

## Difference Between Anxiety and Depression with Respect to Marital Adjustment and Sexual Functioning

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**Abstract:** The present study aimed to examine the differences between patients of Anxiety Disorder ( $n = 40$ ) and Major Depression ( $n = 40$ ) with respect to marital adjustment and sexual functioning. A purposive sample was taken from four psychiatric units of teaching hospitals, Lahore. The research tools were Symptom Checklist –R, Marital Adjustment Test and the Sexual Functioning Questionnaire. Independent sample  $t$  test showed significant difference between both clinical groups on marital adjustment and sexual functioning. Moreover, significant impairment was found more in depressive group with respect to marital adjustment and sexual functioning. The present study therefore highlights that the marital and sex therapy is more important in the treatment of patients with depression as compare to anxious patients.

**Key words:** Marital adjustment • Sexual Functioning • Purposive Sampling

### INTRODUCTION

Marriage is an important relationship between men and women. It promotes physical and emotional health of individuals [1]. It makes the person's life longer, happier and satisfactory [2]. Marital adjustment can be a slow and ongoing process. Marital adjustment is defined as the state in which both husband and wife feel happy and satisfied with their marriage and with each other [1].

One of the most important aspects of the marriage is sexual relationship which makes the relationship strong and healthy [3]. Similarly in Islam, the sexual relationship is also emphasized in marital relationship. It was believed that the literal meaning of Nikah is sexual intercourse [4].

Quality of marriage plays an important role in determining the health status of individual as Hawkins and Booth (1935)[3] reported that the health problems are higher in those who are experiencing marital adjustment problems and are less satisfied in their marital relationship as compare to those who are having good marital quality. Marital problems have been reported to be increasing day by day which lead toward psychological disorder [5].

Psychological disorders do not occur in vacuum but always develop in the context of interpersonal relationship. More recently, research work has been focusing on understanding the relationship between interpersonal relationship (marital adjustment) and

psychological disorders such as depression [6-9] anxiety disorder [10, 11].

Many previous studies were conducted with the aim of finding the association of marital adjustment and sexual functioning with anxiety and depression group. In Pakistan, relatively little attention has been devoted to the marital and sexual functioning of patients with depression and anxiety. Sexual issues always remain a neglected area in Pakistan. Patients consulted with the psychological problems usually feel shy to report their sexual problems to the doctor which in turn increases the psychological symptoms. People don't understand that marital problems and poor sexual functioning might be a source of more psychological problems in patients.

In Pakistan, not a single study explored the marital adjustment and sexual functioning in patients with anxiety and depression. The western literature could not be applicable here in Pakistan because of the difference in cultural system. So the current study was unique in many respects as it would be a first study in Pakistan. It helped in identifying relationship between marital and sexual functioning in depressed and anxiety patients.

### MATERIALS AND METHODS

In cross sectional research study, between group designs was used in which a purposive sampling strategy

was employed [12]. The participants were married patients, under the treatment of Major Depression and Anxiety disorder (Generalized Anxiety disorder, Panic Disorder, Phobia, Obsessive Compulsive Disorder) selected from four teaching based government hospitals of Lahore, Pakistan. The patients, who were divorced, widowed or with poly gummous marriage or with the diagnosis of a psychotic disorder, any co morbid disorder or current substance abuse was excluded from the study. Among the 80 participants used in the study half of them were diagnosed with depression and other half with anxiety disorder. The whole data was collected within two months (20<sup>th</sup> April to 12<sup>th</sup> June, 2012). One hundred and fifty patients were approached for the study. Among them some were excluded because they were not fulfilling the inclusionary criteria and some refused to participate (10 %). A trial study was carried out on 25 patients, to find out the level of conceptual clarity, timing of administration, fatigue factors of the three tools. After piloting, G\* power 3 analysis [13] was run. The statics showed 81 powers with a sample size of 40 for each group and alpha level is 0.16 in two tail tests. The trial study data was included in the main sample of the study. The whole sample was comprised of 31(39%) males and 41 (61%) females. Their ages ranged from 18 to 64 with a mean of 36.6 years. The most common anxiety disorder was GAD (25 %) followed by OCD (11%), panic disorder (9%) and phobia (5%).

The Symptom Checklist (SCL-R) [14] was used to screen out the depression and anxiety symptoms. SCL- R is s an indigenous tool to assess the psychopathologies in Pakistani population. The SCL-R was composed of six subscales i.e. Depression, Somatoform Disorder, Anxiety, OCD, Schizophrenia and LFT. The responses are rated on a 4 point Likert scale. In the present study, only two subscales of Depression and Anxiety of SCL-R were used to quantify the symptoms in research participants. The SCL-R Scale I (Depression Scale) was validated against BDI- I Urdu Version which was validated and adapted by Bashir and Sitwat in 1990 [14] with the value of 0.73. The test re test reliability of Depression Scale was 0.88 for normal population and for psychiatric population 0.96. In the present study, the Cronbach's alpha for Scale I was 0.62. The SCL-R Scale II (Anxiety Scale) of Symptom Checklist was validated with State Trait Anxiety Inventory which was adapted by Ashraf and Rahman in 1998 [14] with a score of  $r = 0.47$ . The test retest reliability of Anxiety Scale for normal population was reported 0.81 and for psychiatric population 0.95 [14]. In the present study, the Cronbach's alpha for Scale II was found 0.59.

The Sexual Functioning Questionnaire (SFQ) [15] as originally developed for cancer survivors, but afterwards it was also evaluated on matched controls from the general population. The SFQ was adapted from the Brief Sexual Functioning for women (BISF –W; Taylor *et al.*, in 1994 as cited in [15]. It consists of 25 items that are grouped into nine subscales: Interest, Desire, Arousal, Orgasm, Satisfaction, Behavior, Relationship, Masturbation and Problems. The SFQ overall score is a mean of all items used to generate the nine subscales. For overall score and each subscales score, a higher number means better sexual functioning and the lower numbers mean poor sexual functioning. The SFQ can be use with men and women; items for eight of the nine domains are applicable to both genders. Only the 'problems' subscale includes different questions for men and women, for example, erection and ejaculation items for men and lubrication and vaginal penetration items for women. Cronbach's alpha for all the original scales was more than 0.80, including that for the problems scale (0.84 for men, 0.81 for women). The SFQ has been shown to be a reliable and valid measure for use [15]. So to use it on Pakistani population, Urdu back translation procedure was followed. In the present study, the Cronbach's alpha of SFQ- males is 0.854 and for Females was 0.89 identified by the present researcher.

Lock and Wallace Marital Adjustment Test (MAT) [16] was used for the assessment of marital adjustment. The Marital Adjustment Test (MAT) developed by Lock and Wallace in 1959 [16] adjustment. It is a short, reliable and valid instrument consists of basic 15 items. The marital adjustment test contain one global question which assess level of happiness, eight question measuring areas of disagreement, six questions were measuring conflict resolution, cohesion and communication. The split-half reliability coefficient (Spearman-Brown formula) for the original test was = 0.90 and the validity were reported to be that people known to be well-adjusted in their marriage scored much higher on the scale than maladjusted people. In the present study, the Urdu translated version of the tool [17] was used. Permission was taken from both authors of English and Urdu version. The Cronbach's alpha of the Urdu translated version was 0.77 identified by the present researcher.

A Demographics Variable Questionnaire was developed specifically for the present study to obtain information regarding the following: age, education, number of children, economic status, type of marriage (consanguineous or non consanguineous marriage), blood relationships between the woman and her husband,

Number of previous depression episodes, previous history of anxiety disorder, average duration of illness (years), average duration of marriage (years), the onset of the illness, sexual treatment history.

The formal official permission of the relevant tools from the respective authors and hospital departments for collecting data were taken before beginning the research process. The research synopsis was approved for empiricism and ethics by the Departmental Doctoral Program committee (DDPC). The Back Translation of Sexual Functioning Questionnaire SFQ [15] was carried out to administer it onto the local population. A two way translation procedure (forward and backward) was used in which parallel translation procedure was used [18]. Five translators with more than 18 years education and proficient in both English and Urdu language translated the items into Urdu. The translators were advised to conceptually translate the items. After each one had translated the tool into Urdu independently, a reconciliation committee, comprised of two translator coordinators reconciled the discrepancies and agreed on final version which taps the best of the independent translations or, alternatively, appears in the course of discussion. Almost three to four items were retranslated by the two members of the committee. Once Urdu items were selected they were given to another set of five individuals to be translated back conceptually to English and again the similar reconciliation process was followed. Before finalizing the questionnaire, it was verified by an Urdu Language expert for grammatical errors and sentence correction [15, 19]. Additionally, a short demographic sheet was formulated which covered some of the basic demographics e.g. name, age, sex, education marital status etc. The diagnosis of psychiatrist and clinical psychologist was cross checked with the help of DSM IV-TR Criteria [20]. To assess the level of severity of depression and anxiety two subscale of Symptom Checklist-R (Scale I and II) were administered. Scale I was given to depressive patients and scale II was given to anxiety patients (OCD, Panic, Phobia and GAD).

All measures were individually administered on the selected participants. Confidentiality of information was assured by taking written informed consent. Each Participant was given the right to withdraw from the study at any stage. The diagnosis of psychiatrist and clinical psychologist was cross checked with the help of DSM IV-TR criteria. Distraction was controlled by informing the hospital staff about research purpose and requesting them not to enter the room when administration was being carried out. The Participant was given the right to withdraw from the study at any stage.

The SPSS software program version 17 was used to analyze the data. Independent sample *t*-test was used to find out the difference between depression and anxiety on marital adjustment and sexual functioning.

## RESULTS AND DISCUSSION

The independent *t*-test showed significant difference on marital adjustment ( $t = -2.58$ ,  $df = 78$ ,  $p = 0.01$ , two tailed) and sexual functioning ( $t = -3.33$ ,  $df = 78$ ,  $p = 0.001$ , two tailed) between depression and anxiety respectively. The marital adjustment was more impaired in depressed individual ( $X\bar{X} = 61.8$ ) than anxiety patients ( $X\bar{X} = 79.8$ ). Similarly the sexual functioning was also more impaired in depressive patients ( $X\bar{X} = 1.89$ ) as compare to anxiety patients ( $X\bar{X} = 2.49$ ) (Table 1).

The present researcher had hypothesis that there would be a significant difference between depression and anxiety in marital adjustment and sexual functioning. The results supported the hypothesis. The difference between anxiety and depression on marital adjustment and sexual functioning was significant with significant impairment in depression group only.

The present researcher attributed that the significant difference between both clinical groups might be due to the difference in nature of symptoms of both disorders. In depression, there were more negative symptoms e.g. loss of interest, loss of appetite and sleep, loss of energy, suicidal intentions as compare to anxiety.

Table 1: Independent Sample *t*-test for Depression and Anxiety for Difference of Marital and Sexual Functioning

	Depression		Anxiety		<i>t</i>	<i>p</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
Marital Adjustment	61.8	31.3	79.08	29.05	2.58	0.13*
Sexual functioning	1.89	.747	2.49	.857	3.33	.001*

Note: *M* = Mean, *SD* = Standard Deviation, \* $p < 0.05$ .

Moreover, the loss of sexual desire was also included in the diagnostic criteria of depression but not with anxiety disorders [20]. So it might be the negative symptoms which directly and significantly affect the marital and interpersonal relationship as compare to anxiety patients.

A comparison showed that the present study results were very similar to western studies regarding the research variables. Therefore, the present study seems to indicate the universality of the fact that depressed patients tend to have more of sexual and marital problem in comparison to anxious patients. Furthermore, perhaps the reasons for the difference are also the same.

During study, the researcher came to know that many patients suffered from the sexual problem and many eligible participants 10 % were not willing to participate in the study. So the representative sample couldn't be approached within specified time constraints of the study.

In the present study, due to limited resources, all hospitals of Lahore city could not randomly selected and data was also small. It is proposed that sample should be larger to represent Lahore to start with and later the study could be expanded to other cities.

Despite the above given limitations, the present research has unique and has different clinical implications. Most importantly the uniqueness of the research was due to many reasons: the sensitive and a tabooed area were studied first time in Pakistan. The research findings have contributed in the understanding of the marital and sexual functioning of clinical population.

The implication hence is to develop or devise sex education packages in Pakistan for patients so that they can understand and handle their associated sexual problems as well. The present study opens the door for further researches in an area of immense significance. Further, qualitatively research can be carried out to identify what type of sexual and marital adjustment problems depressed and anxious patients are facing. Moreover, the efficacy of sex and marital therapy could be assessed in clinical population. A longitudinal research could be conducted to assess the change in marital and sexual relationship during course of depression and anxiety.

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