ORIGINAL ARTICLE

Mediation effects of individuals' sexual quality of life on the relationship between sexual quality of life of partners and its predictors: a path analysis

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ABSTRACT

Sexual function and the sexual quality of life of an individual could be influenced by several factors. Sexual dysfunction could affect the sexual quality of life of the individual and, possibly, have an impact on their partners. Treatments that improve sexual function among individuals tend to improve the sexual quality of life of their partners. This study explored the mechanism by which an individual's sexual quality of life mediates the relationship between factors, such as age, sexual dysfunction, perception of IELT, and the partner's sexual quality of life. Path analysis was used to determine if this effect was via direct or indirect mechanisms. Outpatients attending the Maamobi and Tema General Hospitals, as well as their partners, were recruited for this study. A total of 130 males and their partners, as well as 116 females and their partners, were recruited. The GRISS was used to evaluate the sexual function of participants. The sexual quality of life questionnaire was used to evaluate participants and their partners. Ageing in both sexes had a direct effect on the sexual quality of life of their partners. Ageing also indirectly compromises the sexual quality of life of male partners. Impotence indirectly affects the sexual quality of life of female partners. Vaginismus indirectly affected the sexual quality of life of their male partners. Among the male participants, avoidance of sexual activity had both direct and indirect effects on the sexual quality of life of their female partners. Avoidance of sexual activity by female participants only had an indirect effect on the sexual quality of life of the male partners. Ageing in both sexes, directly compromises the sexual quality of life of their partners.

Key words:
sexual quality of life; path analysis; indirect effects; direct effects; mediation analysis

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INTRODUCTION

Sexual function and the sexual quality of life of an individual are influenced by several psychogenic, and biochemical, as well as anthropometric factors. Sexual quality of life usually encompasses multiple dimensions that an individual may associate with a healthy and pleasurable sexual life [1]. Psychogenic factors, such as perception of IELT, quality of partner relationship, body image, and sexual abuse, as well as sociocultural factors could influence an individual's sexual quality of life. Biochemical parameters, such as dyslipidemia, metabolic syndrome, inflammation and dietary habits have been reported to be associated with sexual dysfunction. Anthropometric parameters, such as obesity, weight, waist-to-hip ratio, etc., have also been linked to sexual dysfunction. These factors have been suggested to influence sexual function in both males and females. The presence of any of these factors could compromise sexual function, which invariably, affects the sexual quality of life (SQoL) of an individual. However, it is still unclear as to whether these factors affect the SQoL of their partners via their effect on the sexual function of the individual or by direct mechanisms. Risk factors for sexual dysfunction, such as age, [2-4] obesity [5-10] and dyslipidemia [11, 12] have been reported in various studies, indicating that they tend to influence the sexual quality of life of an individual. This could invariably influence the sexual quality of life of their sexual partners. The effect on the partner's sexual quality of life could be achieved via a direct effect on the domains of sexual function of the individual, which could influence the way the individual responds to sexual advances from the partner, and this could, thus, compromise the sexual quality of life of the partner as well. The relationship between these variables, as well as the pathways by which these effects occur, is still not fully understood. For example, ageing has been reported in several studies to influence sexual function in both sexes and could affect the sexual quality of life [13-16] of the individual. The mechanism by which ageing in an individual affects their sexual function is still poorly understood. It is argued that a compromise in sexual function could compromise the sexual quality of life of the individual and this is likely to compromise the sexual quality of life of their partners, even if their partner does not have sexual dysfunction. Forbes and his colleagues [13] have suggested that the effect of ageing on domains of sexual function could account for the negative relationship between ageing and sexual quality of life. It is possible that ageing in an individual compromises the SQoL of the partners by both direct and indirect mechanisms. Thus, by compromising the domains of their sexual function, and, subsequently, compromising the SQoL of the individual, ageing could eventually compromise the SQoL of the partner. Obesity, [5-8] hypertension [17-20] and the presence of other comorbidities have also been reported to influence sexual function. Interestingly, whether these factors influence the sexual function of their partners directly or indirectly is still not very clear. Some of the risk factors may have both a direct as well as indirect influence on the sexual quality of life of their partners. Recent studies have reported that men with erectile dysfunction had female partners with reduced sexual experience. [21] Some studies have also reported that females whose partners were treated with PDE5 inhibitors had an improved sexual function, [22] more satisfying sexual experience [21] and a better sexual quality of life [23, 24] as compared to females whose partners were not treated with PDE5 inhibitors. Thus, sexual dysfunction in individuals could certainly impact the sexual function and sexual quality of life of their partners. However, whether the pathway of influence on the

partner is by direct or indirect mechanisms is yet to be reported. In this study, we investigated how ageing, sexual dysfunction and its domains, as well as perception of IELT, influence the sexual quality of life of individuals as well as their partners. We sought to establish whether these factors affect the sexual quality of life of the partners via direct or indirect mechanisms using individuals' sexual quality of life as a mediator.

METHODS

Outpatients attending the Mamobi General Hospital in Accra, Ghana, and the Tema General Hospital, Ghana, as well as their partners were recruited for this study between the periods of March 2017 and April 2019. A total of 246 couples, 130 male participants and their partners, as well as 116 female participants and their partners were recruited for this study. Participants and their partners had to be at least 18 years old and had to be engaged in a stable heterosexual relationship for at least two years prior to enrolment into the study. Participants with any form of obvious or reported physical disability were excluded from this study. Participants were recruited into the study within the OPD of the two hospitals. In addition, phone calls were made to their partners, and the study was explained to them. Participants and partners who agreed to be included in the study were interviewed in their homes on agreed dates. The home interview was used to reassure participants of the confidentiality of the information they provided to the researchers. Unique code numbers were used in identifying each participant and their partners. Participants and their partners were interviewed separately. An informed and signed consent was obtained from each participant, as well as their partners. The Committee on Human Research Publication and Ethics (CHRPE) of the School of Medical Science, Kwame Nkrumah University of Science and Technology, Kumasi, and the Komfo Anokye Teaching Hospital (KATH), Kumasi, gave prior ethical approval for this study. The Sexual function of participants was screened using the Golombuk Rust Inventory for Sexual Satisfaction for males (GRISS-M) and females (GRISS-F)[25]. The GRISS questionnaire was used to evaluate the various domains of sexual function of participants using a face-to-face interview. Participants were also screened for their perceptions of adequate, too short, too long and desirable Intravaginal Ejaculatory Latency Time (IELT). The sexual quality of life questionnaire for males (SQoL-M) [26] and females (SQoL-F) [27] was used to evaluate the sexual quality of life of the participants and their partners. For both the GRISS and the SQoL questionaires, the interviewer scored participants on the questionnaire sheet for every question until the questionaires were filled. Demographic characteristics were also captured, including employment status, educational level and age.

The Golombok-Rust Inventory of Sexual Satisfaction (GRISS)

The GRISS consists of a 56-item (28 for males and 28 for females) inventory designed as a self-reporting tool to evaluate both the quality of a heterosexual relationship and each partner's level of sexual functioning within a relationship. The GRISS consists of 7 domains for males and 7 domains for females, as well as a global score that summarizes the overall quality of the relationship and sexual functioning in the couple. Domains concerning female sexuality are anorgasmia, vaginismus, avoidance, nonsensuality, dissatisfaction, infrequency and non-communication. Domains for male sexuality are impotence, premature ejaculation, avoidance, nonsensuality, dissatisfaction, infrequency, and

noncommunication. Each scale is scored on a five-point Likert-type scale, ranging from always, usually, sometimes, hardly ever, and never. Subscale scores are transformed to standardized stanine scores with scores of 5 to 9 indicating sexual difficulties.

The Sexual Quality of life (SQoL)

The sexual quality of life of participants was assessed using the SQoL questionnaire. Participants were asked to give their opinion regarding their quality of life as affected by sexuality. Respondents were required to indicate how they felt when they think about their sex life. The questionnaire is an 18 item questionnaire for females and an 11 item questionnaire for males. Both questionnaires have a six-point Likert scale, ranging from completely agree (1) to completely disagree (6). The raw scores are then transformed into a standardized scale of 0 to 100, with increasing scores implying a greater quality of life.

Statistical analysis

Path analysis, which is a component of structural equation modelling (SEM), was used to model relationships in the dataset. Path analysis models multiple hypothesized relationships among manifest variables. [28-29] The models were fitted using the robust maximum likelihood (MLR) method under structural equation modelling. The MLR approach estimates the parameters in the model by minimizing the function in equation (1), with robust standard errors, where $\Sigma(\theta)$ is the implied covariance matrix, S, **the sample covariance matrix,** p, the number of observed variables and tr, the trace.

$$\mathrm{FML} = \log \Sigma(\theta) - \log \mathrm{S} + \mathrm{tr}[\mathrm{S}\Sigma(\theta)^{-1}] - \mathrm{p} \qquad (1)$$

The maximum likelihood (ML) approach was proposed for quantitative data that satisfy the multivariate normality. However, it produces inconsistent standard errors for nonnormal data. [28, 30] As a result, a maximum likelihood estimator, with robust standard error (MLR), was used, since the data deviated slightly from multivariate normality [28, 30-31]. The models were assessed using fit indices, such as chi-square test statistic, relative chi-square test statistic, root mean square error of approximation (RMSEA), standardized root mean square residual (SRMR), comparative fit index (CFI), goodness of fit index (GFI) and Tucker-Lewis Index (TLI). A nonsignificant chi-square test implies the model is good and it could be used to explain the covariance in the observed data. Since the chi-square test is sensitive to sample size, a model with a relative chi-square test statistic between 2 and 5 was considered as a good model, whilst values less than 2 are highly recommended. Moreover, models with RMSEA and SRMR values less than 0.1 were considered acceptable, while values less than 0.05 were considered highly recommended. A model is also considered good if the CFI, TLI, and GFI values are greater than or equal to 0.90, with values of 0.95 or more recommended. [28, 31-32]

The dataset was collected from 246 couples, comprising 130 males and 116 females. The Kaiser-Meyer-Olkin statistics confirmed the sample was adequate for modelling by reporting a value of 0.624, and Bartlett's test of sphericity reported 581.76 (p-value < 0.0001), implying that the correlation matrix (Table 2) was appropriate for modelling. [32]

Hypothesized relationships between sexual quality of life of study participants, sexual quality of life of their partners, impotence, avoidance, noncommunication, perception of desirable and adequate intravaginal ejaculatory latency time, while controlling for age (see Table 1) were presented in the conceptual model (Figure 1).

Table 1: The variables used

Name of Variable	Abbreviation	Scale of measurement
Sexual Quality of Life	SQoL	Ratio
Avoidance Score	AV_SC	Ratio
Sexual Quality of Life (Partners)	SQoL_P	Ratio
Sexual Quality of Life (both male and female individuals)	SQoL_MF	Ratio
Sexual Quality of Life (male individuals)	SQoL_M	Ratio
Sexual Quality of Life (female individuals)	SQoL_F	Ratio
Non-communication Score	NC_SC	Ratio
Impotence and Vaginismus score	IM_VG	Ratio
Impotence score	IM_SC	Ratio
Vaginismus score	VG_SC	Ratio
Desirable IELT	DES	Ratio
Adequate IELT	ADEQ	Ratio

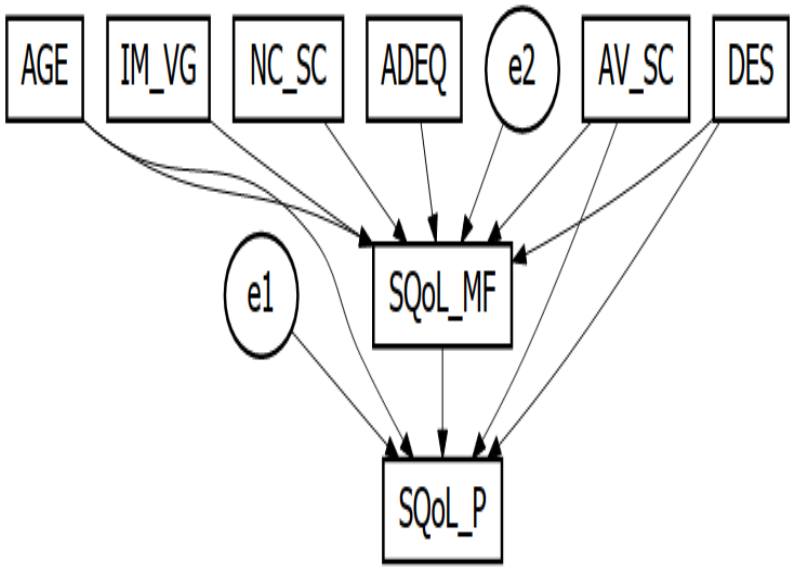

Figure 1: Conceptual model for assessing the mediation effects of an individual's sexual quality of life between risk factors and the partner's sexual quality of life

RESULTS

The study participants reported a mean age of 60.18±10.62, with the following age range (29.00, 89.00). Males constituted 53%, with a mean age of 63.04±10.85, while females were aged 56.98±9.42. Those with basic education constituted 70.7%, secondary/technical education 25.2%, and tertiary 4.1%. About 50% of the individuals are workers, 41% have retired and 9% are nonworkers.

Table 2: Correlations between variables

	SQoL_MP	SQoL_P	AGE	IM_VG	AV_SC	NC_SC	DES	ADEQ
SQoL_MF	1.000							
SQoL_P	0.668***	1.000						
AGE	-0.378***	-0.504***	1.000					
IM_VG	-0.191**	-0.080	-0.026	1.000				
AV_SC	-0.580***	-0.488***	0.339***	0.213**	1.000			
NC_SC	0.113	0.132*	-0.177**	0.007	-0.110	1.000		
DES	-0.032	-0.070	-0.056	0.000	-0.138*	-0.137*	1.000	
ADEQ	-0.052	-0.051	-0.092	0.021	-0.019	-0.020	0.729***	1.000

****p-value<0.001, **p-value<0.01, *p-value<0.05, SQoL_MF- Sexual Quality of Life (both male and female individuals), SQoL P-Sexual Quality of Life (Partners), IM VG-Impotence and Vaginismus, AV_SC-Avoidance Score, NC_SC-Non-communication Score, DES-Desirable IELT, ADEQ-Adequate IELT*

Table 3: Model adequacy measures

Fit indices	**Model 1**	**Model 2**	**Model 3**
Chi-square test statistic (p-value)	0.151(0.985)	6.377 (0.095)	3.870 (0.276)
CFI	1.000	0.985	0.991
TLI	1.045	0.936	0.962
RMSEA (p-value)	0.000 (0.994)	0.093 (0.185)	0.050 (0.396)
SRMR	0.002	0.021	0.022
Chi-square/df	0.050	2.126	1.290
GFI	1.000	0.980	0.973

Using SEM to model the data showed that the models fit the data correctly. The maximum likelihood estimation reported non-significant chi-square tests for all modes (Model 1, Model 2 and Model 3). The relative chi-square test statistic, RMSEA, SRMR, CFI, GFI and TLI also reported that models are fitted correctly (Table 3).

Table 4: Types of effects in Model 1 (Both males and females)

Hypothesized paths	Through	Direct effect	Indirect effect	Total effect
AGE → SQoL_MF		-0.167**		-0.167**
IM_VG→ SQoL_MF		-0.120**		-0.120**
AV_SC → SQoL_MF		-0.527***		-0.527***
NC _SC → SQoL_MF		-0.012		-0.012
DES → SQoL_MF		-0.156*		-0.156*
ADEQ → SQoL_MF		0.124		0.124
SQoL → SQoL_P		0.479***		0.479***
AGE → SQoL_P		-0.296***	-0.080**	-0.376***
DES → SQoL_P	SQoL_MF	-0.101*	-0.075*	-0.176**
ADEQ → SQoL_P	SQoL_MF		0.059	0.059
AV_SC → SQoL_P	SQoL_MF	-0.095	-0.253***	-0.347***
IM_VG → SQoL_P	SQoL_MF		-0.057*	-0.057*
NC_SC → SQoL_P	SQoL_MF		-0.006	-0.006

****p-value<0.001, **p-value<0.01, *p-value<0.05, SQoL_MF - Sexual Quality of Life (male and female), SQoL_P-Sexual Quality of Life (Partners), IM_VG-Impotence and Vaginismus, AV SC-Avoidance Score, NC SC-Non-communication Score, DES-Desirable IELT, ADEQ-Adequate IELT*

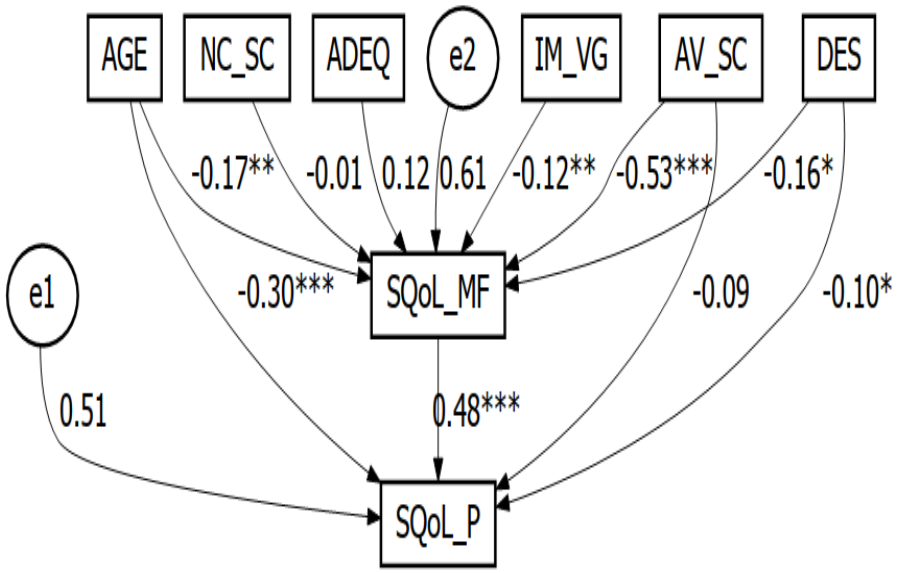

Figure 2: A path model of factors influencing the sexual quality of life of both male and female partners

When both male and female participants were treated as one group (Figure 2), avoidance of sexual activity (direct effect = -0.527, p-value<0.001), ageing (direct effect = -0.167, p-value=0.005), perception of desirable intravaginal ejaculatory latency time (direct effect = -0.156, p-value=0.024) and impotence/vaginismus (direct effect = -0.120, p-value=0.009) had significant negative effects on an individual's sexual quality of life. The model also showed that

the higher the individual's sexual quality of life, the better their partners' sexual quality of life (direct effect = 0.479, p-value<0.001). Ageing has both a direct negative effect (direct effect = -0.296, p-value<0.001) and an indirect effect (indirect effect = -0.080, p-value=0.009) on the sexual quality of life of the partners involved in this study. Higher perception of desirable intravaginal ejaculatory latency time in the participants directly (direct effect = -0.101, p-value=0.017) and indirectly (indirect effect = -0.075, p-value= 0.044) reduced the sexual quality of life of the partner. Furthermore, the model showed that avoidance of sexual activity had no direct influence on the sexual quality of life of the partner (direct effect = -0.095, p-value=0.171). However, avoidance affects the sexual quality of life of partners indirectly (indirect effect = -0.253, p-value<0.001) via the sexual quality of life of the individual (Table 4). Moreover, perception of desirable intravaginal ejaculatory latency time (indirect effect = -0.075, p-value=0.044) and impotence/vaginismus (indirect effect = -0.057, p-value=0.018) have significant indirect effects on the sexual quality of life of the partners by compromising the sexual quality of life of the individual.

Table 5: Types of effects in Model 2 (Males)

Hypothesized paths	Through	Direct effect	Indirect effect	Total effect
AGE → SQoL_M		0.018		0.018
IM_SC → SQoL_M		-0.128*		-0.128*
AV_SC → SQoL_M		-0.708***		-0.708***
NC_SC → SQoL_M		0.001		0.001
DES → SQoL_M		-0.015		-0.015
ADEQ → SQoL_M		0.056		0.056
SQoL_M → SQoL_P		0.459***		0.459***
AGE → SQoL_P	SQoL_M	-0.122*	0.008	-0.114
DES → SQoL_P	SQoL_M	-0.083	-0.007	-0.090
ADEQ → SQoL_P	SQoL_M		0.026	0.026
AV_SC → SQoL_P	SQoL_M	-0.366**	-0.325**	-0.691***
IM_SC → SQoL_P	SQoL_M		-0.059	-0.059
NC_SC → SQoL_P	SQoL_M		0.000	0.000

****p-value<0.001, **p-value<0.01, *p-value<0.05*

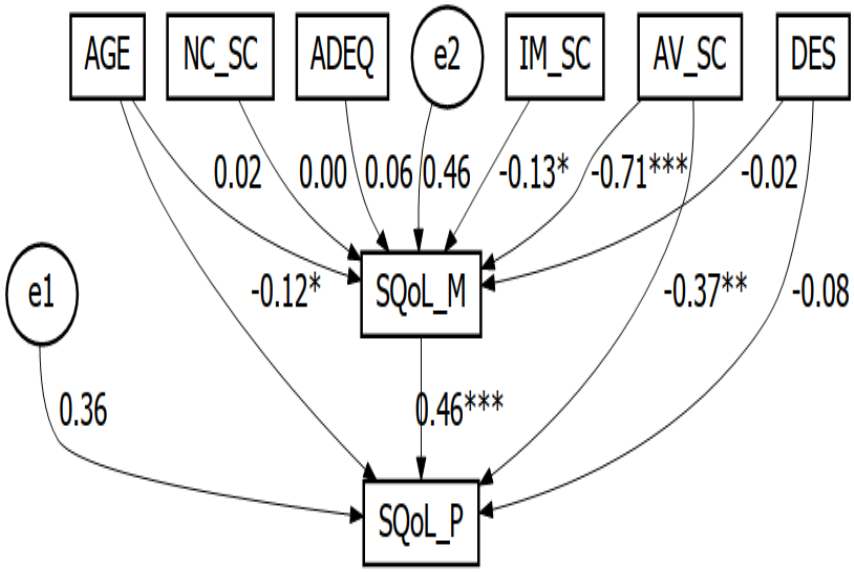

Figure 3: A path model of factors influencing the sexual quality of life of female partners of male participants

Figures 3 & 4 contain the models, when the two sexes were treated as separate groups. Results from Figure 3 showed that the ageing of male individuals did not affect their sexual quality of life (direct effect = 0.018, p-value= 0.772). Rather, it negatively affected their partners' sexual quality of life directly (direct effect = -0.122, p-value= 0.035). The results showed that impotence in male participants in this study affected their sexual quality of life (direct effect = -0.128, p-value= 0.018). Avoidance of sexual activity among the male participants affected the sexual quality of life of their partners either by directly (direct effect = -0.366, p-value= 0.005) compromising the SQoL of the female partners or by indirectly compromising the sexual quality of life of the male participants, which, invariably, affected the SQoL of the female partners (indirect effect = -0.325, p-value= 0.002). Also, avoidance of sexual activity among the male participants negatively affected their sexual quality of life (direct effect = -0.708, p-value< 0.001). Moreover, higher sexual quality of life of males (direct effect = 0.459, p-value< 0.001) leads to higher sexual quality of life of female partners (Table 5).

Table 6: Types of effects in Model 3 (Females)

Hypothesized paths	Through	Direct effect	Indirect effect	Total effect
AGE → SQoL_F		-0.175*		-0.175*
VG_SC → SQoL_F		-0.235**		-0.235**
AV_SC → SQoL_F		-0.407***		-0.407***
NC_SC → SQoL_F		0.055		0.055
DES → SQoL_F		-0.213*		-0.213*
ADEQ → SQoL_F		0.106		0.106
SQoL → SQoL_P	SQoL_F	0.414***		0.414***
AGE → SQoL_P	SQoL_F	-0.382***	-0.072*	-0.454***
DES → SQoL_P	SQoL_F	-0.082	-0.088	-0.170*
ADEQ → SQoL_P	SQoL_F		0.044	0.044
AV_SC → SQoL_P	SQoL_F	0.004	-0.168**	-0.165*
VG_SC → SQoL_P	SQoL_F		-0.097**	-0.097**
NC_SC → SQoL_P	SQoL_F		0.023	0.023

****p-value<0.001, **p-value<0.01, *p-value<0.05*

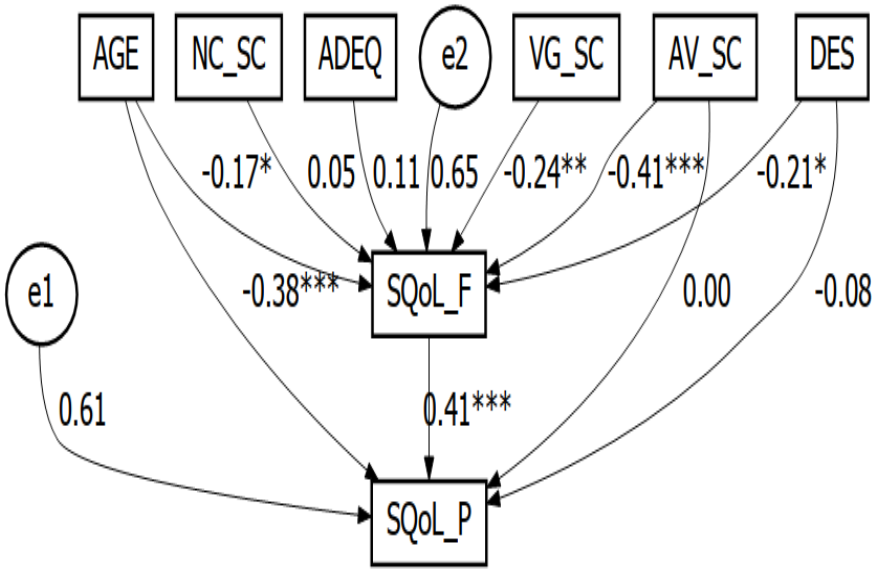

Figure 4: Path model of factors influencing sexual quality of life of male partners of female participants

Figure 4 and Table 6 show the model fit results for female study participants. This figure shows that when the female participants were modelled as a separate group, ageing in the female participants compromised the sexual quality of life of their male partners either by directly compromising the SQoL of the male partners (direct effect = -0.382, p-value<0.001) or by indirectly compromising the SQoL of the female participant, and, thus, affecting the SQoL of the male partner (indirect effect = -0.072, p-value= 0.037). Higher perception of what a desirable intravaginal ejaculatory latency time should be, in a female participant showed no significant indirect effect on the SQoL of the male partner (indirect effect =

-0.088, p-value=0.062). However, a total effect (total effect = -0.170, p-value=0.031) was seen (Table 6). Thus, a higher perception of desirable IELT by the female participant could impact the sexual quality of life of the male partner. Avoidance of sexual activity (indirect effect = -0.168, p-value=0.001) and the presence of vaginismus (indirect effect = -0.097, p-value=0.005) amongst female participants in this study indirectly affected the SQoL of the male partners by compromising the SQoL of the female participants. They, however, did not directly affect the SQoL of their male partners. Ageing (direct effect = -0.175, p-value=0.038), presence of vaginismus (direct effect = -0.235, p-value=0.003), avoidance of sexual activity (direct effect = -0.407, p-value<0.001) and perception of what a desirable intravaginal ejaculatory latency time (direct effect = -0.213, p-value=0.050) amongst female participants significantly affected their SQoL, negatively. Higher sexual quality of life of females (direct effect = 0.414, p-value<0.001) leads to higher sexual quality of life of male partners.

DISCUSSION

An increase in avoidance of sexual activity, perception of desirable intravaginal ejaculatory latency time, impotence/vaginismus, and ageing significantly reduce an individual's sexual quality of life. Ageing in men has a direct effect on the sexual quality of life of their female partners. Thus, as male participants aged, the sexual quality of life of their female partners significantly decreased, and this decrease was by direct mechanisms. Ageing in men has been strongly linked to an increase in comorbidities, [33] decreases in testosterone levels, and increased binding of SHBG, [34-36] resulting in a significant decline in the levels of free testosterone in men. The declining levels of free testosterone could induce erectile dysfunction (impotence) amongst ageing men. As erectile dysfunction decreases a man's readiness to engage in sexual activity, the avoidance that comes with this could ultimately influence how he responds to the sexual needs of his female partner and this could compromise the sexual quality of life of the female partner. This could occur even if the sexual quality of life of the male participant is not significantly compromised.

In females, however, the impact of ageing in reducing the sexual quality of life of their male partners involves both direct and indirect mechanisms. Thus, whereas ageing in males does not necessarily compromise the sexual quality of life of the males themselves, ageing in females compromises the sexual quality of life of the women, and this subsequently compromises the sexual quality of life of their male partners.

De Graaff and his colleagues [37] reported in a study amongst women with endometriosis that depressive symptoms among females consequently resulted in a compromise of their sexual function. They observed that this did not, however, affect the sexual function of the male partners. Thus, sexual dysfunction in females might not necessarily result in a direct effect on the sexual function of their male counterparts. The current study, however, shows that there was still a possibility of female sexual dysfunction indirectly influencing the sexual quality of life of male partners.

This study indicates that avoidance of sexual activity by females indirectly affected the sexual quality of life of the male partners. Avoidance of sexual activity by males, on the other hand, affected the sexual quality of life of their female partners via both direct and indirect mechanisms. Thus, as avoidance compromises the sexual quality of life of the male partners, it invariably decreases the sexual quality of life of their female

partners. Avoidance of sexual activity could also compromise the sexual quality of life of the female partners directly. The avoidance of sexual activity by male participants could be interpreted by the female partner as rejection, and feeling not very wanted. In effect, a female's sexual quality of life could be compromised via a poorer self-perception and decreased self-worth. Sexual dysfunction in females has been reported to be strongly linked to psychogenic factors. Thus, any compromise in self-worth and a feeling of rejection could directly impact the sexual quality of life of a female partner.

Higher perception of the desirable intravaginal ejaculatory latency time of an individual could negatively affect their sexual quality of life directly and affect the sexual quality of life of the partners by both direct and indirect mechanisms.

Impotence (ED) in male participants, as well as vaginismus in female participants, had no direct effect on the sexual quality of life of the male and female partners, respectively. The effect of vaginismus in females affects the sexual quality of life of their male partners by compromising the sexual quality of life of the female subjects themselves, before indirectly affecting the sexual quality of life of their male partners. In an earlier study, [38] men who had wives with vaginismus were reported to have a high rate of sexual dysfunction and sexual dissatisfaction. It is possible that vaginismus in the females in that study could have resulted in a reduced interest in sexual activity, thereby impacting the sexual function of their male partners, and, eventually resulting in dissatisfaction in the sex life of the men. Thus, such situations could easily compromise the sexual quality of life of their male partners. Moreover, individuals' sexual quality of life could mediate the relationship between the sexual quality of life of partners and risk factors: namely, age, perception of desirable intravaginal ejaculatory latency time, avoidance of sexual activity and impotence/vaginismus.

RECOMMENDATIONS

Ageing in males and females directly compromises the sexual quality of life of their partners. Avoidance of sexual activity and vaginismus indirectly compromise the sexual quality of life of the partners by compromising the sexual quality of life of the individuals. Individuals' sexual quality of life is a significant mediator in explaining the relationships between sexual quality of life of partners and age, perception of desirable intravaginal ejaculatory latency time, avoidance of sexual activity and impotence/vaginismus. In overcoming these challenges, clinicians and sex therapists should consider evaluating the sexual function of the partners of their clients, so as to enable them to devise a holistic intervention that would improve the sexual quality of life of their patients as well as their partners. Future research should focus on a longitudinal study that follows couples through various stages of life to further broaden our understanding of the various factors that influence sexual functioning in couples.

LIMITATIONS OF THE STUDY

The relationships between risk factors and sexual quality of life of partners and mediator (individual's sexual quality of life) in this study were modelled, while controlling for age, other confounding variables could be considered in a further study. The reliance on self-reported, face-to-face interviews could introduce some deficiencies in the accuracy of the data. The findings of this study should not be unduly generalized and the setting of the study must always be considered.

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