

Sexual disabilities are not singularities

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This report is based on a survey (performed 1996) of sex life in a nationally representative sample of Swedish women ($n=1335$) and men ($n=1475$) aged 18–74 y. From that survey we have previously reported on prevalence of sexual disabilities and problems caused by them.¹ The main object of this article is to describe intra- and inter-gender concurrence of sexual disabilities and problems in sexually active subjects. Furthermore, the relative risk of low level of sexual well-being as predicted by sexual disabilities and distress is addressed. Respondents (59% of target sample) participated in an investigation which combined structured interviews with questionnaires/checklists. Main results are that within and across genders sexual disabilities concur to significant degrees. Of the women 48 and 26% reported at least one own and partner sexual disability or distress caused by them, respectively. For the men the corresponding proportions were 26 and 17%, respectively. Odds ratios showed that for the women low sexual interest, difficulties in obtaining orgasm and partner's early ejaculation were significant predictors of low level of sexual well-being. For the men low level of interest and partner's difficulties in obtaining orgasm were the only, but equally powerful, predictors. It is concluded that in clinical practice and for those who have a partner, sexual disabilities and distress caused by them should be regarded from the partner relationship perspective.

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Introduction

The last decade has seen an upsurge of epidemiological surveys of sexual life in the adult population, many of which have recently been excellently surveyed by Simons and Carey.² Nevertheless, only a handful of them have focussed upon a broader spectrum of sexual disabilities in both genders. Some large-scale nationally or regionally representative investigations encompassing both genders have been conducted in Denmark,³ France,⁴ Finland,⁵ Iceland,⁶ the USA⁷ and in Sweden.^{1,8} In these investigations the prevalence of sexual disabilities in women and men has been described and prevalence has been related to health conditions and to socio-demographic circumstances. The extent to which sexual disabilities concur has, however, only fragmentarily been investigated.

Prevalence of sexual disabilities in Sweden

In a previous report¹ on the same sample the Swedish prevalence of sexual disabilities and problems caused by them were given. Table 2 is a condensation of some of these findings. Of the Swedish women 47%, a proportion very close to that reported in the US,⁷ had at least one sexual disability, while this was the case for half as many (23%) of the men. Among those participants who reported that a sexual disability caused distress, generally only minorities (15–35%) reported that their sexual life was at least satisfying.

These prevalences pertain, as do those in the present report, to the women (83%) and men (88%) who had been sexually active during the last 12 months. Fifty-six percent of the women and 61% of the men had been so during the preceding week. The greatest proportions of sexually active women (92–95%) and men (92%) were found among the 25–49 y olds. Somewhat lower proportions were evident for the 18–24 y old women (87%) and men (85%). Furthermore, 76% of the women aged 50–65 y olds and 50% of those aged 66–74 had been sexually active during that year.

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The corresponding proportions for the men were 89 and 71%.

With this background, the focus of this report is to describe the extent to which different sexual disabilities (a label we prefer to the somewhat ambiguous term: dysfunction¹) occur simultaneously within and across female and male genders. Moreover, the relative likelihoods of own and a partner's sexual disabilities and accompanying own problems causing low level of sexual satisfaction are explored.

Sample and methods

The target sample was a nationally representative sample of 4781 Swedish women and men aged between 18 and 74. These were drawn from the Swedish Central Population Register. Respondents should be linguistically, mentally and physically able to participate. Fifty-nine percent ($n=2810$, 1335 women and 1475 men) of the eligible persons volunteered in 1996 to participate in a combination of structured interviews performed by specially trained professional interviewers and strictly structured checklists/questionnaires that were returned to the interviewer in a sealed envelope. The latter procedure, applied to all the questions given in Table 1. For the overwhelming majority the investigation took place in their home. A total of about 800 variables were included and the internal drop-out rate was negligible, as no single individual broke up the interview prematurely. In no case was more than one person per household pre-selected to participate.

The initial drop out of 41% is about 10% greater than could be expected in Nordic interview studies. The reasons given for unwillingness to participate were: the subject (sex-life) ($n=630$), lack of time ($n=241$), principles ($n=596$), other reasons ($n=394$). A further 136 subjects could not be

located. *Post hoc* analyses showed only one possible bias: drop-out was somewhat more common in older, and in particular female, than in younger subjects. As, with few exceptions,¹ and as expected, sexual disabilities were more prevalent after the age of about 50 y, the prevalence may rather be somewhat under than overestimated.

Using the questions given in Table 1, the level of each sexual ability/disability in sexually active women and men during the preceding 12 months was reported along a six-graded scale: never/hardly ever/quite rarely/quite often/nearly all the time/all the time. The six-graded ordinal scale enabled the level of ability to be quantified. Operationally dichotomizing the scale into never/hardly ever /quite rarely vs quite often/nearly all the time/all the time offers a possibility to calculate the prevalence of no and mild (sporadically occurring) vs manifest disability.

All questions on female sexual abilities/disabilities and problems (distress) caused by them reasonably conform to the A and B categories of the DSM IV.⁹ In other investigations several questions were used to characterize each disability. These are sometimes aggregated to create indices. As described above, we chose in this descriptive epidemiological study to use only one question for each disability, a simplification which, common as it is, may be disputed. On the other hand aggregation of questions into indices may serve to obscure the focus, especially if different concepts are mixed.¹⁰

The phrasings furthermore enabled the women to report their perception of the male partner's abilities concerning erection and ejaculation. Likewise, the men could report their perceptions of the female partner's vaginal lubrication, orgasm and the female occurrence of vaginismus.

Following each of these questions participants were asked: 'Has this been a problem in your sexual life during the last 12 months?' The answering alternatives to all these questions and their

Table 1 Phrasings of eight statements addressing sexual abilities during the preceding 12 months. All statements were followed by the question: 'Has this happened in your sexual life during the last 12 months?'

Sexual interest (w or m)	It happens that people have periods of decreased interest in sex. Has this...
Vaginal lubrication (w)	It happens that the woman's vagina does not become sufficiently wet during intercourse. Has this...
Penile erection (m)	It happens that the man's penis does not become rigid or gets flaccid during intercourse. Has this...
Orgasm (w)	It happens that the woman has difficulties to reach orgasm. Has this...
Ejaculation (m) too early too late	It happens that the man has ejaculation very shortly after intromission. Has this... It happens that the man has difficulties in achieving ejaculation. Has this...
Vaginismus (w)	It happens that the woman gets spasms in her vagina so that penile penetration is difficult or impossible. Has this...
Dyspareunia (w or m)	It happens that intercourse is associated with pain in the genital organs. Has this...

Table 2 Prevalence (%) of own sexual disabilities and of those perceived to prevail with respondent's partner (italics). The extent to which own or partner's sexual disability causes problems for respondents is also given. Proportions of problems are given in brackets if number of subjects with disabilities is less than 50. This table is a condensation of results given elsewhere.^{1,8} A disability and a concomitant problem is defined by: has occurred quite often, nearly all the time or all the time

	Women		Men	
	<i>Disability</i>	<i>Disability is a problem</i>	<i>Disability</i>	<i>Disability is a problem</i>
Low sexual interest (w or m)	33%	43%	16%	38%
Lubricative disability (w)	12%	63%	6%	48%
Erectile disability (m)	4%	74%	5%	69%
Orgasmic disability (w)	22%	45%	15%	36%
Ejaculatory disability (m)				
too early	6%	38%	9%	49%
too late	3%	(56%)	2%	(55%)
Vaginismus (w)	1%	(92%)	1%	(89%)
Dyspareunia (w or m)	6%	69%	1%	(58%)

operational dichotomy into no/marginal problems vs manifest problems are identical to those given above. Both in the DSM IV (B category) and in a consensus report on definitions and classification of female sexual dysfunctions,¹¹ it has been proposed that sexual dysfunction (disability) and concomitant personal distress should be combined in the definition of female disorders of sexual desire, arousal, orgasm and sexual pain, a suggestion which closely resembles the definition of male erectile dysfunction established by a consensus development panel.¹² As previously¹ suggested by us, this mixture may, however, serve to create conceptual confusion. We have, therefore, preferred to separately measure both sexual ability/disability and the extent to which sexual disabilities lead to problems (distress).

One statement addressing level of sexual satisfaction was phrased 'My sexual life is: very satisfying/satisfying/rather satisfying/rather dissatisfying/dissatisfying/very dissatisfying'. This statement can validly¹³ be dichotomized into the first two answering alternatives denoting sexual satisfaction vs the remaining four alternatives simply indicating that the person is not satisfied. We regard this statement as expressing level of sexual well-being.

Statistics

The data are all treated using the SPSS™ (version 10) program. For simple analyses of associations Spearman's ρ (full-scale entered) or χ^2 (dichotomies) are applied. To obtain an impression of the relative risks of the different sexual disabilities or perceived problems for causing low level of sexual satisfaction, odds ratios were computed through logistic regression analysis. For all statistical analysis the chosen level of significance was $P < 0.05$.

Results

The concurrence of different manifest sexual disabilities (dichotomized scales, cf. Methods) within and across genders is given in Tables 3 (women) and 4 (men). Some main results are that insufficient lubrication, which was reported by 12% (Table 2) of the women, was accompanied by low or decreased sexual interest for 65%, by low orgasmicity in 48%, vaginismus in 5% and dyspareunia in

Table 3 Women: proportions of simultaneously occurring manifest sexual disabilities—own as well as perception of partner's (in a nationally representative sample of Swedish 18–74-y-old women ($n = 1030$) who had a partner and had been sexually active during the last year). Proportions are given in brackets when number of sexual disabled persons (rows) is less than 50

<i>Disability</i>	<i>Low interest</i>	<i>Insufficient lubrication</i>	<i>Low orgasmicity</i>	<i>Vaginismus</i>	<i>Dyspareunia</i>
<i>Own</i>					
Low interest	—	26%	37%	3%	13%
Insufficient lubrication	65%	—	48%	5%	30%
Low orgasmicity	53%	28%	—	3%	13%
Vaginismus	(75%)	(55%)	(64%)	—	(55%)
Dyspareunia	67%	61%	48%	9%	—
<i>Partner's</i>					
Erectile disability	60%	44%	52%	2%	17%
Ejaculation:					
early	54%	24%	50%	3%	14%
delayed	(50%)	(36%)	(42%)	(3%)	(19%)

Table 4 Men: proportions of simultaneously occurring manifest sexual disabilities—own as well as perception of partner's (in a nationally representative sample of Swedish 18–74-y-old men ($n = 1162$) who had a partner and had been sexually active during the last year). Table should be read horizontally. Proportions are given in brackets when number of sexually disabled persons (rows) is less than 50

Disability	Low interest	Erectile disability	Ejaculation early	Delayed	Dyspareunia
<i>Own</i>					
Low interest	—	15%	13%	6%	5%
Erectile disability	45%	—	23%	30%	7%
Ejaculation:					
early	26%	15%	—	0%	2%
delayed	(37%)	(57%)	(0%)	—	(3%)
Dyspareunia	(58%)	(21%)	(11%)	(5%)	—
<i>Partner's</i>					
Insufficient lubrication	39%	15%	18%	6%	6%
Low orgasmicity	24%	9%	18%	4%	3%
Vaginismus	(40%)	(10%)	(20%)	(0%)	(30%)

30%. Furthermore, among those women who felt that the partner had an erectile dysfunction (ED), 60% had low/decreased sexual interest, 44% had insufficient lubrication and more than half (52%) had low orgasmicity. Considerably fewer (2%) female partners of men with ED reported vaginismus, but the prevalence of this condition in the total population was 1%, and nearly three times as many as in the total population (17%) reported dyspareunia, a condition which *per se* was commonly accompanied by low interest, insufficient lubrication and low orgasmicity.

Reading Table 3 by columns, low or decreased sexual interest was reported by the majority (53–75%) of those who themselves had one of the other disabilities and by 50–60% of those whose male partners experienced erectile or ejaculatory disability. Relatively large proportions of women also reported low orgasmicity (37–64%) and insufficient lubrication (24–61%) to be concomitant with own or partner's sexual disabilities.

In the same way sexual disabilities reported by the men (Table 4) were commonly associated with own and partner's disabilities. For instance, ED was accompanied by low interest for 45%, by early and delayed ejaculation for 23 and 30%, respectively, and the number of dyspareunic men (ie men reporting genital pain during intercourse) was 7-fold higher in men with ED than in the total sample of those sexually active within the last year.

Men less often than women reported their own sexual disabilities concomitant with those perceived to prevail for their partner, and in this context it should be borne in mind (see Table 2) that the men experienced their female partner having sexual disabilities to a considerably smaller extent than did the women themselves. In contrast, the women's perceptions of their male partner's disabilities was generally fairly close to those actually reported by the male sample. However, low/

reduced level of interest was common with all other own or perceived partner's sexual disabilities. In fact, all male sexual disabilities were represented in different combinations, the only exception being that early and delayed ejaculations were not reported to occur together. Among the women 48% and among the men 35% reported at least one own or partner's disability, while about half as many women (26%) and men (17%) experienced at least one of the disabilities being a problem for them.

So far we have focussed on the dichotomy: no disability/disability. The extent to which the full six-graded scales from being fully able to being fully disabled were associated with each other is given in the Appendix, which demonstrates close correlations between levels of all own abilities/disabilities and those perceived to prevail in partners. The one and only exception for the women was a male ejaculatory parameter (not at all delayed—always delayed), which was not significantly associated with level of sexual interest. For the men there was, of course, no significant correlation between the two ejaculatory parameters.

The authors previously¹ (see Table 2) demonstrated that, in this nationally representative sample, sexual disabilities do not necessarily imply sexual problems (distress). Table 5 gives odds ratios for the likelihood (or risk) of disabilities or concomitant problems (using the dichotomies) being associated with a non-satisfying sexual life. For the women odds ratios of above 2.0 emerged for all items except vaginismus, indicating an appreciable risk of a broad spectrum of sexual disabilities being associated with a non-satisfying sexual life. This risk was especially high for problems due to low own interest > partner's early ejaculation > own orgasmic disability, where 5–6 fold higher risks were evident. For most items, except partner's ED, delayed ejaculation and own dyspareunia, problems carried higher risks of relatively low level of

Table 5 Odds ratios for sexual disabilities and problems caused by disabilities as estimators of relative risk of low level of sexual satisfaction. Proportions of correctly classified subjects (using the dichotomy: satisfied/very satisfied vs very dissatisfied/dissatisfied/rather dissatisfied/rather satisfied) by each of the four logistic regression analyses (columns) are given in brackets

	Women		Men	
	Disability (75%)	Disability is a problem (75%)	Disability (66%)	Disability is a problem (68%)
Low interest (w or m)	5.0 ^a	5.8 ^a	2.8 ^a	6.5 ^a
Insufficient lubrication (w)	1.6	3.0 ^b	1.4	1.9
Erection (m)	3.0 ^c	2.5	2.0	1.7
Low orgasmicity (w)	3.1 ^a	4.8 ^a	2.3 ^a	4.3 ^a
Ejaculation (m)				
early	2.2 ^c	5.6 ^b	1.5	1.0
delayed	3.3 ^c	3.0	0.9	0.7
Vaginismus (w)	0.7	1.3	7.9	5.3
Dyspareunia (w or m)	2.4 ^c	2.1	0.7	2.0

Letters refer to *P*-value in logistic regression equations: ^a*P* < 0.001; ^b*P* < 0.01 > 0.001; ^c*P* < 0.05 > 0.01.

sexual well-being than did the disabilities *per se*. It should be noted, though, that in the logistic regression analyses not all items were significant classifiers of sexual satisfaction.

For the men clearly fewer of the items had appreciably high odds ratios. The highest risks for low level of sexual satisfaction were problems due to own low interest > partner's vaginismus > problems with partner's orgasmic disability. Somewhat surprisingly, ejaculatory disabilities/problems had no appreciable and erectile disability only a marginal impact on sexual satisfaction.

Discussion

The main new findings are that, gender independently, sexual disabilities whether one's own or one's partner's concur to an appreciable extent. Moreover, sexual disabilities and problems caused by them generally carry with them quite high risks of low level of sexual well-being.

Whereas it is common clinical sexological knowledge that patients seeking help for a particular sexual problem often complain of other sexual disabilities, we have been able to locate hardly any epidemiologically based confirmation of such occurrence. One exception is the report by Bejin¹⁴ in which erectile disability and premature ejaculation were studied. Interpolating Bejin's findings we found that, among the 7% of French men 18–69 y old who often had ED, 29% often had premature ejaculation. Among the 11% who often had premature ejaculation 18% often had ED. In spite of different phrasings of questions and of scales the French findings appear to agree well with those demonstrated here, while Blanker *et al.*¹⁵ found that among 50–78 y old Dutch men half of those with early

ejaculation also had ED. Viraq and Beck-Ardilly,¹⁶ moreover, reported that in 18–70 y-old French men ED frequently was accompanied by 'loss of libido' (37%)—a problem which is not very far from the 45% of men with ED with low interest found here. These authors on the other hand reported a much higher proportion of premature ejaculators (40%) among men with ED than was found by us in Sweden. Such a high prevalence raises the question whether and to what extent premature ejaculation interferes with the NIH definition¹² of ED concerning maintenance of erection and may emphasize that questions on ED should generally be accompanied by questions on occurrence of premature ejaculation.

In this context, and perhaps somewhat surprisingly, it should be emphasized that the likelihood (odds ratios) of male erectile and ejaculatory disabilities leading to low level of sexual well-being (ie low level of sexual satisfaction was clearly greater for the female partners than for the men themselves.

In contrast, vaginismus had a very pronounced negative influence on men's sexual well-being, but not so for the women. A tentative explanation for this latter phenomenon may be that men experience vaginismus as a manifest physical obstacle for vaginal penetration. For women with vaginismus as the disability may serve as an adequate defence mechanism.

The finding that, with relatively few exceptions, problems caused by disabilities rather than the disabilities themselves carried risks for low level of sexual well-being appear to lend (clinical) validity to the classification of female sexual dysfunction suggested by the B categorization of the DSM IV⁹ and by Basson *et al.*¹¹ It moreover appears to support our previous discussion of the causal chain: disabilities may lead to problems which, if occurring, result in low or decreased level of sexual satisfaction.¹ In our opinion, however, further

qualitative investigations are needed to shed light upon the complexity of causalities. In this respect the most pronounced contradiction was vaginismus as experienced by the men. Conceivably the picture is much more complex.

That low level of female ability to reach orgasm, especially if this causes problems, has equally negative high-ranking impact on sexual satisfaction for both men and women may simply indicate that female sexual fulfilment is as important for men as for the women themselves.

By and large, however, the close associations of virtually all sexual disabilities, including all phases of the sexual response cycle: desire (interest)/excitation/orgasm and ejaculation and also vaginismus and dyspareunia may rather serve to stimulate further research than to provide more or less speculative explanations.

One facet of this epidemiologically based report is that it demonstrates such a complexity of sexual disabilities and problem that none of them can *a priori*, when removed from their total context, reasonably be regarded as a singularity. For instance, among the 22% of 18–74 y-old women who had an orgasmic disability, 45% (ie approximately 10% of the total population in this age span) perceive it as a problem. Moreover, with female partner's low orgasmicity 15% of men have ED (which is a problem for two-thirds of them). Now, given this simplified complexity, what can be regarded as causal? Should we, in a true biostatistical tradition, create one or more syndromes within which a certain amount of criteria should be fulfilled? Somebody might even create an index of factor-analytical different entities just to bring them together within the caption of a 'disease'. We believe that such indexes are not reasonable. Our distancing ourselves from indices is mainly built upon the contention that aggregates of items will obscure the possibilities of interpretation by the multitude of different combinations.^{10,17}

Moreover, the odds ratio results are indicators of the need for clinical practitioners (and also for those involved in clinical trials) to clarify in each case the possible concurrence of different sexual disabilities and the extent to which they cause distress for both partners. Hence, and in particular from a clinical point of view, our findings emphasize the importance of meticulous case histories.

This discourse does naturally not preclude sexual disabilities to be symptoms of diseases or, for instance, conditions due to age-related endocrinological changes. Moreover, sexual disabilities, although prevailing in nearly 50% of women and a quarter of men aged 18–74, can hardly from a biopsychosociological point of view be regarded as lifestyle aberrations when, regardless of aetiology, they are adaptationally invalidating obstacles to sexual well-being.

Conclusion

Let us in clinical practice talk more about the sexually problematic partner relationship than about singular sexual dysfunctions.

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Appendix

Women

Table A1 Analyses (Spearman's ρ) for associations between levels of own and partner's (as perceived by the respondent) sexual abilities; $n = 1030$ sexually active women aged 18–74. Full six-graded scale entered

<i>Abilities</i>	<i>Interest</i>	<i>Lubrication</i>	<i>Orgasm</i>	<i>Vaginismus</i>	<i>Dyspareunia</i>
<i>Own</i>					
Lubrication	0.001	—	—	—	—
Orgasmicity	0.001	0.001	—	—	—
Vaginismus	0.001	0.001	0.001	—	—
Dyspareunia	0.001	0.001	0.001	0.001	—
<i>Partner's</i>					
Erection	0.001	0.001	0.001	0.001	0.001
<i>Ejaculation:</i>					
Not early–early	0.005	0.001	0.001	0.001	0.001
Not delayed–delayed	N.S.	0.001	0.001	0.005	0.001

Men

Table A2 Analyses (Spearman's ρ) for associations between levels of own and partner's (as perceived by the respondent) sexual abilities; $n = 1162$ sexually active men aged 18–74. Full six-graded scale entered

<i>Abilities</i>	<i>Interest</i>	<i>Erection</i>	<i>Ejaculation: not early–early</i>	<i>Not delayed–delayed</i>	<i>Dyspareunia</i>
<i>Own</i>					
Erection	0.001	—	—	—	—
<i>Ejaculation:</i>					
Not early–early	0.001	0.001	—	—	—
Not delayed–delayed	0.001	0.001	N.S.	—	—
Dyspareunia	0.001	0.001	0.001	0.001	—
<i>Partner's</i>					
Lubrication	0.001	0.001	0.001	0.001	0.001
Orgasmicity	0.001	0.001	0.001	0.001	0.001
Vaginismus	0.005	0.001	0.001	0.001	0.001