and not be left behind in the competition, he has pushed his sexual urges and needs to the bottom of his priority list; however when a need to perform arises, he might be faced with the biggest shock of his life, a sexual dysfunction!

A sexual dysfunction can arise as a result of biological problems, relationship problems, lack of proper sexual knowledge or a combination of these. India is often known as the land of Kamasutra. But as far as sexuality research is concerned, there is a paucity of relevant data from India. In view of this, we conducted a study to assess the psychosocial profile of males presenting with sexual dysfunction to psychiatry out-patient department of a tertiary medical hospital.

Materials and Methods: Hundred consecutive male patients presenting with sexual dysfunction were screened using Arizona Sexual Experiences Scale for clinical sexual dysfunction and after obtaining their informed consent were included in this study. They were assessed using a semi-structured proforma, Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision criteria, Mini-International Neuropsychiatric Interview, and Dyadic Adjustment Scale.

Results: Majority of our respondents were in the 18–30 years age group and were married. The main source of sex knowledge for 69% of them was peer group. Age of onset of masturbation was 11–13 years for 43% of them. Premature ejaculation was the most common sexual dysfunction seen in the respondents. Marital discord was seen in significantly lesser number of respondents (32.35%) as also major depressive disorder that was seen in only 16%.

Discussion: Premature ejaculation was the most common sexual dysfunction in our sample. Despite the sexual dysfunction, marital discord and depression were seen less commonly in our respondents.

Key words: Erectile dysfunction, male sexual dysfunction, marital discord, premature ejaculation, psychiatric co-morbidity

ABSTRACT

Introduction: Sexual dysfunction can occur due to biological problems, relationship problems, lack of proper sexual knowledge or a combination of these. India is often known as the land of Kamasutra. But as far as sexuality research is concerned, there is a paucity of relevant data from India. In view of this, we conducted a study to assess the psychosocial profile of males presenting with sexual dysfunction to psychiatry out-patient department of a tertiary medical hospital.

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INTRODUCTION

Human sexuality is clearly set apart from that of most other animals in being relatively separate from mere reproduction. Thus for humans, sex obviously plays a wider sociobiological function than mere production of an offspring. An individual’s sexuality is influenced to a large extent by his or her personality traits, the biological makeup, by life circumstances, by one’s relationship with others and by the culture in which one lives.[1] Man’s evolution and progress have brought along with it, a variety of stresses. In a marathon to win against others

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How to cite this article: Kalra G, Kamath R, Subramanyam A, Shah H. Psychosocial profile of male patients presenting with sexual dysfunction in a psychiatric outpatient department in Mumbai, India. Indian J Psychiatry 2015;57:51-8.
today occur with a frequency that would overwhelm the health services if they all presented for help.\textsuperscript{2} Unfortunately, this aspect of human development and functioning has received very little attention from researchers in India. Sexual problems, despite being prevalent have been accorded low priority; physicians either show no interest or tend to ignore patients’ psychosexual complaints.\textsuperscript{3} There are no reliable estimates of sexual disorders, and even basic clinical data are not available from India. This area of psychosexual research in India suffers from a general inhibition on the part of the sufferers to seek medical help and indifference on the part of researchers to study these problems.\textsuperscript{4}\textsuperscript{4} In an attempt to contribute to this lacuna in Indian sexuality research, we did a study on male sexual dysfunction.

\section*{MATERIALS AND METHODS}

The study was a cross-sectional, single interview study that was approved by the Institutional Review Board. It was conducted at the psychiatry outpatient department (OPD) of a tertiary care medical hospital. The psychiatry department had a daily general OPD (of about 20 new cases and 80 follow-up cases) which also included patients of sexual dysfunction accessing psychiatric services. The approximate number of patients presenting with sexual dysfunction varied from 1 to 3 cases per OPD. All interviews were conducted by the first author.

\subsection*{Respondents}

Hundred consecutive male patients presenting to the psychiatric OPD with complaints of sexual dysfunction were screened on Arizona Sexual Experiences Scale (ASEX) for clinically significant sexual dysfunction. Patients between the age group of 18 and 50 years were briefed about the study and recruited after obtaining their informed consent. Patients with co-existing medical illness or evidence of organic etiology on history or clinical examination were excluded from the study. The age range in our sample was 18–50 years with 53% respondents being 18–30 years of age, 33% being 31–40 years of age and 14% being 41–50 years of age. 75% of them were educated from primary school to postgraduate level. In the case of illiterate respondents, questionnaires were read out to them by the first author and their responses were recorded. About 62% of the respondents were married, 32% were unmarried and 6% were divorced at the time they participated in the study. Hinduism was a majority religion (69%); there were also Muslims (29%) and Christians (2%) among the respondents.

\subsection*{Instruments}

\textit{Self-constructed semi-structured pro forma}

It included details about sociodemographic profile, childhood history, family history, past history, and substance use history.

\textit{The Arizona Sexual Experiences Scale}

Was developed by the Department of Psychiatry and Psychology at the University of Arizona and the Department of Psychiatry and Behavioral Sciences, Stanford University. It is designed to measure 5-item identified as core elements of sexual function. These elements are sexual drive, arousal, penile erection/vaginal lubrication, ability to reach orgasm, and satisfaction from orgasm. The items are rated on a 6-point Likert scale ranging from 1 (hyperfunction) to 6 (hypofunction). Possible total scores range from 5 to 30 with higher scores indicating more sexual dysfunction.\textsuperscript{5}\textsuperscript{5} The scale has two versions, one for males and one for females, with a difference in question 3 that references penile erections versus vaginal lubrication. The scale may be used to assess current levels of sexual dysfunction or to monitor changes in sexual dysfunction over time following clinical interventions. A total score of \textgreater{}18 on the ASEX or a score of 5 (very difficult) or greater on any one item is associated with clinical sexual dysfunction. Only patients who had clinical sexual dysfunction (on ASEX) were included in our study. The scale has an excellent internal consistency and reliability with a Cronbach’s alpha of 0.9055 and a strong test-retest reliability. It has very good validity, and the items correlate relatively well with the items of other scales like the Brief Index of Sexual Functioning.\textsuperscript{3}\textsuperscript{3}

The ASEX was used in our study as it is a very user-friendly scale that is short unlike the more traditional and lengthy scales for assessing sexual dysfunctions. It is easy to understand, score and interpret with less intrusive questions. It can be used for both heterosexual and homosexual populations and even for those without sexual partners.

\textit{Diagnostic and Statistical Manual of Mental Disorders, 4\textsuperscript{th} Edition, Text Revision diagnostic criteria}

Diagnostic and Statistical Manual of Mental Disorders, 4\textsuperscript{th} Edition, Text Revision (DSM-IV TR) was used to assess the respondents for the diagnosis of sexual dysfunction. The Mini International Neuropsychiatric Interview (MINI)\textsuperscript{6}\textsuperscript{6} was used as a brief structured interview for diagnosis of psychiatric disorders specifically depression. MINI can be administered over a short period and is divided into modules corresponding to diagnostic categories from the DSM-IV TR.

\textit{Dyadic Adjustment Scale}

Devised by Spanier\textsuperscript{7}\textsuperscript{7} it is a 32-item self-report measure with a good reliability and has been used in many research studies with a variety of couples (married, co-habiting, homosexual and divorced) indicating good validity. It is a frequently used instrument for measuring adjustment in relationships. Its primary distinction from other adjustment scales is its being multidimensional. The person taking this test can obtain a score from 0 to 151. Higher the score, better is the person’s adjustment in marriage or a relationship. It measures four dimensions of marital
There are no norms available for Indian population. For this study, DAS was translated in Hindi by using the method of back-translation to ensure equivalence of meanings and to include non-English speaking subjects. If precisely translated, a questionnaire in different languages would presumably be the most effective means for obtaining accurate data for crosscultural studies. However, there may be a question if the translated instrument measures exactly the same thing in a new language, especially when used within a different cultural context to that in which it originated and has been tested.

Data was pooled and statistical analysis was done using descriptive statistics and Chi-square test using SPSS version 16.

RESULTS

A total of 100 male patients in the age range 18–50 years participated in this study.

Sociodemographic and other patient-related variables

These are discussed in the section of respondents above. 84% of our respondents were heterosexual oriented, while others were homosexually (3%) or bisexually (5%) oriented. Around 8% had a history of casual homosexual contact, but identified themselves as heterosexual. Orientation was assessed by directly questioning the respondents in the interview. Apart from this, 72% of respondents sought consultation by themselves while 28% were asked by their partners to seek help for their sexual dysfunction. 52% of respondents had not taken any treatment prior to consultation with the psychiatry department; 31% had taken some alternative treatment for their dysfunction that included Ayurvedic and other herbal treatments whereas 17% had taken some allopathic treatment for the same. Majority of the respondents had no present (63%) or past (87%) use of the substance. None of the respondents had a present or history of substance use in abuse or dependence pattern.

Parental variables in childhood

Ninety percent of respondents perceived that their parents were conservative with 57% of them belonging to father dominant families. Other details can be seen in Table 1. About 11% of the respondents had some history of psychiatric illness in their families.

Sexual and relationship history

For a majority of the respondents, main source of their knowledge of sex was from their peer group (69%), while books were a source for only 27% and media (including print and television) for 4%. Around 43% of our respondents started masturbating by the age of 11–13 years. About 10% refused to have masturbated all in their childhood. Around 14% of our respondents had been prohibited by their parents or other elders from masturbating at some point of time, while 8% had received some sort of punishment for being caught during the act of masturbating. Masturbation was continuing at a frequency of “once per day” in about 52% of our respondents while 21% reported a “weekly” frequency, and 17% reported “more than once per day” frequency. Of all the respondents who were married at the time of this study, 17% had a history of postmarital masturbation. Masturbatory guilt was reported by 51% and was assessed by direct questioning.

The most common sexual dysfunction in our sample was premature ejaculation (PME) [Table 2]. Respondents in the younger age group (18–30 years) suffered more from PME (58.5%) compared to other age groups. PME was reported significantly more (71.4%) in respondents belonging to higher socioeconomic strata (Chi-square value 13.045; P = 0.011). Respondents with PME were more likely to have been asked by their spouse (64.3%) to seek help for

| Table 1: Parental variables in patient’s childhood |
|--------------------------------------------------|
| **Percentage**                                  |
| Parental attitude                               |
| Conservative                                    | 90 |
| Open                                            | 10 |
| Parenting                                       |
| Mother dominant                                 | 25 |
| Father dominant                                 | 57 |
| Equal-dominance                                 | 18 |
| Parent conflict                                 |
| Yes                                             | 29 |
| No                                              | 71 |
| Parental substance use                          |
| Yes                                             | 27 |
| No                                              | 73 |

| Table 2: DSM-IV-TR diagnosis of the patients      |
|--------------------------------------------------|
| **Percentage**                                  |
| Sexual dysfunction on DSM-IV-TR                 |
| PME                                             | 55 |
| ED                                              | 27 |
| ED+PME                                          | 18 |
| Total                                           | 100 |

Chi-square value (one-way classification, medcalc software V9)=22.340; P<0.0001. PME - Premature ejaculation; ED - Erectile dysfunction; DSM-IV-TR - Diagnostic and statistical manual of mental disorders fourth edition text revision.
their problem compared to respondents who had erectile dysfunction (ED) (21.4%) \( (P = 0.5) \). Older respondents (41–50 years) suffered more with both ED and PME (42.9%).

About 52% respondents attributed their past habit of masturbation to their current sexual dysfunction, while 14% attributed it to stress in their life [Figure 1].

Of the 68 respondents who were administered the DAS, a significantly higher percentage \((n = 46; 67.64\%)\) did not show any marital discord compared to a smaller percentage \((n = 22; 32.35\%)\) of those who had discord \( (\text{Chi-square value} = 10.023; P = 0.04) \) and those who were currently using substance \((55.6\%)\) \( (\text{Chi-square value} = 11.015; P = 0.001) \). Marital discord was also reported significantly higher \((60\%)\) in respondents with a past history of substance use \( (\text{Chi-square value} = 4.095; P = 0.04) \).

**Psychiatric morbidity**

Only 24% of the respondents had comorbid depressive disorders, while the rest did not. Depressive disorders included major depressive disorder (16%), adjustment disorder with depressed mood (6%), and dysthymia (2%). However, none of the patients were on antidepressants. Rest of the respondents did not meet DSM-IV-TR criteria for any other psychiatric disorders. A significantly \((P = 0.01)\) higher percentage of patients with PME \((58.3\%)\) had depressive disorders compared to those with ED \((41.7\%)\).

Depressive disorders were significantly found in those respondents \((41.4\%)\) who reported parental conflict in their childhood compared to those who did not report of such conflict \((16.9\%)\) \( (\text{Chi-square value} = 6.764; P = 0.009) \). Respondents who had the guilt due to their habit of masturbation in the past were more likely to be depressed \( (\text{Chi-square value} = 8.407; P = 0.004) \).

**DISCUSSION**

Findings from the present study focus on male sexual dysfunction presenting to the psychiatric OPD. Most of our respondents who participated in the study were in the 18–30 year’s age group and the majority of them were married. Majority of our respondents were heterosexually oriented. Some also identified as homosexual (3%) or bisexual (5%) on self-reporting. The most common method of assessing sexual orientation for research is through self-reported label,\(^{[12]}\) which has received some support as a valid measure.\(^{[13]}\) Similar rates of homosexual orientation were reported by Chandra et al.,\(^{[14]}\) \((2–4\%)\) and Janus and Janus\(^{[15]}\) \((4\%)\). Rates of bisexual orientation were however higher in our sample than that reported by Chandra et al.,\(^{[14]}\) \((1–3\%)\) in their sample of 13,495 men. Around 8% of our respondents had a history of casual homosexual contact at different points of time which was higher than the 5% rate reported by Verma et al.,\(^{[16]}\) in their sample from North India. Rogers and Turner\(^{[17]}\) estimated about 5–7% same sex sexual contacts in men from five probability surveys, 1970–1990.

All our respondents came alone for the consultations, and none was accompanied by their partners. 45% of the married respondents were asked by their partners to seek help for their dysfunction. In a couple where one partner has sexual dysfunction but the other has normal sexual function, the latter is termed the “invested partner.”\(^{[18,19]}\) Often the invested partner may persuade the dysfunctional partner into treatment. For other respondents who were not motivated by their partners to seek help, one could hypothesize various factors. It is likely that the sexual dysfunction did not affect the relationship/sexual life satisfaction to the extent that help-seeking was considered important by the dyad. There is also a possibility of an expectation in such relationships that the female partner will not talk to the male partner about getting help for the dysfunction, as that would mean pointing out his inability to satisfy her.

Prior to the consultation with the psychiatry department 31% of our respondents had consulted alternative medicine specialists, particularly Ayurveda practitioners. It is a known fact that in the pluralistic medicine system in India, patients take different pathways to reach formal care for sexual dysfunction.\(^{[20]}\) They may consult their own peer-group, hakeems or roadside sexperts, before finally coming to sexologists, psychiatrists, gynecologists or urologists. This makes the pathway to help-seeking in these cases long and more complicated, often causing distress to the patient.\(^{[20]}\) Most of these Ayurvedic preparations may contain Shilajit or Ashwagandha. Shilajit is a pale-brown to blackish-brown exudate from rocks in Himalaya Mountains of the Indian subcontinent.\(^{[21]}\) Though it is supposed to have antioxidant and immune-modulatory activity, it lacks substantial evidence.\(^{[22]}\) Similarly Ashwagandha \( (Withania Somnifera)\)
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is an important medicinal plant that is widely claimed to have potent aphrodisiac and rejuvenating properties. It may improve semen quality by regulating reproductive hormone levels and oxidative stress in semen of infertile men,[23] however it has been shown to have no effect in ED.[24] Often these patients get some relief once their semen quality improves which is perceived by them as an increase in the thickness of semen and hence potency.

None of the respondents had either a past or present history of substance use in abuse or dependence pattern. Many of them reported of having stopped substance use at different points of time owing to the onset of their sexual dysfunction. However, since the respondents had come alone and weren’t accompanied by any objective data, it was difficult to confirm this history.

Ninety percent of respondents perceived that their parents and family environment was conservative. Sex was never discussed at home and was considered taboo. This could have diverse effects on the relationship and sexual satisfaction of the individuals.[25] In general, a conservative attitude of parents towards sex and considering sex discussion a taboo[26] may inhibit communication about sex. The child may grow to become an adult and when he gets into a relationship, often sex is not discussed in the couple due to the inhibitions. Sexual communication contributes to sexual satisfaction which in turn increases the dyadic adjustment,[27] which means that the opposite may also be true. Conservative family environments also make the children turn to their peers for sex-talk and as a source of sex knowledge.[28] This reflected in the main source of knowledge of sex for a majority of our respondents which was their peer group (69%); studies indicate that adolescents most commonly rely on peers for information about sexual matters.[28] Parents or other family members were not a source of information about sex for any of our respondents; this could be understood because often sexual conversations are embarrassing for adolescents as well as parents.[29] With peers being a major source, the norms that they set and the knowledge that they share, tends to be more influential than other sources.[30] However, the credibility and reliability of this knowledge is questionable.

For the majority of our respondents (43%), masturbation began by 11–13 years of age. In a study by Janus and Janus,[13] 53% of men started masturbation by the ages of 11–13 years. Sorensen[31] in his study of American adolescents reported 43% of boys having started masturbation between the ages of 13 and 15 years and 70% starting between 16 and 19 years of age. Masturbatory guilt was also present in a significant number of our respondents. Verma et al.[14] found a lesser number of patients (33.4%) in their sample who reported the masturbatory guilt. One major reason for the presence of the masturbatory guilt is a common belief in Indian society that this practice leads to reduced sexual potency.[32] The belief of decrease in sexual well-being and loss of resistance to all illnesses due to loss of semen stems from ancient Ayurvedic teachings.[33] Presence of the masturbatory guilt needs to be examined in detail in patients presenting with sexual dysfunction as it can be the cause of depression and even other sexual dysfunctions.[34]

About 10% reported that they have never masturbated at all in their life. This number was double of that reported by Janus and Janus.[19] Some of them were also prohibited in their childhoods from masturbating by older members of their families, usually same sex members such as elder brother or father. A small number had also been punished after being caught during the act of masturbating. Of the married respondents (62), 17% continued postmarital masturbation citing different reasons for the same. Some of these reasons included, having more frequent sexual thoughts compared to what they can demand from their partners, not satisfied with their partners in sex, staying away from partners (these respondents being migrants from outside of Mumbai). Surprisingly none of our respondents were doing masturbation as a complementary practice to their relationship. It was compensatory to partnered sex, which means that masturbation for these married respondents was compensating for the absence of intercourse with a partner.[34]

The most common sexual dysfunction in our sample was PME seen in 55% of the total respondents. It is, in fact, the most common male sexual dysfunction in various studies in every country.[35-38] Verma et al.[16] reported higher PME (77.6%) in their sample from Northern India. Similarly Jain et al.[39] also reported a higher PME prevalence (66%) in their sample. The prevalence of ED in both these studies were less than that seen in our study (Verma et al., - 23.6%; Jain et al., - 15%). Interestingly there were no other sexual dysfunctions reported by our respondents such as hypoactive sexual desire disorder, sexual aversion disorder, inhibited male orgasmic disorder, or sexual pain disorder. Any query to them regarding a possibly reduced desire did not elicit a positive reply. In fact, all of our respondents reported a normal desire to have sexual intercourse. This warrants for future studies on similar lines with larger clinical samples to understand the types of sexual dysfunctions seen in our country.

In our study, those in the younger age group (18–30 years) suffered more from PME compared to other age groups. PME tends to occur more often in individuals of a younger age.[40] Often the novelty of the act and inexperience is considered to contribute to this. However, Tang and Khoo[41] found no significant association between age and PME. PME was also reported significantly more in the respondents belonging to higher socioeconomic strata in our study. This could simply be because of the higher help-seeking attitude of individuals from this stratum. Respondents with PME were
Couples with marital conflict alone. There is a possibility that, sexual dissatisfaction may occur even in happy functioning. In his study, couples with both marital conflict and sexual distress may operate independently of one another. Thus, effective treatment of marital discord may be neither a necessary nor sufficient condition for improvement in sexual functioning. In his study, couples with both marital conflict and sexual dysfunction appeared to be less disturbed than couples with marital conflict alone. There is a possibility that the presence of a discrete dysfunction in sexual activity provides the distressed couple with an attributional strategy to perceive and explain their problems in a specific, functional way. This, in turn, may promote greater evidence of adaptive functioning in patterns of overt behavior. However, this interpretation is purely speculative. Marital discord is important since couples who have marital discord are the ones that are the most difficult to treat.

Educated respondents in our study had greater marital discord; however this could be due to better help-seeking attitude of such respondents. A past or present history of substance use affected the marital relationship by contributing to the discord. The causal connection between substance use and marital discord is complex and bi-directional. Substance use leads to reduced marital satisfaction for partners. Similarly, a stressful marital relationship may increase problematic substance use.

Despite the sexual dysfunction, psychiatric co-morbidity was noted in only 24% of our respondents. Depressive disorders included major depressive disorder, adjustment disorder with depressed mood and dysthymia. Sexual dysfunctions are frequently associated with various psychiatric illnesses, depression and anxiety being the most common comorbid conditions. Patients with sexual dysfunction invariably develop an increasing fear of failure and self-consciousness about their sexual performance. They often have a low self-esteem and all these factors may contribute to the depression seen in them.

However, many patients with sexual dysfunction are usually free of any psychiatric disorders. A significantly higher percentage of patients with PME (58.3%) and ED (41.7%) had depressive disorders. Lack of control over ejaculation in PME, often results in greater dissatisfaction with sexual and emotional relationship, greater emotional distress, feelings of inadequacy, disappointment and anxiety; all this could contribute to depression. Recent studies have confirmed this relationship between PME and depression in Asian men. ED may also be associated with a high incidence of depressive symptoms. The relationship between depression and ED appears to be bidirectional: The presence of or alteration in one of these conditions may be the cause, consequence, or modifier of the other. Respondents who had the masturbatory guilt were more likely to be depressed, and this is in keeping with the finding of Chakrabarti et al.

CONCLUSION

Our study on 100 males with sexual dysfunction indicates that PME is the most common sexual dysfunction and is more commonly seen in the younger individuals. It can lead to clinically significant depression and distress in the
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patient as well as the dyad. Despite the sexual dysfunction, marital discord is not visible in our sample, thus pointing to various other factors that may be responsible for this. Similarly, depression was less noted in our sample again pointing to some protective factors against depression.

Through this study, we intended to understand the psychosocial profile of men with sexual dysfunction who seek help from a psychiatric OPD. With a huge paucity of data on sexual dysfunction in the Indian context, this study helps add to the literature.

ACKNOWLEDGMENTS

The authors would like to thank Dr. Abhiram Kasbe, Professor of Preventive and Social Medicine (PSM) at TNMC and BYLNCH, Mumbai for helping with the statistics of the study.

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**Source of Support:** Nil, **Conflict of Interest:** None declared