

## SEXUAL FUNCTIONING OF WOMEN IN SERBIA: RELATIONS WITH ATTACHMENT

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### Abstract

Attachment style is an important element of partnership dynamics and can be related to different indicators of relationship quality, including sexual relationship. The purpose of this study was to explore the relationship between female sexual functioning (FSF) and characteristics of partner attachment. In this paper, female sexual functioning will be examined through the following dimensions: the intensity of sexual desire, arousal, lubrication, orgasm, sexual life satisfaction, and pain during intercourse. In case of existing issues, these categories of functioning are considered to be indicators of female sexual dysfunction. The research was conducted on a convenience sample of 284 female participants aged 18 to 65, from Serbia, all having partner relations longer than 6 months. Female sexual dysfunction (FSD) was present in 24.6% of the sample, while 75.4% had no symptoms. Looking at dimensions of sexual functioning separately, the most common issues were related to sexual desire and the least commonly reported problems were related to lubrication and pain. There were moderate correlations between the total measure of FSF and dimensions of attachment. Canonical correlation analysis indicated that attachment is highly correlated with subjective experience of sexual life satisfaction. Research results are in accordance with the results of foreign studies and, despite many limitations, they represent a significant starting point for future studies in our region relating attachment to sexual behaviour or dysfunctions.

**Key words:** female sexual functioning, Serbia, attachment, anxiety, avoidance.

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## СЕСУАЛНО ФУНКЦИОНИСАЊЕ ЖЕНА У СРБИЈИ: РЕЛАЦИЈЕ СА АФЕКТИВНОМ ВЕЗАНОШЋУ

### Апстракт

Обрасци партнерске афективне везаности представљају значајан елемент динамике партнерске релације и могу бити повезани са различитим индикаторима квалитета везе, па тако и са сексуалним односима. У истраживању је анализирана повезаност сексуалног функционисања жена са карактеристикама партнерске афективне везаности. Сексуално функционисање жена у овом раду биће посматрано кроз следеће димензије: израженост сексуалне жеље, постизање узбуђења, овлаживање, постизање оргазма, задовољство сексуалним животом и бол приликом односа. Ове категорије функционисања, уколико у њима постоје проблеми, сматрају се индикаторима сексуалне дисфункције. Истраживање је спроведено на пригодном узорку сачињеном од 284 испитанице, узраста од 18 до 65 година, из Србије, које су у партнерској вези дужи од шест месеци. Значајно присуство симптома сексуалне дисфункције забележено је код 24,6% испитаница, док је 75,4% без присуства симптома. Када су у питању појединачне димензије сексуалног функционисања, највише је проблема са сексуалном жељом, а најмање са овлаживањем и болом. Између укупног броја симптома и димензија афективног везивања добијене су умерене корелације. Каноничка корелациона анализа указала је на то да су димензије афективне везаности повезане у највећој мери са субјективним доживљајем задовољства сексуалним животом. Резултати спроведеног истраживања су у складу са резултатима иностраних студија и, поред многобројних ограничења, они представљају значајну полазну тачку за будућа истраживања релација афективног везивања и сексуалног понашања или дисфункција на нашим просторима.

**Кључне речи:** сексуално функционисање жена, Србија, афективна везаност, анксиозност, избегавање.

### INTRODUCTION

Attachment theory and research suggest that adult attachment processes are related to numerous behaviors in romantic/love relationships. Adult romantic relationships include the integration of three behavioral systems: attachment, caregiving, and sexual mating (Shaver, Hazan, & Bradshaw, 1988). In adulthood, attachment has a status of disposition and it relies on experiences in early relations with caregivers in which relatively stable internal working models are formed, which define a person's understanding of closeness, intimacy, trust, and close relationships in general (Feeney, 2008). Sexual behavior is a defining feature of most love relationships. Therefore, it could be expected that adult attachment is relevant to this behavior as well as to sexual problems and dysfunctions.

In this paper, female sexual functioning will be examined through the following dimensions: the intensity of sexual desire, arousal, lubrication, orgasm, sexual life satisfaction, and pain during intercourse. In case of existing issues, these categories of functioning are considered to be indicators of sexual dysfunction. Hence, in this paper, they are also referred

to as symptoms of female sexual dysfunction. In the literature, most information about sexual functioning is found in papers on sexual dysfunction. Therefore, this approach offers a broader framework within which the results could be understood and interpreted. Female sexual dysfunction (FSD) includes four major categories of dysfunction: desire disorders, arousal disorder, orgasmic disorder, and sexual pain disorders, as described in the DSM-V (American Psychiatric Association, 2013). Diagnostic criteria in the past gave importance to physiological components of the disorder, such as vaginal moisture and lubrication, which correlate with desire and arousal. The newer diagnostic criteria (B in DSM-IV, C in DSM-V) are that aforementioned symptoms provoke difficulties in functioning and distress.

In the last two decades, studies on female sexual functioning have questioned former attitudes, definitions, and diagnostic categories and there are still vivid discussions about the suitability of even the most recent descriptions of FSD (Damjanović, Duišin, & Barišić, 2013; IsHak & Tobia, 2013; Sungur & Gündüz, 2014). Although the "interpersonal difficulty" determinant, which was a diagnostic criteria in DSM-IV-TR, has been replaced with "clinically significant distress in the individual" in order to take into account the possibility that people without partners could also suffer FSD, it is necessary to bear in mind that in sexual functioning of women, as well as dysfunctions, there is an important role of psychosocial variables such as partner relationship satisfaction, self-image, previous sexual experiences, etc. The new revised and extended definitions of female sexual dysfunctions should be in accordance with latest information about the nature of female sexuality, with the aim of improving the efficiency of clinical treatment of dysfunctions (Damjanović, Duišin, & Barišić, 2013).

The study of the highest volume on the topic of FSD so far is *The Global Study of Sexual Attitudes and Behaviours*. The study was performed to estimate the prevalence and correlates of sexual problems in more than 25,000 women and men from 29 countries, aged 40–80 years. Different types of FSD were present in women in Europe ranging from 9% (pain during sexual intercourse) to 29.6% (lack of sexual interest). For women, lack of interest in sex and inability to reach orgasm were the most common sexual problems across the world (Laumann et al., 2005). In all samples, the frequency of the problems increases with age.

The most frequently cited study on FSD prevalence until now is the one by Laumann, Paik, and Rosen (1999), who investigated 1,749 women aged 18–59 years living throughout the USA. In this landmark investigation, 43% of women reported on FSD. Individual studies in different countries provide similar results. Castelo-Branco et al. assessed FSD in 534 healthy women ( $52 \pm 6$  years) living in Chile and the prevalence of FSD increased from 22% in the younger age group to 66% in the

over-60 years of age group. Kadri et al. investigated 728 women ( $37 \pm 13$  years) living in Morocco using the same questionnaire as Castelo-Branco. FSD was present in 27% of women. Abdo et al. analysed 1,219 women ( $36 \pm 12$  years) living in Brazil and found that FSD was present in 49% of women (Ponholzer, Roehlich, Racz, Temml, & Madersbacher, 2005). Researchers in Japan found the prevalence of different FSD symptoms on a sample of 2,095 women to be 15-28% in women older than 30 and 32-58% in women older than 60 (Hisasue et al., 2005).

There are not many studies that have assessed the prevalence of FSD in apparently healthy women, conducted in Europe. Cayan et al. studied the issue in 179 Turkish women aged 18–66 years using the Female Sexual Function Index. The prevalence of FSD increased from 22% in those aged 18–27 years to 66% in those aged 48–57 years (Ponholzer et al., 2005). A study in Austria was conducted on a sample of 703 women aged  $43 \pm 15$  years, where 22% reported on desire disorders, 35% on arousal disorders, and 39% on orgasmic problems, all increasing significantly with age (Ponholzer et al., 2005).

The characteristics of partner attachment are recognized as one of the key correlates of the functionality of partner relations. The predominant view of adulthood attachment describes this construct through dimensions of anxiety and avoidance that represent the readiness of a person to enter close relationships and his or her capacities to maintain them (Brennan, Clark, & Shaver, 1998). The effects of attachment on the sexual aspect of relationship functioning are recognized as key factors for partner relation dynamics in those couples that attend partner therapy for dyadic as well as individual problems (Brassard, Peloquin, Dupuy, Wright, & Shaver, 2012). On the individual level, higher anxiety and avoidance scores are related to lower sexual satisfaction. Higher attachment-related anxiety strengthens the relationship between sexual relation satisfaction and overall satisfaction with partner relationship (Butzer & Campbell, 2008; Birnaum, 2007) by direct effects, as well as mediated by lower sexual self-esteem and higher sexual anxiety (Brassard, Dupuy, Bergeron, & Shaver, 2013). Avoidance is an important determinant of couple dynamics characterized by the restriction of intimacy in sexual intercourse, while anxiety is related to avoiding sex and the experience of discomfort in sex-related intimacy (Brassard et al., 2013).

A 2012 meta-analysis, which included 73 previous studies with 118 independent samples, explored the relations between attachment and partner relationship quality (Li & Chan, 2012). The meta-analysis that explored relations of attachment with sexual relations was done on only 15 studies that satisfied the criteria for inclusion. The results showed that both anxious and avoidant attachment were consistently associated with less satisfying sexual experiences in married, dating, and homosexual couples. Additionally, avoidant attachment is generally associated with

lower intercourse frequency in both males and females (Stefanou & McCabe, 2012).

In our region (Serbian speaking area), there have been few studies of FSF, mainly the ones that explored the effects of pharmacotherapy or mental health problems on sexual functioning. There have been no studies that bring into relation attachment and sexual behaviour.

The research problem in this study was exploring relations between sexual functioning of women in stable partner relations and the characteristics of partner attachment. In accordance with the problem, the following research aims were set:

1. To explore the prevalence and distribution of FSD symptoms and attachment styles on a sample of women from Serbia, including the prevalence of symptoms and styles in women that differ according to various socio-demographic variables. Within this aim, data were gathered on sexual intercourse frequency and the frequency of avoiding sex.

2. To explore the relations of FSD symptoms and attachment. Within this aim, it was assessed whether different categories of the symptoms of FSD, as well as total measure of FSD, correlated with attachment dimensions, anxiety and avoidance.

## METHOD

### Sample

The research was conducted on a convenience sample of 284 female participants, aged 18 to 65, from Serbia. All participants had partner relations longer than 6 months at the moment of data collection. Three quarters of women were married (74.3%), and one quarter had regular partners but were not married. The majority of women had children (68.3%). Other demographic data are shown in Table 1.

Table 1. Demographic characteristics of the sample

Age	%	Residence	%	Education	%	Employment status	%	Economic status	%	Family structure	%
18-29	23.4	city	69.4	secondary	20.8	employed	72.2	bad	4.2	alone	11.9
30-39	38.7	town	20.4	college	7.0	periodically	7.0	average	66.2	with partner	23.0
40-49	26.1	village	10.2	graduates	72.2	unemployed	13.1	very good	29.6	partner, children	57.9
50-65	8.4					student	7.7			partner, children and someone...	7.2

Participation in the study was voluntary. The questionnaires were disseminated online, and the procedure guaranteed anonymity. Participants were informed of the aim of the study and by accepting to fill the questionnaire they gave consent to participate in the research.

### *Instruments*

Apart from the socio-demographic questionnaire, the following instruments were applied:

*The Female Sexual Function Index (FSFI, Rosen et al., 2000).* Brief, multidimensional self-report instrument for assessing key dimensions of sexual function in women. The scale consists of 19 items that assess sexual functioning over the past 4 weeks and yield domain scores in six areas: sexual desire, arousal, lubrication, orgasm, satisfaction, and pain. Participants who did not have sexual relations during the previous four weeks were not included in the sample. The participants evaluate the intensity of each symptom on a 5-grade scale. In the original version, lower scores indicate a higher level of FSD symptoms. Considering the fact that the scale was applied for the first time on a sample of women from Serbia, its factor structure was checked. The obtained factor solution did not differ from the one reported by the scale authors. The six factors explained 82% of the variance. The scale reliability on our sample was satisfactory and for individual scales it ranged from  $\alpha = .85$  to  $\alpha = .92$ , while for the whole instrument it was  $\alpha = .86$ .

*Modified Brennan Experiences in Close Relationships Scale (Kamenov & Jelić, 2003).* A short version of the scale was applied (Brennan et al., 1998). Factor structure of the modified scale was the same as the original, meaning that partner relations in adulthood are operationalized through dimensions of anxiety and avoidance. The scale consists of 18 items with a 7-grade Likert-type response scale. The scale provides two separate scores for dimensions of anxiety and avoidance. Higher scores indicate higher avoidance or anxiety, respectively. The attachment style is determined based on the combination of the two scores. Four attachment styles can be distinguished: secure attachment and three insecure attachment types: preoccupied, dismissive and fearful-avoidant. Scale reliability on our sample was satisfactory; for the dimension of Anxiety  $\alpha = .84$ , and for Avoidance  $\alpha = .80$ .

## *RESULTS*

### *Prevalence and Distribution of FSD Symptoms and Attachment Styles on a Sample of Women from Serbia*

For this research goal, descriptive statistical methods were applied. The results are presented in Table 2.

Table 2. Descriptive statistical parameters of the FSFI and ECR questionnaires

	Min	Max	M	SD	Sk	Ku
FSFI Total score	11.20	36.00	28.74	4.77	-1.119	.809
Desire subscore	1.20	6.00	3.63	.98	-.195	.208
Arousal subscore	1.20	6.00	4.85	.98	-1.010	.655
Lubrication subscore	1.20	6.00	5.28	.99	-1.689	2.601
Orgasm subscore	1.20	6.00	4.63	1.41	-1.066	.169
Satisfaction subscore	1.20	6.00	4.95	1.12	-1.257	1.176
Pain subscore	1.20	6.00	5.40	1.02	-2.234	5.301
ECR Anxiety	9.00	58.00	18.52	8.19	1.369	2.096
Avoidance	9.00	55.00	23.10	11.02	.920	.302

Legend: Min-minimal value, Max-maximal value, M-mean, SD-standard deviation, Sk-skewness, Ku-kurtosis

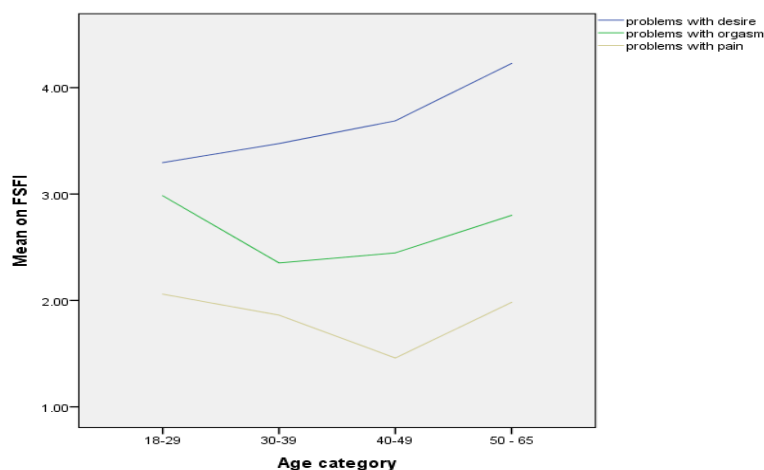
The review of Table 2 indicates that skewness and kurtosis values do not deviate from normal distribution, if by deviation a value greater than  $\pm 2.58$  (Field, 2013) is considered, with the exception of kurtosis of the pain subscale, which indicates more distinct grouping of results around the mean.

*Levels of sexual dysfunction.* An extensive validation study suggests using the total scale score of 26 or less as the cut-off score for diagnostic classification purposes, which indicates the presence of FSD (Wiegel, Meston, & Rosen, 2005). In our research, the score of 26 or less was attained by 70, or 24.6% of participants, while 214, or 75.4% had a score higher than 26, which indicates the absence of sexual dysfunctions. Looking at dimensions separately, the most common issues were related to sexual desire (the lowest average score) and the least commonly reported problems were related to lubrication and pain (the highest average scores).

*Dimensions of sexual functioning and socio-demographic variables.* There were no differences in total measure of FSF between groups of participants with different socio-demographic characteristics, including women's age. The differences were registered only regarding the economic status. The group of women that described their economic status as very good had a score that indicated higher presence of problems or FSD symptoms ( $M = 27.41$ ), compared to women that described their economic status as average or worse than average ( $M = 29.30$ ;  $t = -3.087$ ,  $df = 2$ ,  $p < .01$ ).

Participants with FSD (total scale score of 26 or less) did not differ significantly in the frequency of sexual intercourse from participants without FSD symptoms (a score higher than 26). However, participants with symptoms of FSD reported higher frequency of avoiding sexual intercourse (69.1% with FSD compared to 24.3% without FSD,  $\chi^2 = 43.553$ ,  $p < .01$ ). The described regularity was observed in participants with FSD, regardless of their attachment style.

When it comes to specific dimensions of sexual functioning, differences between participant groups with different socio-demographic characteristics were examined by employing the multivariate analysis of variance method (MANOVA). The variables included age, parenthood (whether they had children), place of residence, education level, employment status, and economic status. Statistically significant differences were obtained for the age variable (Wilks' Lambda = .819,  $F = 2.893$ ,  $p < .01$ ). The values of F-tests for each dimension of sexual functioning revealed differences in subdimensions of sexual desire ( $F = 5.618$ ,  $df = 3$ ,  $p < .01$ ) pain ( $F = 4.242$ ,  $df = 3$ ,  $p < .01$ ), and orgasm ( $F = 3.011$ ,  $df = 3$ ,  $p < .05$ ). The obtained arithmetic mean values for the abovementioned variables are shown in Graph 1, with data recorded so that higher scores indicate higher presence of FSD symptoms.



Graph 1. Age differences in dimensions of FSF

The graph clearly shows that more advanced participant age was related to greater problems with sexual desire (which was the dimension with the highest number of reported problems). Conversely, younger participants had more difficulties reaching orgasm. The issue of pain was least common in participants in the fourth decade of their lives (pain was the dimension with the lowest number of reported problems).

*The prevalence of attachment styles.* The frequency of attachment styles is shown in Table 3 and it indicates the theoretically expected domination of securely attached women. The result is expected, considering the fact that the women in our sample were in partner relationships that were described as stable.



*Table 3. The prevalence of attachment styles in our sample*

Style	Frequency	Percent	Percentage of women with secure and insecure attachment
secure	234	82.4	82.4
preoccupied	36	12.7	
fearful-avoidant	5	1.8	17.6
dismissive	9	3.2	
Total	284	100.0	

Regarding attachment dimensions, there were no differences between groups of women by any socio-demographic variable, nor were there significant correlations with the frequency of sexual intercourse or the frequency of avoiding sex.

*The relationship between FSD symptoms and attachment dimensions*

Between the total score of FSFI and attachment dimensions, moderate correlations were obtained, with the avoidance dimension  $r = .404$  and the anxiety dimension  $r = .303$ , significant at the 0.01 level. These correlations, with data recoded so that higher scores indicate higher presence of FSD symptoms, indicate that problems with sexual functioning were more common in individuals with higher scores on the avoidance and anxiety dimensions.

The structure of relations between FSD symptoms and attachment dimensions was explored via the canonical correlation analysis. The results are shown in Tables 4 and 5.

*Table 4. The parameters of isolated canonical functions*

	Correlation	Eigenvalue	Wilks Statistic	F statistic	Degrees of Freedom	Significance
1	.506	.345	.726	7.971	12.000	.000
2	.152	.024	.977	1.313	5.000	.259

*Table 5. The structure of canonical function*

Subdimension (FSFI* and ECR scales)	Standardized Canonical Correlation Coefficients	
	Set 1	Set 2
Sexual desire (FSFI)	-.115	
Arousal (FSFI)	.256	
Lubrication (FSFI)	-.020	
Orgasm (FSFI)	.149	
Satisfaction (FSFI)	.704	
Pain (FSFI)	.158	
Avoidance (ECR)		.719
Anxiety (ECR)		.546

\* - recoded so that higher scores indicate higher presence of problems/symptoms

Canonical correlation analysis that included dimensions of sexual functioning showed that perceived problems with experiencing *sexual life satisfaction* has the highest correlation with the canonical function. Both dimensions of attachment are highly correlated with the canonical function.

### DISCUSSION

In our region (Serbian speaking area), there had been no studies about sexual functioning of women, nor about the prevalence of FSD symptoms and its correlates. Compared to studies in other countries, it could be concluded that our results, according to which 25% of the participants had significant level of FSD symptoms, do not deviate significantly from the data obtained by other researchers.

Several studies discussed in the introductory segment of this paper reported the following percentages: 22 (the Chilean study), 27 (the Moroccan study; Ponholzer et al., 2005) 15-28 (the Japanese study; Hisasue et al., 2005). The study conducted in Turkey used the same instrument that was employed in the present research and reported 22% (Ponholzer et al., 2005). Some papers reported higher percentages of women with symptoms of FSD. This is the case with the study of Laumann, Paik, and Rosen (1999), in which 43% of women living in the USA reported FSD, while Abdo et al. reported that FSD was present in 49% of women living in Brazil (Ponholzer et al., 2005). In all samples, the frequency of the problems increased with age. The age variable emerged as relevant in our research as well.

In our sample of women from Serbia, the most common problems were related to sexual desire, while problems with lubrication and pain were least common. Several other authors reported similar results. Within The Global Study of Sexual Attitudes and Behaviours, the issue of pain during sexual intercourse was least common (9% of women) and the most commonly reported problem was a lack of sexual interest (29.6%). A study involving participants from 29 countries showed that for women, a lack of interest in sex and the inability to reach orgasm were the most common sexual problems (Laumann et al., 2005). In the present research, problems with sexual desire were related to the age of the participants, with the incidence increasing with age. On the other hand, problems with reaching orgasm were less common with increasing age. The age was not related to the overall incidence of problems with sexual functioning, while the relationship between overall incidence and the pain dimension was not entirely clear. Therefore, future studies are needed to explore this relation in greater detail.

As far as other socio-demographic variables are concerned, differences were registered only when the variable of economic status was correlated with the total score on FSFI scale. The group of women that de-

scribed their economic status as very good had a score that pointed to a higher number of FSD symptoms, compared to other groups of women. It is necessary to explore this relation more thoroughly, in order to find an adequate interpretation for it, especially having in mind that the direction of correlation is not expected. It is well known that good economic status is a protective factor and a resource for coping with stress, and that in research it is most commonly correlated with better family and partner functioning (Šakotić-Kurbalija, 2016).

Some authors indicate that the prevalence estimates of FSD vary substantially across instruments, study populations, methods of assessment and definitions of FSD, and that a direct comparison between studies is hampered by the lack of a uniform, validated FSD questionnaire (Hayes, Dennerstein, Bennett, & Fairley, 2008). One interesting result is that changing the request for recalling symptoms from the previous month to a longer time period produced different estimates for all disorders in question.

Although the Female Sexual Function Index (FSFI) is currently the most frequently used FSD questionnaire, it has not been formerly validated in other languages (Hayes et al., 2008). Besides that, it is important to emphasize that the instrument has been in use since the year 2000 and it assesses sexual life during the previous four weeks, while in the latest diagnostic classification, the length of symptoms of at least 6 months is taken as a diagnostic criterion (B). In this sense, all previous results should be taken into account with caution, if we consider them as indicative of the prevalence of the FSD disorder.

The frequency of attachment styles indicates the theoretically expected domination of securely attached women. The result is expected, considering the fact that the women in our sample were in partner relationships that were described as stable. There were no differences in distribution of attachment styles among the groups of participants with different socio-demographic characteristics.

When it comes to relations between FSD symptoms and attachment, there are moderate correlations between the total measure of FSD and attachment dimensions, significant at the 0.01 level. Previous research has also registered the correlation between the symptoms of FSD and attachment, so that the prevalence of FSD is higher in people with higher anxiety and/or avoidance, as a meta-analysis by Stefanou and McCabe (2012) reports. A more recent study conducted on a big sample of student population (mean age 20 years) showed that attachment style of women accounted for a significant amount of the variance in the FSFI total scores and subscales (Dunkley, Dang, Chang, & Gorzalka, 2016). In another study (Brassard et al., 2013), the authors found that higher levels of anxious and avoidant attachment predicted poorer overall sexual functioning and lower sexual satisfaction. The authors of a paper published in

2014 report on correlations of FSD and attachment, more with avoidance, less with anxiety, as well as with the degree of differentiation of self (Buri, Schweitzer, & O'Brien, 2014). By comparing groups of women with sexual problems and healthy women, the authors report differences in three of the four scales referring to insecure attachment (Ciocca et al., 2015).

Canonical correlation analysis indicated that dimensions of attachment correlated highly with subjective experience of satisfaction with sexual life, indicating that women with higher scores on the avoidance and anxiety dimensions reported more problems with experiencing sexual pleasure. Other dimensions had low or absent correlations with the canonical function. In a research conducted in Dutch female students, in which the same instruments were applied, the variables of body appreciation and romantic attachment dimensions explained the highest percentage of variance (28.5%) exactly for the dimension of sexual life satisfaction (Van den Brink, Smeets, Hessen, & Woertman, 2016).

The results of this study are important for the discussion that has been led about the adequacy of the definition of FSD in diagnostic classifications DSM-IV and ICD 10. The aforementioned definition includes four categories of disorders that the diagnosis of FSD includes: desire, arousal, orgasmic, and sexual pain disorders. A work group made of leading European and North American investigators met in 2000 with the aim of determining the appropriateness of each category and definition. The group suggested expanding the definition in order to include psychological aspects of the disorder. Therefore, the diagnostic criteria included "marked distress or interpersonal difficulty" in DSM-IV-TR. The group even suggested including a new diagnostic category of *sexual satisfaction disorder* into the diagnostic classification, but consensus was not achieved and the suggestion was not accepted (Basson et al., 2000). The DSM-V classification excluded the criterion of personal distress that was replaced with the determinant "clinically significant distress in the individual" (IsHak & Tobia, 2013; Sungur & Gündüz, 2014). In our study, the dimension of sex life satisfaction was singled out as an aspect of FSD that contributes the most to the registered relationship between FSD and attachment.

The exclusion of psychological factors that represent potential causes or correlates of FSD from research, diagnostics, and therapy necessarily leads to the medicalization of the disorder. The medicalization of FSD implies focusing on the genital response as the essence of the disorder, and neglecting dissatisfaction with other aspects such as emotional and relational aspects of sexual experience (Tiefer, 2002). Some authors (Tiefer, 2002) believe that the main barrier to understanding women's sexuality is the medical classification scheme in current use, developed by the American Psychiatric Association (APA) in 1980 and revised later. "The DSM's reduction of 'normal sexual function' to physiology implies, incorrectly, that one can measure and treat genital and physical difficulties without regard to the relationship in which sex occurs" (p. 133). This

orientation could affect the approach fostered within sex education programs, where quick solutions with medical means could be promoted. It could also affect motivation of women to engage in psychotherapy and prognosis for further functioning. Based on their own studies, there are authors that claim that it is fundamental to identify attachment and relational styles in patients receiving counselling and psychological treatments focused on sexual problems (Ciocca et al., 2015), especially for sexual desire and orgasm difficulties in women (Brotto et al., 2016).

The presence of FSD symptoms did not correlate significantly with the frequency of sexual intercourse in our sample. However, it was found that participants with FSD avoided sex significantly more often compared to participants without symptoms. This result is not surprising, given that adequate sexual functioning is an important condition for motivation for sexual intercourse. This assumption was confirmed in some other studies (Hisasue et al., 2005). The relation between FSD and avoiding sexual intercourse should be investigated more thoroughly, considering the fact that there is most likely a circular connection of the two variables in question, with the basis in the wide context of the overall partnership dynamics.

### CONCLUSION

In our study, FSD symptoms was registered in 24.6% of participants, while 75.4% had no symptoms of sexual dysfunctions. The most prominent problems were related to sexual desire. Physiological problems related to lubrication and pain during sexual intercourse were least common. Foreign studies report similar results. Theoretically expected distribution of attachment styles was found, with securely attached women as predominant.

Between the total measure of FSF/FSD and attachment dimensions, moderate correlations were registered. Canonical correlation analysis showed that the dimensions of attachment are most strongly related to subjective experience of satisfaction with sex life.

Limitations of the study are numerous. The sample was convenient, gathered by online dissemination. For this reason, data about women with a high education level were prevalent (70% of the sample). This makes it difficult to generalize the significant results to the population. The sample exclusively included women and it relied on individual perspectives to describe the dynamic nature of their sexual relationships. In the future, it is expected from dyadic research to provide special contribution, as there are multiple combinations of attachment styles that can impact the experience of sex between dyads. However, since there are no previous studies about the prevalence of FSD symptoms in women in our region (Serbian speaking area), nor the correlates of the disorder, the results of this study are an important starting point for future research, as well as for recording and tracking sexual health of women, with the aim of improving the efficiency of clinical treatment of dysfunctions.

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## СЕСУАЛНО ФУНКЦИОНИСАЊЕ ЖЕНА У СРБИЈИ: РЕЛАЦИЈЕ СА АФЕКТИВНОМ ВЕЗАНОШЋУ

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### Резиме

На нашим просторима су ретка истраживања сексуалног функционисања ван релације са ефектима фармакотерапија неких других болести или проблема у менталном здрављу. Не постоје истраживања која доводе у везу афективну везаност са сексуалним понашањем или са сексуалним дисфункцијама, иако се сама афективна везаност доводи у везу са другим карактеристикама партнерског функционисања. Обрасци партнерске афективне везаности представљају значајан елемент динамике партнерске релације и могу бити повезани са различитим индикаторима квалитета везе, па тако и са сексуалним односима. Ефекти афективне везаности на сексуални аспект функционисања у вези препознају се као кључни чинилац динамике односа у паровима који се јављају на брачну терапију због дијадних, као и индивидуалних, проблема. У овом истраживању је анализирана повезаност сексуалног функционисања жена са карактеристикама партнерске афективне везаности. Сексуално функционисање жена у овом раду посматрано је кроз следеће димензије: израженост сексуалне жеље, постизање узбуђења, овлаживање, постизање оргазма, задовољство сексуалним животом и бол приликом односа. Ове категорије функционисања, уколико у њима постоје проблеми, сматрају се индикаторима сексуалне дисфункције. Истраживање је спроведено на пригодном узорку сачињеном од 284 испитанице, узраста од 18 до 65 година, из Србије, које су у стабилној партнерској вези дужи од шест месеци. Значајно присуство симптома сексуалне дисфункције забележено је код 24,6% испитаница, док је 75,4% без присуства симптома. Када су у питању појединачне димензије сексуалног функционисања, највише је проблема са сексуалном жељом, а најмање са овлаживањем и болом. Између укупног броја симптома и димензија афективног везивања добијене су умерене корелације. Каноничка корелациона анализа указала је на то да су димензије афективне везаности повезане у највећој мери са субјективним доживљајем задовољства сексуалним животом. Ограничења студије су вишеструка. Узорак је прикупљен путем онлајн-дисеминације. Из тог разлога доминирају подаци о женама високог образовања (70% узорка), чиме је отежана генерализација значаја резултата. Узорак је укључивао искључиво жене и ослањао се на индивидуалну перспективу приликом описа динамике природе њиховог сексуалног живота. У будућности се може очекивати да „дијадичка истраживања” пруже специфични допринос, узимајући у обзир то да постоје вишеструке комбинације стилова везивања који могу утицати на сексуално искуство између дијада. Поред наведених ограничења, потребно је истаћи да су резултати спроведеног истраживања у складу са резултатима иностраних студија и представљају значајну полазну тачку за будућа истраживања релација афективног везивања и сексуалног понашања или дисфункција на нашим просторима.