Original Article

Sexual Dysfunctions in Rural Population as Indicators of Psychiatric and Addiction Problems

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Abstract

Introduction: Sexual response is a psychosomatic process. Sexual dysfunctions are very common among people, but most of these cases remain undetected due to lack of awareness. Patient acquired knowledge related to sexual functioning from newspapers, magazines, friends, and from roadside information which may be misinterpreted by patient leading to exacerbation of pre-existing anxiety related to sexual functioning.

Aims and Objectives: Assessment of sexual dysfunctions and co-morbid illnesses in patients with primary presenting complaints of sexual problems in a rural area.

Materials and Methods: The study was carried out at psychiatry outpatient department (OPD) of tertiary care centre in a rural area. Patients came with primarily with sexual problems were informed regarding the study, and their consent was taken. Socio-demographic profile of patients noticed in semi-structured performa. Then detail clinical history and examination diagnosis of problems were made according to ICD 10 DCR. After that patients with suspected medical or surgical co-morbidities were referred for management of respective ailments.

Result: Of all subjects 87% patients were male. The mean total duration of sexual symptoms was 19.7 months. 52% of the patients visited OPD within a year of presenting sexual symptoms. Major sexual dysfunctions were premature ejaculation (PME) (26%), low libido (26%), PME + erectile dysfunction (22%), and Dhat secretion (22%). Common psychiatric morbidities were mild depression (30%), generalized anxiety disorder (26%), mixed anxiety depression (22%), and nicotine dependence (28%). Only 17% of subjects did not have any psychiatric morbidity and found to have only medical morbidity along with sexual dysfunction.

Conclusion: Psychiatric co-morbidity is common in patients presenting with sexual dysfunctions. Patient with psychiatric and addiction problems may present primarily with sexual problems especially in a rural population. Addressing excessive worry related to sexual functions and treatment of co-existing psychiatric illness is important in treatment planning of such cases.

Keywords: Anxiety, Co-morbidities, Depression, Erectile dysfunction, India, Premature ejaculation, Rural, Sexual dysfunction

INTRODUCTION

Sexual dysfunction covers the various ways in which an individual is unable to participate in a sexual relationship as he or she would wish. There may be a lack of interest, lack of enjoyment, failure of the physiological responses necessary for effective sexual interaction (e.g., erection), or inability to control or experience orgasm.

Sexual response is a psychosomatic process; and both psychological and somatic processes are usually involved in the causation of sexual dysfunction. It may be possible to identify an unequivocal psychogenic or organic etiology, but more commonly, particularly with such problems as erectile failure or dyspareunia, it is difficult to ascertain the relative importance of psychological and/or organic factors. In such cases, it is appropriate to categorize the condition as being of either mixed or uncertain etiology.[1]

Misinterpretation of Sexual Dysfunctions

Sexual disorders are among the most prevalent psychological disorders in the general population. Sexual dysfunctions though being very common among people, still a large number of cases remain undetected. Its reason can be

attributed to the conservative Indian society. Due to this, vulnerable people trying to seek knowledge regarding sexual functioning approach easily accessible inappropriate sources available in the market. Resulting in people getting sexually educated through highly unreliable sources namely newspapers, magazines, peer group, or from roadside information, which can be easily misinterpreted, thus exacerbating pre-existing anxiety related to sexual functioning and performance.

Verma *et al.* (1998) analyzed data on 1000 consecutive patients' sexual disorders at All India Institute of Medical Sciences attending the psychosexual clinic. They found premature ejaculation (PME) (77.6%) and nocturnal emission (71.3%) frequent problems followed by a feeling of guilt about masturbation (33.4%), small size of the penis (30%), and erectile dysfunction (ED) (23.6%). Excessive worry about nocturnal emission, abnormal sensations in the genitals, and venereophobia was reported in 19.5%, 13.6%, and 13% of patients, respectively.[2]

Nakra *et al.* (1977) studied sexual disorders in 150 male referred patients with the primary complaint of disorder of potency considered to be psychogenic of a teaching general hospital. About three-fourth of the patients who masturbated developed potency disorders and guilt associated with masturbation was found in about 43%. Nocturnal emission was found in 95% of the patients and adolescent homosexual contacts in 16% and among 69% and 39%, respectively, had feelings of guilt with it. 64% of the subjects considered loss of semen to be harmful.[3]

These two studies correspond to the saying "Little knowledge is a dangerous thing." Thus, there is a need to make people aware about "What actually is meant by sexual dysfunction," "What are the symptoms," "When should they report to psychiatrist for consultation," etc. It's time that haze of misconceptions from common man's mind should be cleared, and they should be provided with authentic knowledge about the sexual functions.

Common Sexual Dysfunctions

Avasthi *et al.* (1994) did a study, 66 male patients with psychosexual dysfunction with respect to sociodemographic and clinical variables. Respectively, 30% of patients reported of ED, 12% of PME, 45% combination of ED and PME, and 9% of Dhat syndrome.[4]

Gupta *et al.* (2004) clinically assessed 150 patients attending dermatology outpatient department (OPD) for psychosexual problems. The most common among them was ED (34%) followed by PME (16.6%), Dhat syndrome (15.3%), and nocturnal emission (14%).[5]

Sexual Dysfunctions and Co-morbidities

Patients presenting primarily with sexual dysfunctions often have associated co-morbidity. Association of depression and sexual dysfunctions is quiet common. Loss of libido is frequently and consistently associated with major depression.[6]

Sexual dysfunction is especially common among people who have anxiety disorders. In some cases, very first presentation of anxiety-related problems is as a case of sexual dysfunction. For instance, a patient with generalized anxiety may first clinically present as a case of performance anxiety or ED. Pain during intercourse is often a co-morbidity of anxiety disorders among women.[7]

Above two studies highlight the importance of assessment and treatment of co-morbidities while planning management of sexual dysfunctions. In many cases, treating underlying co-morbidity has been successful in alleviating symptoms related to sexual activity. Treating underlying co-morbidity also hastens the treatment process.

MATERIALS AND METHODS

Objective of the Study

The aim of the study was to assess sexual dysfunctions and its relationship with associated co-morbid illness in patients primarily presenting with sexual problems.

Methodology of the Study

The study was conducted on patients presenting primarily with sexual problems in OPD of tertiary care center situated in a rural area of India, after taking ethical committee clearance. Other departments were informed to send the patient with sexual disorders to psychiatry OPD for assessment and treatment. The subjects of study were 54 newly registered male and female patients presenting primarily with sexual problems and who gave consent to be part of the study. Patients who are known case of psychiatric illnesses were excluded from the study.

A semi-structured performa was used in the study to record socio-demographic profile of patients. Clinical interviews and examinations were conducted by consultant psychiatrists to assess sexual dysfunctions and presence of psychiatric illness. Appropriate data needed for the study were collected. After that patients with suspected medical or surgical co-morbidities were referred for management of respective ailments and feedback regarding medical or surgical problems recorded from other consultants.

The data collected during the study were entered in the Microsoft excel format and were analyzed using SPSS

10 version Microsoft software Statistical Package for the Social Sciences (SPSS-IBM). Frequency distribution for categorical variables and measures of mean along with a standard deviation for continuous variables were calculated.

RESULTS

Results of the Study

Most of the referral cases (70%) received from dermatology, general surgery, and general medicine departments. Only few cases (30%) came directly to psychiatry OPD. The result of this study states that the mean age of the total subjects of the study visiting for consultation (irrespective of their sex) was 31.85 years (Table 1) with 85% of them between 20 and 40 years of age group (Table 2). 87% of total subjects were males (Table 3).

The mean total duration of sexual symptoms was 19.7 months (Table 4). 52% of the patients visited OPD within a year of presenting symptoms and 40% within 1-5 years (Table 5). Major sexual dysfunctions were PME (26%), low libido (26%), PME + ED (22%), Dhat secretion (22%), and ED (4%) (Table 6).

Common psychiatric morbidities were mild depression (30%), generalized anxiety disorder (26%), mixed anxiety depression (22%), and nicotine dependence (28%). Only 17% of subjects did not have any psychiatric or addiction morbidity (Table 7). Even in patients who were not having any psychiatric or addiction problem frequently had misconceptions related to sexual functioning, penis size, semen consistency, and masturbation.

Approximately, 83% of the patients did not have any physical morbidity. Around 15% of subjects had hypertension or diabetes (Table 8). Nine patients have more than one co-morbidity (psychiatric, addiction, or medical).

Table 1: Age of the study patients

Duration	Minimum	Maximum	Mean
Age (in years)	21.5	55	31.8

Table 2: Age group distribution of study patients

Age groups	Frequency	Percentage
20-30	31	57.4
30-40	15	27.8
40-50	4	7.4
50-60	4	7.4
Total	54	100

Table 3: Sex distribution of the study patients

Status	Frequency	Percentage
Male	47	87
Female	7	13
Total	54	100

Table 4: Duration of sexual symptoms

Duration	Minimum	Maximum	Mean	Standard deviation
Time (in months)	2	60	19.7	14.1

Table 5: Group distribution of duration of sexual symptoms

Duration	Frequency	Percentage
<1 year	28	52
1-5 year	22	40
>5 year	4	7
Total	54	100

DISCUSSION

In this study, mean age of patients was 32 years, stating that sexual dysfunctions are common among middle adulthood. The results also highlight that more than 80% were married

Table 6: Sexual dysfunctions in study patients

Diagnosis	Frequency	Percentage
PME	14	26
PME+ED	12	22
ED	2	4
Low libido	14	26
Dhat secretion	12	22
Total	54	100

PME: Premature ejaculation, ED: Erectile dysfunction

Table 7: Psychiatric morbidities in study patients

Diagnosis	Frequency	Percentage
Mild depression	16	30
Generalized anxiety disorder	14	26
Mixed anxiety and depressive disorder	12	22
Nonorganic vaginismus	3	5.5
Nicotine dependence	15	28
Harmful use of health supplements (containing caffeine)	3	5.5
Alcohol dependence	2	3.7
No psychiatric or addiction morbidity	9	17

Table 8: Physical morbidities in study patients

Diagnosis	Frequency	Percentage
Amenorrhea	1	1.85
Phimosis	1	1.85
Hypertension	4	7.4
Diabetes	4	7.4
No physical morbidity	45	83

men stating that sexual dysfunctions are mostly diagnosed during married life or phase of being sexually active.

Of all patients, 51% of the patients report to doctors within a year of appearing symptoms but at the same time, the average duration of symptoms was around 20 months. This inconsistency may be because of poor response to treatment of the primary doctor, hesitancy in referring patients to specialist or treatment by quacks. The reason may be any but ultimately it's the patient at losing end. This brings in the importance of taking sexual history, same time focusing on co-morbidities.

Major sexual dysfunctions included PME, low libido, PME + ED, Dhat syndrome, and ED, which are similar to findings of Avasthi *et al.* (1994).[4]

There are common risk factor categories associated with sexual dysfunction for men and women which include the following: General health status of the individual, the presence of diabetes mellitus, the presence of cardiovascular disease, concurrence of other genitourinary disease, psychiatric/psychological disorders, other chronic diseases, and sociodemographic conditions.[8]

In our study, psychiatric morbidities such as anxiety and depressive disorders are common with sexual dysfunctions similar to studies of Bartlik *et al.* (1999) and Coretti and Baldi (2007).[6,7] Sexual response is a psychosomatic process.[1] Hence, treatment of psychological co-morbidities will bring improvement in disorders of sexual response. It may also reduce the duration of treatment and improve treatment outcome for sexual dysfunctions.

Wig (1960), coined the term "Dhat syndrome," characterized by vague somatic symptoms and guilt attributed to semen loss through nocturnal emissions, urine and masturbation though there is no evidence of loss of semen.[9] This "semen loss" related psychological distress has been extensively reviewed by Prakash (2007).[10] In our study, 22% subject were suffering from Dhat syndrome unlike study done by Gupta *et al.* (2004), who found 15.3% of study subjects suffering from Dhat syndrome.[5] Which may be explained by predominant rural population in our study. For the treatment of Dhat syndrome Chadda and Ahuja (1990) advocated psycho-education and culturally informed cognitive behavioral therapy.[11] Bhatia and Malik (1991) found anti-anxiety and anti-depressant drugs better as compared to psychotherapy.[12]

There is a lack of research in identifying the prevalence of psychiatric, addiction, surgical, and medical problems-related risk factors in patients primarily presenting with sexual dysfunctions. One study found that working on modifiable risk factors such as obesity and sedentary lifestyle significantly improve ED in 40-70 years of the male population.[13] There is a need to identify risk factors in patients primarily presenting with sexual dysfunction and response after control in modifiable risk factors with further studies.

CONCLUSION

Psychiatric and addiction morbidities are common in patients presenting with sexual dysfunctions. In the treatment, focus should be on cause of the sexual dysfunctions and co-morbidities, which can be psychological, medical, or combined (psychological and medical) in origin.

In India, due to lack of knowledge and stigma especially in a rural population, people do not seek a consultation for psychiatric and addiction problems. But same time, sexual symptoms, which are common with psychiatric and addiction problems, bring them for medical attention. Thus, psychiatric referral provides a unique opportunity for evaluation and treatment of such cases. It may also save patient money and time by minimizing required investigations.

Sometimes, it is a combination of psychiatric, addiction, and medical problems, which lead to sexual problems in patient. Such cases are therapeutic challenge for physicians, if not assessed and treated for co-morbid illnesses properly. It is better to have some designated referral department for such patient in hospitals, where they can be assessed and treated for psychiatric problems.

In India, many Government Medical College run Marital and Sexual Clinic in Psychiatry Department, but such designated department or services are frequently lacking in private hospitals. Considering the high prevalence of psychiatric and addiction co-morbidities, such cases can be referred for a psychiatrist opinion for better therapeutic outcomes.

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