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Symptom Distress as Predictors of Sexual Dissatisfaction among Nursing Mothers in Awka, Nigeria.

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Abstract

Sexual dissatisfaction may best be described as a multidimensional experience involving thoughts, feelings, personal and socio-cultural attitudes and beliefs, combined with biological factors. This also involves any situation in which one or more sexual partners is unhappy with the quality, style or quantity of sexual activity in which they are engaging. In this study, the researchers investigated symptom distress as predictors of sexual dissatisfaction among nursing mothers in Awka. A total number of 220 nursing mother volunteers from Awka North and South LGAs and participated in the study. The age of the participants ranged from 18 to 50, with a mean age of 27.69 years, and standard deviation of 5.17. The Symptom distress checklist- 90 (1977) and Index of sexual satisfaction (1982), with reliability co-efficient which ranged from .77 to .90 and .92, were used for data collection. The collected data was analyzed using multiple regression analysis. The result showed that: 1) Psychoticism followed by Paranoid Ideation, Depression, Somatization, Hostility and Obsessive-compulsive predicted Sexual Dissatisfaction negatively among nursing mothers in Awka. 2) Phobic anxiety followed by Interpersonal sensitivity, Anxiety and Neuroticism predicted sexual dissatisfaction positively in the same population. Based on the findings of the study, the researchers recommended that Doctors, Nurses, Family therapists, Counselors and Clergy should give more attention to the psychological needs of women at this time (post natal period) and indeed at all times so as to make couples and young families healthier.

Keywords: Sexual Dissatisfaction, Symptom Distress, Postpartum Period, Nursing Mothers.

INTRODUCTION

The birth of a child/baby is an awaited event; whether planned or not, is always accompanied by major changes in the life and relationship of a couple (Southern Community Health Services Research Unit, 1990; Oakley, 1980). Whilst both parents of the new-born baby/child must now undertake new responsibilities, the mother is the one most profoundly affected because this major life event confronts women with specific physical, psychological, and social changes (Thorp Krause & Lynch 2004). This implies that while it is often considered as a positive event to become a parent, it is well known that the birth of a child/baby atleast for mothers represents a time of vulnerability to several experiences ranging from mood disorders to dysfunction in critical areas due shift in attention from the usual to the new born child/baby (as wives and mothers) and loss of intimacy between them and their spouses/husbands in most cases (Moss & Schwebel, 1993). Furthermore, some women at this point experience loss of sexual desire, which maybe associated with depression and/or dissatisfaction with sexual

activities, which can occur as a result of physical, psychological, or interpersonal factor (Fisherman, Rankin, Soekan & Lenz, 1989).

Thus, while some women resume sexual activity with their spouse few weeks after birth, some find it disinteresting to get along and as a result, sexuality after childbirth is a frequently occurring concern in clinical practice with postpartum often report decreased interest in sexual activity (Dejudicebus & McCabe 2002; Olsson, Lundquist, Faxelid & Nissen, 2005) and sometimes report distress over relationship with their partners regarding this lack of desire (Ahlborg, Dahlot & Hallberg, 2005). Thus the issue of postpartum intimacy and libido (sexual desire) affect approximately eight million new parents (O'Brien & Peyton 2005).

The concept of sexual dissatisfaction, the opposite state of satisfaction, refers to as a multidimensional experience involving thoughts, feelings, personal and socio-cultural attitudes and beliefs, combined with biological factors (Gil, 2005). This also involves any situation in which one or more sexual partners is unhappy with the quality, style or quantity of sexual activity in which they are engaging. Kruger (2007) suggests that sexual dissatisfaction can occur as a result of physical, psychological or interpersonal factors, hence if either member of a couple is unhappy with other partner in other areas of lives together, this can result in a dissatisfying sex life. Kruger (2007) also opined that if a couple is inexperienced sexually, their lack of sexual knowledge can reflect in their overall sexual experience and if there is a discrepancy between the desired frequencies of sexual activity, either or both partners can become dissatisfied. Lynch (2000) had observed that in situations where a partner does not communicate his/her sexual needs, the likelihood of dissatisfaction over sexual activity are high, and if either partner is engaging in sex with someone who is of the opposite gender of preference, sexual dissatisfaction is likely.

According to Hyde and Delamater (2000), sexual dissatisfaction means dissatisfaction in sexual activity and emotional dissatisfaction. It is not just physical displeasure but consists of all remaining feelings after positive and negative aspects of sexual relationship. Therefore, sexual dissatisfaction includes human's dissatisfaction from sexual activities to orgasm. Marital sexual dissatisfaction takes place in two ways:

1. Dissatisfaction with sexual activities.
2. Affective and emotional dissatisfaction.

Sexual dissatisfaction occurs when a man or a woman is not able to fully, healthily, and pleasurably experience some or all of the various physical stages the body normally experiences during sexual activity. These stages can be broadly thought of as the desire phase, the arousal phase, and the orgasm phase. Female sexual dissatisfaction is actually quite common. It has been estimated that about 40% of women experience sexual dissatisfaction.

Psycho-Social Perspective of Sexual Dissatisfaction

The psycho-social model/perspective of sexual dissatisfaction looks at the psychological combined with social factors that result in sexual dissatisfaction in humans; thus, this anchors on those emotional/environmental factors that can trigger dissatisfying sex life in an individual. These factors include:

Interpersonal Components/Relationship Factors

A person's view of their own sexuality is largely influenced by culture, society, and personal experience. It may be intimately connected to their own or society's ideas about the appropriate or inappropriate expression of sexual behaviour. These feelings may cause anxiety

because of a personal or cultural association of sexual experience and pleasure with immorality and bad behaviour. Anxiety is then expressed physically by the body in a way that prevents normal sexual function/satisfaction. Anxiety can do this, for example, by stopping or slowing the state of sexual excitement that allows for the lubrication or moistening of the female genitalia - an important step towards fulfilling forms of sexual activity.

The level of sexual dissatisfaction or the sexual problems of the individuals do not affect negatively the individual only. Moreover, sexual dissatisfaction or sexual problems may be originated from both individual and relational resources. The sexual relationship of the couple can be seen as a kind of microcosm of the general relationship (Crowe, 1995).

According to Dziegielewski and Resnick (1998), relationship nature and relational problems may affect the sexual satisfaction of the couples. Similarly, emphasizing the effects of relationship factors on sexual dissatisfaction, Hawton (1985) claimed that, general relationship discord, dislike, loss of affection, or resentment between partners may negatively affect the sexual relationship. Also hostility, anger, distrust, distress, difficulty in talking about sex and few months after childbirth are regarded as the negative contributors of sexual life (Crowe, 1995). In addition, Colebrook Seymour, III (1998) found that, length of marriage and the number of children positively related with sexual dissatisfaction.

In a study by Kimes (2001), many participants emphasized the closeness in the relationship as the most rewarding and exciting element of their sex lives. However, women tended to mention closeness and men tended to mention physical pleasure more, when compared to each other. Women needed an orgasm to get emotional satisfaction; however, men needed it to experience physical satisfaction in addition to emotional satisfaction. Most of the respondents in the study emphasized lack of relationship with the partner as the reason for sexual dissatisfaction. Disagreement between partner's sexual preferences and lack of understanding the other's sexuality were also found to be significantly related to lack of sexual adjustment; since it makes sexual interactions mutually unacceptable and undesirable. It is concluded that lack of understanding denies one knowing how to satisfy the partner (Purnine & Carey, 1997).

Sexual communication is also reported as an important element in a couples' sexual relationship (Berg-Cross, 2001) more importantly in long-term relationships (Means, 2000) and especially for women (Means, 2000). Masters, (1995) stated that communication between partners on sex enhances sexual pleasure and protects them from being physically or psychologically uncomfortable. Communication also provides the opportunity of understanding other partner without "mind-reading". Trying to guess the partner's needs, thoughts, and feelings may cause misconceptions. Additionally, sexual communication problems are the reason of unexpressed sexual problems (Hawton, 1985).

Character, Disposition, and Life Experience

Fear of intimacy can be a factor in arousal problems. Experiences of abuse, either in childhood or in past or current relationships, can establish a cycle of associating sex with psychological or physical pain. Attempting sexual activity in these circumstances causes more psychological or physical pain. For example, if anxiety prevents lubrication, sexual intercourse can be painful. This can lead to sexual dissatisfaction.

Inhibited Sexual Desire

This involves a lack of sexual desire or interest in sex. Many factors can contribute to a lack of desire, including hormonal changes, medical conditions and treatments (for example, cancer

and chemotherapy), depression, pregnancy, stress, and fatigue. Boredom with regular sexual routines also may contribute to a lack of enthusiasm for sex, as can lifestyle factors, such as careers and the care of children.

Inability to become aroused

For women, the inability to become physically aroused during sexual activity often involves insufficient vaginal lubrication. This inability also may be related to anxiety or inadequate stimulation. In addition, researchers are investigating how blood flow problems affecting the vagina and clitoris may contribute to arousal problems.

Lack of Orgasm (Anorgasmia)

This is the absence of sexual climax (orgasm). It can be caused by a woman's sexual inhibition, inexperience, lack of knowledge, and psychological factors such as guilt, anxiety, or a past sexual trauma or abuse. Other factors contributing to anorgasmia include insufficient stimulation, certain medications, and chronic diseases.

Conclusively, social psychological perspective of sexual dissatisfaction centers on the following hypotheses:

- Self-perception theory: people make attributions about their own attitudes, feelings, and behaviours by relying on their observations of external behaviours and the circumstances in which those behaviours occur
- Over-justification hypothesis: when an external reward is given to a person for performing an intrinsically rewarding activity, the person's intrinsic interest will decrease
- Insufficient justification: based on the classic cognitive dissonance theory (inconsistency between two cognitions or between a cognition and a behavior will create discomfort), this theory states that people will alter one of the cognitions or behaviours to restore consistency and reduce distress

Gender Perspective of Sexual Dissatisfaction

One can say that, women and men experience sexuality differently. They have different needs, desires, expectations, and feelings (Barash & Lipton, 2002). After a meta-analysis of 177 sources (126,363 respondents; 58,553 males and 69,810 females), Oliver and Hyde (1993) reported several gender differences on sexual attitudes and behaviors. In terms of attitudes, males reported greater acceptance of pre-marital sexual intercourse, casual sex, sexual permissiveness, extra-marital sexual intercourse, and masturbation. Females reported more sexual anxiety. In terms of behaviors, males reported a higher incidence of sexual intercourse, a younger age of first sexual intercourse, more frequent sexual intercourse, and larger number of sexual partners.

In terms of the relationship between gender and sexual dissatisfaction, there are inconsistent findings in the literature. Some researchers report that women have greater sexual dissatisfaction than men (Renaud & Byers, 1997), however, some report that women exhibit lower sexual dissatisfaction (Kabakçı & Daş, 2002). In addition, some researchers reported that there is no gender difference and that women and men experience similar levels of sexual dissatisfaction (Oliver & Hyde, 1993; Timm, 1999).

In a study examining thoughts and feelings about sexuality (Rosenthal, 1998), many woman subjects reported that they need to be at peace with themselves, feel less shame and hold greater self-acceptance in order to be more satisfied with their sexuality. Research indicates

that low self-esteem and negative body-image significantly correlated with sexual dissatisfaction (Munnariz, et al., 2000) and dissatisfaction with physical or interpersonal self-image positively affects the sexual dissatisfaction (Hawton, 1985; Warren, 2000). The effects of age and different life periods on sexual dissatisfaction are also investigated in the sexuality research. Masters, et al. (1995) states that, psychological need for intimacy; excitement and pleasure do not have to diminish by the person gets older. In contrast, most people, especially women, discover their sexuality in mid-adulthood. Means (2000) opines that women between the ages of 35 and 45 are the most sexually responsive group, while aging and menopause decrease the intensity and duration of sexual response. Çetin (1995) points a positive association between age and sexual dissatisfaction in men. Timm (1999) emphasizes that, the focus on sexual performance of younger couples diminishes by leaving its place to more sensual activities when the couple become older.

"Sexual self-schemas" (sexual self-concepts) are also investigated in terms of the contributions of cognitive variables on sexuality. Andersen and Cyranowski (1994) reported that, women with positive sexual schema reported a more positive view on sex, higher levels of sexual arousal, and more sexual experiences. Conversely, women with negative schema described themselves as cold, conservative, unromantic, self-conscious, embarrassed, not confident and inhibited in their sexual and romantic relationships. These women also held negative attitudes about sex. Thus, there may be some potential vulnerability for sexual dissatisfaction for negative schema women. In addition, similar results were reported when a similar study conducted on male subjects (Andersen, et al., 1999). Literature also indicates a relationship between physical and psychological health and sexuality. Psychological factors such as depression, stress and anxiety (Crowe, 1995; Hawton, 1985) and physical factors such as, hormonal abnormalities, Parkinson's disease, spinal cord injury, multiple sclerosis, and thyroid disease (Crowe, 1995; Kohn & Kaplan, 2000) are reported as having negative effects on sexuality.

In addition to the effects of health on sexuality, lower level of education is found to be correlated with orgasm frequency and sexual dissatisfaction (Çetin, 1995). Additionally, in another study by Kimes (2001), participants reported that, being sexually inexperienced, sexually less-driven and sexually inactive are positively related to emotional and physical sexual dissatisfaction.

SYMPTOM DISTRESS

Symptom distress can be best described as symptoms associated with distress, often experienced by psychiatric outpatients and with the experience of anguish arising from the problems of living among people in the general population (Derogatis, Lipman, and Covi, 1977). It is also a measure of several manifestations of distress/symptoms in 10 primary categories or domains, which includes Somatization, Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Phobic Anxiety, Hostility, Paranoid Ideation, Psychoticism, and Neuroticism.

Somatization, the first domain in the Symptom Distress is defined by Lipowsk (1988) as the propensity of a patient to experience and report physical/somatic symptoms that have no pathophysiological explanation, to misattribute them to disease and to seek medical attention for them. According to Derogans, Lipman and Covi (1977), somatization is characterized by bodily pains, discomfort, and dysfunction, thus somatizing patients are not feigning symptoms, and somatization is distinct from factitious disorder and malingering. In addition, misattribution of symptoms to somatic disease may result in, or arise out of, the belief that

disease is present; hence there is an ample opportunity for misattribution (Egan & Beston 1987). As such Neuropsychological testing has shown that somatization is associated with information-processing deficits (Rief & Nanke 1999).

Alexithymia meaning "being without word to describe emotions" has been described as an important factor in somatization (Sifness 1996) and it is proposed that in the absence of the ability to describe emotions, inidividuals respond to stressful life situations in a maladaptive way and one of these, is to express emotional distress as physical symptoms. Alexithymic individuals focus on facts, details, and external events and tend to have a limited fantasy life. Additionally, factor including education and cultural sub-culture (e.g. macho males) also play a part in somatization and intelligence is negatively associated with the number of functional somatic symptoms reported (Kingma, 2009).

Obsessive-Compulsive, the second domain in the Symptom Distress, is a type of anxiety disorder in which people suffer from recurrent, unwanted thoughts or ideas (obsessions); engage in repetitive, irrational behaviours or mental acts (compulsion) or both (National Institute of Mental Health 2006). Obsessive-Compulsive disorder is said to be accompanied with irresistible thoughts, impulses, and actions (Derogans et al., 1977) and current research opined that among people with Obsessive-Compulsive disorder, carrying out compulsive behavior tends to ease feelings of anxiety while repressing compulsive behavior causes stress.

According to the National Institute of Mental Health, Obsessive-Compulsive disorder affects about 2.3% of the United States population age 18 to 54 years (i.e, approximately 3.3 million Americans). An additional 1 million children and adolescents have the disorder. The condition typically begins during early childhood or adolescence and affects men and women equally (National Institute of Mental Health 2006). In addition, up to two-thirds of people with Obsessive-Compulsive disorder suffer from additional psychiatric conditions. These conditions, including depression, eating disorders, personality disorder, attention deficit disorder, and other anxiety disorders (e.g, social phobia and separation anxiety disorder) can make it difficult for physicians to diagnose and treat Obsessive-Compulsive disorder due to overlapping symptoms. Of these additional conditions, major depressive disorder appears to be the most common, affecting up to 55% of Obsessive-Compulsive disorder patients. Bipolar disorder affects as many as 30% of Obsessive-Compulsive disorder patients, while social phobia impacts 23% (Cosoff, 1998).

A clinical diagnosis of the disorder requires that the behaviors be extreme enough to interfere with everyday activities (take more than one hour per day) or significantly interfere with a person's relationships, health, social functioning, or occupational functioning. For example, up to 70% of people report problems with family relationships, and more than half report interference with social and work relationships (Koran 2000; Hollander 1997; Koran 1996; Calvocoressi 1995). As a result, most people with Obsessive-Compulsive disorder struggle to rid themselves of obsessive thoughts and stop compulsive behaviors.

Interpersonal sensitivity (IPS), the third domain in the Symptom Distress, is a term that describes the ability to sense, perceive accurately, and respond appropriately to one's personal, interpersonal, and social environment (Bernieri, 2001). The information used to achieve interpersonal sensitivity includes verbal and nonverbal cues exposed through expressive behavior. Nonverbal cues include any detectable signal that has meaning but is not explicitly stated. For example, facial expressions, body language, and vocal intonations are considered nonverbal cues. As a multifaceted construct, interpersonal sensitivity consists of a

variety of skills, capabilities, and incentives that vary across individuals and contexts (Davis, 2002). Moreover, it is likely that multiple situational variables, including cognitive resources, emotional states, and motivation level influence how well an individual can detect nonverbal cues (Simpson, Orina, & Ickes, 2003). Hence, interpersonal Sensivity or interpersonal accuracy is the ability to assess another's states and traits correctly (Schmid Mast, Murphy, & Hall, 2006; Hall & Bernieri, 2001).

In their work, Hall, Andrzejewski and Yopchick (2009) distinguished between attentional accuracy, which is paying attention to the social interaction partner's cues (i.e., remembering others' verbal, nonverbal, and appearance cues); and inferential accuracy, which is the correct interpretation of perceived cues. This distinction corresponds to detection and utilization in the realistic accuracy model of personality described by Funder (1995). Attentional accuracy has been operationalized by accurate recall of others' verbal messages (Overbeck & Park, 2001) or of others' nonverbal cues (Hall, Murphy, & Schmid Mast, 2006) and of others' appearance (Schmid Mast and Hall, 2006; Horgan, SchmidMast, Hall & Carter, 2004). Research on inferential accuracy has shown that people are able to correctly infer other people's emotions (Ickes 2003; Matsumoto, 2000), motives and thoughts (Ickes, 2003); others' personality traits (Murphy, Hall, & Colvin, 2003; Ambady, LaPlante, & Johnson, 2001); and the type of interpersonal relationship in which two or more persons are involved (Schmid Mast & Hall, 2004). As in the realistic accuracy model of personality (Funder, 1995), the attentional part of interpersonal sensitivity is a precursor to being able to draw accurate inferences. Thus, the concept of interpersonal sensitivity is defined as being attuned to and correctly inferring another person's states and traits (Bernieri, Davis, Rosenthal, & Knee, 1994).

Depression, the fourth domain in the Symptom Distress, is defined as a disturbance in mood, thought, and body, characterized by varying degrees of sadness, disappointment, loneliness, hopelessness, self-doubt, and guilt. According to Derogans et al., (1977), depression is a mood disorder characterized by loss of vital energy, interest, and motivation. This implies that the concept of depression includes a wide range of symptoms including normal feelings of depressed mood that affects almost everyone from time to time, to more severe depressive states that meet diagnostic criteria for a depressive disorder.

Furthermore, depression shows high rate of relapse and chronicity as reported in several studies (e.g., Paykel, 1992). Specifically, research indicates that about 50% of those who experienced one depressive episode will be depressed again within one year and about 70% within two years (Angst & Preisig, 1995a; Angst and Preisig, 1995b). Thus, depression is a complex disorder with a multi-factorial genesis. It is well established in the study conducted by Research Agenda for Psychosocial and Behavioural Factors in Women's Health (1996) that depression is approximately twice as common in women as in men and that it affects people of all ages; hence depression has been called the most significant mental health risk for women, especially young women of child bearing and childrearing age (Glied & Kofman, 1995). Moreover, genetics, adverse events in childhood, as well as other stressful events later in life are well documented risk factors for depression (Levinson, 2006; Kendler, Karkowski, & Prescott, 1999).

In addition, depression has been observed as having a negative effect on sexual functioning (Frohlich & Meston, 2002), since it is a common understanding that depression is associated with decreased interest in activities that are customarily pleasurable, including sex (APA, 2000; Lykins, 2006). However, it would be a mistake to automatically presume that depression affects each aspect of the sexual response cycle equally. Some researchers have reported that,

for a portion of the female population, depressed states increase sexual desire (e.g., Lykins, 2006). At the same time, women with depression have been reported to have more than twice the odds of experiencing sexual problems than non-depressed women (Shifren, 2008). Therefore, it is apparent that depression has a significant comorbid relationship with sexual dysfunction/dissatisfaction (APA, 2000), but the exact manner in which it affects sexual functioning seems unclear (Elliott & O'Donohue, 1997).

Anxiety, the fifth domain in the Symptom Distress, is defined as an emotion characterized by feelings of tension, worried thoughts, and physical changes like increased blood pressure. This is also marked with restlessness, nervousness, and tension (Lipman et., al 1977). Feelings of anxiety affect almost everybody from time to time and may be regarded as a normal part of human life. To consider anxiety as an illness, distress and impaired function should also be present.

As is true for depression, anxiety disorders are more common in females and risk factors for developing the disorder are similar to those of depression. Also, anxiety disorders are strongly associated with depressive illness (Kessler, 1995), and research suggests that an anxiety disorder may precede and increase the risk for developing depression (Bittner, 2004; Stein, 2001). Similar to depression, anxiety has been given a generalized sense of interference with sexual functioning/satisfaction and as such, anxiety is a broadly defined risk factor of sexual dissatisfaction and is characterized by excessive worry and apprehensive anticipation (American Psychological Association, 2000). Although depression and anxiety are often seen as highly comorbid (APA, 2000; Rodney, 1997), it is presumptuous to assume that these states have the same effect on the sexual response cycle or that they have an identical effect on the sexual response cycle when identified as the aggravators of sexual dissatisfaction.

Hostility, the sixth domain in Symptom Distress, is defined by Matthews, (1984) as a multidimensional construct that is thought to have cognitive, affective, and behavioral components. By extension, the cognitive component is defined as negative beliefs about and attitudes toward others, including cynicism and mistrust. The affective component typically labeled as anger refers to an unpleasant emotion ranging from irritation to rage and can be assessed with regard to frequency, intensity, and target. The behavioral component is thought to result from the attitudinal and affective component and is an action intending to harm others, either verbally or physically (Matthews, Jamison & Cottington, 1982). In addition, scholars such as Derogans, Lipma, and Covi (1997) viewed hostility as a feeling of anger, hatred, repression, and unfriendliness.

In psychological terms, Kelly (1996) in his model defined hostility as the willful refusal to accept evidence that one's perceptions of the world are in some way out of alignment with current objective reality. Thus, instead of realigning one's feelings and thoughts with objective reality, hostile persons attempt to force or coerce the world to fit their view, even if this is a forlorn hope, and even if it entails emotional expenditure and/or harm to self or others. In this sense hostility is a form of psychological extortion - an attempt to force reality to produce the desired feedback, even by acting out in bullying by individuals and groups in various social contexts, in order that preconceptions become ever more widely validated. In this sense, hostility is an alternative response to cognitive dissonance.

However, hostility is often confused with anger, and although closely related, they are not identical concepts. Hostility is often defined as a personality characteristic of having a rather stable attitude of ill will and negative evaluation of people and events. Anger, on the other

hand, is often described as an emotion evoked when a person is blocked in the attainment of a goal or in the fulfillment of a need (Mendes de Leon & Meesters, 1991). Therefore, hostility is seen as a multifaceted phenomenon that includes cognitive, affective, and behavioral manifestations. (Siegman1994).

Phobic anxiety, the seventh domain in the Symptom Distress is defined as intense, irrational fear of specific objects or situations that cannot be voluntarily controlled or reasoned away and that lead to avoidance of phobic situation (Marks 1989). This is also said to be associated with irrational fear and avoidance of objects, places, and situations (Derogans et al., 1977). Therefore, phobias often appear peculiarly dissociated from the intentional verbal-cognitive control that typically is held to characterize normal psychological functioning.

To capture this aspect of phobia, psychoanalysts have interpreted them as unconscious way of coping with anxiety. By investigating the unconsciously originated anxiety in a symbolically related external object, which can be avoided, it is assumed that the ego can be saved from manifest anxiety. An alternative contemporary perspective anchors irrational fears in early, automatic information-processing mechanisms that are inaccessible to intentional control. For example (Ohman & Soares, 1993) has proposed that preattentive, automatic analysis of some types of emotional relevant stimuli is sufficient to activate components of a phobic reaction such as autonomic responses. These preattentive stimuli analysis mechanisms are unconscious both in the sense that they work outside of the focus of attention and that they are inaccessible to introspection and verbal report (Greenwald, 1992). This implies that important components of phobic responses are set in motion before the phobic stimulus is represented in awareness as the subject consciouly identifies what he or she is reacting to. Therefore, conscious perception of the phobic stimulus occurs against a background of rising physiological activation that is likely to feed back to the stimulus appraisal process, further enhancing the fear. Thus, phobia may appear to be involuntary and irrational because the fear response is initiated before conscious, intentionally controlled processes come into play.

Paranoid ideation, the eighth domain in the Symptom Distress, is defined by Colby (1981) as persecutory delusions and false beliefs whose propositional content clusters around ideas of being harassed, threatened, and harmed, subjugated, persecuted, accused, mistreated wrong, tormented, disparaged, vilified and so on, by malevolent others, specific individuals or groups. In their work, Lipman et al., (1977) asserted that paranoid ideation is associated with suspiciousness, distrustfulness and blaming others.

In addition, Morey (1991), proposed that paranoid ideation is characterized by intense, irrational mistrust and suspicion, resentment, hypervigilance, persecutory delusion as well as hostility. Freeman and Garety, (2004) added that this anxiety leads towards a sense of resentment for others.

However, persons with paranoid ideation and/or persecutory delusions due to their distinct cognitions and beliefs are reported to have numerous distinct information processing style characterized by less information seeking before making judgments (Garety, Hemsley, and Wessely, 1991); selective attention to threats and jumping to conclusion (Blackwood, Howard, Bentall, and Murray 2001); better memory for threatening words (Bentall, kaney, Bowen-Jones 1995); self-consciousness (Fenigstein and Vanable, 1992) and else, and thus are subjected to frequent research.

Psychoticism, the nineth domain in Symptom Distress, is defined by Covi et al., (1977) as a personality dimension that is associated with hallunication, delusions, and externally manipulated thoughts. This also refers to a personality pattern typified by aggressiveness and interpersonal hostility.

According to Sybil Eysenck (1986), psychoticism can be conceived as a set of correlated behaviour variables indictive of predisposition to psychotic breakdown, demonstrable as a continuous variable in the normal population and independent of Extraversion and Neuroticism. However, in the Eysenckian personality scheme (Eysenck & Eysenck, 1985), psychoticism constitutes the third personality dimension, orthogonal to extraversion and neuroticism. It is conceptualized as a continuum of liability to psychosis (principally schizophrenia and bipolar affective disorder) with "psychopathy" (i.e., antisocial behavior) defined as "a halfway stage towards psychosis". Thus, schizophrenics, bipolars, and psychopaths are viewed by as being different only in degree, rather than qualitatively, from normals, with the single personality dimension of psychoticism differentiating normals from psychopaths (intermediate in psychoticism) and from schizophrenics and bipolars (extreme in psychoticism). Self-report questionnaire scales have been developed (Eysenck, & Barrett, 1985), including a children's version that attempt to measure psychoticism. High scorers on the Psychoticism (P) scale are conceptualized as "cold, impersonal, lacking in sympathy, unfriendly, untrustful, odd, unemotional, unhelpful, antisocial, lacking in insight, strange, with paranoid ideas that people were against him."

Neuroticism, the tenth domain in the Symptom Distress, derives from the word ‘neurosis’ introduced by the Scottish physician William Cullen in 1769 to refer to disorders of sense and motion caused by a general affection of the nervous system. This is consistent with the view that individual differences in neuroticism represent differences in mental noise “operationalized as reaction time standard deviations” (Robinson & Tamir, 2005). This is also viewed by (Lipman et al., 1977), as a state characterised by poor sleep and appetite, and feeling of unwellness.

In Eysenck’s (1990) PEN model, neuroticism has been related to activation thresholds in the sympathetic nervous system or brain regions that govern fight-or-flight responses when confronted with danger. This perspective has received ample support from research on individual differences in the responsiveness of the avoidance (vs. approach) system (Carver, Sutton, & Scheier, 2000). In their view Costa and McCrae (1992), referrred to neuroticism as a general tendency to experience negative affects. Another conceptualization regards neuroticism as a general negative emotionality (Tellegen, 1985). According to this notion, high-neurotics individuals have a higher likelihood than emotionally stable individuals to experience feelings of anxiety and depression (Church, 1994) and people high in neuroticism are prone to have irrational ideas, be less able to control their impulses, and to cope more poorly than others with stress (p. 14).

Thus, it is not surprising that when Karney and Bradbury (1995) reviewed the literature on personality and marriage, they concluded that neuroticism was the trait most strongly associated with negative marital outcomes. In fact, two theoretical perspectives can explain this link. First, interpersonal models (Caughlin, Huston, & Houts, 2001) suggest that those higher in neuroticism should be less satisfied with their relationships because they tend to create negative life events through negative behavior and emotional contagion. Second, intrapersonal models (Cote´ & Moskowitz, 1998) suggest that those higher in neuroticism are less satisfied with their relationships because they are less satisfied with their lives generally,

possibly because they perceive life events more negatively. Though both perspectives suggest that neuroticism affects marriage and sexual activity in marriage through perceptual or behavioral processes, attempts to uncover such processes have been unsuccessful. For example, Karney and Bradbury (1997) found no evidence that the observed nature of couples' communication behaviors accounts for the effects of neuroticism on marriage.

POSTPARTUM PERIOD

The term postpartum period refers to as the time following childbirth or delivery (Hendrick, 1998) or a period generally thought of as the time immediately following the birth of a baby, generally six weeks (Cowlin, in Varney, Kriebs, & Gegor, 2004). For the purpose of research, this period was defined from three months, up to twelve months following the birth of a child.

In a medical perspective, the postpartum period refers to the period of time required, after the childbirth, for the reproductive organs to return to their pre-pregnancy state, which takes about six weeks (McGovern et al., 2006). It is important to note that the resumption of the sexual life, after childbirth does not depend only on the female physical recovery and comfort, both partners must feel prepared (Byrd, Hyde, DeLamater, & Plant, 1998). However, Doctors usually recommend that women avoid sex in the first six weeks postpartum, both to promote healing and to reduce the risk of infection. But 26 percent of women did engage in intercourse before their six-week checkup, after seven weeks, that number jumps to 61 percent Van Anders (2000). Masturbation rates of 40 percent in the first few weeks suggest that women are interested in getting back to being sexual. Health-care providers often do not discuss too much about sexuality before that six-week period except to express that women should not be doing anything penetrative until after that time frame, however, Van Anders (2000) notes that women engage in a host of behaviours they feel like.

STATEMENT OF THE PROBLEM

Sexual intercourse has been one of the gratifications in marital life, and sexual satisfaction has been shown to be very cardinal to the maintenance of psychological wellbeing among couples (Ezeilo, 1995). Indeed, non-gratification of sexual needs seems to be one of the major causes of matrimonial discord, just as infidelity is one of the major causes of divorce. It follows that any situation which may precipitate sustained break in sexual communication, or sexual dissatisfaction will prelude matrimonial discord and family psychological break down.

Behaviour scientists opine that a woman experiences psychological ups and downs at the postpartum period and that many do not recover quickly from that. Indeed, Inwood (1996), implies that beginning/experiencing motherhood for most women affects other relationships. Again, experts in obstetrics hold that for the best physical and psychological development of neonates, they should be fed exclusively with breast milk. Traditionally, house wives in this part of the world breast feed for up to 12months, hence the period of nursing in Awka lasts between 6 and 8months for most mothers.

This period is too long to risk for many couples, and it is suggested that sexual dissatisfaction which starts at this time is indeed the prelude to many cases of couple separation. It is therefore a formidable issue. This seeks to explore this issue/problem of sexual dissatisfaction from the perspective of distress since Russell (1998) strongly believes that the complex physiological and psychological changes that are associated with childbirth are stressful for most women, and not much has been done to understand this, among Nigerians.

Specifically, this study is intended to find out whether:

1. Psychoticism followed by paranoid ideation, depression, somatization, hostility and obsessive-compulsive will predict sexual dissatisfaction negatively.
2. Phobic anxiety, followed by interpersonal sensitivity, anxiety, and neuroticism will predict sexual dissatisfaction positively.

HYPOTHESES

1. Psychoticism followed by paranoid ideation, depression, somatization, hostility and obsessive-compulsive will predict sexual dissatisfaction negatively.
2. Phobic anxiety, followed by interpersonal sensitivity, anxiety, and neuroticism will predict sexual dissatisfaction positively.

METHOD

Participants

Two hundred and twenty nursing mothers, who were randomly selected (using simple random sampling technique) from nine towns in two Local Government Areas (Awka North and South), in Anambra State, participated in the study. The health facilities selected for the study are located in: Achalla, Mgbakwu, Urum and Amansea for Awka North, and Amawbia, Nibo, Nise, Okpuno and Awka, for Awka South. The participants' ages ranged from 20 to 50 years with the mean age of 27.69 years and standard deviation of 5.17

Instruments

Two standardized instruments were adopted for use in the study and elapsed into a questionnaire. This comprised the Symptom Distress Checklist 90 (SCL-90) designed by Derogans, Lipman and Covi (1977) and the Index of Sexual Satisfaction (ISS) designed by Hudson (1982), whose scores were reversed to measure Sexual Dissatisfaction. In addition, demographic variables which included marital status, gender, and age were included in the overall instrument used for the study. In the whole, the questionnaire contained 115 items (90 for SCL-90 and 25 for ISS).

Symptom Distress Checklist (SCL-90) Scale:

This is 90-item scale designed by Derogatis, Lipman and Covi (1977), to assess 10 primary categories of symptoms associated with distress among psychiatric outpatients and with the experience of anguish arising from the problems of living among people in the general population. It comprises of A-Somatization, B-Obsessive Compulsive, C-Interpersonal Sensitivity, D-Depression, E-Anxiety, F-Hostility, G-Phobic Anxiety, H-Paranoid Ideation, I - Psychoticism and J-Neuroticism. In this scale, sections A-J are scored separately, after which the values of the numbers shaded in each item of each section is added together to obtain the score for the section. The overall values for 10 sections are further added up, to obtain the overall SCL-90 score. The scoring was done on 5-point simple response format of 0-Not At All, 1-A Little Bit, 2-Moderately, 3-Quite a Bit, 4-Extremely

Index of Sexual Satisfaction

This is a 25-item scale developed by Hudson (1982) to measure the degree to which an individual drives satisfaction from sexual relationship with his or her partner. Satisfaction is evaluated in terms of an individual's attitude, feeling, or preference for various forms and aspects of sexual behaviour. There is a direct scoring and a reverse scoring of items; the direct score items are items 4,5,6,7,8,11,13,14,15,18,20,24 and25, while reverse score items are 1,2,3,9,10,12,16,17,19,21,22 and 23. To get the final score during scoring, the result of the direct scores and the reverse scores are added together to obtain the raw score, after which 25 is subtracted from the raw score to obtain the final score. The scoring was done on 5-point

response format of (1-Rarely or None of the Time, 2-A Little of the Time, 3-Some of the Time, 4-Good Part of the Time, 5-Most or all of the Time).

However, for the purpose of this study, the scores of Index of Sexual Satisfaction (ISS) were reversed in descending order, such that higher scores reflected sexual dissatisfaction where 0 became 4, 1-3, 2-2, 3-1, and 4-0. This was done so that the scale will be able to measure sexual dissatisfaction. However, before adopting the Index of sexual satisfaction to measure sexual dissatisfaction, the researchers subjected the scale to pilot study, through which the researchers obtained raw data, whose scores were reversed and with which, norm for sexual dissatisfaction for the present study was established.

Validity and reliability of the instruments

Symptom Distress Checklist (SCl-90)

Erinoso (1996) reported significant coefficients of concurrent validity between Retirement Stress Inventory, Omoluabi (1996) and SCL-90 Scales which ranged from .26 for Scale F (Hostility) to .47 for Scale J (Neuroticism). Derogatis et al. (1977) reported alpha coefficients which ranged from .77 for Psychoticism to .90 for depression. The one week interval test-retest reliability coefficients ranged from .78 for Hostility to .90 for Phobic Anxiety.

Index of Sexual Satisfaction (ISS)

A concurrent validity coefficient of -.20 was obtained by Nwobi (1998) by correlating Index of Sexual Satisfaction with Sexual Anxiety Inventory (Hoon & Chambless, 1986). The reliability coefficients reported by Hudson (1998) are: Cronbach alpha internal consistency of .92 and 2-hour test-retest of .94.

In order to obtain the internal consistency of the scales (SCL-90 and ISS) for this culture, the researchers subjected the scales to study. A total number of 150 students of the Department of Psychology, Nnamdi Azikiwe University Awka, participated in the study. The scores collected through the study were subjected to statistical analysis and the following scores were obtained, showing the Cronbach Alpha Reliability Coefficients for the two scales:

Table I: Showing the Cronbach Alpha Reliability Coefficient of the SCL-90 and ISS obtained through study carried out with the Students of Psychology, Nnamdi Azikiwe University, Awka

S/N	Scales	No of Items	Cronbach Alpha Coefficient
A	Somatization	12	.88
B	Obsessive Compulsive	10	.85
C	Interpersonal Sensitivity	9	.76
D	Depression	13	.83
E	Anxiety	10	.88
F	Hostility	6	.65
G	Phobic Anxiety	7	.85
H	Paranoid Ideation	6	.77
I	Psychoticism	10	.83
J	Neuroticism	7	.77
K	Sexual dissatisfaction	25	.86

(Source: Anazonwu, Obi-Nwosu & Ifedigbo, 2013)

Again, with the data gathered through the pilot study, a new norm was established for each of the subsection of the symptom distress checklist (SCL-90) and sexual satisfaction (whose

scores were reversed to measure sexual dissatisfaction), with the responses of 150 students of Department of Psychology, Nnamdi Azikiwe University, Awka.

Table II: Showing standardized norm for Nigerian University Students ages 18-26 by Onighaiye and Erinoso (1996), in Lagos, Western Nigeria in comparison with the norm by Anazonwu, Obi-Nwosu & Ifedigbo (2013), in Awka, Eastern Nigeria for Symptom Distress Checklist Domains SCL-90 and Sexual satisfaction (whose scores were reversed to measure sexual dissatisfaction).

SCALES	YORUBA CULLINE (WEST)	IGBO (EAST)
	ONIGHAIYE AND ERINOSO (1996), LAGOS.	ANAZONWU, OBI-NWOSU AND IFEDIGBO (2013), AWKA
A-J	F(n=80)	F(n=150)
A – Somatization	14.96	15.29
B – Obsessive-compulsive	14.95	15.83
C – Interpersonal sensitivity	12.51	12.63
D – Depression	17.55	18.19
E – Anxiety	10.66	11.37
F – Hostility	8.44	7.62
G – Phobic anxiety	4.95	5.11
H – Paranoid ideation	4.95	6.63
I – Psychoticism	7.95	9.88
J – Neuroticism	7.61	8.62
SCL-90	108.31	111.17

General Population SCL-90 norm = 97

SCALE	NWOBI (1998)	ANAZONWU, OBI-NWOSU & IFEDIGBO (2013)
	F(n=90)	F(n=150)
Sexual Satisfaction	36.61	76.24

Norm for the reversed scores of Index of Sexual Satisfaction

(Source: Anazonwu, Obi-Nwosu & Ifedigbo, 2013)

PROCEDURE

In the context of this study, 'Awka' comprises Awka North and Awka South Local Government Areas of Anambra State. The researchers sought and obtained permission from the Health Departments of the Local Governments, and were subsequently introduced to the Primary Health Care Coordinators and Maternal/Child offices of the centres during a meeting at the Head Quarters. Appointments were then fixed for each centre, when the researchers should visit nursing mothers who were still coming for routine immunization at the respective centres. At the centres, through the assistance of the PHO's, it was easy to obtain informed consent for the mothers in their groups and only a few declined participation. Copies of the questionnaire were distributed to all mothers and they were allowed to take their time to complete them. Out of two hundred and thirty-six copies administered, two-hundred and twenty were completely filled, six were not returned while ten were not completely filled; hence 220 nursing mothers participated.

DESIGN AND STATISTICS

One-factor (Symptom distress checklist with ten '10' domains) on a dependent variable (sexual dissatisfaction) predicting design, and the multiple regression analysis statistics was used for testing the hypotheses.

RESULTS

Table III: Showing summary of Regressional Analysis of Symptom Distress with Sexual Dissatisfaction

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.
		B	Std. Error	Beta		
1	(Constant)	110.518	5.715		19.339	.000
	Depression	-3.901	2.612	-.172	-1.493	.137
	Somatization	-2.509	1.668	-.114	-1.504	.134
	obsessive compulsive	-.887	2.128	-.039	-.417	.677
	interpersonal sensitivity	2.470	2.386	.116	1.036	.302
	Anxiety	.988	2.276	.045	.434	.665
	Neuroticism	.516	2.121	.023	.243	.808
	Psychoticism	-7.157	2.220	-.315	-3.224	.001
	phobic anxiety	6.304	2.434	.275	2.590	.010
	Hostility	-.910	2.140	-.043	-.425	.671
	paranoid ideation	-5.227	2.297	-.233	-2.276	.024

a. Dependent Variable: sexual dissatisfaction

Results from the table above indicated that, Psychoticism (t = -3.22, p<.05 = .001), Paranoid Ideation (t = -.23, p<.05=.02), Depression (t = -1.49, p<.05=-.14), Somatization (t = -1.50, p<.05=.13), Hostility (t = -.43, p<.05=.67) and Obsessive-compulsive (t = -.42, p<.05=.68) predicted sexual dissatisfaction negatively. The table also indicated that, Phobic Anxiety (t=2.59, p<.05=.01), Interpersonal Sensitivity (t =1.04, p<.05=.30), Anxiety (t=.43, p<.05=.67), and Neuroticism (t=.24, p<.05=.81) predicted sexual dissatisfaction positively.

SUMMARY OF FINDINGS

In the light of the hypotheses, at ranking level, Psychoticism (t = -3.22, p<.05 = .001), Paranoid Ideation (t = -.23, p<.05=.02), Depression (t = -1.49, p<.05=-.14), Somatization (t = -1.50, p<.05=.13), Hostility (t = -.43, p<.05=.67) and Obsessive-compulsive (t = -.42, p<.05=.68) predicted sexual dissatisfaction negatively. Therefore the hypothesis, which stated that "Psychoticism, Paranoid Ideation, Depression, Somatization, Hostility, and Obsessive-compulsive would predict sexual dissatisfaction negatively," was upheld. This is to say that the higher the level of Psychoticism, Paranoid ideation, Depression, Somatization, Hostility and Obsessive-compulsive, the lesser the Sexual Dissatisfaction.

Similarly, at ranking level, Phobic anxiety (t=2.59, p<.05=.01), Interpersonal Sensitivity (t =1.04, p<.05=.30), Anxiety (t=.43, p<.05=.67) and Neuroticism (t=.24, p<.05=.81) predicted sexual dissatisfaction positively. Therefore, the hypothesis, which stated that "Phobic anxiety, interpersonal senstivity, anxiety, and neuroticism would predict sexual dissatisfaction positively," was upheld. This implies that the higher the level of phobic anxiety, interpersonal sensitivity, anxiety and neuroticism, the more the sexual dissatisfaction.

DISCUSSION

The study investigated "Symptom distress (somatization, interpersonal sensitivity, obsessive-compulsive, depression, anxiety, phobic anxiety, hostility, paranoid ideation, psychoticism, and neuroticism) as predictors of sexual dissatisfaction among nursing mothers."

Results obtained in this study show that hypothesis one, which stated that "Psychoticism, Paranoid ideation, Depression, Somatization, Hostility and Obsessive-compulsive would predict sexual dissatisfaction negatively," was confirmed. This agrees inversely with the study reported by Rose Marie, Eckert Kunaszuk, and Jana Mossey (2005), who studied the impacts of intimacy, libido, and depressive symptoms on sexual satisfaction and marital satisfaction and result found that depressive symptoms had negative impact on sexual and marital satisfaction.

It is also somewhat related to the findings of: (Heaven, Fitzpatrick, Craig, Kelly, & Sebar 2000), who found that higher psychoticism predicted lower sexual satisfaction in women but higher sexual satisfaction in men, and to that of Costa, (1992), who worked with clients from a sex therapy clinic and found that higher psychoticism predicted lower sexual satisfaction in men but not women.

However, the disparity maybe accounted for by cultural differences, level of ante-natal preparation, number of pregnancies/children previously had and level of husband's education of the different sets of participants. Again, it is plausible that 'Omugo' practice in Igbo land (the area of the present study) also has impact on the general wellbeing of the post natal mother hence such symptoms as depression, hostility, obsessive compulsive, psychoticism, somatization and paranion ideation may not have been so severe as to predict sexual dissatisfaction significantly.

Similarly hypothesis two which stated that "Phobic anxiety, interpersonal sensitivity, anxiety, and neuroticism will predict sexual dissatisfaction positively" was upheld. This is in tandem with the discovery of (Hall, 1984; McClure, 2000) who investigated how interpersonal sensitivity relates to other variables such as relationship satisfaction and discovered from meta-analyses that women, in general, are more interpersonally sensitive in emotional cues such as sexual activity than are men. Similarly, the finding corroborates the work of Vann Minnen and Kapman (2000) on the effect of anxiety on sexual dissatisfaction among non-clinical women, which showed that anxiety, is a contributor to sexual dissatisfaction.

This study went further to compare postpartum women who were experiencing symptom distresses on each of the subscale and those who were not, using their responses. This was to see if the nursing mothers who were experiencing one distress or another would differ from those who were not experiencing such distress on their level of sexual dissatisfaction at the postpartum period. In doing this, Independent t-test statistics was used to test for significant differences in the responses of the postpartum mothers on each of the subscales. Also, those that scored high and those that scored low were compared, and the following results obtained:

1. There was a significant difference between postpartum mothers who scored high on somatization and those who scored low, on their level of sexual dissatisfaction.
2. There was a significant difference between postpartum mothers who scored high on obsessive-compulsive and those who scored low, on their level of sexual dissatisfaction.
3. There was a significant difference between postpartum mothers who scored high on interpersonal sensitivity and those who scored low, on their level of sexual dissatisfaction.

4. There was a significant difference between postpartum mothers who scored high on depression and those who scored low, on their level of sexual dissatisfaction.
5. There was no significant difference between postpartum mothers who scored high on anxiety and those who scored low, on their level of sexual dissatisfaction.
6. There was no significant difference between postpartum mothers who scored high on hostility and those who scored low, on their level of sexual dissatisfaction.
7. There was no significant difference between postpartum mothers who scored high on phobic anxiety and those who scored low, on their level of sexual dissatisfaction.
8. There was a significant difference between postpartum mothers who scored high on paranoid ideation and those who scored low on their level of sexual dissatisfaction.
9. There was no significant difference between postpartum mothers who scored high on psychoticism and those who scored low, on their level of sexual dissatisfaction.
10. There was a significant difference between postpartum mothers who scored high on neuroticism and those who scored low, on their level of sexual dissatisfaction.
11. The reason for variation in experience/manifestation of distresses maybe linked to such factors as: a) personality of the postpartum, b) Kind of environment, c) Personality of spouse d) Socio-economic status of the couple, e) Marital relationship between the postpartum couples f) Level of education/exposure g) Religious belief, h) Personal values, i) History of psychological disorders such as depression and anxiety, k) Type of relation, and l) Sex of the baby. Some of these may act as co-morbid factors to symptom distress, which may in turn result to sexual dissatisfaction in the postpartum.

CONCLUSION

The study examined the Symptom distress as predictors of sexual dissatisfaction among two-hundred and twenty (220) nursing mothers in Awka. Two hypotheses were tested using Multiple Regression Analysis. The first, showed that Psychoticism, followed by Paranoid ideation, Depression, Somatization, Hostility and Obsessive-compulsive predicted sexual dissatisfaction negatively. The second, showed that Phobic anxiety, followed by Interpersonal sensitivity, Anxiety, and Neuroticism predicted sexual dissatisfaction positively. The two hypotheses were both upheld at $p<.05$.

These findings very strongly suggest that six dimensions of symptom distress (Psychoticism, Paranoid ideation, Depression, Somatization, Hostility and Obsessive-compulsive are negative significant predictors of sexual dissatisfaction among nursing mothers. This implies that as Psychoticism, Paranoid ideation, Depression, Somatization, Hostility, or Obsessive-compulsive becomes more obvious/severe, Sexual Dissatisfaction goes down. Again, the findings also strongly suggest that the remaining four dimensions of symptom distress (Phobic anxiety, Interpersonal sensitivity, Anxiety and Neuroticism) are positive significant predictors of Sexual Dissatisfaction in the same population. This also goes to say that as Phobic Anxiety, Interpersonal Sensitivity, Anxiety, or Neuroticism becomes more obvious or severe, Sexual Dissatisfaction increases.

These findings are expected to benefit nurses, midwives, health workers, the clergy, marriage counselors, and family psychologists/therapists who may from time to time need to deal with couple conflicts, especially when postnatal women are involved. The knowledge shared during antenatal period could serve a precautionary purpose to family members, and assist women to come off such difficulty faster, if it presents.

It is therefore recommended that doctors, nurses, therapists, and counselors should pay more attention to the psychological needs of women at this time (post natal period) and indeed at all times so as to make couples and young families healthier.

LIMITATIONS

No exclusion criteria (eg presence of previous history of sexual/marital problems, or of psychopathology) were considered in this study. This may impact generalization.

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