Univerzita Karlova v Praze

1. lékařská fakulta

Studijní program: Doktorské studijní programy v biomedicíně

Studijní obor: Lékařská psychologie a psychopatologie

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Determinanty sexuální spokojenosti u českých mužů

Determinants of sexual satisfaction in Czech men

Doktorská disertační práce

Vedoucí závěrečné práce / Školitel:

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Praha 2021

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ACKNOWLEDGEMENTS

This thesis is dedicated to my dear parents: my dear father who has passed away in 2010 who always encouraged me to do my best and to never surrender in front of adversity, and to my dear mother for her inexhaustible patience, waiting that I held my promise to finish my doctoral studies.

I would also like to thank the following people who have helped me undertake this research:

- My supervisor, Prof. PhDr. Petr Weiss, PhD., DSc., for his continued support, guidance, encouragement, and his patience.
- Christopher Fox, PhD, senior lecturer in Sexual Health at Westmead Clinical School, Faculty of Medicine and Health, University of Sydney, Australia, my external academic advisor, and my incredibly good friend, for his insightful comments and investing his time to help me out tremendously.
- My friend, Mike Johnson for friendship during our study at the University of Oxford, who introduced me to my supervisor, Prof. Petr Weiss.

My special thanks to Alexis. Thank you for your immense patience and love, and for always be there for me; whether though reading my work and offering your advice and support, or through the knowledge that you truly believe in me.

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Abstrakt

Medicína i odborná literatura se, zejména pak v oblasti sexuologie, zcela legitimně zaměřují na studium a léčbu všech poruch a dysfunkcí, které ovlivňují člověka a jeho sexualitu. Prostřednictvím této disertační práce jsme se pokusili zjistit faktory, které ovlivňují sexuální spokojenost u mužů. Jsem si přitom vědomi toho, že sexuální spokojenost je plně subjektivní pojem, v současné době určovaný například i snadným přístupem k pornografickým materiálům, které vedou každého muže ke srovnávání, jakkoli jsou jejich měřítka nereálné.

K měření sexuální spokojenosti existuje mnoho nástrojů. Bylo však prokázáno, že hodnocení sexuální spokojenosti prostřednictvím jediné otázky je téměř stejně spolehlivé jako využití podrobných dotazníků. Vzhledem k tomu, že je tato disertace začleněna do mnohem rozsáhlejšího výzkumu založeného na dotazníku o 90 otázkách, bylo rozhodnuto použít pouze jednu otázku týkající se sexuální spokojenosti. Tato otázka byla však rozdělena do dvou podotázek; jedna se týká celkové spokojenosti se sexuálním životem, druhá se zabývá aktuální sexuální spokojeností ve vztahu s partnerem. Odpovědi na tyto dvě otázky byly porovnány se sociodemografickými charakteristikami každého respondenta, aby bylo možné identifikovat parametry určující ty, kteří se svou sexualitou vyjádřili

spokojenost, a těch, které chybí nebo jsou méně zastoupené u mužů nespokojených.

S ohledem na alespoň částečné přizpůsobení se obecnému trendu bylo zkoumáno i to, zda určité charakteristiky jsou překážkou pro sexuální spokojenost. Pro hodnocení fyziologických aspektů sexuálního života byly vybrány dva nástroje: IIEF - International Index of Erectile Function (Mezinárodní index erektilní funkce) a IILT - Index of Intravaginal Latency Time (doba od zavedení penisu do pochvy až po výron semene). Tyto nástroje měří parametry, o nichž je známo, že ovlivňují sexuální spokojenost. Porovnání těchto specifických aspektů sexuálního života respondentů s celkovým zhodnocením jejich sexuální spokojenosti se ukázalo jako přínosné.

Jako potenciálně negativní anamnestická charakteristika z hlediska sexuální spokojenosti se projevila především zkušenost se sexuální traumatizací v dětství. Oběti tuto traumatizaci ve formě sexuálního zneužití často potlačují a nehovoří o něm, hovor na toto téma je málokdy iniciován i odborníkem. Je proto užitečné zjistit závažnost dopadu takového traumatu z dětství na sexuální život dospělého jedince.

Do studie se zapojil vzorek 1004 mužů, kteří byli reprezentativní pro českou populaci podle kritérií věkového rozložení, socioekonomických charakteristik a regionu ČR. Tito muži poskytli nezávislé a anonymní odpovědi na 90 otázek v rámci dotazníku, který zahrnoval všechny aspekty jejich sexuality včetně sexuální spokojenosti, a také několik charakteristik jejich života, ať už na osobní, rodinné či společenské úrovni.

Predikční model sexuální spokojenosti založený na věku, typu a frekvenci pohlavního styku byl vytvořen pomocí vícenásobné regresní analýzy, která měla posoudit korelaci různých sociodemografických a fyziologických parametrů souvisejících se sexuální spokojeností.

Tyto analýzy umožnily provést následující zjištění, která prokazují pozitivní korelaci se sexuální spokojeností u mužů:

- Věk mezi 30 a 44 lety (míra spokojenosti 34,6 %). Tato charakteristika svědčí o tom, že ne pouze mladší věk, ale i určité zkušenosti mohou přispět k vyšší sexuální spokojenosti. Nerealistická očekávání mohou vést k bolestným zklamáním. Věk s sebou přináší určitou rozvážnost, díky níž se člověk dokáže spokojit s tím, co má, a toto postupné uznání nahrazuje mladistvý elán.
- Manželství (míra spokojenosti 50,9 %). To potvrzuje, že dobrá znalost partnera podporuje kvalitu sexuálního vztahu. Je také pravděpodobné, že jistota manželství zbavuje muže stresu souvisejícího s očekávanými výkony při pohlavním styku. Snaha o dosažení synchronizace a harmonie tak převáží nad individuálními potřebami.
- Vyšší úroveň vzdělání (úroveň spokojenosti 42,8 %). Víme, jak důležitý vliv má fantazie na bohatost a kvalitu sexuálního života. I když je k dosažení orgasmu nezbytná určitá míra „sebezapomnění“, v této křehké rovnováze mezi „divokým“, instinktivním pohlavním stykem a harmonickými sexuálními

vztahy zůstává převládajícím faktorem aktivita našeho mozku. To by mohlo vysvětlovat vyšší výskyt mužů s vyšším vzděláním mezi sexuálně spokojenými.

- Dobrý vztah s matkou v dětství (míra spokojenosti 54,3 %). Zdá se, že souvislost mezi důvěrou a náklonností k první ženě v životě muže ho připravuje k navazování kvalitnějších vztahů se všemi následnými partnerkami. Toto zjištění platí i pro osoby s homosexuální orientací, což naznačuje, že harmonie rodinných vztahů v dětství bude určovat jeho spokojenost bez ohledu na pohlaví partnera.
- Absence náboženského přesvědčení (ateismus) (míra spokojenosti 78,5 %). Toto zjištění se může zdát v rozporu s institucí manželství, která jako by upřednostňovala určitou společenskou konformitu. Většina náboženství prosazuje reprodukční funkci pohlavního styku na úkor jakékoli jiné funkce, zejména pak vyhledávání rozkoše, proto nelze vyloučit, že osvobození se od stresu z nerespektování náboženských zákazů umožňuje lepší prožitek sexu. Zdá se, že všudypřítomný Boží zrak až příliš silně doléhá na sexuální svobodu věřícího, jenž si tak nemůže svou sexualitu užívat nerušeně.
- Dobrá erektilní funkce. Mezi tímto indexem zjišťovaným dotazníkem IIEF a sexuální spokojeností existuje dokonalá korelace, která může sloužit jako predikce pro obě tyto složky. Nejde o nic překvapivého; při analýze však lze pozorovat, že kritérium vnímání kontroly ejakulace zjišťovaný dotazníkem

IILT je zásadní pro celkové vnímání erektilní funkce. To dokládá význam kognitivních funkcí při souloži.

- Intravaginální latence delší než 1 minuta. I ta se může jevit jako nedostatečná doba pro zdařilou soulož, avšak analýza dokládá, že mezi tímto ukazatelem předčasné ejakulace a vyjádřenou sexuální spokojeností existuje pouze nízká korelace.
- Absence sexuálního zneužívání v dětství. Navzdory nízkému počtu účastníků studie (25), kteří uvedli, že v dětství utrpěli sexuální trauma, existovala poměrně významná korelace mezi tímto traumatem a výskytem sexuálních poruch různých typů, z nichž všechny jsou antagonistické vůči sexuální spokojenosti. U pacientů se sexuálními dysfunkcemi je proto důležité tento biografický aspekt zkoumat. Jejich problémy mohou mít původ v minulosti.

Co se posledního kritéria týče, bylo by zajisté přínosné, aby informace o případném sexuálním zneužívání byly uvedeny v pacientově anamnéze. To jsou ponaučení, která lze z této disertační práce vyvodit. Fixace na aktuálně pozorované symptomy by nás neměla činit slepými vůči jejich základním příčinám, byť mohou mít původ i v dávné minulosti. Někteří odborníci dokonce tvrdí, že nevyřčená rodinná tajemství mohou narušit psychiku několika generací. Aniž bychom se chtěli vydávat do nebezpečných vod genetické paměti, tento výzkum potvrzuje, že ve vztahu ke stavu pacienta je třeba dávat přednost holistickému přístupu. I v případě řešení problému, který je zdánlivě fyziologické povahy, může k výběru nejvhodnějšího terapeutického prostředku přispět pouze dobrá znalost

rodinného a společenského prostředí pacienta a odhalení eventuálních traumat z jeho dětství. Sexualita je pro mnohé lidi stále tabu. Naučit se přistupovat k tomuto tématu beze strachu je v dnešní době povinností každého terapeuta. Nechť tato disertační práce přispěje ke svobodné diskuzi o sexuální spokojenosti.

Determinants of sexual satisfaction in Czech men

Abstract

Very legitimately, medicine as well as medical literature, especially in the field of sexology, focuses on the study and treatment of all disorders and dysfunctions that affect the human race and its sexuality. Through this thesis, we attempted to resist against this general trend and sought anything that would facilitate or promote a man's achievement of an accomplished and happy sexuality. These terms imply a sexuality that satisfies this man. There is indeed nothing more subjective than sexual satisfaction, despite the easy access to pornographic material that tends to introduce some elements of comparison in the mind of each man, however unrealistic.

There are many tools to measure sexual satisfaction. However, it has been demonstrated that assessing sexual satisfaction with a single question is nearly as reliable as using more detailed questionnaires. As this thesis is integrated into a much larger research based on a 90-item questionnaire, it was decided to use only one question regarding sexual satisfaction. However, it has been divided into two variants, one on the overall sex life satisfaction, and the other on the recent sexual satisfaction in the relationship with a partner. The answers to these two questions were cross-referenced with each participant's socio-biographical factors to identify the existence of invariants in the profiles of men who expressed

satisfaction with their sexuality and the invariants that should be absent or less prevalent among the profiles of men dissatisfied with their sexuality.

To partly conform to the general trend, whether certain biographical or physiological elements would constitute an obstacle to sexual satisfaction was also studied. Two tools were selected to evaluate the physiological aspects of sexual life: the International Index of Erectile Function (IIEF) and the Index of Intravaginal Latency Time (IILT). These tools measure parameters known to influence sexual satisfaction, and it appeared interesting to compare the detailed assessment that participants could make on these specific aspects of their sexual life with their overall appreciation of their sexual satisfaction.

As a potentially antagonistic biographical element of sexual satisfaction, only childhood sexual trauma was retained. This trauma is often repressed and unexpressed by the victims and perhaps out of modesty, rarely addressed by doctors. Therefore, it is useful to ascertain the seriousness of the impact of this childhood trauma on the adult's sex life.

The study involved a sample of 1004 men, representative of the Czech population, whether by the distribution of age, socio-economic criteria, or geographical origin. They responded independently and anonymously to a 90-item questionnaire inclusive of all aspects of their sexuality, including sexual satisfaction, and several aspects of their lives, whether on a personal, family, or social level.

A predictive model of sexual satisfaction based on age, type, and frequency of sexual intercourse was established by a multiple regression

analysis to assess the correlation of the various socio-biographical and physiological parameters retained with sexual satisfaction.

These analyses made it possible to make the following observations showing a positive correlation with sexual satisfaction among men presenting the following characteristics:

- Aged between 30 and 44 years (satisfaction level 34.6%). This reveals that the vigor of youth is not everything and that some experience helps to appreciate the pleasures of life. Excessive expectations may lead to painful disappointments. With age, an individual learns to admit realistic expectations and settles for what they have. This gradual acknowledgement replaces the frenzy of youth and is rewarded by a greater sexual satisfaction.
- Being married (satisfaction level of 50.9%). This confirms that good knowledge of the partner promotes the quality of the sexual relationship. It is also likely that the security of marriage liberates sexual intercourse from the stress of a supposedly expected performance. The search for synchrony and harmony takes the lead on any other selfish consideration.
- Have a high level of education (satisfaction level 42.8%). We know the importance of phantasm construction in the richness and quality of a sex life. Even if a certain level of self-oblivion is essential to reach orgasm, the brain function remains predominant in this delicate balance between bestial coitus and

harmonious sexual relationships. This could explain the higher prevalence of postgraduates among sexually satisfied men.

- Having had a good relationship with your mother during childhood (satisfaction level 54.3%). It seems that a relationship of trust and affection with the first woman in his life prepares a man to build bonds with all the subsequent partners that promote the quality of his sexual relations. It should be noted that this observation is also valid for homosexuals, suggesting that the harmony of childhood family relationships will benefit an individual throughout life, regardless of the gender of his or her partner.
- Being an atheist (satisfaction level 78.5%). This observation may seem contradictory to that of marriage, which seemed to favor a certain social conformity. However, if it is considered that most cults promote the reproductive function of sexual intercourse to the detriment of any other function, and in particular the search for pleasure, it can be suggested that being freed from the stress of not respecting a religious prohibition facilitates the enjoyment of the moment. This minimizes the value commonly attributed to the excitement that getting rid of a ban is supposed to bring. A true believer's perception that God is observing his actions seems to be an obstacle in his sexual enjoyment.
- Have a high index of erectile function. There is a perfect correlation between this index and sexual satisfaction, one that can serve as a predictor for the other and vice versa. This is not

surprising; however, it can be observed in the analysis that the criterion of perception of ejaculation control is essential in the overall perception of erectile function. This demonstrate that the altered state of consciousness necessary in achieving an orgasm must be limited for a man to let him fully enjoy the moment.

- An intravaginal latency time of more than one minute. This may seem modest but the analysis shows that there is only a weak correlation between this indicator of premature ejaculation and the expressed sexual satisfaction. This observation intersects with the remark already made about age criteria, pointing to the acceptance of an imperfect situation as being nonetheless considered satisfactory.
- Not having been sexually assaulted as a child. Despite the small number of study participants who reported having suffered from childhood sexual trauma (25), there was a fairly significant correlation between this trauma and the occurrence of sexual disorders of all kinds, all antagonistic to sexual satisfaction. It is, therefore, important to explore this biographical aspect in patients with sexual dysfunctions. The origin of their problem may be hidden in their past.

As with the latter criterion, it would be beneficial to mention the above in the patient's history. These are the lessons that can be learned from this thesis. The obsession with the present symptom should not blind us to its underlying causes, even from the distant past. Some go so far as to claim that unspoken family secrets can create disturbances in the psyche of

several generations. Without venturing into the slippery terrain of genetic memory, this research affirms that a holistic approach to the patient's condition must be preferred. Even to solve a problem that is supposedly physiological, only a good knowledge of the patient's family and social environment and the revelation of his possible childhood traumas can help determine the most appropriate therapeutic solution for his case. The importance of speech in the relationship with the patient has been known since Hippocrates. Listening to a patient tell his or her life will never be a waste of time for a doctor and may allow him to discover truths that are sometimes hidden by the patient from himself. Sexuality is still a taboo for many. Learning to approach the subject without fear is, in our time, a doctor's duty. May this thesis modestly contribute to free the speech on the legitimate and universal search for a satisfactory sexuality.

DETERMINANTS OF SEXUAL SATISFACTION IN CZECH MEN

I. INTRODUCTION

A large majority of studies or theses have focused on the dysfunctional aspects of sexuality, a logical trend considering that sexually satisfied people rarely seek medical help to mitigate their pleasure. Nevertheless, a good comprehension of functional individuals can help professionals to assist dysfunctional ones in achieving sexual satisfaction by drawing their attention on the diagnosis efficiency gained by separating the symptoms originating from past biographical context from the symptoms originating from recent health degradation and planning the treatment accordingly.

Therefore, after considering the origins of sexuality and the differences between sexual pleasure, sexual performance, and sexual satisfaction, this thesis analyzes the possible correlations between self-declared sexual satisfaction, as expressed by men, and diverse aspects of their sociocultural background, personal history, and sexuality. From 1998 to 2013, a national survey on Czech men's sexual practices has been performed every five years.

This thesis is based on the 2013 national survey. It includes a large sample of 1004 participants aged between 15 and 82 years, representative of the national census. In a 90-item questionnaire oriented to detect dysfunctional aspects of sexual life, two questions inquired about sexual satisfaction. By comparing the positive answers to these questions with

different aspects of participants' life, such as education, religion, or marital status, it was possible to define the profile of the fortunate man who is most likely to be satisfied by his sexual life.

Based on the previous research examining the characteristics that elicited the most negative answers, such as childhood sexual trauma or erectile dysfunction, factors that are the most antagonist of sexual satisfaction were determined. It facilitated in completing the profile of the fortunate man who benefited from the best environment and could prepare for a happy sexual life.

Additionally, it allowed us to identify the biographic event that must be avoided to preserve his potential for sexual satisfaction. Further correlations between erectile function, ejaculatory function, and sexual satisfaction were performed to analyze the sexual satisfaction of Czech men. This study offers an encompassing view of the correlates of sexual satisfaction among Czech men.

II. THEORETICAL OVERVIEW

1. Reproduction methods and the rise of sexuality

Through eons, nature selected multiple methods for perpetuating life through the reproduction of living beings. It began with prokaryotic cells, which used an asexual method of reproduction. In this process of mitosis, each individual makes an internal copy of his genome and then splits his body into two

identical replicas of the original individual. Some variations in the gene code may be episodically introduced by the possibility of voluntary exchange of genetic material with other types of cells (Sieber, Bromley, and and Dunning Hotopp, 2017), involuntary gene addition after contamination by a virus, or a gene mutation under the effect of high-energy particles, but this remains marginal.

A recent study contradicts the dogma of an almighty DNA that contains all the information and the idea that only the DNA is passed from one generation to the next. RNA molecules, proteins, and ions also appear to be transmitted and seem to contribute through epigenetic regulation of the expression of DNA-encoded genes.

This allows a cloned individual to benefit from the life experience of his ancestors while keeping a strictly identical DNA code (Marré and al., and 2016). However, a population of mostly identical individuals will be decimated if confronted with a rapid change in the environment. Nature selected a second reproduction method to prevent this terminal event— the meiosis— that became common for eukaryotic cells.

Each diploid individual splits its genome into two equal but non-identical parts, and then splits into two non-identical haploid cells, the gametes. The creation of a new viable individual implies that two haploid cells merge and unite their different gene codes, creating an individual who is different from the two parents who contributed to his genome.

The exact origin of sexual reproduction is still disputed; however, its preeminence is well-established (Xu, 2004). Nowadays, asexual methods are mainly observed among microorganisms, small marine animals, and in the cells of multicellular animals and human beings, where it allows growth and replacement of dead cells in the organs.

However, asexual reproduction can even be observed in large female animals such as some shark species or the Komodo dragon (Lampert 2008). When no male partner is available, these females reproduce by parthenogenesis. In species where parthenogenesis is the standard reproduction mode, each individual of the population can reproduce alone, thereby increasing the probability of the survival and expansion of species. The sexual reproduction mode allows only half of a given species population to reproduce, except for hermaphrodites such as snails (Escobar and al. 2011).

Despite this numerical disadvantage, sexual methods eventually prevailed through the evolution of life on earth.The mixing of genomes allow a massive increase in the genetic variety in the population as well as the probability of mutations, both of which are assets for adaptation to any environmental change. The natural selection then operates to select the fittest for reproduction and transmission of an improved gene set to the next generation.

The mutual attraction generally required for a successful sexual encounter was also designed by evolution to accelerate the selection. To promote a genetically gifted individual, his quality to

potential partners is revealed through a more alluring aspect or the diffusion of more appealing pheromones (Roberts and Little 2008; Lie , Simmons, and Rhodes 2010). This gene status transmission is sufficiently accurate to allow humans to feel a preference for people having the most different HLA class merely from olfactory stimuli (Pause and al., 2006; Sorokowska and al., 2018). An elective choice will improve the efficiency of the children's immune system (Tybur and Gangestad 2011). As a reward for the constituted couple, it simultaneously increases the probability of their sexual satisfaction (Kromer and al., 2016).

For both animals and humans, mating is a time-consuming and energy-consuming activity (Gangestad and Simpson 2000). Evolution selected an incentive to ensure that animals and humans will endure the hurdles and dangers of finding a suitable partner: sexual pleasure.

2. Sexual pleasure

a — Sexual pleasure from an evolutionary perspective

The origin of sexual pleasure is disputed. Hundred million years ago, sea animals did not have sexual intercourse, and many of them still do not. A simultaneous release of ovule and sperm in the aquatic environment was the only way to ensure reproduction. As synchronization cannot be produced by physical contact, external elements such as tides and moon

phases have to be used as a common reference (Bentley, Olive, and Last 2001; Mercier and Hamel 2010).

However, it is not sufficient to determine a short duration for perfect synchronicity, and many animals, besides the gametes, release pheromones in the sea that elicit a similar reaction among nearby individuals of the same species or even of other species. It is generally considered that this hormonal trigger progressively evolved into the orgasmic event associated with sexual intercourse.

This evolutionary view of sexuality is supported by a growing number of studies (Gallup and al., and 2018). Considering that the initial purpose of sexuality was the selection of the best gene combination to transmit to the next generation, we will now observe what remains of these ancient synchronization and mating methods in modern humans, beginning with women.

b — Sexual pleasure from women's perspective

During the evolution of our species, a decoupling occurred between orgasm and ovulation. This observation triggered investigations to determine whether women's orgasm is just a vestigial trait of ancient functions and has no meaning or usefulness now.

A growing number of studies have demonstrated that women's orgasm plays a role in partner selection (Shackelford and al., 2000; Puts and al., 2012; Coria-Avila and al., 2016; Lodé, 2020). The more a male partner presents the external signs of manhood, such as an attractive symmetrical face, wide shoulders, narrow hips, and, as mentioned

previously, a different HLA complex perceptible through his body odor, the higher is the probability that the woman will experience a stronger orgasm with him (Garver-Apgar and al., 2006). Considering that pleasure is a way for nature to promote the repetition of a successful behavior and that repeating a sexual encounter is the best way to promote reproduction, sexual pleasure is definitely connected with successful reproduction.

Notably, this ability of proper mate selection through body odor works only among women following their natural hormonal cycle. The use of contraceptive pills by women reverts the feeling and enhances their preference of a partner with the most similar HLA complex, an unfortunate choice for the quality of their children's immune system (Birnbaum, Birnbaum, and Ein-Dor 2017).

In the absence of this chemical perturbation, a woman will choose a man with physical and genetic characteristics who are more likely to give her healthiest children, and as a natural reward, a man who will allow her to enjoy the most intense orgasms. Since the vaginal contractions associated with orgasm facilitate the retention and the transport of the sperm to the ovule (King, Dempsey, and Valentine 2016), the probability of a successful reproduction is again increased by this feedback effect. To summarize, a genetically superior partner will trigger a better and more frequent orgasm that will facilitate fecundation.

This was the overview on the usefulness of sexual pleasure from a woman's perspective; however, since this thesis is focused on male sexual satisfaction, an evaluation of the usefulness of male sexual pleasure must be also conducted.

c — Sexual pleasure from a man's perspective

The differences between male and female orgasm are less obvious than they are commonly perceived. In an ancient but still accurate study (Vance and Wagner 1976), their written description of the orgasm in men and women was degendered and then presented to professionals and non-professionals who were requested to identify the gender of the description's author. None of them succeeded in making a suitable guess than throwing a coin would do, demonstrating the high similarity of the perception of orgasm that exists regardless of gender.

The fact remains that for male animals and men, there would be no ejaculation without orgasm and no reproduction without ejaculation. After this first evidence, we can observe that a process similar to the one operating in women exists for men for them to increase the probability of successful reproduction with the most genetically apt woman.

The acidity of the vagina would be lethal for the sperm if the alkalinity of the seminal fluid would not promptly adjust the Ph to a more viable level (Burch and Gallup 2006). Hence, the quantity of sperm and other seminal fluids emitted during ejaculation increases the probability of a successful conception. Studies demonstrate that there is a proportionality between the intensity of the male orgasm and the quantity of fluids emitted in the ejaculate (Alwaal, Breyer, and Lue 2015).

Consecutively, we must consider the promoters of men's orgasm intensity. It is well documented that women's physical proportions, face harmony, and global sex-appeal provide weak but still reliable hints about

their underlying health and reproductive condition (Tovée, Edmonds, and Vuong 2012). It was also demonstrated that the vision of an attractive woman increases the ejaculate volume of genetically gifted men and decreases the ejaculate volume of men with low genetic qualities, as suggested by their appearance (Leivers, Rhodes, and Simmons 2014).

Therefore, we can infer from these converging evidences that men's sexual pleasure has been selected through evolution to promote the reproduction between the fittest by slightly increasing the probability of successful reproduction between genetically gifted and well-assorted partners to favor their offspring's resistance and adaptability.

d — Sexual pleasure from a physiological perspective

We perceive sexual pleasure through the senses. The brain must integrate the data collected from a complex sensory environment to generate a mental image that will be compared with the image generated by the individual expectations for an ideal sexual encounter. If these two images match, then the sexual pleasure arises and culminates.

In case something is missing in the sensorium for some physiological reason, only a part of the sensations is present but the coalescence of phantasm and feelings does not operate, and the anticipated climax remains out of reach. This can ultimately be a cause of erectile dysfunction. When the sensations override the moderate self-control necessary to achieve timely sexual encounters, premature ejaculation regrettably interrupts the coitus.

Senses may also be confused. A low percentage of the population suffers from synesthesia syndrome. In the 19th century, a connection was curiously made between homosexuality, or sexual inversion as it was then named, and synesthesia, blaming both syndromes as a mark of degeneration (Nordau 1898).

Nowadays, this fantasist hypothesis has been discarded; however, the origin of synesthesia is still disputed. Links have been established with a genetic origin (Ward and Simner 2005), but correlations have been found with the process of language learning (Watson and al. 2017). The precise number of individuals diagnosed with this syndrome is extremely variable from one study to another. The lowest is given at 0.024% (Rich, Bradshaw and and Mattingley 2005), and the highest at 23% (Uhlich 1957). The authors of another study are rather confident that their approach to encompassing multiple manifestations of this syndrome allow them to provide the best evaluation of its prevalence. They established the prevalence at 4% (Simner and al. 2006).

Taking this last percentage for granted, it is interesting to explore the potential consequences of a relatively frequent syndrome on human sexuality. Studies on this topic are scarce; however, a relatively recent one (Nielsen and al., 2013) provides some clarification. It appears that, compared to the control group, men and women diagnosed with synesthesia report a better sexual appetence but a lower sexual satisfaction.

A tentative explanation of this observation is that synesthetes would be more focused on their strange inner world and thus, unable to accord sufficient attention to their partner during coitus, impairing their ability to

create the bodily harmony that precludes a really satisfying sexual encounter.

Besides synesthesia, a more subtle kind of sensory confusion can occur at a similarly deep level of neural connections. It is objectum sexuality or the arousal feeling and love for inanimate objects. The people presenting this particularity are distinguished from fetishists since the object of their love is usually deprived of any sexual content, such as a bridge or a wall. A recent study demonstrated that a correlation can be established between objectum sexuality and synesthesia (Simner, Hughes, and Sagiv 2019), which allows us to consider the possibility that these specific sexual attractions may find an origin in some uncommon connections in the brain since a similar correlation has been found between synesthesia and autism (Baron-Cohen and al. 2013).

e — Sexual pleasure from a psychological perspective

Therefore, a successful sexual intercourse implies a subtle balance between the ability to focus on the present to avoid perturbating thoughts and the ability of self-forgetfulness, often called absorption, that allows a person to perceive the partner's feelings and reactions. A correlation has been found for men between this trait for absorption and the frequency of sexual intercourse (Rui Miguel Costa, Pestana, and Costa 2018), showing that a tendency of self-oblivion during a sexual relationship may be productive in the domain of coitus frequency.

However, this state does not enhance men's sexual satisfaction as it does for women. The two genders react differently to the sexual pleasure

that is often described as an altered state of consciousness. The word "trance" is also often used to describe this moment when the time seems to slow down and the environment disappears, and the two partners become entangled in their ecstatic communion, oblivious of anything else but them.

This altered state of consciousness can be separated into three categories. Greater sexual responsiveness was correlated with simultaneous loss of spatial awareness and focus on body sensation for both sexes. The correlation of sexual responsiveness with the loss of time awareness is the exclusive apanage of women (Rui M. Costa and al. 2016).

Another element of differentiation between sexes is the sex drive. In a meta-analysis, women did not present a sex drive higher than men in any of the analyzed studies (Vohs, K. D., Catanese, K. R., and Baumeister, R. F. 2004). This higher sex drive induces men to be more inclined to engage in sexual relations; a proactive attitude that may be excessive in some men and degenerate into violence.

f — Sexual pleasure and violence

The sexual pleasure evocated above is implicitly a byproduct of a harmonious sexual encounter between two partners acting freely on their own volition. Nature and social reality do not always respect these ideal conditions, and violence is considered by some as a necessary medium to obtain sexual pleasure.

It is common in nature that the physical differences between males and females induce a mechanical power relationship between partners. Humans are no exception. Even if the remarkable variety of human

polymorphism does not provide a warranty that a man will always present a physical dominance toward his female partner, on average the "strong sex" is not a completely undue nickname for men. The duality of the genital structure of the two genders also contributes to establishing a relation that without prejudice can be qualified as an emitter-receiver, which already implies an idea of hierarchy between sexes.

Hormones aggravate this physical imbalance with the addition of a different kind of behavior and personality between genders. Heritage of our male animal ancestors who had to fight for food and reproduction, men still present a personality more prone to aggressivity than women. The criminal statistics illustrate this fact. About 85% criminals are men and only 15% are women; a proportion that has not changed since the 19th century (Pons 2017).

A similar imbalance can be observed in domestic relations. The victims of domestic violence include 26% men and 74% women (CDC 2015). This male aggressivity, when not kept under control, may induce aggressive sexual behaviors and ultimately rape. This crime can occur even in a very ordered social environment such as an army, with the same psychological damages as in the civilian society. An acronym has been coined for this specific category of post-traumatic stress disorder— MST for Military Sexual Trauma. The existence of rape in well-ordered societies, as well as its use as a weapon during the war, elicits interrogation on the origin of this violent sexual behavior.

Numerous studies have demonstrated that rapists benefit from a significant fecundity advantage compared to men having consensual

relations (Gottschall and Gottschall 2003); from the Darwinist perspective, this advantage may have been selected and transmitted from one generation of rapists to another.

The exact nature of this advantage is disputed, but the most structured hypotheses propose that considering the observed fact that men find women more attractive during the few days marking the peak of fertility of their ovulation period and that the rapists do not have to qualify through the selective barrage of a woman's choice of partner, the probability for rapists to successfully fecundate a woman is higher than for other men who are more respectful of women's freedom of choice (Gottschall and Gottschall 2003).

At this bleak picture of uncontrolled domestic or social violence, a small proportion of accepted and even researched violence must be examined. This is the situation for couples adept at sadomasochism. In this specific case, a reasonable level of violence and pain is considered necessary to reach the orgasm. The preliminaries become an important part of the sexual game as well as role-playing that justifies the controlled violence. This is an opportunity for some men to abandon the dominant role they assume in society to adopt a submissive attitude that seems to flatter a repressed part of their personality (Beckmann, 2011).

These behaviors emphasize the importance of phantasm in successful sexual relations. The specificity of sadomasochist practices is that it provides participants with an opportunity to physically realize the phantasms that they would have otherwise fantasized about to spice up a sexual encounter. The fact that the dramatization of what could be just a

bland sexual encounter contributes to providing a required novelty, especially welcome among old couples, and explains the progress of such practices among the general population. The attractiveness of such practices probably lay in the fact that they trigger some old genetic springs inherited from the gregarious and strongly hierarchized society of our prehistorical ancestors. Even a submissive position can be somehow relaxing since a painful certitude is more preferable than an unsettling incertitude for some individuals.

3. Sexual satisfaction

Considering that most of the research about sexual satisfaction emphasizes its loss by any cause, accident, aggression, surgical operation, illness, disease, or inappropriate mental condition, it is essential to dedicate some research to study the positive aspects of sexual satisfaction and create a control group that can be used as a healthy reference for this feeling. Sexual health, sexual pleasure, and sexual satisfaction are necessary components of a fully accomplished human life. Pushing a bit further, it could be said that sexual satisfaction is a part of human rights (Ford and al., 2019). Hence, establishing the precise aspects and circumstances of its apparition, perception, and memorization is a useful challenge; a challenge, because sexual satisfaction is a more complex feeling than sexual pleasure since it integrates time in the equation.

Based on memory, it also comprises all the incertitude and approximation of an engram. Health contributes equally in the level of

satisfaction. Numerous studies have shown that any dysfunction in the complex chain of mental, biological, and physical reactions leading to an orgasm may impair the ability to reach it and fully enjoy it. Moreover, since we are considering mostly sexual intercourse and no other solitary sexual activities, the partner's response has a significant part in the satisfaction produced by the coitus. It is such an essential aspect that some studies have demonstrated that a consequent proportion of people evaluate their sexual satisfaction level not by referring to their feelings but through their partner's response (Pascoal and al., 2014).

This also shows the difficulty in the scientific evaluation of an essentially subjective feeling that is prone to change with time and circumstances. In a retrospective and systematic review of studies on sexual satisfaction as a core component (Sánchez-Fuentes, Santos-Iglesias, and Sierra 2014a), four dimensions of an individual's personal life have been observed to significantly influence sexual satisfaction:

a. *Individual variables such as socio-demographic and psychological characteristics as well as physical and psychological health status;*
b. *variables associated with intimate relationships and sexual response;*
c. *factors related to social support and family relationships;*
d. *cultural beliefs and values such as religion.*

A detailed analysis of some of these dimensions of sexual satisfaction is necessary to encompass the complexity and subjectivity of the topic.

a — Sexual satisfaction and memory

Memorization is a complex and progressive process in which successive steps and exact circuitry have not yet been completely elucidated. From the initial anatomic description of brain structures (Broca 1878) through the first insight into the emotion circuits (Papez 1937) to the present complexification of the intermingled memorization and emotion circuits (Bubb, Kinnavane, and Aggleton 2017), the fact remains that emotion and memorization are deeply connected and influence each other (Jin and Maren 2015). In the process of remembering an event, the associated emotional charge will define the strength and perenniality of the engram. Working memory (WM) is the first step of memorization.

Short-term memory functions to keep an information item accessible. The WM not only maintains the vividness of an event memory but also performs analyses and comparisons on it. There is a dispute to determine if the WM also ascertains its value, the necessity to act on it, and the usefulness of remembering it for a longer duration than the present instance.

The basic feelings of pleasure, pain, and fear as well as the mood associated with an event will influence the WM on the final decision to retain the memory of the event (Storbeck and Maswood 2016). Sexuality is naturally a great purveyor of emotions. Consequently, it weighs specifically on memorization ability. It may be a distractor; the vision of pornographic images has been demonstrated to degrade WM performances (Laier, Schulte, and Brand 2013) and decision-making (Laier, Pawlikowski, and

Brand 2014). However, it has also been demonstrated that positive arousal through sexual stimuli facilitates WM performance (Lindström and Bohlin 2011).

b — Sexual satisfaction and gender

Men and women appraise sexual content differently (Spiering, Everaerd, and Laan 2004). The fact that identical images with sexual content elicit a different reaction among women and men already indicates the gap that will separate the view of each gender about their appreciation of a sexual encounter. Variation in the dyadic composition does not change the observation. In heterosexual or homosexual couples, the appreciation of sexual satisfaction derives from the gender of the individual who evaluates the event and not from his or her partner's gender (Holmberg and Blair 2009).

Successive studies have also confirmed the differences between genders toward expectations from a sexual encounter. The first difference is the sexual appetite. Women in most studies appear less demanding than men. This attitude may be related to hormonal balance but may also be influenced by youth time by the social consensus that judges a woman engaging in premarital sex to be of little virtue when for a man, it is a mark of strength and vigor, the two generally appraised male virtues. Another difference is the attention accorded to the psychological environment of a sexual encounter.

For a woman, the affective and loving quality of the relationship with the partner matters. While for a man, the physical action matters

more than the psychological context. This may induce a discrepancy in the partners' appreciation of the encounter since good sex for one may be perceived as spiritless coitus by the other.

c — Sexual satisfaction and partners

As mentioned at the beginning of this chapter, the sexual pleasure examined here is not of solitary quality. Hence, the partner's reaction will greatly influence the perception of sexual satisfaction. The level of this influence depends on each individual's personality. It can be expected that for an egocentric personality, the partner's pleasure and feelings will matter less than for an individual with an altruistic personality. To provide a stable background to what essentially remains a subjective feeling, few studies have been conducted on this topic; however, they are impaired by the intimate conditions of the act. The interaction between partners is a form of communication. Before sex, it is mostly verbal with a touch of postural attitudes that contribute greatly to sex-appeal.

A correlation has been found between affinity-seeking communication and the likelihood of a sexual encounter (La France, 2010). During sex, speech may regress to the level of grunts and the body language prevails. Some nonverbal communication modes may even be idiosyncratic to a given couple. The work, Human Sexual Response (Masters, Johnson, and Reproductive Biology Research Foundation (U.S.) 1966), is considered as the founding work in this branch of sexual studies. Based on the observation of couples' sexual encounters in a time where sexual freedom was the new norm, it presented a sex therapy based on

enhancing the participants' focus on their sensations. It is still used with regular improvements (Weiner and Avery-Clark 2017).

A measurement tool has been developed and validated to assert the effect of an improvement in couple communication without being too invasive in the bedroom, the "Sexual Communicator Style Scale" (Brogan and Fiore 2009). Communication during sexual encounters is mostly nonverbal for efficiency purposes.

Experiments have demonstrated that verbal communication during sex is not correlated with sexual satisfaction (Babin 2013; Mark and Jozkowski 2013; Blunt-Vinti, Jozkowski, and Hunt 2019). Communication between partners is important, and it may be useful to identify when a relationship began to turn sour. Therefore, the Romantic Partner Conflict Scale (RPCS) was developed to evaluate the level of conflict in a couple. One of the items evaluated by this scale is sexual communication, which has a significantly positive correlation with relationship satisfaction (Zacchilli, Hendrick, and Hendrick 2009).

One's own sexual functioning is evidently essential to obtain sexual satisfaction for an individual but the sexual functioning of one's partner also plays a role in one's sexual satisfaction. Each gender reacts differently. A man's sexual satisfaction will be positively improved when his partner succeeds in reaching an orgasm, a fact known instinctively by women who may kindly fake an orgasm to flatter a man's ego and enhance his sexual satisfaction.

Correlatively, a woman's empathy also applies when a man perceives a sexual dysfunction, even in the absence of erectile dysfunction,

her partner's dissatisfaction will reduce her own satisfaction (Velten and Margraf 2017).

d — Sexual satisfaction, relationship satisfaction, and duration

Common sense suggests a relationship between sexual satisfaction and relationship satisfaction. This spontaneously supposed correlation has been studied and effectively demonstrated (Haavio-Mannila and Kontula 1997a). A causal link between sexual satisfaction and relationship satisfaction has also been demonstrated. Causality is amplified by the quality of the communication between partners (Byers 2004).

This shows that habituation, far to generate boringness, is propitious to establish a complicity between partners that will enhance their sexual pleasure and sexual satisfaction. Studies, including this thesis, demonstrate that marriage is favorable to sexual satisfaction (Barrientos and Páez 2006). An interpretation of this fact can be suggested. Besides the complicity evocated above, marriage places the partners out of the competition for sex and reproduction, at least officially. This may relax the sexual encounter, which loses the aspect of "performance expectations" to become a mutual service rendered between partners; an uninhibited couple hedonism propitious to sexual satisfaction.

The positive effects of communication on sexual satisfaction mentioned in the "sexual satisfaction and partners" section is even higher for married couples as compared to dating couples (Mallory, Stanton, and Handy 2019). However, the improvement in sexual satisfaction observed among married couples is not evenly and synchronously distributed

between genders. On average, considering the duration of the relationship, men benefit the most. For women, the first years appear to be less rewarding and the sexual satisfaction comes as a progressive acquisition through the couple life, as long as aging or any illness does not interfere with sexual functioning (Heiman and al. 2011).

e — Sexual satisfaction and beauty

Beauty may be considered as a quality too ethereal to be connected with sexuality. The difficulty in defining beauty is also an obstacle since it is commonly considered to be "in the eyes of the beholder." However, it is precisely the relativity of the beauty that says what it is. It is a means of communication.

A tool used by an emitter to trigger something in the receiver. In a 2015 conference, the 2004 Physics Nobel Prize laureate Frank Wilczek, elegantly defined it: "*Beauty is what we experience when the external world stimulates our reward system, causing a release of dopamine we feel as pleasure. Natural selection uses this device to encourage behavior that increases fitness. Sexual partners are beautiful; so are things that make sense.*" He targeted the beauty of physics equations but his remark about sexuality remains true.

In this domain, beauty is a way for nature to advertise an individual's fitness. Therefore, beauty is a quasi-universal language. Understanding the message that beauty conveys is sufficiently deeply encoded in our genome that even without sexual content, we can perceive, at least among vertebrates, the beauty of the harmonious body of a stallion or the attractive show of a peacock tail. Beauty is a component of sex-

appeal, but besides favoring a sexual encounter, it also promotes sexual satisfaction, which can only reinforce the attractiveness of beauty.

Studies have demonstrated that the perceived beauty of the partner influences the level of sexual satisfaction in a couple (Dosch and al. 2016). However, in a more narcissistic manner, the level of self-esteem of each partner will correlate with his own appreciation of the sexual encounter. This is particularly true for women for whom self-confidence in their own attractiveness appears to be a predictor of sexual satisfaction (Babin, 2013).

For men, the ability to mention and appreciate the beauty and attractiveness of a potential partner appears to be hormone dependent. The responses to olfactory and visual cues of attraction in men are modulated by the reproductive hormone kisspeptin. The areas in the brain, whose activity is enhanced by this hormone, govern beauty perceptions and sexual behaviors (Yang and al., 2020).

4. Measures of sexual satisfaction

Over the past decades, diverse tools have been developed and competed to measure or at least evaluate sexual satisfaction.

The Index of Sexual Satisfaction (ISS), (Hudson and al., 1981)

It was developed to focus on sexual satisfaction with a relatively short questionnaire of 25 items when most of the scales at the time were trying to encompass all aspects of a couple's life with

tools such as the DSFI, a 257-item questionnaire (Derogatis and Melisaratos 1979).

The Pinney Sexual Satisfaction Inventory (PSSI) (Pinney and al., and 1987)

This self-report questionnaire is limited to women's sexual satisfaction. Since this thesis concerns men's sexual satisfaction, the use of this scale was not considered. For the same reason, a more recent scale, the Sexual Satisfaction Scale for Women (SSS-W) (Meston and Trapnell 2005), was not selected.

The Global Measure of Sexual Satisfaction (GMSEX) (Lawrance and Byers 1995a)

The GMSEX is one of the scores that can be extracted from the Interpersonal Exchange Model of Sexual Satisfaction (IEMSS) questionnaire, which is based on the hypothesis that a sexual encounter is an exchange of services that may have costs (efforts, pain, …) and rewards (pleasure, self-esteem, …). It evaluates the balance between costs and rewards for each individual, then compares it with his expectations and also with his partner's balance. This balance evaluation concerns the couple's activity before, during, and after the sexual encounter to integrate the relationship quality in the score. It ranges from 5 to 35 in proportion to sexual satisfaction.

The Young Sexual Satisfaction Scale (YSSS) (Mickael Young and al. 1998)

This 70-item questionnaire focuses on married couples. This scale was rejected for this thesis considering the length of the questionnaire and the fact that being married was not a selection criterion of this thesis sample.

The New Sexual Satisfaction Scale (NSSS) (Štulhofer, Buško, and Brouillard 2010)

This 20-item questionnaire comprises two subscales: the participant's appreciation of his personal feelings and sensations, and his appreciation of his partner and their sexual activity. A short version of this scale (NSSS-S) retains most of the qualities of the integral version, notably to be neutral toward gender, sexual orientation, and relationship status.

Each creator of a new scale has a comprehensible tendency to despise the efficiency of the previous ones. Using the psychometric item response theory, the authors of a new scale, the Quality of Sex Inventory (QSI) (Shaw and Rogge 2016) demonstrated that ISS, PSSI, and YSSS are not perfectly reliable and provide what they politely deemed as a *suboptimal level of precision in assessing sexual quality*.

Other comparisons have been made that provide a slightly different image of the efficiency of these tools. A comparison between the Index of Sexual Satisfaction (ISS), the Global Measure

of Sexual Satisfaction (GMSEX), the New Sexual Satisfaction Scale-Short (NSSS-S), and a single-item measure of sexual satisfaction as used in the questionnaire created for this thesis have been performed (Mark and al., 2014).

All these methods, notably the single-item measure, demonstrated an appropriate distribution of scores and adequate internal consistency. In contrast to the ISS, the single-item measure, GMSEX, and NSSS-S were found to have convergent validity. Considering that the general questionnaire, which is the base of this thesis, was already 90-items long, it was decided to use the single-item evaluation of sexual satisfaction, which had sufficient reliability.

An additional reason was that the general questionnaire already included the International Index of Erectile Function (IIEF), whose scores have been demonstrated to correlate well with sexual satisfaction (Weiss and and Brody 2011b). The weakness of the single-item measure is the reliability in the case of test and retest. This emphasizes the importance of time in self-evaluation of sexual pleasure, since the reconsideration of the past may reveal it under a more or less favorable light than when it was considered the first time.

Furthermore, the hormonal level at the moment of the test may change the individual's appreciation of his own sexual life as this has been demonstrated for women using hormonal contraceptives (Sabatini and Cagiano 2006). Mood is also a

significant predictor of sexual satisfaction for both genders regardless of sexual orientation (Janssen, Macapagal, and Mustanski 2013), a characteristic that may evolve with time.

5. Sexuality of Czech men

The Czech population is relatively genetically homogenous. Its origins are traced back to the mixing of Slavic, German, and Bohemian tribes that occurred in the early middle age (Malyarchuk and al. 2006). Subsequent wars and struggles for the political control of the land, until the independence, did not significantly alter the population's composition. The three existing ethnic minorities together represented less than 10% of the population in 2007 (Wolff 2009).

Amongst the cultural aspects that may interfere with sexuality, religion has a specific weight. As a probable consequence of the communist era, a large majority of Czech (72%) declared themselves as irreligious or atheists, while 26% declared themselves as Christians and only 2% belonged to other faiths. This granted Czech Republic the title of Europe's first most atheist country (« Religious Belief and National Belonging in Central and Eastern Europe » 2017).

The relative absence of religious taboos in Czech society is mostly confirmed by previous studies that describe a relatively open-minded attitude of the Czech population toward sexuality. In a 1997 survey, it was observed that *24% (18.3% of men, 30.9% of women) were against extramarital intercourse, while 44.0% of men and 25.7% of women thought it was natural and*

normal. 7% (5.0% of men, 9.6% of women) were against masturbation and considered it harmful, while 65.5% of men and 58.4% of women thought it was a natural manifestation of human sexuality and 6% (6.1% of men, 5.7% of women) were against homosexual intercourse, while 33.4% of men and 41.0% of women thought it was a disease, which those afflicted could not help (Weiss and Zverina 1997).

As in most European countries, the attitude toward sexuality relaxed during the subsequent years. The age of the first sexual encounter has regularly decreased, and since 2010, a growing proportion of boys and girls have their coitarche before the age of 15 years (Pastor, Weiss and Sigmundová 2017). A study in the domain of paraphilias showed similar openness. Observing that a high percentage of men indulged themselves at least once in practices, such as fetishism (28.2%), voyeurism (36.8%), and exhibitionism (43.5%), suggest that these practices should be considered as a sexual variant and not as a pathology (Klapilová and al. 2017).

Like in any population, a darker side of men's sexuality exists. In a recent survey, 24.9% of a large sample of Czech men declared a preference for non-consensual sexual practices, with a large proportion of sadists preferring either pain or humiliation (Androvicova and al. 2018). These rates have been updated in a 2020 study and confirmed globally.

A total of 31.3% of men (n = 1,571) and 13.6% of women (n = 683) admitted to at least one paraphilic preference. Moreover, 15.5% of men and 5% of women reported more than one paraphilic preference (Bártová and al. 2020).

These rates could appear high, but a similar study in a German city produced even more striking numbers, with 64.2% of men reporting a

paraphilia-associated sexual arousal pattern (Ahlers and al. 2011). This study by Ahlers and al. (2011) considers sexual fantasies and not sexual practices, but it shows the ubiquity of such preferences among men. In conclusion, the sexuality of the Czech men as expressed in these studies and the questionnaire on which this thesis is based does not distinguish this population from other European ones.

III. EMPIRICAL STUDIES

1 — Sociological Correlates of Sexual Satisfaction in Men

1a — Goal of the research

As mentioned in the introduction of this thesis, a large majority of studies focus on the dysfunctional aspects of sexuality. Nevertheless, a good comprehension of functional sexuality may help professionals to assist dysfunctional individuals in their pursuit of happiness. The existing literature on functional sexuality focuses on the correlation between sexual satisfaction and specific sexual behaviors; however, the potential influence of individual background on sexual satisfaction is seldom addressed.

The closest matching studies, without the "men only" criterion, was a Swedish study published at the end of the 20th century (Haavio-Mannila and Kontula 1997b), and a more recent one from Chile (Barrientos and Páez 2006). According to a recent systematic review (Sánchez-Fuentes, Santos-Iglesias, and Sierra 2014b), between 1972 and 2012, the concept of sexual satisfaction was at the core of 197 studies. However, this systematic

review confirmed that most of the studies considered sexual satisfaction in an extreme context, such as a surgical intervention (Kigozi and al. 2007), a severe disease (The Eurosupport Study Group and al. 2012), or a dire psychological situation (Nicolosi and al. 2004b).

In a more optimistic view, some studies focused on a specific aspect of sexual intercourse and its impact on sexual satisfaction, such as the advantage of simultaneous orgasm (Brody and Weiss 2011), the importance of the frequency of coitus (Tao and Brody 2011b), the necessity of erection quality (Weiss and Brody 2011c), the influence of the use of condoms (Hensel and al., 2012; Janssen and al., 2014), and BDSM practices (Monteiro Pascoal and al., 2015).

Additionally, the sociological aspects of sexual relations were well-represented, such as the influence of premarital relationships (Sprecher 2002) and the impact of religion (McFarland, Uecker, and Regnerus 2011). Previous studies have reported contradictory results on the impact of age on sexual satisfaction, both positive (The Eurosupport Study Group and al. 2012) and negative (Mitchell and al. 2013). The present study, which covered a large age span, provides a hint on the possible origin of this apparent discrepancy.

This study aimed to determine the background characteristics (sociological, cultural, and demographic) that were the most prevalent among self-declared sexually satisfied men. Our results may constitute a propitious basis for further research on the development of a satisfying sexuality and how this enviable condition may evolve with age.

1b — Methods

The present study received ethical approval from the First Faculty of Medicine of Charles University in Prague,The study was conducted in accordance with the principles of the Helsinki Declaration.

Our study relied on a self-administered questionnaire; therefore, expressed sexual satisfaction was purely subjective and therefore cannot be defined here. About 1,004 men who participated in this study were randomly selected from a non-clinical general population. The self-motivated responses to a single question were collected without an analytic filter that would provide a structured psychometric test, such as the GRISS (Rust and Golombok 1985).

To provide ample statistical power to detect small effect sizes and adequately sample various ages and geographical regions, a large nationally representative sample of non-institutionalized citizens of the Czech Republic aged 15–88 years was collected by the marketing agency CEGEDIM[1] in 2013 under the supervision of the First Faculty of Medicine of Charles University in Prague.

The participation rate was 82%, and respondents were representative of the national census regarding municipality size, national region, age distribution, and education. The participants (for minors, their parents, or guardians) provided informed consent, which included a statement regarding the confidentiality of the responses and the right to discontinue the study at any time, and received clarifications regarding doubts in the meaning of any survey item. Data were fully anonymized,

[1] *Presently named IMS Health Technology Solutions Czech Republic s.r.o*

and all available responses were analyzed. The sample size was large enough to omit missing data. The tables below show that this may reduce the effective sample from 1004 to 720 in the worst case, a number that did not necessitate an adaptation of the statistical tools.

A predictive model of sexual satisfaction based on age and the type and frequency of sexual behavior was established through a multiple regression analysis. Complementary analyses included correlations with demographic parameters such as education level, marital status, and family relationships. Statistical analysis was performed to determine the prevalence of various background characteristics in a group of self-declared sexually satisfied men. For comparison and disambiguation purposes, the background characteristics of unsatisfied men are also reported here. The results below present only the demographic and socio-cultural characteristics that demonstrated a significant correlation with the level of expressed sexual satisfaction.

1c — Main outcome measures

The participants completed a questionnaire that included demographic questions, which were presented in a Likert-type format (discrete visual analogue scale) with ratings ranging from 0 to 6 (corresponding to very positive and very negative responses, respectively), such as "How do you rate your relationship with your mother (or another woman who raised you) during your childhood?" This type of questionnaire item has some similarities to clinical interview rating questions, and this type of simple rating scale was used in several other

sexual medicine studies. All questions were written in the Czech language. The results presented here are a selection of the most significant socio-cultural items in the questionnaire.

Each of these items was correlated in a bivariate association with the following question: "Over the past 4 weeks, how satisfied have you been with your overall sex life?" (1 = very satisfied, 2 = moderately satisfied, 3 = equally satisfied and dissatisfied, 4 = moderately dissatisfied, and 5 = very dissatisfied). To clarify and acknowledge that evaluating sexual satisfaction through a single question reduces the robustness of the answer, the two positive answers and the two negative answers were regrouped to form a more dualistic scale as follows: very to moderately satisfied, equally satisfied and dissatisfied, and moderately to very dissatisfied.

1d — Results and Discussion

Table 1 shows a bivariate association between age and sexual satisfaction. The group of sexually satisfied Czech men represents 61.2% of the individuals who answered questions about their sexual satisfaction. The dominant age of men in this group was between 30 and 44 years. The present study suggests that sexual pleasure is not a linear function of age that culminates around 20 and then declines.

This contradicts the common preconception on the subject (Alicia Barr, Bryan, and Kenrick 2002). We observed that after a difficult start, presumably due to inexperience or unrealistic expectations and possibly underestimated physiological troubles (Higgins and al. 2011; Rastrelli and

Maggi 2017), sexual satisfaction increased progressively to culminate between 30 and 44 years of age and then slowly declines over time, probably due to the combined effects of habituation and health decline (Erens and al. 2019). Nonetheless, the number of satisfied men was still higher in the oldest group than in any of the other groups.

A previous study by Finnish researchers (Haavio-Mannila and Kontula 1997b) presented similarities to our study that allow for some comparison. Regarding the age effect (pp. 406–407), the enjoyment of sexual encounters is described as relatively stable, while the enjoyment of a partnership presented a steady decrease with age. A less pronounced peak than that in the present study was also observed for the age group of 35 to 44 years; however, the dissatisfaction of the youngest and the eldest groups was missing.

The smaller age range in the Finnish study (18–74 years of age) compared with the present study (15–85 years of age) may explain this difference. Another cause of this discrepancy may be the change in attitude toward sexuality during the time elapsed between these two studies. A population study on older Swedish people (Beckman and al., 2008) observed that the rate of sexual satisfaction steadily increased from one generation to the next during the last quarter of the twentieth century.

Table 1. A bivariate association between age and sexual satisfaction.

For this set of results, $\chi^2(10) = 102.210$, $p < 0.001$

Table 1 Age and sexual satisfaction	AGE												Total	
	15 - 17 years		18 - 29 years		30 - 44 years		45 - 59 years		60 years or more		No answer			
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Very to moderately satisfied	14	2.50%	120	21.30%	194	**34.50%**	136	24.20%	82	14.60%	17	3.00%	563	100.00%
Equally satisfied and dissatisfied	16	8.80%	30	16.60%	29	16.00%	40	22.10%	57	31.50%	9	5.00%	181	100.00%
Moderately to very dissatisfied	24	13.60%	35	19.90%	27	15.30%	24	13.60%	58	33.00%	8	4.50%	176	100.00%
Total	54	5.90%	185	20.10%	250	27.20%	200	21.70%	197	21.40%	34	3.70%	920	100.00%

Table 2 shows a bivariate association between marital status and sexual satisfaction. Traditionalism prevails in this table. Even if a marriage is not lifelong in the modern era, it remains an attribute of couples who are reasonably convinced that their relationship will last for many years. The fact that the sub-group of married men among the group of sexually satisfied men comprises a slight majority (50.8%) is a result that corroborates studies (Lawrance and Byers 1995b) showing relationship duration as a parameter correlated with sexual satisfaction. The Finish study (Haavio-Mannila and Kontula 1997b) (pp. 414-415) added that pleasure was enhanced for men who were married and had more than one sexual partner. Table 2 shows, in contrast, that being a widower is comprehensively the worst status for sexual enjoyment, combined with the psychological distress of loss with the relatively advanced age at which this traumatic event usually occurs.

Table 2. A bivariate association between marital status and sexual satisfaction. For this set of results, $\chi^2(6) = 32.312$, $p < 0.001$

Table 2 Marital status and sexual satisfaction	MARITAL STATUS										Total	
	Single		Married		Divorced		Widower		No answer			
	N	%	N	%	N	%	N	%	N	%	N	%
Very to moderately satisfied	187	33.20%	286	**50.80%**	71	12.60%	18	3.20%	1	0.20%	563	100.00%
Equally satisfied and dissatisfied	69	38.10%	73	40.30%	22	12.20%	16	8.80%	1	0.60%	181	100.00%
Moderately to very dissatisfied	81	46.00%	53	30.10%	30	17.00%	12	6.80%	0	0.00%	176	100.00%
Total	337	36.60%	412	44.80%	123	13.40%	46	5.00%	2	0.20%	920	100.00%

Table 3 shows that atheism is only slightly favorable for sexual satisfaction, as the prevalence of atheists in the groups of satisfied and unsatisfied men is nearly identical. Conversely, religion appears to be an antagonist of sexual satisfaction, as believers are the least represented population in the group of satisfied men. The negative effect of beliefs about sexuality, religious or not, was also found in previous studies (Carvalho and Nobre 2011; McFarland, Uecker, and Regnerus 2011) that showed the negative influence of preconception in the sexuality domain, a detrimental effect confirmed by another study on dysfunctional sexual beliefs (Peixoto and Nobre 2014). Carnal love and divine love appear to be in conflict, which may be due to the nearly universal religious ban on non-reproductive sexual encounters, especially those outside of marriage (Adamczyk and Hayes 2012). The feeling of guilt, which for some individuals may induce the thrill of transgression, may unconsciously

perturb unmarried couples' enjoyment of the sexual act (Darling and Davidson 1987).

Table 3. A bivariate association between religion and sexual satisfaction. For this set of results, $\chi^2(2) = 9.288$, $p < 0.010$.

Table 3 Religion and sexual satisfaction	Religion						Total	
	Believer		Atheist		No answer			
	N	%	N	%	N	%	N	%
Very to moderately satisfied	117	20.80%	427	**75.80%**	19	3.40%	563	100.00%
Equally satisfied and dissatisfied	58	32.00%	119	65.70%	4	2.20%	181	100.00%
Moderately to very dissatisfied	41	23.30%	133	75.60%	2	1.10%	176	100.00%
Total	216	23.50%	679	73.80%	25	2.70%	920	100.00%

Table 4 shows that the most sexually satisfied men were those with a secondary education. The least sexually satisfied group only had a primary education. These results confirm the prominence of intellect over physique in the domain of sexuality (Dennis, 2004) and are consistent with previous research on correlates with male sexual satisfaction (Nimbi and al. 2018; Rew 1990).

Table 4. A bivariate association between education level and sexual satisfaction. For this set of results, $\chi^2(6) = 44.964$, $p < 0.001$.

Table 4 Education level and sexual satisfaction	Education										Total	
	Primary		Vocational training with school leaving certificate		Secondary with school leaving certificate		University		No answer			
	N	%	N	%	N	%	N	%	N	%	N	%
Very to moderately satisfied	30	5.30%	166	29.50%	239	**42.50%**	124	22.00%	4	0.70%	563	100.00%
Equally satisfied and dissatisfied	33	18.20%	57	31.50%	61	33.70%	29	16.00%	1	0.60%	181	100.00%
Moderately to very dissatisfied	34	19.30%	47	26.70%	65	36.90%	29	16.50%	1	0.60%	176	100.00%
Total	97	10.50%	270	29.30%	365	39.70%	182	19.80%	6	0.70%	920	100.00%

Table 5 shows a bivariate association between the quality of a man's relationship with his mother and the results to the question "In general, how satisfied are you in your sexual relationship with your partner?" For this question, the percentage of sexually satisfied men reached 67.2%. Despite its similarity, the results to the question "Over the past 4 weeks, how satisfied have you been with your overall sex life?" reached 62.2% and did not satisfy the *p*-value criteria. This result suggests that having a partner and thus having a stable relationship is an asset for enjoying sex, and that a harmonious relationship between a man and his mother during childhood is essential in the development of a heathy sexual life (Table 5). Based on

this finding, childhood may be considered a training period for later relationships with other women or any sexual partner.

Table 5. A bivariate association is present between the relationship quality with the mother (or a surrogate) and sexual satisfaction with the partner. For this set of results, $\chi^2(12) = 35.262$, $p < 0.001$.

Table 5 Relationship with mother and sexual satisfaction with the partner	Relationship quality with mother (or surrogate)																Total	
	No woman raised me		Very positive		2		3		4		5		Very negative		No answer			
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Very to moderately satisfied	4	0.80%	255	**50.30%**	153	30.20 %	65	12.80 %	15	3.00%	6	1.20%	5	1.00 %	4	0.80 %	507	100.00 %
Equally satisfied and dissatisfied	0	0.00%	36	28.60%	49	38.90 %	29	23.00 %	5	4.00%	4	3.20%	1	0.80 %	2	1.60 %	126	100.00 %
Moderately to very dissatisfied	2	1.60%	45	36.90%	39	32.00 %	19	15.60 %	10	8.20%	4	3.30%	2	1.60 %	1	0.80 %	122	100.00 %
Total	6	0.80%	336	44.50%	241	31.90 %	113	15.00 %	30	4.00%	14	1.90%	8	1.10 %	7	0.90 %	755	100.00 %

1e — Conclusions

In a group of sexually satisfied Czech men, the most prevalent characteristic profile included a harmonious relationship with their mothers, the completion of secondary education, age between 30 and 44 years, and having a lasting relationship or, even better, being married. Moreover, being an atheist may act as a buffer against religious dogma that could interfere with sexual pleasure.

One of the limitations of this study is that it would be misleading to imply that these results identify the socio-cultural characteristics that constitute the best predictors of sexual satisfaction in men. Such an analysis

could be the subject of another study dedicated to identifying the predictors of sexual satisfaction, an underrepresented topic in the literature. Another limitation of this study is the origin of the sample. It was extracted from a society relatively homogenous in its ethnic, religious, and cultural aspects. The generalization of these findings necessitates more studies based on populations from different countries and cultural backgrounds.

The few existing studies that focus on the promoters of sexual satisfaction appear to demonstrate that despite their methodological, geographical, temporal, and cultural differences, some commonalities appear in the socio-cultural background of sexually satisfied men. This fact may help sexologists to provide specific assistance to distressed patients whose personal background appears to be distant from the ideal profile defined here.

To complete this thesis on the determinant of sexual satisfaction oriented preferentially on the bright side of sexuality, it appeared necessary to research few discrete elements that could handicap a man in his pursuit of happiness. These obstacles include sexual organ functionality and the correlation between erectile function efficiency and ejaculatory and ultimately sexual satisfaction.

2 — Clinical correlation between erectile function and ejaculatory function

2a — Goal of the research

Sexual dysfunction is characterized by distress with changes during any stage of the sexual response cycle. Sexual dysfunctions can affect men and women at any time of their lives and impact their perception of sexual satisfaction (Raymond C Rosen 2000). In men, erectile dysfunction (ED) and premature ejaculation (PE) are the two main complaints (Hatzimouratidis, Amar, Eardley, Giuliano, Hatzichristou, Montorsi, Vardi, and Wespes 2010).

Erectile dysfunction is defined as the persistent inability to attain and/or maintain an erection to permit satisfactory sexual performance (Hatzimouratidis, Amar, Eardley, Giuliano, Hatzichristou, Montorsi, Vardi, and Wespes 2010). Estimates suggest that it affects up to 52% of men, from which 5% to 20% experience moderate to severe symptoms (Moritz Braun and al. 2000; Hatzimouratidis, Amar, Eardley, Giuliano, Hatzichristou, Montorsi, Vardi, and Wespes 2010). Furthermore, it is believed that erectile function can be influenced by psychological disorders (Meisler and Carey 1991a), including depression (Nicolosi and al. 2004a), anxiety (Giovanni Corona and al. 2006a; Mourikis and al. 2015), and panic attacks (Okulate and al., and 2003a).

Premature ejaculation (PE) is defined as a persistent or recurrent ejaculation with minimal sexual stimulation before, on, or shortly after

penetration and before the person desires ejaculation (Serefoglu, McMahon, Waldinger, Althof, Shindel, Adaikan, Becher, Dean, Giuliano, Hellstrom, Giraldi, Glina, Incrocci, Jannini, McCabe, Parish, Rowland, Segraves, and al. 2014a). It is considered the most common sexual dysfunction in men, with 3% to 30% prevalence (McMahon and al. 2013a; Waldinger and al. 2005b; Edward O Laumann and al. 2005).

Men with PE also report reduced or absent perceived ejaculatory control and the presence of negative personal consequences (Serefoglu, McMahon, Waldinger, Althof, Shindel, Adaikan, Becher, Dean, Giuliano, Hellstrom, Giraldi, Glina, Incrocci, Jannini, McCabe, Parish, Rowland, Taylor Segraves, and al. 2014). Premature ejaculation is strongly associated with performance anxiety (Corretti and al. 2006b).

One in three men with ED also experienced PE (G Corona and al. 2004). Jannini, Lombardo, and Lenzi explain the ED-PE interaction as a consequence of the man's attempt to control his ejaculation that results in a reduced excitement level (which can result in ED). The resultant ED leads to a greater focus on arousal (and excitement) to encourage the erection to return with this increased excitation leading to PE (Jannini, Lombardo, and Lenzi 2005).

Although erection and ejaculation occur at different phases of a man's sexual response, there are commonalities. Both processes are associated with pelvic floor muscles, and good function contributes to better erections and ejaculatory control (Lavoisier and al. 2014). Psychological distress, anxiety (including performance anxiety), and depression are associated with erectile dysfunction and premature

ejaculation (Mourikis and al. 2015; Rajkumar and Kumaran 2015). The comorbidity of ED and PE is linked through a number of physiological and psychological processes and variables.

Good sexual function has a positive impact on people's sexual and psychological well-being (Brody 2010; Weiss and Brody 2011a; Klapilová and al. 2015). A healthy sex life has been reported to contribute to better physiological and psychological functions for men and women, including better sex-life satisfaction, higher levels of relationship satisfaction, increased mental health, and higher satisfaction with general life (Nowosielski and al. 2010; Tao and Brody 2011a).

Healthy erections (erectile quality and duration) have been reported to be associated with better outcomes for female partners and include improved body image (Pujols, Meston, and Seal 2010) and a higher level of relationship satisfaction (Haavio-Mannila and Kontula 1997c), along with a higher probability of an orgasm and sexual satisfaction.

Pleasure is a main objective of human sexual expression, with men's perception of increased duration of sexual play leading to increased enjoyment for him and his partner (Jannini, Lombardo, and Lenzi 2005). With the desire for increased pleasure, ejaculation time has become central to a couple's perception of sexual and relationship satisfaction. Althof and colleagues, along with Giuliano and colleagues, reported that better control over ejaculation has a significant positive effect on perceived satisfaction with sexual intercourse and an inverse effect on the level of personal distress associated with rapid ejaculation (Giuliano and al. 2008b; Althof and al. 2006).

This research explored the relationship between premature ejaculation and erectile dysfunction (Giovanni Corona and al. 2015). The specific determinants and underlying factors linking ED and PE are yet to be identified (Giovanni Corona and al. 2015). Therefore, this study aimed to analyze the relationship between erectile function and three dimensions of ejaculatory function: control over ejaculation, satisfaction with ejaculation, and distress levels caused by early or rapid ejaculation in a sample of Czech men. The research outcomes will contribute to the development of a psychosexological treatment protocol for PE-ED as a comorbid condition.

2b — Materials and Methods

Sample: The sample of 1,004 Czech men aged between 15 and 84 years had a mean age of 42.8 years (*SD* = 17.6). Table 1 reports the age categories. Approximately two-thirds of the respondents reported being single (single = 38.1%; divorced = 13.1%; widowed = 6.2%), and 42.6% of the sample were married or in a relationship.

Participants were more likely to have completed secondary studies (39.1%) or vocational training studies (30%), than university education (19.1%) or primary studies (11.8%). Eighty-eight percent of the participants identified themselves as heterosexual with 10.7% identifying as bisexual and 1.4% as attracted by the same sex. The study participation rate was 82%.

Table 1: Age by Categories

Age Category	Number of Participants (n = 1,004)	Per cent
Up to 19 years	96	9.6
20-29 years	173	17.2
30-39 years	187	18.6
40-49 years	139	13.8
50-59 years	141	14.0
60-69 years	164	16.3
70-79 years	57	5.7
80-89	3	0.3

Procedure: Participants completed an anonymous survey pack. The survey contained demographic questions, sexual history, the five-item version of the International Index of Erectile Function (IIEF-5), and the Index of Premature Ejaculation (IPE). The completed survey pack was returned to the researchers. Ethical approval was granted by the First Faculty of Medicine of Charles University in Prague, Czech Republic.

Instruments: The shorter, five-item version of the international index of erectile function (IIEF-5) was used to measure erectile function. The original IIEF contains 15 items and investigates five domains. It is a valid and reliable instrument developed in conjunction with the clinical trial program for sildenafil (Raymond C Rosen and al. 1997; Cappelleri and al. 2000a), with a high reliability in the detection of the effects of erectile dysfunction treatment (Rosen and al. 1997). The IIEF has a very high internal consistency (α = 0.82-0.96) (Raymond C Rosen and al. 1997). The

IIEF-5 is widely used in screening erectile dysfunction due to its fast implementation. It was validated with reported internal consistency with Cronbach's alpha scores of 0.98 and 0.88 (R C Rosen and al. 1999). Lower scores indicate greater severity of ED; men who report scores under 21 are considered to be experiencing erection issues.

Ejaculatory control was assessed using the index of premature ejaculation (IPE), a valid and reliable instrument with three domains: (1) evaluation of control over ejaculation, (2) satisfaction with ejaculation, and (3) distress associated with PE (Althof and al., 2006). The IPE comprises 10 items with very good internal reliability and very high test-retest reliability, with results ranging between 0.70 and 0.90 (Althof and al., 2006). Convergent validity was reported as excellent for all three domains (*control* = 0.75, *satisfaction* = 0.60, and *distress* = 0.68).

Convergent validity was assessed against the intravaginal ejaculatory latency time. Scores in each domain can range from 0 to 100, with higher scores indicating greater control over ejaculation, satisfaction with ejaculation, and lower distress due to ejaculation. The IPE does not have cut-off points for each domain and is not a diagnostic tool.

2c — Results

Participants reported whether they had experienced sexual problems (n = 126; 12.5%) or were currently experiencing a sexual problem (n = 133; 13.2%). Of those men who had experienced a sexual problem, 43 men reported PE (4.3%). The mean age of the experience was 20.43 years (*SD* =

6.79) with the onset as young as 11 years and as old as 45 years. Forty-six men reported a history of ED (4.6%). The mean age for this sub-sample was 41.13 years (*SD* = 18.509) with ages ranging from 15 to 72 years. Of those currently experiencing sexual problems, 12 men reported PE (1.2%) and 75 men reported ED issues (7.5%).

Self-Reported Intravaginal Latency Times

The mean self-reported intravaginal ejaculatory latency time (IELT) was 9.34 minutes (*SD* = 10.37), with 89 men reporting ILTS of less than 1 min (8.9%), and a further 51 men reporting between one and two minutes ILTS (5.1%). Table 2 reports the IELT estimates.

Twelve men (1.2%) reported that they were currently experiencing premature ejaculation (no = 50; missing = 942). There was no significant correlation between self-reported premature ejaculation and researcher's diagnosis (based on IELT). An independent sample *t*-test resulted in no significant differences in self-reported IELT and the perception of premature ejaculation.

A significant negative correlation exists between age and self-reported IELT (r = -.234; p <.001). A one-way analysis of variance was conducted to explore the impact of age on self-reported IELT. There was a statistically significant difference between age groups: F (7,790) = 6.193, p < .001.

Table 2: Self-Reported Intravaginal Latency Times

ILTS	Number of Participants (n = 1,004)	Per cent
< 2 mins	149	14.84
3-10 mins	467	46.51
11-15 mins	64	6.37
16-20 mins	54	5.38
21-30 mins	37	3.69
30+ mins	8	0.80
Don't know	37	3.69
Did not report at all	188	18.73

Index of Premature Ejaculation

Table 3 presents the mean scores of participants in the three domains of the IPE. A statistically significant negative association was recorded between age and the control domain (r = -.251; p <.001), sexual satisfaction domain (r = -.259; p <.001), and the distress domain (r = -.176; p <.001). Analyses of variance were performed to explore the impact of age on each of the domains with significant differences recorded between age groups on each domain: *control* domain (F (6,631) = 9.729, p < .001), *sexual satisfaction* domain (F (6,629) = 10.812, p < .001), and *distress* domain (F (6,633) = 4.444, p < .001).

A diagnosis of IELT of one min or less was used to classify the presence of PE (Giuliano and al. 2008b). Eighty-nine men were identified and a dichotomous variable (yes/no) was applied. Significant Pearson's correlation was found for all three domains: *control* (r = .156; p < .001), *sexual satisfaction* (r = .214; p < .001), and *distress* (r = .109; p < .001).

Table 3: Mean Scores, Standard Deviations, and Ranges for the Domains of the IPE

IPE Domain	Mean Score	Std Dev.	Range (min-max)
Control	81.13	17.72	6-100
Sexual satisfaction	78.60	20.59	6-100
Distress	86.86	18.32	13-100

Erectile Function

The mean score on the IIEF-5 was 19.28 (*SD* = 2.53). Scores ranged from nine (moderate ED) to 24 (no ED). No participant indicated severe ED, and 10.5% (*n* = 105) indicated no ED. Approximately two-thirds of the sample reported some level of ED.

Table 4 presents the IIEF-5 data. Seventy-five men (7.5%) self-reported current ED. There was no association between self-reports of ED and IIEF-5 scores. There was a statistically significant negative correlation between age and ED (as measured by the IIEF-5; $r = .260$; $p < .001$). Significant mean differences existed between age groups on the IIEF-5 mean scores ($F(6,727) = 10.950$, $p < .001$).

Table 4: IIEF-5 Scores

IIEF-5 Range	Number of Participants (n = 1,004)	Per cent
0-7 (Severe ED)	0	0.0
8-11 (Moderate ED)	7	0.1
12-16 (Mild-Moderate ED)	105	10.5
17-21 (Mild ED)	549	54.7
22-25 (No ED)	105	10.5
Missing	238	23.7

The relationship between the presence of ED and the three domains of the IPE was significant and positive for IIEF-5 scores and the dichotomous variable: presence of ED/absence of ED.

With the increase in perceived control and sexual satisfaction, the IIEF-5 scores (less ED) also increased. The increase in distress marked Inversely, the distress score showed lower distress as the IIEF-5 scores increased. Table 5 reports the correlations for these data.

The PE-ED Relationship

A significant association was observed between the presence of PE and ED (r = 0.162; p <.001). Age influences the presence of PE and ED as well as the three domains of the IPE. Partial correlations were conducted between IIEF-5 scores and the three domains of the IPE (C*ontrol, Satisfaction, and Distress)* while controlling for age. An inspection of the zero-order correlations suggested that controlling for age had little effect on the relationship. These data are presented in Tables 5 and 6.

Table 5: Correlations between IIEF-5, ED, and the Domains of the IPE

Domain/Measure	IIEF-5	Presence of ED (Y/N)
Control	.473*	.157*
Sexual satisfaction	.400*	.100**
Distress	.424*	.115***

*p < .001
** p = .011
*** p = .003

Multiple regression was used to identify the role of age, control, satisfaction, and distress in predicting ED. These independent variables explained 2.9% of the total variance (F (4,616) = 4.547, p = .001). Control was the only statistically significant predictor (*Beta* = .148, p = .003).

2d — Discussion

The rates of self-reported PE in this sample were lower than reported in epidemiologic studies (4.3% *vs.* 20-30%) (Hatzimouratidis, Amar, Eardley, Giuliano, Hatzichristou, Montorsi, Vardi, and Wespes 2010; Edward O Laumann and al. 2005; Giuliano and al. 2008b). The self-reported rates for ED were at the lower end of prevalence estimates (5% *vs.* 5%-20%) (Feldman and al. 1994)). Based on IELT measures (1–2 min), slightly higher rates of PE were recorded for the sample and were consistent with the previous estimates of lifelong PE (Patrick and al. 2005).

This was also similar in the application of the IIEF-5 scores to determine the presence of ED – more men (approx. two-thirds) were recorded as experiencing some level of ED. There is a discrepancy between self-reported and measured rates of the occurrence of PE and ED. There was no statistical support for any relationship between self-reported and researcher-measured PE or ED. This discrepancy and lack of support between self-report and objective measures suggests that reliance on self-report of sexual dysfunctions may be problematic. This relationship warrants further investigation.

Premature ejaculation was found to be negatively correlated with age. Older men were more likely to report a shorter IELT. This was further supported through analysis, and differences were found between age groups; PE was more prevalent among older men than younger men. The relationship between the domains of the *Index of Premature Ejaculation* (Brody and Weiss 2015) and IELT was investigated. Men recorded as

experiencing PE based on self-reported IELT were more likely to perceive lower levels of ejaculatory control, lower sexual satisfaction, and higher sexual distress. The domains were also explored in relation to age, with older men perceiving lower ejaculatory control, higher sexual satisfaction, and lower levels of sexual distress. Although older men may experience PE and perceive less control, they are more likely to be satisfied and experience less distress about PE.

The rates of recorded ED based on diagnosis using the IIEF-5 scores were similar to other studies (Nicolosi and al. 2003; Serefoglu, McMahon, Waldinger, Althof, Shindel, Adaikan, Becher, Dean, Giuliano, Hellstrom, Giraldi, Glina, Incrocci, Jannini, McCabe, Parish, Rowland, Segraves, and al. 2014b and). The increase in ED rates with age is also consistent with previous literature. As men age, they are more likely to experience ED. The current findings were confirmed through an analysis of variance, where differences were found between age groups (Nicolosi and al. 2003; Moreira and al. 2003). Erectile dysfunction was associated with IPE domains. Higher rates of perceived control and satisfaction and lower distress were correlated with lower levels of erectile dysfunction.

A relationship exists between the presence of PE and ED, as confirmed in this study. Age was found to be associated with each variable. Further analysis through partial correlations, however, found that when controlled, age had little effect. In exploring the predictability of ED as an outcome of PE, only *control* was found to be a significant predictor, as presented in Table 6. This suggests that when working with men who

experience PE, a lower level of perceived control is more likely to indicate the presence of ED.

Table 6: Partial Correlations between the Domains of the IPE and IIEF-5 Scores

IPE Domain	IIEF-5 *rho*	*p*-value	Change from zero-order
Control	.435	.000	0.033
Sexual satisfaction	.353	.000	0.038
Distress	.411	.000	0.024

Using the Jannini, Lombardo, and Lenzi model of PE-ED, men who experience PE and ED are also likely to perceive less control because their focus on controlling ejaculation is likely to result in distraction and erection loss (Jannini, Lombardo, and Lenzi 2005). The loss of erection in turn requires greater arousal, resulting in rapid ejaculation. This circular relationship is likely to result in perceptions of no control. Further investigation is required to confirm the role of perceived control in predicting PE-induced ED.

The main limitation of this study is the focus on Czech nationals. Additionally, the reliance on self-report measures also produces possible limitations as identified in this study. This limits the generalizability of the results to wider populations. A further limitation is the application of correlational analysis, which does not allow for confirmed causality. Future research can explore the causal relationships between variables.

Subsequent research can also focus on the psychobiological factors common to erectile and ejaculatory functions, considering the key role that they both have in maintaining good sexual health and the high prevalence of ED and PE in society. This link should also be considered when developing new therapeutic interventions to improve both functions.

As has been identified, further research is required to study the relationship between self-report and objective measures of sexual well-being. In this study, no relationship was found to exist with less men self-reporting the presence of PE and ED than identified through IELTs (admittedly still self-reported) and application of the IIEF-5 for diagnosing ED. The role of control in predicting ED for PE sufferers is also recommended for further research. Given the limited research on the role of ED as an outcome of PE, more research into this relationship is warranted. Age was found to be associated with all variables, yet was found to have limited impact upon further analysis. Future research could consider age as a mediator or moderator of the relationship between PE and ED given the role age has in both of these conditions. The mediation–moderation relationship could be explored with the three domains of the IPE and its function between PE and ED.

The results of this study support a positive link between ejaculatory and erectile functions (Giovanni Corona and al. 2015). Furthermore, when attention is focused on the variable of erectile function, it seems that people with greater erectile problems score less on the dimensions of control and satisfaction with erectile ejaculation and report greater distress. These results coincide with the meta-analysis of Corona and al. (2015) (Giovanni

Corona and al. 2015). The current results must be interpreted with caution since the authors have only investigated the risk of experiencing PE-ED and not diagnoses.

The results of this study are also consistent with frequent observations in the clinical psychosexual and sexual medicine practice, where men report erectile function issues preceded by difficulties with the ejaculatory function (Jannini and al., and 2005). Therefore, there are certain factors that would affect both functions and explain the PE-ED link. Both functions share biological mechanisms (Lavoisier and al. 2014), whose appropriate functioning would facilitate the proper development of both processes and would be key for good sexual health.

For example, the use of drugs, such as sympatholytic, selective serotonin reuptake inhibitors, or methadone, would affect both functions (Cabello and Lucas 2002). Endocrine alterations such as hyperthyroidism or neurologic diseases such as diabetic neuropathy can also cause disturbances in erectile and ejaculatory functions at the same time. Psychological variables such as distress and mood disorders also play a decisive role in both functions (Rajkumar and Kumaran 2015). In this context, distress affects both functions by generating an increase in the sympathetic tone (Palace and Gorzalka 1990), and this anxiety, in many cases, would be caused by thoughts and concerns about sexual performance, therefore becoming a vicious circle.

Erectile and ejaculatory functions are affected by sexual performance anxiety (Beck and Barlow 1986). This would cause an

increase in the sympathetic tone, hindering erection due to peripheral vasoconstriction, which in turn accelerates the ejaculatory reflex, which would increase the initial distress levels upon confirmation of poor performance.

The strength of this study lies in the representativeness of the sample, considering the size and selection criteria, and the measures used (notwithstanding the limitation on generalizability noted above).

2e — Conclusions

PE and ED functions are related and have common biological and psychological factors for their appropriate maintenance. Considering this relationship, it is recommended that an evaluation of both functions should be made in the clinical management of PE and ED, regardless of whether only one of them is the reason for seeking psychosexual and/or medical attention. This would facilitate the selection of a more appropriate treatment and a better understanding of the underlying mechanisms of these dysfunctions.

A second obstacle in a man's progression to sexual satisfaction is the psychological order. A very high number of children suffer from sexual assault. It is necessary to determine if this traumatic event has an impact on their later sexual life in general and specifically sexual satisfaction.

3 — Impact of Childhood Sexual Assault on Sexual Function

3a — Goal of the research

Childhood sexual assault (CSA) can be defined as any sexual contact between a child and an adult or older person. It can include oral, vaginal, or anal fondling or penetration with a penis, digit, tongue, or foreign object; and non-contact sexual assault/abuse (e.g., exhibitionism or voyeurism) (Pulverman and al., and 2018; Myers and al., and 2011). The prevalence of CSA among boys is reported to be between 3% and 31% (Stoltenborgh and al. 2011). Globally, it is suggested that one in every six boys are sexually assaulted (Mathews and al., 2017; Fergusson and al., 1999). This statistic is most likely underestimated as many incidences of childhood sexual assault are not detected or reported (Cermak and Molidor 1996). Childhood sexual assault among girls has been reported at higher rates than for boys (Garnefski and Arends 1998). The reasons for this gender difference are contested, unclear, and probably multiple.

This discussion is beyond the scope of this paper. The reported incidence rates of CSA are influenced by the socio-cultural context and local jurisdictions, legal definitions of CSA offenses, and measures of and/or collection of data (Goldman and al., 2000). Childhood sexual assault is a violation of a child's sexual rights and, therefore, human rights (World Association for Sexual Health 2014). It can have a lasting impact on the survivors' well-being (Dworkin 2018; Havig 2008).

Little is known about the impact of CSA perpetrated against boys on their later sexuality as adult men. A search for articles using the search-string "sexual assault" AND "sexual function" AND "men" in the PubMed™ database returned zero articles and two articles in a similar search of PsychInfo database (Masters 1986; Turchik 2012). Both articles considered the impact of adulthood sexual assault. A third article was also located in a Spanish-language journal with a focus on the impact of CSA on Chilean men (Pinto-Cortez, Beltrán, and Fuertes 2017). The number of studies focusing on the post-traumatic effects of CSA among men is much lower than the number of those on women (Moore and al. 2010).

The impact of CSA on adult women's sexual function is better documented. Women who reported CSA histories also reported issues with sexual function and satisfaction (Pulverman, Kilimnik, and Meston 2018; Easton and al. 2011; Davis and Petretic-Jackson 2000). Desire and arousal dysfunctions were most frequently reported (Pulverman, Kilimnik, and Meston 2018). Sexual arousal disorders were reported as high as 84% in a treatment-seeking sample (Pulverman, Kilimnik, and Meston 2018; Westerlund 1992), and between 49% and 62% in clinical samples (Pulverman, Kilimnik, and Meston 2018; Jehu, Gazan, and Klassen 1988; Becker and al., 1984; 1986). Desire-related difficulties were also high, ranging from 51% to 59% of reported samples (Pulverman, Kilimnik, and Meston 2018; Westerlund 1992; Jehu, Gazan, and Klassen 1988; Becker and al. 1984; 1986; Sarwer and Durlak 1996). Orgasmic difficulties were also found to be high in women who reported CSA histories (Pulverman, Kilimnik, and Meston 2018; Kinzl, Traweger, and Biebl 1995).

Sexual dysfunction in men can range from erectile function issues to ejaculatory control issues (premature or delayed ejaculation). Population studies suggest that erectile dysfunction (ED) can affect approximately 52% of men. It is estimated that between 5% and 20% of men report moderate to severe symptoms of erectile dysfunction (Hatzimouratidis, Amar, Eardley, Giuliano, Hatzichristou, Montorsi, Vardi, Wespes, and al. 2010; M. Braun and al. 2000; Park, Hwang, and Kim 2011). Erectile dysfunction is influenced by a man's level of psychological well-being (Meisler and Carey 1991b). Psychological issues with known associations with erectile dysfunction include anxiety (Giovanni Corona and al. 2006b), depression (Nicolosi and al. 2004c), and panic attacks (Okulate, Olayinka, and Dogunro 2003b).

The level of education and age are also associated with erectile dysfunction; ED increases with age and is more prevalent among men with lower levels of education. The absence of a spouse or stable partner is also positively associated with ED (Ahn and al. 2007; Kamnerdsiri, Watcharaphol, Bartakova, Jana, and Weiss 2015; Park and Chung 2019). Pathophysiological factors such as diabetes, hypertension, hypercholesterolemia, cardiovascular disease, and renal failure are also well-documented causes of ED (De Tejada and al. 2005; Maas and al. 2002). Delayed or premature ejaculation is the most commonly reported sexual dysfunction in men, with reported prevalence rates between 3% and 30% (McMahon and al. 2013b; Waldinger and al. 2005a). Psychological distress including performance anxiety has been found to be associated with premature ejaculation (Serefoglu, McMahon, Waldinger, Althof,

Shindel, Adaikan, Becher, Dean, Giuliano, Hellstrom, Giraldi, Glina, Incrocci, Jannini, McCabe, Parish, Rowland, Segraves, and al. 2014c; Corretti and al. 2006a). A comorbidity of sexual dysfunction (premature ejaculation and erectile dysfunction) has also been observed (Kamnerdsiri and al. 2018). A history of CSA is also associated with higher levels of psychological distress, including depression and anxiety (Easton and al. 2011; 2017).

In the context of this study, it is essential to acknowledge the cognitive processes associated with ED and PE. The traumatic experience of CSA may result in traumatic flashbacks at the moment of the sexual encounter. These flashbacks can activate the adrenergic system, resulting in premature ejaculation, or the intrusive memories interrupt the erotic focus necessary to maintain an erection (Yehuda and al., and 2015; Traish and al., 2000).

The limited literature focusing on men reporting CSA history displays results similar to the previous literature on women with CSA history. A study reported that North Chilean men with a CSA history were more likely to report sexual difficulties than men without CSA history (Pinto-Cortez, Beltrán, and Fuertes 2017).

Another study reported the impact of CSA history on three aspects of sexual function: *emotional* (fear of touch, sexual guilt), *behavioral* (issues with [being] touched, issues with arousal), and *evaluative* (sexual satisfaction) (Easton and al. 2011). The authors reported that approximately one-third of the respondents indicated sexual fear (37.5%)

and sexual guilt (31.3%). Issues with sexual touch was reported by 43.8% of the sample. A similar result was reported for sexual dissatisfaction (40.6%). Approximately one in five men reported issues with arousal (21.9%) (Easton and al. 2011). An in-depth study explored a range of sexual dysfunctions in men, yet it did not report frequency data (Turchik 2012). It concluded that sexual victimization had an impact on men's sexual functioning. Masters argued that parallels could be drawn between male and female survivors (Masters 1986).

The small volume of research on women's experiences and even smaller volume on men suggests that CSA impacts later sexual well-being affecting desire, arousal (erections), and satisfaction. No data were found on the relationship between a history of CSA and ejaculatory control. The present study aimed to add to the body of knowledge on the relationship between a history of CSA and sexual function in men and to inform practitioners of the relationship to assist them in improving survivors' overall well-being.

The small volume of data on men with a CSA history also suggests that they experience sexual function issues at a higher rate than men without a history of CSA. It is hypothesized that men who report a history of CSA will also report sexual function issues (e.g., erectile dysfunction and premature ejaculation) at rates higher than men who report no history of CSA. This exploratory study identified the relationships between sexual assault histories and sexual function issues to inform practice and future research.

3b — Materials and methods

Sample: The sample was 1,004 Czech men aged between 15 and 84 years, with a mean age of 42.8 years (*SD* = 17.6). Less than half of the sample reported being in a relationship (42.6%) while approximately one-third of the sample was single (38.1%), divorced (13.1%), or widowed (6.2%). The sample was well-educated; 39.1% of men had completed secondary studies, 30% had completed vocational studies, and 19.1% had a university-level education. One in ten men reported a primary education (11.8%). Heterosexuality was reported by 88% of the sample, with 1.4% indicating same-sex attraction and 10.7% identifying as bisexual.

Procedure: Participants were recruited through a social research agency, CEGEDIM, in the Czech Republic. A nationally representative sample of non-institutionalized men of the Czech Republic aged 15–88 years was collected by CEGEDIM in 2013, under the supervision of the 1st Faculty of Medicine, Charles University, Prague. The agency reported an 82% participation rate. The sample is representative of the national census concerning municipality size, region, age, and education level. After participants provided informed consent (which included a statement of confidentiality of responses and the right to discontinue at any time) and received clarifications to any doubts regarding the meaning of survey items, they anonymously completed the paper-based survey and returned it to the social research agency.

The survey included demographic questions (e.g., age, relationship status, highest level of education completed, and sexual identity), sexual history (including history of CSA; See Appendix A), the International Index of Erectile Function Five item version (IIEF-5) (Davison and al. 2009; Cappelleri and al. 2000b), and the Index of Premature Ejaculation (IPE) (Giuliano and al. 2008a). The IPE was not used in the analysis of these data because of the small sample size of the participants with CSA. This would not have produced meaningful results.

Premature ejaculation was measured using self-reported IELTs. Premature ejaculation was defined as an IELT of two minutes or less (Serefoglu, McMahon, Waldinger, Althof, Shindel, Adaikan, Becher, Dean, Giuliano, Hellstrom, Giraldi, Glina, Incrocci, Jannini, McCabe, Parish, Rowland, Segraves, and al. 2014c; McMahon and al. 2013b). Ethical approval was granted by the ethics committee of the First Faculty of Medicine of Charles University in Prague, Czech Republic.

This exploratory study adopted a correlational approach. The sample of men who reported CSA was small, and detailed analysis using inferential statistics was not justifiable or warranted. The variables under investigation included self-reported sexual assault history, self-reported sexual function issues, calculated IIEF-5, and self-reported IELTs scores. Erectile function was determined based on a score lower than 21 on the IIEF-5 (R CRosen and al. 1999). Premature ejaculation was recorded where a participant reported an IELT below two minutes (Corty and Guardiani 2008). These data served as the basis for correlational analyses.

3c — Results

The results section first explores the participants' history of CSA to provide a context and understanding of CSA, followed by an exploration of reported sexual function issues (erectile function and premature ejaculation).

Twenty-five men (2.5%) reported a history of CSA. Thirteen men (1.3%) indicated that the CSA was a once-only event, while 12 men (1.2%) reported that the CSA was repeated more than once. Participants were asked at what age the abuse began, which revealed higher rates during adolescence than during childhood (see Table 1).

Table 1: Age at which Abuse Began

Age (years)	N
8	1
9	1
10	1
11	2
12	0
13	5
14	6
15	9

The perpetrator was identified as a relative for five participants (20.8%). Twelve participants (50%) reported that their perpetrator was a person known to them. It was a stranger (not known to them) for seven men (29.2%). One participant did not disclose the perpetrator-victim relationship.

Two-thirds of the survivors (*n* = 15; 62.5%) did not report the CSA to anybody. Four men (16.7%) told their parents, three participants (12.5%) told their friends, one survivor reported the CSA to his school, and one reported it to the police. Participants were asked why they had not reported the incident to the police. Participants were able to select up to four responses: *shame* (*n* = 10; 76.9%); *fear of revenge by the perpetrator* (*n* = 6; 46.2%), *fear of not being believed* (*n* = 8; 61.5%), and *not wanting to hurt the perpetrator* (*n* = 14; 73.7%).

Participants were asked about the impact of the CSA on their later life with eight participants (32%) reporting *no impact* and 17 participants (68%) reporting an impact on later life. Seven men reported that the impact of CSA continued at the time of completing the survey. Table 2 lists the impacts reported by participants.

Table 2: Reported Impact of CSA on Participants

Impact of CSA	**N**
Fear of women	3
Sexual disorders	1
Mood disorders (anxiety, depression)	4
Lack of self-confidence	4
Relationship issues	2
Had to seek psychiatric or psychological support	3

Participants were also asked about adulthood sexual assault. Twenty-seven participants (2.7%) reported being forced into sexual intercourse by violence or the threat of violence, and 14 participants (1.4%) reported being forced into intercourse repeatedly. The perpetrator of the

adult sexual assault was reported to be a male in 13 cases (35.1%) and a female in 24 cases (64.9%). Eleven participants reported that the adult sexual assault had an impact on their later lives. Continual or ongoing, the impact of the assault was reported by six participants. Of the twenty-five participants who reported a CSA history, 15 participants (60%) also reported adult sexual assault: five men (20%) reported a single event of adult sexual assault, and 10 men (40%) reported more than a single event of sexual assault.

Sexual Functioning

One hundred and twenty-six men (12.5%) reported a lifetime history of sexual function issues, with 133 men reporting current experience of sexual function issues. Table 3 reports the lifetime and current experiences of sexual function issues.

Table 3: Experiences of Sexual Function Issues – Current and Lifetime Experiences.

Sexual Function Issue	**Lifetime Experience**		**Current Experience**	
	N	**N (%)**	**N**	**N (%)**
Lack of sex drive or desire	29	2.9	40	4.0
Premature ejaculation	43	4.3	12	1.2
Delayed ejaculation	13	1.3	8	0.8
Inability to attain orgasm	19	1.9	32	3.2
Anejaculation/Inability to ejaculate	8	0.8	16	1.6
Erection issues	46	4.6	75	7.5
Hyper-sex drive	28	2.8	22	2.2
Pain or unpleasant feelings during sex	14	1.4	7	0.7

NB Not all participants responded to these questions.

Of those participants who reported a CSA history, 12 men (48%) also reported a sexual function issue at some point in their life and 11 men (45.8%) reported a sexual function issue at the time of completing the survey. Table 4 reports the lifetime and current experiences of sexual function issues among men with a CSA history.

Table 4: Experiences of Sexual Function Issues for Men with a History of CSA – Current and Lifetime Experiences

Sexual Function Issue	Lifetime Experience	Current Experience
	N	N
Lack of sex drive or desire	2	4
Premature ejaculation	1	6
Delayed ejaculation	4	6
Inability to attain orgasm	2	5
Anejaculation/Inability to ejaculate	3	5
Erection issues	3	2
Hyper-sex drive	3	5
Pain or unpleasant feelings during sex	4	7

Current erectile function was assessed using the five-item version of the international index of erectile function (IIEF-5). The IIEF-5 has been validated with reported Cronbach's alpha scores of 0.98 and 0.88 (R C Rosen and al. 1999). Lower scores indicate greater severity of ED; men having scores under 21 are considered to be experiencing erection issues. One hundred and five men (10.5%) were scored as having erection issues (i.e., scores below 21). Of these, three men (2.9%) also reported a history of CSA.

Current premature ejaculation was assessed using self-reported intravaginal ejaculation latency time (IELT). An IELT of less than two minutes is considered to be premature ejaculation (Corty and Guardiani 2008). Thirty-one participants (3.1%) reported an IELT of two minutes or less. Of these participants, two men also reported a history of CSA.

Correlations

Pearson's correlations were performed to explore the relationships between the variables. A significant correlation was recorded between *ever suffered a sexual function iss*ue and *current experience of a sexual function issue* (r = .506; p < .001). A significant association was reported between a history of CSA and *having ever suffered a sexual function issue* (r = .173; p < .001) and *current experience of sexual function issue* (r = .150; p < .001).

Significant relationships were also recorded between a life-history of sexual function issues and premature ejaculation (r = .0.88; p = .006) and erection issues (r = .116; p = .001). Significant correlations were found between the current experience of sexual function issues and premature ejaculation (r = .098; p = .002) and erection issues (r = .269; p < .001).

A history of CSA was also significantly correlated with the presence of erection issues (r = .079; p = .030) and experiences of adult sexual assault (r = .217; p < .001) but not with premature ejaculation (r = .004; p = .890).

3d — Discussion

The present study aimed to add to the body of knowledge on the relationship between a history of CSA and sexual function. The hypothesis that men with a history of CSA will also report sexual function issues was supported. The statistically significant associations reported in this study were considered small to moderate. The self-reported rate of CSA was in the lower levels of reported rates, with Doyle and colleagues suggesting between 3% and 31% (Doyle Peter 1986) and a less than the one-in-six ratio (Mathews and al. 2017). Approximately half of the sample experienced repeated incidences of CSA with onset age between 8 and 15 years. In approximately 71% of cases, the perpetrator was known to the participant, either as a family member or another known person associated with the participant.

The low levels of reporting are consistent with previous research (Doyle Peter 1986; Fergusson and al. 1999; Olafson 2011; Briere and Elliott 2003; Abajobir and al. 2017; Boroughs and al. 2015). It has been reported that the low levels of reporting of CSA results from fear of family breakdown (if CSA is reported), fear of personal safety, a sense of responsibility for other children, and fear of not being believed (Neame and Heenan 2003). For male victims of CSA, it has also been suggested that perceptions of being emotionally weak, gay, not masculine, or fear of the victim-cum-perpetrator narrative contribute to non-reporting of CSA (Neame and Heenan 2003).

Childhood sexual assault was reported to have later impacted nearly two-thirds of the participants, with seven men still experiencing the impact at the time of completing the survey. Sexual trauma can affect individuals throughout life. It can have devastating effects on some survivors. It can have both psychological and physiological impacts (Abajobir and al. 2017; Boroughs and al. 2015; Dorahy and Clearwater 2012; Lewis and al. 2016; Paul and al. 2001). For these men, the impacts varied and included sexual and mood disorders as well as impacts on the sense of self and relationships.

Adult sexual assault was also reported by some participants. These incidence data, like the CSA incidence data, are at the lower ends of the reporting range when compared to other research (Wolfe-Clark and al., 2017; Classen and al., and 2005; Aosved and al., and 2011). The incidence rates of men with CSA and adult sexual assault is within the previously reported ranges (Classen and al., and 2005; Aosved and al., and 2011).

The incidence of induced sexual function disorders cannot be not easily compared. There is no data on global rates of sexual function. The current experience of sexual function issues is consistent with the previous literature (McMahon and al. 2013b; Waldinger and al. 2005a; Hatzimouratidis, Amar, Eardley, Giuliano, Hatzichristou, Montorsi, Vardi, Wespes, and al. 2010; M. Braun and al. 2000; E. O. Laumann and al. 2005). Data comparison and triangulation are also difficult due to the small sample size.

The hypothesized relationship between the history of CSA and sexual function issues was supported. Men who reported a history of CSA also reported past and/or current experience of sexual function issues. Not surprisingly, men who had suffered a sexual function issue were also likely to experience sexual function issues during the survey period.

Associations were also recorded between past experiences and current experiences of sexual function issues and the presence of rapid ejaculation and erectile function issues. This is an expected finding. Erection issues have also been associated with a history of CSA as well as adult sexual assault.

The presence of sexual function issues and the confirmed relationship has been noted in previous literature (Turchik 2012; Pinto-Cortez, Beltrán, and Fuertes 2017; Easton and al. 2011). These data on sexual function among men with a history of CSA must be understood with caution due to the small sample size. Future research could explore these associations in greater detail.

The dearth of research on the relationship between sexual function and sexual assault makes comparison of the results of this study with previous literature difficult. Sexual assault or sexual trauma is a trauma. The relationship between sexual function and trauma (not necessarily sexual trauma) is documented in the literature on general trauma (Sorensen and al. 2008) and post-traumatic stress disorder (Yehuda and al., and 2015).

The impact of trauma may be experienced in different areas of sexual function, including desire, arousal, and orgasm (ejaculatory) (Yehuda and al., and 2015). The perception of the severity of trauma is associated with the severity of sexual dysfunction (Sorensen and al. 2008). It has been suggested that trauma that results in physical, psychological, or social limitations can lead to issues with sexual function (Sorensen and al. 2008). CSA-related trauma can have psychological impacts. Therefore, there is a greater likelihood of sexual function issues among CSA survivors. The trauma response models applied to sexual function can disturb any and all biological, cognitive, and/or affective processes (Yehuda, Lehrner, and Rosenbaum 2015).

Limitations and Future Research

The sample is reflective of the Czech male population but not of the broader European population. This study is limited by the small sample size of men reporting a history of CSA. This made a comparison between the groups statistically irrelevant. Causation could not be tested and the results cannot be generalized. Although these results are **consistent** with previous literature, it can be argued that a relationship is supported and warrants a more detailed exploration.

The reliance on self-reported data on sexual function and a lack of objective measures to triangulate these data also limits the strength of the results. Although the self-reported data were triangulated with more objective measures, at least for erectile function. The use of objective

measures of premature ejaculation [for example, the *Premature Ejaculation Profile* (Patrick and al. 2009) triangulated with self-reported *intra-vaginal ejaculation latency time]* and sexual satisfaction [for example, *the Global Measure of Sexual Satisfaction* (Lawrance and Byers 1995a) or the *New Sexual Satisfaction Scale*)(Štulhofer, Buško, and Brouillard 2010)] would enhance the reliability, validity, and generalizability of the results.

Given the lack of research investigating this phenomenon, the contribution and support this study provides to the existing small body of literature is welcome. The need for rigorous research specifically focused on this topic – men with a history of CSA and its impact on their sexual function–remains necessary.

Implications for Practice

This research supports the hypothesis and validates the previous literature. Men with a history of CSA are also likely to experience sexual function issues.

Sexual trauma, or trauma resulting from sexual assault, does impact sexual well-being and sexual satisfaction (Bigras, Godbout, and Briere 2015). This may trigger a chain of negative reactions that will impact numerous aspects of a person's life since sexual well-being and sexual satisfaction are major determinants of the quality of life (Wright and al. 2006), and therefore, overall life satisfaction. The intimate relationship may also be negatively impacted since sexual function and sexual satisfaction are important for relationship satisfaction (Schwartz and al. 2009) and

overall well-being (Davison and al. 2009). Relationship strength (as an outcome of relationship satisfaction) is an indicator of good physical and mental health, with healthy relationships operating as a protective factor for better health. A practitioner needs to understand the intricate inter-relationship between sexual trauma, sexual function, well-being, and relationship satisfaction to better support men who have experienced CSA.

When screening for sexual function issues, it is essential to explore sexual assault history as part of the sexual history. Men who present sexual function issues may report a history of CSA (or recent sexual assault). When seeking the etiology of a sexual function issue, the use of open-ended and non-judgmental questions would minimize practitioner-informed re-traumatization.

Understanding that a history of CSA can impact sexual function (erectile function and ejaculatory control), the possibility of somatic-oriented trauma suggests the adoption of a trauma-informed approach by practitioners in the sexological field. A trauma-informed approach is strengths-based and provides the survivor with an opportunity to tell their story rather than being diagnosed as a problem. There is a therapeutic benefit in exploring the narrative of a survivor's life (Kezelman and Stavropoulos 2012; Substance Abuse and Mental Health Services Administration (US) 2014). With the assistance of an informed practitioner, a survivor may succeed in re-authoring the meaning of the traumatic event with a more positive outcome.

3c — Conclusions

This study has contributed to the growing knowledge of the impact of CSA on men's sexual functioning in general and specifically for the Czech population. The research findings are limited and congruent with the previous literature. Men with a history of CSA also reported sexual function issues. The relationship between these two variables was moderate and significant. Future research should explore the causal relationship of these phenomena. A trauma-informed approach to sexual history-taking would provide a safe environment for male survivors to disclose their sexual function issues and history of CSA.

IV. THESIS CONCLUSIONS

As the knowledge corpus on men's sexual disorders and their multiple causes continues to increase, it was interesting to take a different stance and study the conditions of men satisfied by their sexuality. This study on the prevalence of sociological and biographical aspects of their life produced results that were for some mildly counterintuitive, but all instructive about the necessary base of a satisfying sexuality.

No causality should be invoked for these biographical aspects; only their absence appears to be a hindrance to sexual satisfaction. To summarize the information exposed in this thesis, the sexually satisfied

Czech man is aged between 30 to 44 years. He had a childhood protected from any sexual assault and enjoyed a harmonious relationship with his mother. He was successful at school and pursued a higher education. He is now married, and he declares no religious affiliation or practice. He had no significant trouble during sexual encounters with his wife, notably no erectile dysfunction. The duration of the coitus is not impressive, but he does not suffer from severe premature ejaculation, and he is satisfied by his modest performance. What matters to him is to feel in control of his ejaculation, even if it comes relatively soon.

One of the lessons that may be drawn from this portrait of the sexually satisfied Czech man is that the acceptance of a reasonable level of imperfection is the philosophy of life that needs some experience to be acquired and some intellectual capacity to be mastered, as long as childhood trauma does not come to interfere with this accomplishment. Any practitioner taking the history of a patient with a complaint of sexual dysfunction should remember that the absence of any of these traits may contribute to the present disorder. Some are beyond the influence of a doctor but just a verbalization of either an initial trauma or a current condition may help the patient cope with his reality.

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VI. SURVEY I

Vážení přátelé,

nedílnou součástí prevence závažných pohlavně přenosných nemocí včetně AIDS je výzkum sexuálního chování. Sexuologický ústav Všeobecné fakultní nemocnice a 1. lékařské fakulty Univerzity Karlovy připravil dotazníkové šetření, zaměřené na sexuální chování obyvatelstva České republiky. Výzkum je prováděn tazateli společnosti CEGEDIM. Výsledky by nám měly pomoci přesněji předpovědět vývoj epidemie onemocnění AIDS.

Chceme Vás ujistit, že Vámi vyplněný dotazník je přísně anonymní, vedený pouze pod pořadovým číslem. Vaše údaje nemohou být v žádném případě použity k jiným než přísně odborným účelům. Prosíme Vás proto o maximální možnou upřímnost při odpovědích na otázky, které jsou vesměs velmi intimního charakteru.

Náš ústav, stejně jako další zúčastněné instituce, garantují naprostou serióznost tohoto projektu, jakož i anonymitu zpracovávaných dat.

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Dotazník muž

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1. Poprvé jste byl do dívky zamilován:

dosud nikdy 1

již byl ..... 2 a to poprvé v ..... letech

2. První delší partnerský vztah s dívkou (delší než 6 měsíců) jste:

dosud neměl 1

již měl ..... 2 a to poprvé v ..... letech

3. Poprvé jste onanoval (sám se dráždil na přirození):

dosud nikdy 1

již ano ..... 2 a to poprvé ve věku ..... let

4. První výron semene (ve spánku, při onanii nebo při styku) jste:

dosud neměl 1

již měl ..... 2 a to poprvé ve věku ..... let

5. V současné době onanujete:

vůbec ne 1

ano ..... 2 a to v průměru ..... krát měsíčně

Používáte při masturbaci obrazovou pornografii z internetu?

Ano, často……..... 1
Ano, někdy……..... 2
Ne, nikdy……..... 3

6. Poprvé jste zažil necking (mazlení s partnerkou na těle od pasu nahoru)

dosud nezažil 1

již ano ..... 2 a to poprvé ve věku ..... let

7. Poprvé jste zažil petting (mazlení s partnerkou po celém těle včetně pohlavních orgánů)

dosud nikdy 1

již ano ..... 2 a to poprvé ve věku ..... let

8. Poprvé jste souložil s nějakou ženou:

dosud nikdy 1

již ano ..... 2 a to poprvé ve věku ..... let

při první souloži:

jsem měl potíže se ztopořením 1

neměl jsem potíže 2

9. První pohlavní styk jste uskutečnil:

s náhodnou partnerkou 1

se stálou partnerkou 2

10. První pohlavní styk jste uskutečnil:

v bytě svých rodičů 1

v bytě rodičů partnerky 2

v přírodě 3

na internátě (koleji) 4

na chatě, chalupě 5

v autě…….. 6

jinde 7

11. Za celý život jste souložil:

dosud nikdy 1

ano ..... 2 a to celkem s ..... ženami (uveďte počet)

z toho za poslední rok s .....

ženami (uveďte počet)

12. Pohlavní styk s příležitostnou partnerkou (pouze jedenkrát, na jednu noc) jste:

dosud nikdy neměl..... 1

měl..... 2

a to celkem s ..... partnerkami (uveďte počet)

z toho za poslední rok s ..... partnerkami (uveďte počet)

13. S kolika partnerkami jste měl soulož (pohlavní styk) aniž byste měl zájem o dlouhodobý vztah s tímto jedincem?

dosud nikdy jsem s takovou partnerkou pohlavní styk neměl 1

měl jsem s takovou partnerkou styk..... 2

a to celkem s ..... takovými partnerkami (uveďte počet)

14. Jak často si představujete sex s někým, s nímž nemáte vážný partnerský vztah? (prosím zakroužkujte jednu z možností):

1	2	3	4	5
Nikdy	Velmi zřídka	Zhruba jednou za měsíc	Zhruba jednou za týden	Skoro každý den

15. Jak často se vám stane, že se sexuálně vzrušíte, když komunikujete s někým, s nímž nemáte vážný partnerský vztah? (prosím zakroužkujte jednu z možností):

1	2	3	4	5
Nikdy	Velmi zřídka	Zhruba jednou za měsíc	Zhruba jednou za týden	Skoro každý den

16. Jak často máte v každodenním životě spontánní fantazie o tom, že máte sex s člověkem, kterého jste právě potkal? (prosím zakroužkujte jednu z možností):

1	2	3	4	5
Nikdy	Velmi zřídka	Zhruba jednou za měsíc	Zhruba jednou za týden	Skoro každý den

17. Máte v současné době stálý partnerský vztah se ženou?

nemám 1

mám ..... 2 a to v trvání ..... měsíců

18. Nakolik jste ve svém partnerství celkově spokojen? (zakroužkujte jedno číslo na stupnici):

1 2 3 4 5 6

zcela spokojen velmi nespokojen

19. Máte v současné době s touto partnerkou pohlavní styky?

nemám 1

mám ..... 2 a to v průměru ..... krát měsíčně

20. Nakolik jste ve svém partnerství sexuálně spokojen? (zakroužkujte jedno číslo na stupnici):

1 2 3 4 5 6

zcela spokojen velmi nespokojen

21. Preferujete být v partnerství a v sexuálních aktivitách vůči Vaší potenciální partnerce spíše dominantní (nadřízený) či submisivní (podřízený)? (zakroužkujte jedno číslo na stupnici):

V partnerství:

1 2 3 4 5 6 7

zcela submisivní zcela dominantní

V sexu:

1 2 3 4 5 6 7

zcela submisivní zcela dominantní

22. Jak hodnotíte svůj vztah s matkou (či jinou ženou, která vás vychovávala) během Vašeho dětství (tj. do 15 let)? (zakroužkujte jedno číslo na stupnici):

1	2	3	4	5	6
zcela pozitivně					velmi negativně

Rodič ženského pohlaví mne v dětství (do 15 let) nevychovával .....…0

23. Jaké používáte praktiky při sexu se ženami?

	vždy	*v polovině a více*	*méně než v polovině*	*nikdy*
penis do pochvy	1	2	3	4
penis do úst	1	2	3	4
ejakulace do úst	1	2	3	4
penis do konečníku	1	2	3	4
penis do ruky	1	2	3	4
penis do jinam	1	2	3	4
ústa na pochvu	1	2	3	4
ústa na konečník	1	2	3	4

24. Praktikoval jste někdy sadomasochistické styky (aktivity)?

ano, jedenkrát……..... 1
ano opakovaně……..... 2
a to poprvé ve věku .....let

➔**Pokud ano, vaše preferované postavení je:**

dominantní..... 1

submisivní..... 2

proměnlivé…. 3

ne, ale dokáži si představit situaci, ve které bych je praktikoval……... 3
ne a v žádném případě bych je nepraktikoval……..... 4

25. Jakou antikoncepci jste použil při prvním pohlavním styku se ženou?

žádnou 1

kondom 2

partnerka užívala antikoncepční pilulky 3

přerušovanou soulož 4

neplodné dny partnerky 5

jinou antikoncepci ..... 6 a jakou: .....

26. Jakou používáte antikoncepci při styku se svou stálou partnerkou?

nepoužívám 1

používám ..... 2 a to:

	vždy	*občas*	*nikdy*
přerušovaný styk	1	2	3
neplodné dny	1	2	3
kondom	1	2	3
antikoncepční pilulky	1	2	3
nitroděložní tělísko	1	2	3
sterilizace moje	1	2	3
sterilizace partnerky	1	2	3

27. Používáte kondom při styku s náhodnou partnerkou?

Nemám takové partnerky……. 0

nepoužívám 1

používám 2

28. Jaký máte názor na antikoncepci?

Jsem zásadně proti jakékoliv antikoncepci 1

Uznávám pouze tzv. přirozené metody 2

Považuji antikoncepci za nutnou 3

29. V současné době byste potřeboval sexuální vybití:

nepotřeboval vůbec 1

potřeboval ..... 2 a to měsíčně ..... krát

30. V současné době máte pohlavní vybití (z jakéhokoliv zdroje, tedy soulož, onanie atd.):

nemám žádné 1

mám ..... 2 a to měsíčně ..... krát

31. Délku milostné předehry při styku s partnerkou odhadujete v průměru na: ..... minut (uveďte počet minut)

32. Dobu trvání soulože s partnerkou odhadujete v průměru na: ..... minut (uveďte počet minut)

33. Kolik minut při souloži u vás obvykle uplyne mezi začátkem soulože a vaší ejakulací?

Méně než minuta……..... 1

Více než minuta…….... 2 a to……minut

(prosím uveďte číslem)

34. Pokud by záleželo jenom na Vás, pro dosažení orgasmu byste dal přednost:

(zakroužkujte jen jednu možnost)

Masturbaci jen s preferovanými fantaziemi	1
Masturbaci s využitím pornografie	2
Dráždění rukou partnerky	3
Dráždění ústy partnerky	4
Souloži s partnerkou do pochvy	5
Souloži s partnerkou do konečníku	6

35. Trpěl jste někdy ve svém životě nějakou sexuální poruchou?

žádnou 1

ano ..... 2, a to:

	Ano	*Ne*	
nedostatkem sex. potřeby, touhy	1	2	pokud ano, ve věku ..... let
předčasným výronem semene	1	2	pokud ano, ve věku ..... let
poruchami ztopoření	1	2	pokud ano, ve věku ..... let
neschopností dosáhnout vyvrcholení	1	2	pokud ano, ve věku ..... let
nadměrnou sexuální potřebou	1	2	pokud ano, ve věku ..... let
bolestmi a nepříjemnými pocity při souloži	1	2	pokud ano, ve věku ..... let
opožděnou ejakulací (výronem semene)	1	2	pokud ano, ve věku ..... let
chyběním ejakulace	1	2	pokud ano, ve věku ..... let

36. Trpíte nějakou sexuální poruchou v současné době?

žádnou 1

ano ..... 2, a to:

	Ano	*Ne*
nedostatkem sex. potřeby, touhy	1	2
předčasným výronem semene	1	2
poruchami ztopoření	1	2
neschopností dosáhnout vyvrcholení	1	2
nadměrnou sexuální potřebou	1	2
bolestmi a nepříjemnými pocity při souloži .	1	2
opožděnou ejakulací (výronem semene)	1	2
chyběním ejakulace	1	2

37. Pokud trpíte sexuální poruchou, komplikuje vám tato porucha partnerské soužití?

nemám partnerku	1			
komplikuje ho	2	a to:	velmi	1
			středně	2
			málo nebo vůbec ne	3

38. Předstíral jste někdy při pohlavním styku orgasmus? (zakroužkujte jen jednu možnost):

Ne, nikdy	1
Ano, výjimečně	2
Ano, opakovaně	3

39. Pokud ano, z jakého důvodu? (můžete zakroužkovat více možností):

Jste to chtěl už mít za sebou	1
Chtěl jste potěšit partnerku	2
Nechtěl jste, aby si myslela, že trpíte poruchou	3
Věděl jste, že to už stejně nepůjde	4
Jiný důvod, specifikujte:……..……	5

40. Domníváte se, že Vaše partnerka někdy při pohlavním styku předstírala orgasmus?

Nemám stálou partnerku	1
Nevím	2
Ano, předstírala	3
Ne, nikdy orgasmu nedosahuje	4
Ne, dosahuje orgasmu bez problémů	5

41. Sexuálního vyvrcholení dosahuje Vaše partnerka především (zakroužkujte jednu možnost)?

Nemám stálou partnerku	1
Drážděním poštěváčku (klitorisu)	2
Drážděním poševního vchodu	3
Drážděním v hloubce pochvy	4
Drážděním klitorisu i pochvy současně	5
Stejně snadno drážděním klitorisu i drážděním v pochvě	6
Necítí žádné sexuální vzrušení	7
Nevím	8

Následující otázky jsou zaměřeny na to, jak sexuální problémy ovlivňovaly váš sexuální život v posledních čtyřech týdnech. Prosím, odpovězte na ně co nejupřímněji. Je třeba zodpovědět všechny otázky, přičemž u každé z nich je třeba zvolit jen jednu odpověď:

42. V posledních 4 týdnech, když jste souložil, jak často jste byl schopen kontrolovat svou ejakulaci (výron semene), tedy ejakulovat kdy jste chtěl?

Neměl jsem soulož ……	0
Vždy nebo téměř vždy……	1
Ve více než polovině případů……..	2
Asi v polovině případů……	3
Méně než v polovině případů……	4
Nikdy nebo téměř nikdy……	5

43. V posledních 4 týdnech, když jste souložil, jaká byla vaše důvěra, že budete mít výron semene kdy budete chtít?

Neměl jsem soulož …….....	0
Vysoká důvěra…….....	1
Poměrně vysoká důvěra……	2
Ani vysoká, ani nízká důvěra……..	3
Poměrně nízká důvěra.…….	4
Nízká důvěra …….	5

44. V posledních 4 týdnech, když jste souložil, jak často byla pro vás soulož uspokojivá?

Neměl jsem soulož ……	0
Vždy nebo téměř vždy……..	1
Ve více než polovině případů……	2
Asi v polovině případů……	3
Méně než v polovině případů……	4
Nikdy nebo téměř nikdy……	5

45. V posledních 4 týdnech, když jste souložil, jak jste byl spokojen s pocitem kontroly nad tím, že budete mít výron semene tehdy, kdy vy budete chtít?

Neměl jsem soulož …….	0
Velmi spokojený……..	1
Poměrně spokojený ……	2
Ani spokojený a ani nespokojený……....	3
Poměrně nespokojený ……	4
Velmi nespokojený……..	5

46. V posledních 4 týdnech, když jste souložil, jak jste byl spokojen s délkou soulože před ejakulací?

Neměl jsem soulož …….	0
Velmi spokojený……....	1
Poměrně spokojený ……..	2
Ani spokojený a ani nespokojený…….	3
Poměrně nespokojený ……..	4
Velmi nespokojený……..	5

47. V posledních 4 týdnech, jak jste byl spokojen celkově se svým sexuálním životem?

Velmi spokojený…….. 1

Poměrně spokojený …….. 2

Ani spokojený a ani nespokojený…… 3

Poměrně nespokojený …….. 4

Velmi nespokojený…….. 5

48. V posledních 4 týdnech, jak jste byl spokojen celkově se svým sexuálním vztahem s partnerkou?

Velmi spokojený…….. 1

Poměrně spokojený …….. 2

Ani spokojený a ani nespokojený…… 3

Poměrně nespokojený …….. 4

Velmi nespokojený…….. 5

49. V posledních 4 týdnech vám soulož poskytla kolik potěšení, rozkoše?

Neměl jsem soulož ……..……... 0

Hodně potěšení…….……... 1

Poměrně dost potěšení..……..…….. 2

Ani hodně ani málo…….……... 3

Poměrně málo potěšení..…… 4

Málo potěšení…..……. 5

50. V posledních 4 týdnech jak moc jste byl stresován (frustrován, nespokojen) tím, jak krátce to trvalo, než jste ejakuloval?

Neměl jsem soulož ……..…..... 0

Extrémně stresován ……..…. 1

Velmi stresován ……..……..…… 2

Středně stresován ……..……..…….. 3

Trochu stresován ……..…….. 4

Ani trochu ……..…….. 5

51. V posledních 4 týdnech jak moc jste byl stresován (frustrován, nespokojen) svou schopností kontrolovat svou ejakulaci?

Neměl jsem soulož …….……..	0
Extrémně stresován ……..	1
Velmi stresován ……..……..…...	2
Středně stresován …….…….…….	3
Trochu stresován …….……..	4
Ani trochu …….……..	5

U každé z následujících otázek je uvedeno několik možných odpovědí. Vaším úkolem je zvolit tu, která nejlépe odpovídá Vaší skutečné situaci v období posledních 6 měsíců. Je třeba zodpovědět všechny otázky, přičemž u každé z nich je třeba zvolit jen jednu odpověď:

52. Jaká je Vaše důvěra v možnost dosažení a udržení erekce (ztopoření penisu)?

Velmi nízká	1
Nízká	2
Střední	3
Vysoká	4
Naprostá	5

53. Pokud u Vás došlo k erekci, jak často byla dostatečná k pohlavnímu styku?

Neměl jsem žádný pohlavní styk	1
Nikdy nebo téměř nikdy	2
Jen ojediněle (v méně než polovině případů)	3
Občas (zhruba v polovině případů)	4
Většinou (více než v polovině případů)	5
Vždy nebo téměř vždy	6

54. Pokud došlo k pohlavnímu styku, jak často jste byl schopen erekci udržet i po zavedení penisu do pochvy?

Neměl jsem žádný pohlavní styk	1
Nikdy nebo téměř nikdy	2
Jen ojediněle (v méně než polovině případů)	3
Občas (zhruba v polovině případů)	4
Většinou (více než v polovině případů)	5
Vždy nebo téměř vždy	6

55. Pokud došlo k pohlavnímu styku, jak obtížné bylo udržet erekci až do Vašeho vyvrcholení (ejakulace)?

Neměl jsem žádný pohlavní styk	1
Mimořádně obtížné	2
Velmi obtížné	3
Obtížné	4
Nepříliš obtížné	5
Snadné	6

56. Pokud došlo k pohlavnímu styku, jak často byl pro Vás uspokojivý?

Neměl jsem žádný pohlavní styk	1
Nikdy nebo téměř nikdy	2
Jen ojediněle (v méně než polovině případů)	3
Občas (zhruba v polovině případů)	4
Většinou (více než v polovině případů)	5
Vždy nebo téměř vždy	6

57. Měl jste někdy v životě pohlavní styk s prostitutkou?

Nikdy neměl …..... 1

již měl …..... 2

58. Měl jste někdy v životě pohlavně přenosnou nemoc?

neměl nikdy 1

ano, měl 2

59. Měl jste někdy v životě pohlavní styk s mužem?

ne, neměl nikdy 1

ano, měl jednou 2

ano, měl opakovaně …….. 3

60. Považujete se za homosexuála?

ne 1

nejsem si jist 2

ano 3

61. Považujete se za bisexuála?

ne 1

ano 2

62. Měl jste někdy mimomanželské sexuální styky?

nebyl jsem nikdy ženat 1

nikdy jsem takové styky neměl 2

měl jsem takové styky: výjimečně 3

příležitostně .. 4

často 5

63. Pokud jste měl takový styk, jednalo se o:

příležitostný styk 1
delší známost 2
obojí 3

64. Byl jste někdy ve svém dětství (do 15 let) sexuálně zneužit dospělou osobou?

nikdy nebyl 1
byl, a to jednou ..... 2 ve věku ..... let
byl opakovaně ..... 3 od ..... let věku

65. Pokud jste byl sexuálně zneužit, pak pachatelem byl:

dospělý muž 1
dospělá žena 2

66. Pokud jste byl v dětství sexuálně zneužit, pak pachatelem byl:

příbuzný 1
osoba vám známá (učitel, trenér apod.) 2
osoba cizí 3

67. Pokud jste byl pohlavně zneužit, pak:

	Ano	*Ne*
pachatel vás osahával po těle	1	2
pachatel vás onanoval rukou	1	2
pachatel vám dráždil ústy penis	1	2
pachatel vyžadoval, abyste ho dráždil na přirození rukou	1	2
pachatel vyžadoval, abyste ho dráždil na přirození ústy	1	2
pachatel vyžadoval soulož do konečníku	1	2
pachatelka vyžadovala soulož do pochvy	1	2

68. Pokud jste byl pohlavně zneužit:

nikomu jste to neoznámil 1

řekl jste to pouze rodičům 2

řekl jste to kamarádům 3

řekl jste to ve škole učitelům 4

bylo to oznámeno policii 5

69. Pokud jste byl sexuálně zneužit a neučinil jste oznámení na policii, jaké důvody vás k tomu vedly?

	Ano	*Ne*
stud	1	2
obava ze msty pachatele	1	2
obava, že by vám nevěřili	1	2
nechtěl jste pachateli ublížit	1	2

70. Mělo sexuální zneužití, které jste prožil, nějaký vliv na váš další život?

ne, nemělo 1

ano, mělo negativní ... 2, a to:

	Ano	*Ne*
strach z žen	1	2
sexuální poruchy	1	2
úzkosti, deprese	1	2
nedostatek sebevědomí	1	2
partnerské problémy	1	2
musela jsem se na následky zneužití psychiatricky či psychologicky léčit	1	2

ano, mělo pozitivní ..... 3, a to:

	Ano	*Ne*
lepší sexuální prožívání v dospělosti	1	2

zvýšení zájmu o sex 1 2

zvýšení sebevědomí 1 2

71. Pokud mělo zneužití u vás nějaké následky, přetrvávají tyto následky dodnes (jsou trvalého charakteru)?

ano 1

ne, byly jen dočasné ... 2

72. Nutil jste někdy násilím nebo hrozbami nějakou ženu k pohlavnímu styku?

ne, nikdy 1

ano ..... 2 a to:

	Ano	*Ne*
nutil jsem ji k souloži	1	2
nutil jsem ji k dráždění mého penisu ústy (fellaci)	1	2
nutil jsem ji k masturbaci (dráždění penisu rukou)	1	2
nutil jsem ji k análnímu styku (styku do konečníku)	1	2

Pokud ano, jednalo se o:

manželku, stálou partnerku 1

jinou známou ženu 2

neznámou ženu 3

73. Byl jste někdy vy sám přinucen násilím nebo hrozbami k pohlavnímu styku?

ne, nikdy 1

ano, jednou 2

ano, opakovaně 3

74. Pokud jste byl přinucen k pohlavnímu styku, pachatelem by:

muž…….. 1

žena……..... 2

75. Pokud jste byl násilím přinucen ke styku, mělo to vliv na váš další život?

ne, nemělo žádný 1

ano, mělo negativní 2

76. Přetrvávají tyto následky dodnes (jsou trvalého charakteru)?

ano 1

ne, byly jen dočasné 2

77. Jaký máte názor na interrupci (umělé ukončení těhotenství)?

je naprosto nepřípustná ……1

je přípustná pouze ze zdravotních důvodů (např. ohrožení života a zdraví ženy, malformace plodu) ……2

je přípustná i ze sociálních důvodů (např. špatné ekonomické podmínky, svobodná matka apod.) …….. 3

každá žena má právo se svobodně rozhodnout, zda chce donosit dítě …….. 4

78. Jaký máte názor na sexuální styky před manželstvím?

považuji je za naprosto nepřípustné 1

považuji je za přípustné pouze nedojde-li při tom k souloži 2

považuji je za přípustné v rámci trvalého partnerského vztahu 3

považuji za přípustné i nahodilé pohlavní styky před manželstvím 4

79. Jaký máte názor na prostituci?

je potřeba ji zakázat a trestat prostitutky i jejich klienty 1

je potřeba ji zakázat a trestat jen prostitutky 2

je potřeba ji zakázat a trestat jen jejich klienty 3

povolil bych ji jen ve veřejných domech a s lékařskou kontrolou 4

povolil bych ji bez omezení, je to nutné zlo 5

nemám nic proti prostituci, může být dokonce prospěšná 6

80. Jaký máte názor na pornografii?

je třeba ji zakázat 1

považuji ji za škodlivou, umožnil bych prodej jen ve speciálních obchodech 2

nemám k ní výhrady, umožnil bych však prodej jen ve speciálních obchodech 3

nemám k ní výhrady a její prodej bych neomezoval 4

81. Jaký máte názor na skupinový sex?

považuji jej za morálně nepřípustný 1

považuji jej za přípustný, ale sám to odmítám 2

považuji jej za přípustný a neodmítám jej 3

Zúčastnil jste se někdy sám skupinového sexu?

nezúčastnil 1

ano, jednou 2

ano, opakovaně 3

82. Jaký máte názor na mimomanželské pohlavní styky?

považuji je za morálně nepřípustné 1

neodsuzuji je, ale sám bych je neprovozoval 2

je to přirozené a normální 3

83. Jaký máte názor na náhodné pohlavní styky (tzv. na jednu noc)?

považuji je za morálně nepřípustné 1

neodsuzuji je, ale sám bych je neprovozoval 2

považuji je za přirozenou součást sexuality 3

84. Jaký máte názor na onanii (masturbaci, sebeukájení)?

považuji ji za škodlivou 1

je to zlozvyk, který nikomu neškodí 2

je to přirozený projev lidské sexuality 3

85. Jaký máte názor na homosexualitu?

je to zlozvyk, který by měl být trestán 1

je to nemoc, za kterou postižený nemůže 2

odchylka od normálu, která může škodlivě působit na mládež 3

odchylka od normálu, která nikomu neškodí 4

je to přirozený projev lidské sexuality 5

86 Informace o sexualitě jste získal zejména (zakroužkujte pouze jednu odpověď):

od rodičů …… 1

ve škole ……... 2

z filmu, rozhlasu, televize a videa ……...3

z novin, časopisů …… 4

z knížek …….. 5

od kamarádů a známých ……6

z internetu…… 7

jinde (vypište kde):……..8

nebyl jste informován nikde ……9

A NAKONEC VÁS PROSÍME O NĚKOLIK ÚDAJŮ PRO STATISTICKÉ VYHODNOCENÍ DAT:

Kolik je Vám let? (Uveďte číslem) .....

Jste:

svobodný 1

ženatý 2

rozvedený 3

vdovec 4

Vaše nejvyšší dokončené vzdělání:

základní 1

vyučen 2

střední s maturitou 3

vysokoškolské 4

Jaký je Váš vztah k náboženství:

Jste věří..... …… 1

jste nevěřící ……..2

Uveďte, prosím, počet Vašich sourozenců:

Mám…….starších bratrů ……mladších bratrů ……..bratrů dvojčat

Mám…….starších sester ……mladších sester ……..sester dvojčat

Sexuologický ústav 1. lékařské fakulty Univerzity Karlovy a VFN Vám děkuje za Vaše odpovědi.

Vyplněný dotazník nepodepisujte a nedávejte nikomu k nahlédnutí.

Vložte dotazník do obálky, zalepte ji a zajistěte ještě přelepením přiloženou samolepkou s naším razítkem.

VII. SURVEY II

(English Translation)

Dear friends,

Research in sexual behavior is an integral part of the prevention of sexually transmitted diseases, including AIDS. The Institute of Sexology at the 1st Faculty of Medicine at Charles University in Prague and General University Hospital in Prague prepared a questionnaire survey focused on the sexual behavior of the population in the Czech Republic. Research is carried out by the interviewer from CEGEDIM Company. The results should help us to more accurately predict the development of the epidemic of AIDS.

We want to assure you that this questionnaire survey is strictly anonymous and all of your answers will be held confidential and under the serial number only. Your answers will be used for research purposes only. Therefore, we appreciate your thoughtfulness and sincerity when answering the questions, many of which are very intimate ones.

Our Institute, as well as other interested institutions, guarantees absolute seriousness of this project and the anonymity of the processed data.

Prof. PhDr. Petr Weiss, Ph.D., Scientific Secretary, Sexuologická společnost Česká lékařská společnost Jana Evangelisty Purkyně (Sexological Society of Czech Medical Society of Jan Evangelista Purkyně)

Doc. MUDr. Jan Zvěřina, CSc., Chairman, Sexuologická společnost Česká lékařská společnost Jana Evangelisty Purkyně (Sexological Society of Czech Medical Society of Jan Evangelista Purkyně)

Questionnaire – Man

1 When was your first date with a woman?

I haven't had one yet 1

I have already had one ..... 2 the first time was when I was .....

When was the first time you kissed a woman?

I haven't kissed one yet 1

I have already kissed one ..... 2 the first time was when I was.....

When was the first time you were in love with a woman?

I have not been in love yet 1

I have already been in love ..... 2 the first time was when I was.....

When did you have your first long-term relationship with a woman (longer than 6 months)?

I haven't had one yet 1

I have already had one..... 2 the first time was when I was.....

how many relationships like this have you had over the course of your whole life? ..... (state how many)

---

2 When was the first time you masturbated (stimulated yourself on the genitals)?

I have never done that 1

I have already done that ..... 2 the first time was when I was .....

When did you first ejaculate (during sleep, when masturbating or during intercourse):

I haven't experienced that yet 1

I have already experienced that..... 2 the first time was when I was.....

Do you masturbate at the moment?

Not at all 1

Yes ..... 2 on average ..... times a month

---

3. When was the first time you experienced necking (petting with a partner on the body from the waist up)?

I have never experienced that 1

I have already experienced that .... 2 the first time was when I was.....

When was the first time you experienced petting (petting with a partner all over the body including sexual organs)?

I have never experienced that 1

I have already experienced that ..... 2 the first time was when I was.....

---

4. When was the first time you had sexual intercourse with a woman?

I have never had sex 1

I have already had sex ..... 2 the first time was when I was.....

During the first sexual intercourse:

I had problems getting an erection..... 1

I did not have any problems..... 2

First sex was mainly initiated:

Never 1

By me 2

By my partner 3

By both of us 4

When you first have sexual intercourse, your partner was:

Older than you .....1 by ..... years

Younger than you ..... 2 by ..... years

The same age 3

Who did you first have sexual intercourse with?

With a casual partner 1

With a regular partner ..... 2 after ..... months of knowing them

Where did you first have sexual intercourse?

In my parent's flat 1

In my partner's parent's flat 2

In the countryside 3

At the halls of residence 4

In a cottage 5

Somewhere else ..... 6 and where?.....

---

5. How many sexual partners have you had over the course of your whole life?

I have never had sex 1

I have had sex ..... 2 with a total of..... women (state the number)

of which over the past year with ..... women (state the number)

of which over the past five years with ..... women (state the number)

How many one night stands have you had?

I have never had one 1

I have had one ..... 2 with a total of ..... women (state the number)

of which in the past year with ..... women (state the number)

---

6. When did you first get married?

I have never been married 1

I am/have been married .....2 the first time was when I was .....

When did you first get divorced?

I have never been divorced 1

I am divorced ..... 2 the first time was when I was ..... after .....years of marriage

How many times have you been married in your whole life? .....
(state number)

How many children of your own do you have? ..... (state number)

---

7. Are you currently in a long-term relationship with a woman?

No 1

Yes..... 2 for ..... months

Do you currently have sexual intercourse with this partner?

No 1

Yes ..... 2 on average ..... times per month

Which practices do you use during sex with a woman?

	Always	*Half the time or more*	*Less than half the time*	*Never*
Penis in the vagina ……..	1	2	3	4
Penis in the mouth ……..	1	2	3	4
Ejaculation in the mouth …….	1	2	3	4
Penis in the anus ……..	1	2	3	4
Penis in the hand ……..	1	2	3	4
Penis elsewhere ……...	1	2	3	4
Mouth on the vagina …….	1	2	3	4
Mouth on the anus……	1	2	3	4

8. Which types of contraceptive did you use when you first had sexual intercourse with a woman?

None 1

Condoms 2

Partner used contraceptive pills ... 3

Withdrawal 4

Partner's infertile days 5

Other contraceptive ..... 6 state which: .....

Which form of contraceptive do you use during sex with your <u>long-term</u> partner?

I do not use any 1

I use a contraceptive..... 2

	Always	*Sometimes*	*Never*
Withdrawal	1	2	3
Infertile days	1	2	3
Condoms	1	2	3
Contraceptive pills	1	2	3
IUD	1	2	3
I have been sterilized	1	2	3
My partner has been sterilized	1	2	3
Other	1	2	3

which? .....

Which form of contraceptive do you use during a <u>one night stand</u>?

I do not use any 1

I use a contraceptive 2

	Always	*Sometimes*	*Never*
Withdrawal …….....	1	2	3
Infertile days.....	1	2	3
Condoms	1	2	3
Contraceptive pills …….....	1	2	3
IUD …….....	1	2	3
Other	1	2	3

which? .....

What is your opinion on contraception?

I am in principle against any form of contraception 1

I only acknowledge so-called natural methods 2

I regard contraception as necessary 3

---

9. Do you currently need sexual relief?

Not at all 1

Yes, I do ..... 2 ..... times a month

Do you currently have any sexual relief (from any source, i.e. intercourse or masturbation etc.)?

No, I don't 1

Yes, I do ..... 2 ..... times a month

At what age did you feel your greatest sexual need? .....

At what age did you have the most orgasms in one day? .....

How many times in total: ..... (state number)

---

10. How long do you estimate the average length of foreplay before sex with a partner? ..... **minutes** (state number of minutes)

How long do you estimate the average length of intercourse with a partner? ..... **minutes** (state number of minutes)

How long do you estimate the average length of your sensory climax (orgasm) during any form of sexual activity? ..... **seconds** (state number of seconds)

How long do you estimate the average length of your partner's sensory climax (orgasm)? ..... **seconds** (state number of seconds)

---

11. Have you ever suffered from any sexual disorder in your life?

No 1

Yes ..... 2, this concerned:

	Yes	*No*	
Lack of sex drive, desire	1	2	If yes, at what age? .....
Premature ejaculation	1	2	If yes, at what age? .....
Erection problems	1	2	If yes, at what age? .....
Inability to reach orgasm	1	2	If yes, at what age? .....
Excessive sex drive	1	2	If yes, at what age? .....
Pain and unpleasant feelings during sex	1	2	If yes, at what age? .....
Delayed ejaculation	1	2	If yes, at what age? .....
Missing ejaculation	1	2	If yes, at what age? .....
Other disorder	1	2	If yes, at what age? .....

state which: .....

Are you currently suffering from any sexual disorder?

No 1

Yes ..... 2, this concerns:

	Yes	*No*
Lack of sex drive, desire …….....	1	2
Premature ejaculation	1	2
Erection problems	1	2
Inability to reach orgasm …….....	1	2
Excessive sex drive …….....	1	2
Pain and unpleasant feelings during sex …….	1	2
Delayed ejaculation	1	2
Missing ejaculation	1	2
Other disorder	1	2

state which: .....

If you currently suffer from any sexual disorder, has this disorder lasted since the time you started to have a sex life?

Yes 1

No, it started later ……..... 2

If you suffer from a sexual disorder, does this complicate your co-habitation with your partner?

I don't have a partner 1

It does 2

A lot 1

Somewhat 2

Not very much or not at all 3

Have you ever been treated for a sexual disorder?

Yes 1

No 2

If you have been treated for a sexual disorder, were you treated:

	Yes	*No*
Using counselling, with exercises?	1	2
Using medicines?	1	2
In another manner?	1	2

If you have been treated, do you regard the treatment as successful (did it resolve your problem)?

Yes 1

No 2

Have you ever faked an orgasm during sexual intercourse?

Yes, one time 1

Yes, repeatedly 2

No, never 3

---

12. Have you ever had sexual intercourse with a female prostitute?

No, never 1

Yes, I have ..... 2 if you have, which practices did you use during this:

	Always	*Half the time or more*	*Less than half the time*	*Never*
Penis in the vagina	1	2	3	4
Penis in the mouth	1	2	3	4
Ejaculation in the mouth	1	2	3	4
Penis in the anus	1	2	3	4
Penis in the hand	1	2	3	4
Penis elsewhere	1	2	3	4
Mouth on the vagina	1	2	3	4
Mouth on the anus	1	2	3	4

Did you use a condom during sex with a prostitute?

No, never 1

Yes, sometimes 2

Always 3

---

13. Have you ever had an STD in your life?

No, never 1

Yes ..... 2 if you have, was it:

	Yes	*No*
Gonorrhea?	1	2
Syphilis?	1	2
Genital warts?	1	2
Herpes?	1	2
Inflammation of the urethra?.....	1	2
Crabs?	1	2
Scabies?	1	2
Infectious jaundice?	1	2

---

14. Have you ever had sexual intercourse with a man?

No, never 1

Yes, once 2

Yes, several times ..... 3 with a total of ..... partners (state number)

Do you regard yourself as homosexual?

No 1

I'm not sure 2

Yes ..... 3 if you do, are you currently in a long-term relationship with a man:

Yes 1

No 2

Do you regard yourself as bisexual?

No 1

Yes 2

---

15. In comparison with your sexual partner, do you regard yourself as:

Sexually more demanding? 1

Sexually less demanding? 2

Our sexual needs are the same? 3

Are you satisfied with your sex life?

Yes 1

No 2

---

16. Have you ever had extramarital sexual relations?

I have never been married 1

I have never had sexual relations like that 2

I have had sexual relations like that: exceptionally 3

occasionally 4

frequently 5

If you have had extramarital relations, please state the number of such partners: ..... This concerned**:** occasional sex 1

a longer relationship 2

both 3

---

17. Were you ever sexually abused (harassed by an adult) during your childhood (up to the age of 15)?

No, never 1

Yes, once ..... 2 aged .....

Yes, repeatedly ..... 3 from the age of .....

If you were sexually abused, was the perpetrator:

An adult man? 1

An adult woman? 2

If you were sexually abused during your childhood, was the perpetrator:

You own father? 1

Your step father? 2

Your mother? 3

Your step mother? 4

Your brother? 5

Your sister? 6

Your uncle? 7

Your aunt? 8

Your grandfather? 9

Your grandmother? 10

Another relative? 11

A person you knew (teacher, trainer or similar)? 12

A stranger? 13

If you were sexually abused, what did the perpetrator do?

	Yes	*No*
Touched your body	1	2
Masturbated you with their hand	1	2
Rubbed their mouth on your penis	1	2
Demanded that you stimulate their genitals with your hand	1	2
Demanded that you stimulate their genitals with your mouth	1	2
Demanded anal sex	1	2
Female perpetrator demanded vaginal sex	1	2

If you were sexually abused, did you:

Not report it to anybody? 1

Only tell your parents? 2

Only tell your friends? 3

Tell the teachers at school? 4

Report it to the police? 5

If you were sexually abused during your childhood and this offence was reported to the police, do you know whether this offence was investigated and whether the perpetrator was convicted?

Yes, the offence was investigated and the perpetrator convicted 1

Yes, the offence was investigated but the perpetrator was not convicted.... 2

No, the offence was not investigated ……..... 3

I don't know..... 4

If you were sexually abused and did not report it to the police, which reasons led you not to do so?

	Yes	*No*
Shame	1	2
Fear of revenge by the perpetrator	1	2
Fear that they would not believe you	1	2
You did not want to hurt the perpetrator....	1	2

---

18. Did the sexual abuse which you experienced have any impact on your later life?

No, it didn't 1

Yes, a negative impact ..... 2, this being:

	Yes	*No*
Fear of women	1	2
Sexual disorders	1	2
Anxiety, depression	1	2
Lack of self-confidence….....	1	2
Relationship problems	1	2
I had to seek psychiatric or psychological treatment due to this …….....	1	2
Other	1	2

which? .....

Yes, a positive impact ..... 3, this being:

	Yes	*No*
Better enjoyment of sex in adulthood	1	2
Increased interest in sex	1	2
Increased self-confidence.....	1	2
Other	1	2

which? .....

If abuse had any after-effects on you, do these after-effects still last today (are they of a permanent nature)?

Yes 1

No, they were only temporary 2

---

19. Have you ever forced a woman into sexual intercourse by violence or using a threat?

No, never..... 1

Yes ..... 2, that being:

	Yes	*No*
You forced her to have sexual intercourse	1	2
You forced her to stimulate your penis with her mouth (fellatio)	1	2
You forced her to masturbate you (rub your penis with her hand)	1	2
You forced her to have anal sex	1	2

Did this forced sexual intercourse happen:

Only once? ..... 1, whereas this was:

Your wife or long-term partner 1

Another woman you knew 2

A stranger 3

Repeatedly? ..... 2, whereas:

This was always the same partner ……..... 1

You forced several women to have sex 2

how many? .....

Have you ever forced a man into sexual intercourse by violence or using a threat?

No, never 1

Yes, once 2

Yes, repeatedly 3

---

20. Have you ever been forced into sexual intercourse by violence or by using a threat?

No 1

Yes, once ..... 2, at the age of ....., whereas:

the perpetrator was a man 1

the perpetrator was a woman 2

Whereas this was:

Your partner or wife 1

Another person you knew 2

A stranger 3

Yes, several times ... 3, the first time was at the age of ..... whereas:

This was always the same partner ……..... 1

You were forced to have sex by several partners 2

how many? .....

If you have been forced to sexual intercourse, did you report it to the police?

Yes 1

No ..... 2, because (indicate the main reason):

You were embarrassed 1

You didn't want to lose the perpetrator, you loved her/him ... 2

You were afraid your wife or partner would find out 3

Due to those around you, they would judge you 4

Another reason 5

state which: .....

If you reported it, the perpetrator:

Was found and convicted? 1

Was found, their guilt was not proven? 2

Was not found? 3

If you were forced into sexual intercourse by violence, did it have an impact on your later life?

No, none 1

Yes, a negative impact ..... 2, this being:

	Yes	*No*
In your relationships	1	2
Sexually (impairment of your sex life)	1	2
Mentally (anxiety, depression or similar)	1	2
Other	1	2

which? .....

Do these after-effects still last today (are they of a permanent nature)?

Yes 1

No, they were only temporary 2

---

21. What is your opinion on abortion (artificial termination of pregnancy)?

It is absolutely unacceptable..... 1

It is acceptable for medical reasons (e.g. the woman's life or health are in danger, malformation of the foetus) 2

It is acceptable even for social reasons (e.g. bad economic circumstances, single mother or similar) 3

Every woman has the right to decide whether to carry the baby to term 4

---

22. What is your opinion on sexual relations before marriage?

I regard it as absolutely unacceptable 1

I regard it as acceptable only if intercourse does not occur 2

I regard it as acceptable in terms of a long-term relationship 3

I regard even casual sexual relations before marriage as acceptable … 4

---

23. What is your opinion on prostitution?

It should be banned and prostitutes and their clients punished 1

It should be banned and only prostitutes punished 2

It should be banned and only their clients punished 3

I would allow it only in public houses and subject to medical supervision 4

I would allow it without restriction, it is a necessary evil 5

I have nothing against prostitution, it can even be beneficial 6

---

24. What is your opinion on pornography?

It should be banned 1

I regard it as harmful, I would only allow it to be sold in special shops 2

I have no reservations with regards to it, but I would only allow it to be sold in special shops 3

I have no reservations with regards to it and would not restrict its sale 4

---

25. What is your opinion on group sex?

I regard it as morally unacceptable 1

I regard it as acceptable, but reject it myself 2

I regard it as acceptable and do not reject it 3

Have you ever taken part in group sex?

No 1

Yes, once 2

Yes, repeatedly 3

---

26. What is your opinion on extramarital sexual relations?

I regard it as morally unacceptable 1

I don't condemn it, but would not do it myself 2

It is natural and normal 3

---

27. What is your opinion on casual sexual intercourse (one night stands)?

I regard it as morally unacceptable 1

I don't condemn it, but would not do it myself 2

I regard it as a natural part of sexuality 3

---

28. What is your opinion on masturbation?

I regard it as harmful 1

It is a bad habit which doesn't harm anybody 2

It is a natural expression of human sexuality 3

---

29. What is your opinion on homosexuality?

It is a bad habit which should be punished 1

It is an illness which the afflicted person cannot help 2

A deviation from the norm which could especially be harmful to young people..... 3

A deviation from the norm which doesn't harm anybody..... 4

It is a natural expression of human sexuality 5

Do you personally know anybody who is homosexual?

No ……..... 1

Yes 2

---

30. Where did you mainly get your information about sexuality? (Only circle one answer):

From your parents 1

At school ……..... 2

From films, radio, television and videos ……. 3

From newspapers and magazines 4

From books ……..... 5

From friends and acquaintances 6

Elsewhere (state where): ……..... 7

You were never provided with information 8

Do you regard your level of information about sexuality as:

Insufficient? 1

Average? 2

Good? 3

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31. Do you think that a person who is HIV positive should be able to work in the following professions:

	Yes	*No*	*I don't know*
Doctor (non-surgical field)	1	2	3
Surgeon	1	2	3
Nurse	1	2	3
Dentist	1	2	3
Teacher	1	2	3
Sales assistant	1	2	3
Waiter	1	2	3
Chef	1	2	3

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32. Have you changed your sexual behaviour as a result of the risk of contracting AIDS?

No, there was nothing to change because I have never had sex 1

No, there was nothing to change, I have always behaved responsibly 2

Yes, I have 3

If you have, how have you changed your sexual behaviour? Was this:

	Yes	*No*
Decrease in the number of sexual partners	1	2
Decrease in the amount of sexual intercourse	1	2
Change in the method of sexual intercourse	1	2
Sexual intercourse only using a condom	1	2
You completely stopped having sexual intercourse	1	2
You are scared of becoming sexually active	1	2
Something else	1	2

State what: .....

---

33. Have you been tested for HIV?

No 1

Once 2

Twice 3

Three times or more 4

AND FINALLY, WE WOULD LIKE TO ASK YOU FOR A FEW DETAILS FOR STATISTICAL EVALUATION OF THE DATA:

34. How old are you? (State with a number) .....

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35. What is your present job? (State as precisely as possible whether you are a student, pensioner or whether you are unemployed or self-employed.)

.....

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36. Are you:

Single? 1

Married? 2

Divorced 3

Widower 4

37. What is the highest level of education you have achieved:

Primary – no vocational training 1

Primary – with vocational training 2

Other with no school leaving certificate 3

Vocational training with school leaving certificate 4

Secondary with school leaving certificate 5

University 6

38. What is your relationship with religion:

You are Roman Catholic 1

You are of another faith (state which) 2

You believe in God, but you do not profess any religion 3

You are an atheist 4

The Institute of Sexology at the 1st Faculty of Medicine at Charles University would like to thank you for your opinions.

Do not sign the completed questionnaire and do not let anybody see it.

Put the questionnaire in an envelope, seal it and seal it again by sticking the attached sticker with our stamp over the seal.

VIII. PUBLICATIONS RELATED TO THIS THESIS

In Peer-Reviewed Journals with Impact Factor (IF)

1. **Kamnerdsiri WA**, Fox C, Weiss P (2020): Impact of Childhood Sexual Assault on Sexual Function in the Czech Male Population. *Sex Med*. 2020 Sep;8(3):446-453. doi: 10.1016/j.esxm.2020.06.003. **(IF = 1.923)**

2. **Kamnerdsiri WA**, Rodríguez Martinez JE, Fox C, Weiss P (2018): Clinical correlation between erectile function and ejaculatory function in the Czech male population. *PLoS One*. 2018 Jul 12;13(7):e0199588. doi: 10.1371/journal.pone.0199588. **(IF = 2.740)**

IX. ANNEX 8C

Protocol of compliance with requirements for the Dissertation Thesis

Title, first name, surname:

MUDr. Watcharaphol Alexandre Kamnerdsiri

Department of Psychiatry, First Faculty of Medicine, Charles University

Title of the thesis:

- **Determinanty Sexuální Spokojenosti Českých Mužů** (Czech)
- **Determinants of Sexual Satisfaction in Czech Men** (English)

Supervising tutor

Prof. PhDr. Petr Weiss, PhD., DSc.

Institute of Sexology, First Faculty of Medicine, Charles University

Thereby I represent that I submitted the Dissertation Thesis in compliance with the following:

- Rector's Order number 72/2017
  - (available at https://www.cuni.cz/UK-8701.html)
- Rector's Order number 8/2011
  - (available at https://www.cuni.cz/UK-3735.html)
- Dean's Order number 10/2010
  - (available at http://www.lf1.cuni.cz/file/21321/opad10_10.pdf)

Further I represent that in the Student Information System I entered the **full text of my university thesis** with all the compulsory enclosures:

- abstract in Czech language
- abstract in English language
- formal summary of the dissertation

Entering the text of the thesis as well as all the other files, I followed the guidelines available at

- https://www.cuni.cz/UK-7987.html
- http://www.lf1.cuni.cz/file/25838/navod_vkladani_prace.pdf

Subsequently I checked the uploaded files.

I assume full responsibility for correctness and completeness of the electronic version of the thesis as well as all other electronic files enclosed.

4 cloth-bound copies of the thesis submitted at the Department of Science and Research and International Relations of the First Faculty of Medicine of Charles University contain all the compulsory enclosures.

- **Appendix number 1** – Title page, Declaration, ID record, abstract in Czech language, abstract in English language https://www.lf1.cuni.cz/document/35063/logo-10-10-pril1-vzor-zahlavi-a-ident-.pdf
- **Appendix number 3** – formal Summary of the dissertation thesis https://www.lf1.cuni.cz/document/35064/10-10-pril3-autoref-2-3.pdf

Date: **08/01/2021**

Student's signature:

Completeness checked by the person put in charge by the Guarantor: