



Study of comorbid psychiatric diagnoses in premature ejaculation and erectile dysfunction

Abstract

Objective: To study prevalence of comorbid psychiatric diagnoses in cases with either premature ejaculation (PME) and/or erectile dysfunction (ED) among adult males visiting a tertiary care hospital. **Design:** This cross-sectional study was conducted in the outpatient department of Department of Psychiatry, Government Medical College, Latur, Maharashtra, India over a period of two years from 2015 to 2017. **Materials and methods:** Ninety five male patients with either PME and/or ED were recruited from a pool of patients presenting with sexual complaints and were interviewed. Sociodemographic data was collected on semi-structured proforma designed for the study. The tenth revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) criteria were applied to establish psychiatric diagnoses. **Results:** The mean age of the sample was 35.17 years and 70.52% were married. Out of the total patients participating in the study (PME=34, ED=44, both=17), 41 (43.15%) patients were found to have the diagnosis of anxiety disorders and 23 (24.21%) with depression. **Conclusion:** Depression and anxiety affect a significant group of men with sexual dysfunction. Men presenting for the evaluation of PME and ED should be carefully screened for these disorders. These findings merit further investigation on its aetiological, epidemiological, and psychopathological correlates.

Keywords: Sexual Dysfunctions. Depression. Anxiety.

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INTRODUCTION

Sexual behaviour is an important aspect of health, which can impact the overall wellbeing of men and women. Prevalence of undiagnosed disorders of sexual functioning is very high among men and women of all ages, ethnicities, and cultural backgrounds. Premature ejaculation (PME) and erectile dysfunction (ED) are very common male sexual dysfunctions encountered in the clinical setting. In country like India, cultural myths, religious philosophies addressing sex as taboo, and lack of sex education in adolescence make it difficult for patients to express their complaints in clinical setup openly.[1]

Normal sexual behaviour follows certain physiological stages including desire, excitement, plateau, orgasm, resolution, and satisfaction. Psychiatric illnesses can disturb these levels leading to sexual dysfunction.[2,3]

The tenth revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) defines PME/discharge as the inability to control ejaculation sufficiently for both partners to enjoy sexual interaction while ED can be defined as a disorder characterised by the persistent or recurrent inability to achieve or to maintain an erection during sexual activity.[4] The diagnosis of PME in the clinical practice encompasses four dimensions: ejaculatory latency; degree of voluntary control; presence of marked distress; and symptom not due to any other mental,

behavioural, physical disorder. Words like Dhat, munny, drops, and at times paani are used by the local community to describe PME.[5]

Although there is a deficit of data on the prevalence of sexual disorders from any large-scale epidemiologic studies, one study from south India reports 8.76% prevalence of PME and 15.77% prevalence of ED among males.[6] Only a small proportion of these males consider PME and ED as a medical problem and although subjectively it is a distressing symptom but infrequently reported by the patients and very unsatisfactorily inquired by the psychiatrists.[7]

The patient with sexual dysfunction commonly adapt “a leaning forward posture” and “talks in low voice and volume” as an element of guilt and poor manhood along with shame overwhelming these patients.[8]

This study tries to explore presence of comorbid psychiatric diagnoses in those patients who have major sexual complaints in the form of either PME and/or ED in a given sample of men visiting tertiary care hospital.

MATERIALS AND METHODS

Ninety five males with main presenting symptoms of either PME and/or ED were recruited as per inclusion and exclusion criteria by simple random sampling. They were recruited from

a pool of patients presenting with sexual complaints over a period of two years from 2015 to 2017 and were interviewed by mental health professionals. Institutional Ethics Committee approval was obtained and informed consent was taken from participants.

Sociodemographic data was collected on semi-structured proforma designed for the study. ICD-10 criteria were applied to establish psychiatric diagnosis.[4] However, all patients with already diagnosed psychotic disorders, substance use disorders, and major medical conditions with complaints of sexual dysfunction were excluded from this study to reduce the chance of cause and effect of certain unassociated psychiatric conditions and psychopharmacological effects of drugs.

Results of this study are presented using descriptive statistics using mean and range of variables. Information on diagnoses of PME and ED, their age distribution, marital status, educational attainment, and comorbid psychiatric diagnoses are descriptively presented in figure and table.

RESULTS

Ninety five male patients included in this study were in the age range of 19-60 years with a mean of 35.17 ± 5.56 years. Thirty four patients (35.78%) were diagnosed with PME, 44 patients (46.31%) had ED while 17.89% had both. 70.52% (n=67) cases were married while 29.48% (n=28) were single. Educational status of our study population was as given in Figure 1; mean of educational attainment in years was 9.47 ± 2.03 years (range zero to 18 years).

Out of 95 cases, 41 (43.15%) suffered from anxiety disorders; 17 (17.89%) from generalized anxiety disorder,

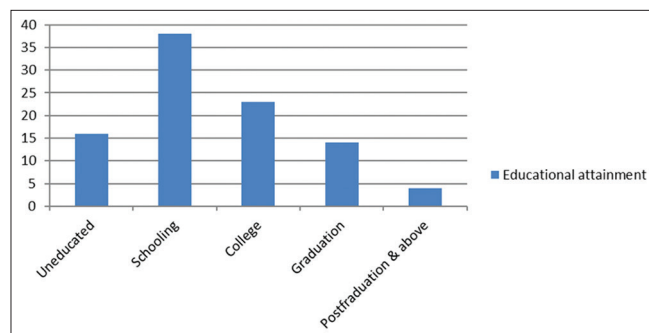


Figure 1: Education level of cases with either premature ejaculation (PME) and/or erectile dysfunction (ED).

Table 1: Prevalence of psychiatric diagnoses in cases with either premature ejaculation (PME) and/or erectile dysfunction (ED)

Psychiatric diagnoses	Number of patients	Prevalence (in%)
Anxiety disorders	n=41	43.15
Generalized anxiety disorder	n=17	17.89
Panic disorder	n=11	11.57
Phobic disorder	n=5	5.26
Obsessive-compulsive disorder	n=8	8.42
Depression	n=23	24.21

11 (11.57%) from panic disorder, five (5.26%) from phobic disorders, eight (8.42%) from obsessive-compulsive disorder. Twenty three (24.21%) patients were suffering from depression as per ICD-10 criteria (Table 1).

DISCUSSION

The study has focused on the patients presenting with chief complaints of PME and/or ED. Males in sample's age range of 19-60 years form an important group in Indian society who is working and sexually active.

Sample was broadly divided into two distinct groups of married and unmarried males. Unmarried males seem to suffer predominantly from Dhat syndrome as Dhat syndrome is predominantly reported in unmarried in previous studies.[9] But this group with culture bound syndrome is not included as comorbidity in psychiatric diagnosis as ICD-10 classification does not recognise this as a valid diagnosis.[10]

There were 13 cases of divorce/separation which seem to be due to failure of marriage consummation due to PME, calling for attention to the association and outcome of the sexual dysfunction and interpersonal issues in institution of marriage.[11]

In our study, the majority of cases (43.15% [n=41]) were diagnosed as anxiety disorder on ICD-10 criteria while 24.21% (n=23) had diagnosis of depression. Generalized anxiety disorder was the commonest anxiety disorder. Our findings are similar to study conducted in Indian population while study from China found much higher proportion of depression and anxiety.[12,13]

Men with comorbid depression are likely to express feelings of worthlessness, guilt, and loss of libido. While subjects with anxiety disorders were more likely to experience performance anxiety related to sex, and to have PME with comorbid ED and Dhat syndrome.[14] Further research is needed to clearly establish nature of association between sexual dysfunction and psychiatric diagnoses of depression and anxiety.

To conclude, depression and anxiety affect a significant group of men with sexual dysfunction. Men presenting for the evaluation of PME and ED should be carefully screened for these disorders.

Clinical implications of our study stress upon importance of identification and treatment of psychiatric comorbidity in patients with either PME and/or ED to improve outcome of underlying sexual dysfunction and improve quality of life for the patient.

Limitations include small clinic-based sample size. Study did not consider underlying socio-cultural conditions and lacked detailed workup to rule out underlying medical conditions.

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