

Original Research

Association of Sexual Dysfunctions and Sociodemographic Characteristics among Married Couples

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Abstract

Background: Sexual dysfunction is a prevalent issue that affects the quality of life and marital satisfaction among couples. This study aims to explore the association of sexual dysfunction with various sociodemographic characteristics among married couples in Bangladesh.

Methods: This cross-sectional study was conducted in Shaheed Monsur Ali Medical College Hospital, Dhaka, Bangladesh during the period from January 2015 to 31st August 2015. A total of 49 married patients with substance use disorder were selected using purposive sampling. Data were collected using a structured questionnaire, DSM-5 criteria for substance use disorder, and the Bangla version of the Arizona Sexual Experience Scale (ASEX). Statistical analyses were performed using SPSS version 25.

Results: The study found that sexual dysfunction was significantly associated with age, gender, education, and occupation. Specifically, 22.22% of participants under 25 years, 44.44% of those between 25 to 40 years, and 33.33% of those over 40 years reported sexual dysfunction ($p=0.025$). Males reported a higher incidence (83.33%) compared to females (0%) ($p=0.04$). Sexual dysfunction was more common among illiterate participants (16.67%) compared to those with higher education levels ($p=0.04$). Farmers reported higher rates of sexual dysfunction (33.33%) compared to other occupations, though this was not statistically significant ($p=0.18$). Income, habitat, and family history of psychiatric illness did not show significant associations with sexual dysfunction.

Conclusion: The study underscores the significant impact of sociodemographic factors on sexual dysfunction among married couples in Bangladesh. Targeted interventions addressing these specific factors are essential for improving sexual health outcomes. Further research should aim to deepen the understanding of these associations and develop culturally appropriate strategies for prevention and management.

Introduction

Sexual dysfunctions, which encompass a variety of conditions such as erectile dysfunction, premature ejaculation, and low sexual desire, are significant health concerns that affect a considerable portion of the global population. Erectile dysfunction, defined as the consistent inability to achieve or maintain an erection sufficient for satisfactory sexual performance, and

premature ejaculation, characterized by ejaculation that occurs sooner than desired, affect millions of men worldwide. Hypoactive sexual desire disorder, a condition marked by a persistent lack of sexual interest, is also prevalent among both men and women. These conditions can have profound impacts on individuals' quality of life and marital relationships^{1,2}. Globally, sexual

dysfunctions are reported to affect approximately 43% of women and 31% of men, underscoring the widespread nature of these issues³. In developing countries, sexual health issues are often underreported and undertreated due to cultural, social, and economic factors. The stigma surrounding sexual health, compounded by limited access to healthcare and inadequate education, significantly hinders the proper management and treatment of these conditions⁴. In Bangladesh, cultural norms and beliefs play a crucial role in shaping sexual health behaviors. The influence of Islamic norms and values, which are deeply ingrained in the societal fabric, can perpetuate practices such as child marriage. This practice, often justified as a means to protect family honor and economic security, has severe implications for sexual health, particularly among young girls⁵. The societal expectation for women to conform to traditional gender roles further complicates the landscape of sexual health in Bangladesh. Women often face significant barriers to accessing sexual and reproductive health services, including societal stigma, restrictive gender norms, and economic dependency on male family members⁶. These barriers are exacerbated by the pervasive influence of patriarchal norms, which dictate that a wife should be sexually available to her husband, often regardless of her own desire or consent⁷. This cultural context not only limits women's autonomy but also increases their vulnerability to sexual dysfunctions and related health issues. Religious beliefs and societal expectations are deeply intertwined in Bangladesh, influencing both the perception and management of sexual health. Islamic teachings, which emphasize modesty and chastity, often discourage open discussions about sexual health, further contributing to the underreporting of sexual dysfunctions. Additionally, the societal pressure to maintain family honor can lead to the normalization of sexual violence within marriage, as seen in studies highlighting the prevalence of spousal abuse and its impact on women's sexual health⁸. The socio-cultural belief system, which often prioritizes male sexual satisfaction over female sexual health, creates a challenging environment for addressing these issues. Despite the high prevalence of sexual dysfunctions, there is a notable lack of research focusing specifically on these conditions among married couples in Bangladesh. Existing

studies tend to concentrate on broader reproductive health issues or the experiences of specific populations, such as adolescents or sex workers⁹. This gap in the literature highlights the need for more targeted research to understand the unique challenges faced by married couples in this cultural context. The influence of sociodemographic factors on sexual dysfunctions is well-documented. Factors such as age, education, income, and employment status significantly impact the prevalence and severity of these conditions. For instance, lower educational attainment and socioeconomic status have been linked to higher rates of sexual dysfunctions, as these factors often correlate with limited access to healthcare and health education¹⁰. In Bangladesh, the intersection of these sociodemographic challenges with cultural and religious norms creates a complex landscape for sexual health. In rural and marginalized communities, the lack of adequate sexual and reproductive health services further exacerbates the problem. Women in these areas often rely on traditional healers and herbal remedies due to the high cost of medical services and the stigma associated with seeking formal healthcare for sexual health issues¹¹. This reliance on non-scientific methods underscores the need for culturally sensitive health education programs that can address these gaps. The importance of marriage and sexual health in Bangladeshi culture cannot be overstated. Marriage is not only a social contract but also a critical determinant of social status and economic stability. Within this framework, sexual health plays a pivotal role in maintaining marital harmony and individual well-being. However, the cultural emphasis on preserving family honor and adhering to traditional gender roles often leads to the neglect of women's sexual health needs¹². In conclusion, sexual dysfunctions are a significant public health issue in Bangladesh, influenced by a complex interplay of cultural, social, and economic factors. The underreporting and undertreatment of these conditions highlight the urgent need for comprehensive research and culturally sensitive interventions. Addressing the unique challenges faced by married couples in Bangladesh requires a nuanced understanding of the cultural context and the development of targeted strategies to improve sexual health outcomes.

Methods

This cross-sectional study was conducted in Shaheed Monsur Ali Medical College Hospital, Dhaka, Bangladesh during the period from January 2015 to 31st August 2015. The study was divided into two phases: problem identification, literature review, protocol writing, questionnaire preparation, and pre-testing in the first phase; and data collection, analysis, and report writing in the second phase. Married patients with Substance Use Disorder (SUD) attending the clinic were selected through purposive sampling. Inclusion criteria included being diagnosed with SUD, being married and living with a partner for at least the last six months, and being aged between 18 and 65 years. Exclusion criteria were pre-existing sexual dysfunction before SUD, severe mental illness, certain medical conditions (e.g., endocrine, neurological, urological diseases, STDs), and medications causing sexual dysfunction. The sample size was 49 participants. Data were collected using a structured questionnaire and the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5), for diagnosing SUD, and the Bangla version of the Arizona Sexual Experience Scale (ASEX) for assessing sexual function. The DSM-5 provides standardized criteria for mental disorders, while ASEX measures sexual drive, arousal, erection/lubrication, ability to reach orgasm, and satisfaction with orgasm. ASEX scores range from 5 to 30, with higher scores indicating greater dysfunction. Sexual dysfunction was defined as a total ASEX score of 19 or more, a score of 5 or more on any item, or a score of 4 or more on three items. Data were processed and analyzed using SPSS version 25. Data were recorded, checked, verified, edited, coded, and entered into the computer. Categorical data were presented as frequency and percentage and compared using cross-tabulation and Chi-square (χ^2) test. A p-value of <0.05 was considered statistically significant. Ethical approval was obtained from the ethical review committee of Sylhet MAG Osmani Medical College. Informed written consent was obtained from all participants. They were informed about the study's nature, purpose, procedures, risks, and benefits, and assured of their right to

withdraw at any time. Confidentiality and anonymity were maintained throughout the study.

Results

The study included 49 participants with the majority (59.18%) falling within the age range of 25 to 40 years. A smaller proportion were under 25 years (18.37%) and over 40 years (22.45%). Most participants were male (93.88%), with only 6.12% being female. Regarding religious affiliation, 73.47% of the participants were Muslim, while 26.53% were Hindu.

Table 1: Sociodemographic characteristics distribution among the participants (N=49)

Variables	Number	Percentage (%)
Age		
<25	9	18.37
25 – 40	29	59.18
>40	11	22.45
Sex		
Male	46	93.88
Female	3	6.12
Religion		
Muslim	36	73.47
Hindu	13	26.53
Education		
Illiterate	4	8.16
Primary	18	36.73
Secondary	9	18.37
Higher secondary	9	18.37
Graduate and above	9	18.37
Occupation		
Farmer	8	16.33
Service	5	10.20
Business	14	28.57
Student	2	4.08
Unemployed	14	28.57
Others	6	12.24
Monthly income		
<3000	16	32.65
3000 - 20000	23	46.94
20000 - 40000	5	10.20
40000 - 60000	5	10.20
Habitat		
Urban	27	55.10
Rural	22	44.90
Family H/O psychiatric illness		
Present	5	10.20
Absent	44	89.80

Educationally, the participants were diverse: 8.16% were illiterate, 36.73% had primary education, 18.37% had secondary education, 18.37% had higher secondary education, and 18.37% were graduates or had higher qualifications. Occupationally, 16.33% were farmers, 10.20% were in service jobs, 28.57% were involved in business, 4.08% were students, another 28.57% were unemployed, and 12.24% were engaged in other occupations. In terms of monthly income, 32.65% earned less than 3000 BDT, 46.94% earned between 3000 and 20000 BDT, 10.20% had incomes ranging from 20000 to 40000 BDT, and 10.20% earned between 40000 and 60000 BDT. The participants were almost evenly split between urban (55.10%) and rural (44.90%) habitats. Finally, a family history of psychiatric illness was present in 10.20% of the participants, while 89.80% reported no such family history.

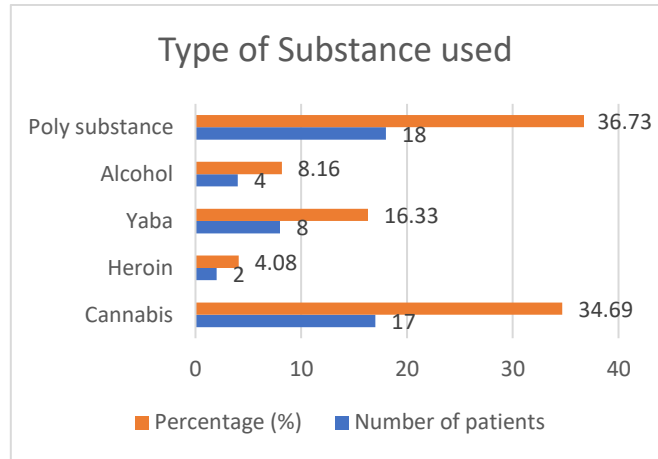


Figure 2: Distribution of participants by type of substance used (N=49)

Among the 49 participants, poly substance use was the most prevalent, with 36.73% (18 patients) reporting the use of multiple substances. Cannabis was the second most common substance, used by 34.69% (17 patients). Yaba, a methamphetamine-based drug, was used by 16.33% (8 patients), while alcohol was used by 8.16% (4 patients). Heroin use was reported by the smallest group, comprising 4.08% (2 patients).

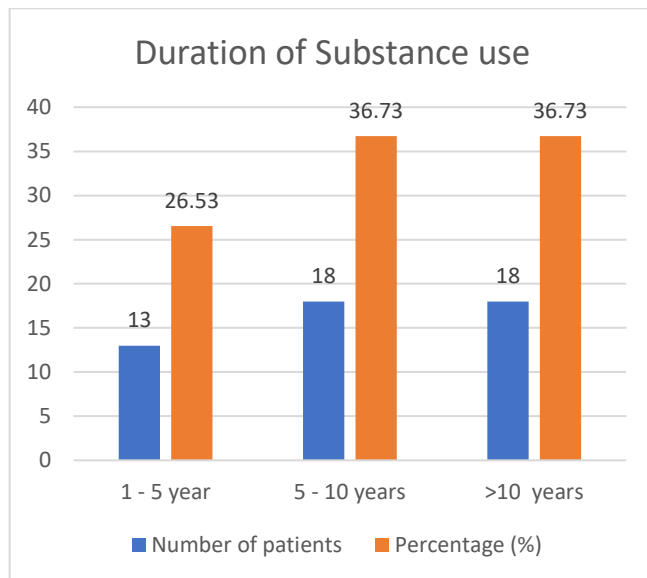


Figure 1: Distribution of patients by pre-operative signs and symptoms (n=60)

The distribution of the duration of substance use among the participants is illustrated in Figure 1. The study revealed that 26.53% of the participants had been using substances for a duration of 1 to 5 years, with a total of 13 patients in this category. A larger proportion, 36.73%, had a substance use duration of 5 to 10 years, accounting for 18 patients. Similarly, another 36.73% of the participants had been using substances for more than 10 years, also comprising 18 patients.

Table 2: Distribution of substance use treatment history among participants (N=49)

H/O treatment	Number	Percentage (%)
Yes	24	48.98
No	25	51.02

Out of the 49 participants, 48.98% (24 patients) had a history of receiving treatment for substance use, while 51.02% (25 patients) had not received any treatment prior to the study.

Figure 3 illustrates the distribution of participants by the incidence of sexual dysfunction. Among the 49 participants, 36.73% (18 patients) reported experiencing sexual dysfunction, while 63.27% (31 patients) did not report any sexual dysfunction. Regarding age, 22.22% of participants under 25 years reported sexual dysfunction, compared to 16.13% who did not, showing a significant association (p=0.025).

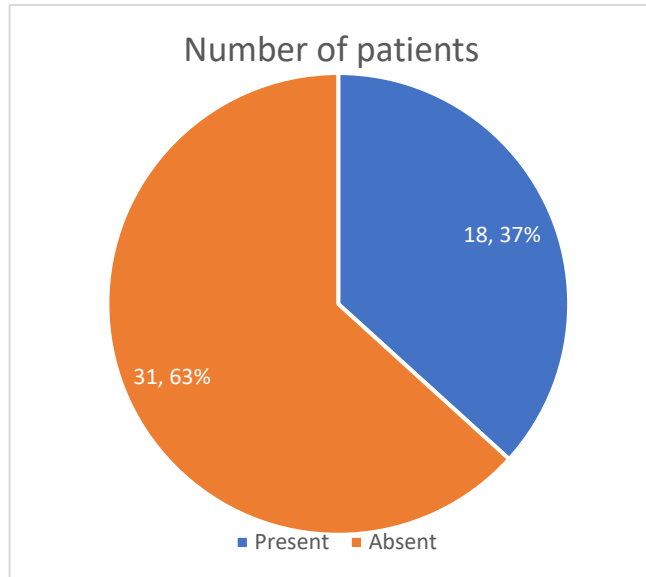


Figure 3: Distribution of participants by incidence of sexual dysfunction (N=49)

Among those aged 25-40, 44.44% reported sexual dysfunction, while 67.74% did not. In the >40 age group, 33.33% experienced sexual dysfunction compared to 16.13% who did not. Sex differences showed that 83.33% of males experienced sexual dysfunction, while none of the females reported it, indicating a significant difference ($p=0.04$). For religion, 61.11% of Muslims had sexual dysfunction compared to 80.65% without, and 38.89% of Hindus had sexual dysfunction compared to 19.35% without, though this was not statistically significant ($p=0.12$). Education level indicated that 16.67% of illiterate participants had sexual dysfunction compared to 3.23% without, with a significant association ($p=0.04$). Participants with primary education constituted 50% of those with sexual dysfunction versus 29.03% without. Secondary education showed no instances of sexual dysfunction, compared to 29.03% without. Higher secondary education showed 22.22% with sexual dysfunction versus 16.13% without, and graduate-level education had 11.11% with sexual dysfunction compared to 22.58% without. Occupationally, 33.33% of farmers reported sexual dysfunction versus 6.45% without. Service workers had 11.11% with sexual dysfunction compared to 9.68% without. Business workers showed 16.67% with sexual dysfunction versus 35.48% without.

Table 3: Association of Sexual dysfunction with sociodemographic characteristics (N=49)

Variables	Sexual Dysfunction present (n=18)	Sexual Dysfunction Absent (n=31)	p-value
	n %	n %	
Age range of the patients			
<25	4 (22.22)	5 (16.13)	0.025
25 – 40	8 (44.44)	21 (67.74)	
>40	6 (33.33)	5 (16.13)	
Sex of the patients			
Male	15 (83.33)	31 (100.00)	0.04
Female	3 (16.67)	0 (0.00)	
Religion of the patients			
Muslim	11 (61.11)	25 (80.65)	0.12
Hindu	7 (38.89)	6 (19.35)	
Education of the patients			
Illiterate	3 (16.67)	1 (3.23)	0.04
Primary	9 (50.00)	9 (29.03)	
Secondary	0 (0.00)	9 (29.03)	
Higher secondary	4 (22.22)	5 (16.13)	
Graduate and above	2 (11.11)	7 (22.58)	
Occupation of the patients			
Farmer	6 (33.33)	2 (6.45)	0.18
Service	2 (11.11)	3 (9.68)	
Business	3 (16.67)	11 (35.48)	
Student	0 (0.00)	2 (6.45)	
Unemployed	5 (27.78)	9 (29.03)	
Others	2 (11.11)	4 (12.90)	
Monthly income of the patients			
<3000	5 (27.78)	11 (35.48)	0.18
3000 - 20000	11 (61.11)	12 (38.71)	
20000 - 40000	2 (11.11)	3 (9.68)	
40000 - 60000	0 (0.00)	5 (16.13)	
Habitat of the patients			
Urban	10 (55.56)	17 (54.84)	0.6
Rural	8 (44.44)	14 (45.16)	
Family H/O psychiatric illness			
Present	2 (11.11)	3 (9.68)	0.61
Absent	16 (88.89)	28 (90.32)	

There were no students with sexual dysfunction compared to 6.45% without. Unemployment showed 27.78% with sexual dysfunction versus 29.03% without. Other occupations had 11.11%

with sexual dysfunction versus 12.90% without, though this was not statistically significant ($p=0.18$). Monthly income showed that 27.78% of those earning less than 3000 BDT had sexual dysfunction compared to 35.48% without. Those earning 3000-20000 BDT included 61.11% with sexual dysfunction versus 38.71% without. For the 20000-40000 BDT range, 11.11% had sexual dysfunction compared to 9.68% without, and none in the 40000-60000 BDT range had sexual dysfunction compared to 16.13% without, though this was not statistically significant ($p=0.18$). Habitat differences indicated that 55.56% of urban residents had sexual dysfunction compared to 54.84% without, and 44.44% of rural residents had sexual dysfunction compared to 45.16% without, showing no significant association ($p=0.6$). A family history of psychiatric illness was present in 11.11% of those with sexual dysfunction compared to 9.68% without, indicating no significant difference ($p=0.61$).

Discussion

The current study examined the association of sexual dysfunction with sociodemographic characteristics among married couples in Bangladesh. The findings revealed significant associations with age, gender, education, and occupation, but not with income, habitat, or family history of psychiatric illness. These results highlight the complex interplay of various sociodemographic factors on sexual health. Age was a significant factor in the prevalence of sexual dysfunction, with the highest rates observed among participants aged 25 to 40 years (44.44%) compared to those under 25 years (22.22%) and over 40 years (33.33%). This pattern aligns with global trends indicating that sexual dysfunction often peaks in midlife due to increased stress and health issues during these years¹³. The higher prevalence among middle-aged participants may reflect the cumulative impact of chronic health conditions and psychological stressors common in this age group. Gender differences were stark, with 83.33% of males reporting sexual dysfunction compared to none of the females, a statistically significant disparity ($p=0.04$). This finding contrasts with some global studies that report significant rates of sexual dysfunction among

women as well, often linked to relationship stress and mental health issues¹⁴. The absence of reported dysfunction in females in this study might be attributed to underreporting due to cultural stigmas surrounding female sexuality in Bangladesh. Educational status also significantly influenced the prevalence of sexual dysfunction. Illiterate participants reported higher rates of dysfunction (16.67%) compared to those with higher education levels. This finding corroborates studies showing that higher educational attainment is associated with better sexual health outcomes due to increased health literacy and access to health information¹⁵. Educated individuals may also have better communication skills to address sexual health issues with their partners and healthcare providers. Occupational status revealed that farmers had higher rates of sexual dysfunction (33.33%) compared to other occupations, though this was not statistically significant ($p=0.18$). Occupational stress and physical labour associated with farming might contribute to higher dysfunction rates, as supported by research indicating that job-related stress impacts sexual health¹⁶. Income did not significantly affect the incidence of sexual dysfunction, though participants with a monthly income of less than 3000 BDT reported higher dysfunction rates (27.78%). Economic strain can affect mental health and well-being, which are closely linked to sexual health¹⁷. However, in this study, the lack of significant association might suggest that other factors, such as education and occupation, play a more direct role in sexual health outcomes. Habitat did not show a significant difference in sexual dysfunction rates between urban (55.56%) and rural (44.44%) residents, indicating that environmental factors might not be as influential as individual sociodemographic characteristics. This finding contrasts with some studies that report higher dysfunction rates in rural areas due to limited access to healthcare and information¹⁸. Finally, a family history of psychiatric illness did not significantly impact sexual dysfunction prevalence ($p=0.61$). This aligns with findings from studies showing that while a family history of mental health issues can influence general health outcomes, its direct impact on sexual dysfunction may be less pronounced¹⁹. In conclusion, the study underscores the multifaceted nature of sexual dysfunction among married

couples in Bangladesh, highlighting the significant roles of age, gender, education, and occupation. These findings suggest the need for targeted interventions that consider these sociodemographic factors to effectively address and manage sexual dysfunction. Further research should explore these associations in more depth, particularly focusing on cultural and societal influences that may affect the reporting and management of sexual health issues.

Limitations of The Study

The study was conducted in a single hospital with a small sample size. So, the results may not represent the whole community.

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Conflict of interest: None declared

Ethical approval: The study was approved by the Institutional Ethics Committee

Conclusion

The present study reveals that sexual dysfunction is significantly associated with age, gender, education level, and occupation among married couples in Bangladesh. The findings indicate that middle-aged participants, males, and those with lower educational attainment are more likely to experience sexual dysfunction. Occupational stress, particularly among farmers, also contributes to higher dysfunction rates. While income and habitat did not show significant associations, the overall prevalence underscores the multifaceted nature of sexual health issues in this population. These insights highlight the necessity for targeted interventions and educational programs to address sexual health, tailored to the specific sociodemographic factors identified. Further research is warranted to explore these associations in greater depth and to develop culturally sensitive strategies for prevention and treatment.

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