$). It should be noted that the men who self-reported were not partners to the women in the female sample, but both samples were population-based. This difference, 0.450, CI [0.131, 0.770] was statistically significant $t(1497.508) = 2.764$, $p = .012$; however, the effect size was minor, $d = 0.132$.

[Table 2 here]

Discussion

In accordance with the first hypothesis of the study, higher levels of PE symptoms in male partners of women were associated with lower relationship satisfaction scores. The earlier research concerning relationship satisfaction and PE has produced ambiguous results. Rosen et al. (2016) and Byers and Grenier (2003) did not find any associations between PE and relationship satisfaction in women. Burri et al. (2014), Patrick et al. (2005), Rowland et al. (2007), Graziottin and Althof (2011), Limoncin et al. (2013) and Giuliano et al. (2008), as well as the literature review by Rosen and Althof (2008), found that PE was associated with higher personal distress in female partners and more interpersonal difficulties in the relationship. It should be noted that none of the studies referred to used the same measure for relationship satisfaction, PRQC, as the present study did. However, the present study showed a clear association between lower relationship satisfaction in women, who reported more pronounced PE problems in their

male partners. This association, however, had a relatively small effect size ($\eta^2_{\text{partial}} = .054$). The sample in the present study is large and population-based and all measures used are validated. The present study can contribute with a robust finding to the earlier equivocal findings.

Also in support of the first hypothesis, higher levels of PE were associated with decreased female sexual functioning. Regarding the six subdomains of the FSFI, the results revealed significant associations but with small effect sizes, which is in line with earlier research. Specifically, associations were found between arousal, orgasm, lubrication, satisfaction, pain and partner-reported PE. These findings are consistent with previous research done by Verze et al. (2018), Canat et al. (2018) and Hobbs et al. (2008). The effect sizes for all associations were small, but this can partially be explained by the fact that the sample was population-based. Population-based samples tend to have smaller effect sizes compared to clinical samples, in which the rate of psychological, physiological and sexual problems usually are higher. Therefore, the results from this study should not be overlooked because of small effect sizes.

However, not all findings concerning the subdomains of FSFI were in line with past studies. In contrast to the findings of Sjögren Fugl-Meyer and Fugl-Meyer (2002) and Kontula (2009) the present study did not show any association between the FSFI subdomain desire and PE. This result might have to do with the fact that this study used life-long questions when measuring FSFI, instead of the standard last four weeks. The life-long version was chosen because measuring only the last four weeks in relationships that on average lasted four to ten years is not very accurate. The life-long questions include a broader perspective on sexual functioning and are more in line with the other questions measuring relationship satisfaction and PE symptoms, which do not have a time limit. Using the questions covering the entire lifespan instead of ones

covering the last four weeks also gives a more accurate view of what is going on in the relationship in a broader perspective. Four weeks is a short period of time, and according to the latest FINSEX study (Väestöliitto, 2019), Finnish women have sexual intercourse on average once a week if their romantic relationship has lasted longer than two years. Therefore, the risk of errors in a four-week measurement period, during which it is reasonable to estimate that around four intercourses have happened, is greater than in life-long measurements, where a greater amount of sexual intercourses in different situations and environments probably are taken into account.

Furthermore, the average age for the participants in the study was 33.2, and the average age for first sexual intercourse is 17.5 years for Finnish women born after 1970. (Väestöliitto, 2019). This also justifies the use of the life-long version, as a majority of the participants have had an active sex life for at least ten years and been in their present relationship between four and ten years. As the purpose of the study was to examine overall sexual functioning, it is justified to use the life-long questions to get the most accurate view of the current functioning in the current relationship. On the other hand, it is possible that the participants were not considering their current relationship and partner, when asked to think about sexual functioning in a life-long perspective. Whether this happened is unclear, but since the mean relationship duration for the participants ranged from 4 to 10 years, it is reasonable to assume that the participants also took the current relationship into account when measuring their sexual functioning.

In regard to the second hypothesis, that is, whether the prevalence rate of PE were similar when comparing self-reports from men to self-reports from women reporting on their male partners, the results showed that men reported slightly higher levels of PE than women reported on behalf of their partners. This finding supports the findings by Kontula (2009), Byers and Grenier (2003) and Kempernees et al. (2018),

who found that women estimated the duration of penetration longer than men did and women also saw PE as less of a problem than men did. In contrast, Sjögren Fugl-Meyer and Fugl-Meyer (2002) and Rowland et al. (2007) who found that men and women estimate similar rates of PE symptoms. It should be noted, however, that the estimates in the present study do not stem from dyadic couples, but from two different population-based data collections, which means that they do not necessarily reflect gender differences in perception of the same objective functioning but might depict different levels of PE in the two populations. The present study suggests that on a population level prevalence estimates are remarkably similar irrespective of whether men report on PE symptoms themselves, or women report on their partners. The earlier studies focusing on this aspect of PE have seldom used a validated measure to investigate how men and women estimate PE. Kempeneers et al. (2018) asked men and female partners to estimate the duration of penetration before PE, but other studies have focused on how men and their female partners experience PE and the circumstances surrounding it differently. Kontula's (2009) measure consisted of one question (whether the man had ejaculated too quickly within the last year) and found that men reported higher rates of PE than women did. The strength of the CHEES-tool used in the present study is that the same five questions were answered by both sexes, and it is in line with the DSM-5 diagnostic criteria (American Psychiatric Association, 2013). The findings of the present study suggest that, when given exact and validated questions, men and women estimate the prevalence of PE very similarly.

Since the present study more or less replicates some of the earlier research and the effect sizes in this study were small, mentioning the ongoing so-called replication crisis is justified. Open Science Collaboration (2015) showed that when replicating published studies, the mean effect size of the replication effects was half the magnitude

of the mean effect size of the original effects. Moreover, many earlier studies cannot be replicated, and those studies that have been replicated only small effect sizes have been found. To that background the results of the present study, with small effect sizes, are just what could be expected in the light of the replication crisis. Much bigger effect sizes in a population-based sample would not be reliable. However, it is defensible to replicate earlier studies, both from the perspective of the replication crisis and the fact that earlier findings in this field are equivocal.

A clear limitation of the present study is that all measures and variables are based on self-reports, which makes our results vulnerable to, for example, recall bias. It was also not possible to determine whether there is agreement between female partners' reports of PE symptoms in her male partner and the partner's self-evaluation of the same symptoms. For example, it is a possibility that women who are unsatisfied with their relationship could more easily exaggerate the PE symptoms in their partner. A limitation that characterizes the whole research field, including the present study, regarding PE, and its impact on relationships and the partners, is the heteronormativity of the research done. Almost every study conducted in the field focuses on heterosexual couples and PE is often measured and diagnosed using intra-vaginal latency time. This means that the results of this study are not generalizable outside of heterosexual couples. However, the present study used a large population-based sample which gives the results better generalizability than a clinical sample could. Another strength was that all measures used were validated and reliable.

Declaration of interest statement

The authors declare no conflicts of interest.

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Tables

Table 1. Descriptive Statistics for Age, Sexual Function, Premature Ejaculation Symptoms and Relationship Satisfaction and Duration.

Variable	<i>M</i>	<i>SD</i>	Range
<i>Women (n = 1,779)</i>			
Age	33.230	4.995	25-56
Relationship duration	4.990	1.089	1-6
PE (partner's)	9.539	3.735	5-25
PRQC	35.214	6.232	7-42
FSFI desire	3.984	0.711	1.2-6
FSFI arousal	2.673	0.907	1.2-7.2
FSFI lubrication	1.863	0.809	1.2-7.2
FSFI orgasm	2.862	1.365	1.2-7.2
FSFI satisfaction	2.645	1.072	1.2-6.8
FSFI pain	1.424	0.650	0.8-4.8
<i>Men (n = 1,024)</i>			
Age	32.940	4.884	23-63
PE, self-reported	9.929	3.364	5-25

Note. PRQC = measurement of relationship satisfaction (higher scores indicate higher satisfaction), PE = Premature Ejaculation (higher scores indicate more pronounced PE symptoms), FSFI = Female Sexual Function Index (higher scores indicate decreased sexual function). *M* = mean, *SD* = Standard Deviation

Table 2. Associations between Partner-Reported Symptoms of Premature Ejaculation, Relationship Satisfaction, and Female Sexual Function.

Variable	Wald χ^2	<i>p</i>	<i>B</i>	<i>SE</i>	η^2_{partial}
PRQC	75.061	<.001	-.390	.045	.054
FSFI desire	0.021	.886	.001	.005	.000
FSFI arousal	28.758	<.001	.036	.007	.019
FSFI lubrication	5.242	.022	.014	.006	.002
FSFI orgasm	21.740	<.001	.043	.009	.012
FSFI sex satisfaction	38.838	<.001	.045	.007	.027
FSFI pain	7.949	.005	.011	.004	.004

Note. PRQC = measurement of relationship satisfaction (higher scores indicate higher satisfaction), FSFI = Female Sexual Function Index (higher scores indicate decreased sexual function). Wald χ^2 = Wald chi squared, *B* = unstandardized regression coefficient, SE = standard error of *B*.