PSYCHIATRIC PRESENTATIONS OF SEXUAL DYSFUNCTION IN PAKISTAN

Syed Ahmer, Faheem Khan, Mukesh Bhimani

ABSTRACT

Objective: To study the clinical and sociodemographic characteristics of people presenting with sexual difficulties to a psychiatric outpatient clinic.

Design: Case-notes review

Place & duration of study: Psychiatry outpatient clinic, Aga Khan University Hospital (AKUH), Karachi, from January 2008 to May 2009.

Subjects & method: Case notes of all patients presenting to the psychiatry outpatient clinic of the AKUH for a sexual problem during the study period were reviewed. The details of socio-demographic data, presenting problems, past history, sexual history, investigations and treatment were extracted from the case notes.

Results: A total of 48 patients (47 males and one female) presented to the clinic with a sexual problem during the study period. The most frequent presenting problems were erectile problems (34 %), premature ejaculation (24 %) and non-consummation of marriage (18 %). After assessment the most frequent diagnoses were erectile dysfunction (29 %), premature ejaculation (27 %) and depression (23 %). Most of the patients (64%) were prescribed SSRIs, while sex therapy was recommended in about 30 % of cases.

Conclusion: The patterns of sexual dysfunction in clinical samples in Pakistan are very similar to patterns found elsewhere. However, considering the large proportions reported in surveys only a few of these people see a psychiatrist to seek appropriate help. We need to break down barriers that inhibit a patient to approaching appropriate health professionals for seeking help, and inhibit doctors in exploring these phenomena in appropriate depth.

Key words: Sexual dysfunction, Erectile dysfunction, Pakistan

INTRODUCTION

The term "Sexual Dysfunctions" has been used in Diagnostic and Statistical Manual of Mental Disorders, fourth edition, (DSM-IV) to refer to a group of disorders "characterized by disturbances in sexual desire and in the psychophysiological changes that characterize the sexual response cycle and cause marked stress and interpersonal difficulty."[1] It includes sexual desire disorders, sexual arousal disorders, orgasm disorders, premature ejaculation and sexual pain disorders.

There are three main population groups that have been studied in terms of sexual dysfunction. The first group includes general population and the most robust method in terms of representativeness in this group is survey like the National Health and Social Life Survey (NHSLS) and the Massachusetts Male Aging Study (MMAS)[2,3]. The NHSLS results showed that as many as 43 % of women and 31 % of men may be suffering from sexual dysfunction. Among men between age of 40 to 70 years about 35 % were suffering from moderate to complete erectile dysfunction (ED). Although survey yields results that are most representative of the true picture of the problem in the population but they are known to be associated with problems like reporting bias, use of different operational definitions of sexual dysfunction in different surveys that make comparison of different surveys results difficult[4]. Also, as people are not being asked for the details of the phenomenon it is unclear whether their ideas of sexual dysfunction conform to clinical categories of the same. This issue is resolved by qualitative interview technique.

The second kind of population in which sexual dysfunction was studied is clinical population with a medical or psychiatric problem in which sexual dysfunc-

Syed Ahmer, Assistant Professor, Department of Psychiatry, Aga Khan University Hospital, Karachii
E mail: syed.ahmer@aku.edu.pk

Faheem Khan, Department of Psychiatry, Aga Khan University Hospital, Karachi

Mukesh Bhimani, Department of Psychiatry, Aga Khan University Hospital, Karachi

Correspondence:

Dr. Syed Ahmer

tion was revealed as comorbidity. For example men attending primary clinics in Nigeria, Egypt and Pakistan reported ad-adjusted prevalence rates of erectile dysfunction of 57 %, 64 % and 81 % respectively.[5] Perlman et al found a prevalence rate of sexual dysfunction of 17 % in psychiatric inpatients.[6] Other studies have reported much higher prevalence rates of sexual dysfunction, 90 % in women suffering from depression[7], 78 % in patients taking antidepressants[8] and 30-54 % in patients taking antipsychotics[9]. The problems again are those of operational definitions and accuracy of diagnostic categories.

The third population that has been studied is people presenting to sexual or marital dysfunction/disorder clinics specifically with a sexual problem.[10]. These are very self-selected samples which may not be representative of the general population as help-seeking for sexual problems is very likely to be influenced by sociocultural and religious factors.[11] On the positive side studying this population is likely to produce most accurate data about details of pathology and diagnostic categories as it presents itself for the most thorough study regarding sexual dysfunction.

A few studies have been conducted in Pakistan on sexual dysfunction. Most of these studies belong to the second category i.e. surveys of sexual dysfunction in different patient populations such as patients with depression[7 12 13], men taking antipsychotics[14], and men attending primary care clinics.[5] There have been two surveys of general population reporting sexual behaviour of women in Pakistan[15] and different ethnic groups of Punjab[16], the largest province of Pakistan, but neither of these studies assessed sexual dysfunction. We have not come across any study reporting data from people presenting specifically for treatment of sexual problems in Pakistan.

SUBJECTS & METHOD

Participants

This study is a case notes review of all patients presenting to the psychiatry outpatient clinic of the AKUH specifically for a sexual problem, from January 2008 to May 2009.

Measures

Data was collected retrospectively from case notes. We devised a data collection form which recorded basic demographic details like age, gender, marital status, education and occupation. We then recorded their presenting complaint(s), duration of problem, who had referred them, history of substance misuse, psychiatric illness or medical illness, what physical investigations they had gone through already, which sources of medical or alternative help they had tried before presenting to the psychiatry clinic, what treatments they had already received and whether depressive symptoms were present on mental state examination. It also recorded history of their sexual experiences, if there was a history of masturbation, their sexual orientation, and in case of males whether nocturnal penile tumescence was present around the time of presentation. The form then recorded which phase of the sexual cycle their presenting complaint corresponded to, the diagnosis at the end of assessment, and the treatment that was prescribed. It also recorded history of their sexual experiences, if there was a history of masturbation, their sexual orientation, and in case of males whether nocturnal penile tumescence was present around the time of presentation.

Data analysis

The data were entered into SPSS 16.0. As the sample was very small we have reported frequencies and percentages, and not attempted statistical analyses as it would have been misleading to extrapolate results from this small sample to the entire population.

RESULTS

A total of 48 people, 47 men and one woman, were seen at the clinic for sexual problems during this time. The median age of patients was 25.5 years with an inter-quartile range of 26-34 years. Seventy nine % (34/43) of the patients had higher than secondary school (10 years) education. Thirty five (73 %) were married, 11 (23 %) were single, and 2 (4 %) were divorced. In terms of current occupation 18 (38 %) were professionals (doctors, nurses, engineers, teachers), 15 (32 %) were businessman, 10 (21 %) were skilled or unskilled labourers, 3 (6 %) were students and 1 (2 %) was unemployed. It means this was a group which consisted predominantly of young, well educated, married, males who were either professionals or businessmen.

The source of referral of the patients to the clinic was as follows; urologist 25 (52%), self-referrers 17 (35%), others e.g. acquaintances 3 (6%), other doctors 2 (4%), and spouse 1 (2%).

General psychiatric and medical histories

Only 15 % (n=7) of patients had history of psychiatric illness (all were suffering from depressive disorder except one who was suffering from schizophrenia). On assessment 23 % of patients meet the diagnostic criteria of a depressive episode. About 70 % of people had no history of substance use, 17% were smokers, and about 8% each had a history of alcohol and gutka/chaalai use. One patient was suffering from Diabetes Mellitus, Hypertension and Ischaemic heart disease, one from Diabetes Mellitus and Hypertension, and two from hypertension.

Sexual histories

About 9 % of patients (4/43) reported a history of childhood sexual abuse. Ninety six percent (45/47) reported having engaged in masturbation at some point in their life. Nineteen % (n=9) of patients had premarital sexual experience, 6 % (n=3) were homosexual, and 4 % (n=2) had extramarital sexual experiences. Informa-

tion about sexual orientation was found in 39 patients and 79.5 % (n=31) of them described their sexual orientation as heterosexual, 13 % (n=5) described as exclusively homosexual and 8 % (n=3) described as bisexual.

In terms of frequency of sexual intercourse 27 % (12/44) of patients reported that they had never had sexual intercourse in life (married 4/32, divorced 1/2, single 7/10), 23 % said they had sex once a year or less, about 18 % each every week or less than once a month, 9 % less than once a week and 4.5 % daily.

Presenting problems

The breakdown of patients' primary reason for presentation to the clinic (presenting complaints) is given in table 1.

Table 1

Patients' Presenting Complains

Presenting Complaints	No (% of Responses)
Erectile problems	21 (33.9 %)
Premature Ejaculation	15 (24.2)
Unconsummated Marriage	11 (17.7)
Other	6 (9.7)
Inability to penetrate	4 (6.5)
Unsatisfactory relations	2 (3.2)
Attraction to same gender	2 (3.2)
Painful intercourse	1 (1.6)

The largest group was people with erectile problems (34 %) followed by those with premature ejaculation (24 %). We have listed 'non-consummation of marriage' separately as this was the specific reason these people had come to the clinic for. The 'other' group included three males, two single, one divorced who had no current sexual dysfunction on assessment but had concerns regarding sexual problems they may have in the future, one person with internet porn addiction, one asking if there were ways to increase the size of penis, and complaining of testicular pain.

When we classified the presenting complaints according to the stages of the sexual response cycle[1] the breakdown was as follows; arousal disorders (39.6 %), orgasmic disorders (35.4%), desire disorders (10.4 %) and sexual pain disorders (8.3%).

Five patients attributed problems to their sexual partners; four said that the partner experienced significant pain during intercourse and one said that the partner had minimal sexual desire.

Table 2 shows what physical investigations patients had already gone through presenting to the clinic. About 44 % of patients had had their serum testosterone levels checked, followed by levels of other hormones (FSH, LH, thyroid hormones) in 33 % of cases.

Table 2

Physical Investigations already done before Presentation (% of Cases)

Investigations	Number (%)
Serum Testosterone level	21 (43.8)
Other hormonal levels	16 (33.3)
Blood sugar	14 (29.2)
Penile ultrasound Doppler	10 (20.8)
Lipid profile	5 (10.4)
None	23 (47.9)

Working diagnosis and treatment prescribed

Table 3 shows the final diagnoses reached at the end of assessment. The percentages add upto more than 100 as some patients received more than one diagnosis e.g. erectile dysfunction and depression.

Table 3

Working Diagnoses reached at end of Assessment

Working Diagnosis	Number (% of cases)
Erectile dysfunction	14 (29.2)
Premature ejaculation	13 (27.1)
Depression	11 (22.9)
Ego-dystonic sexual orientation	5 (10.4)
Organic problem	4 (8.3)
Sexual anxiety	4 (8.3)
? Vaginismus	3 (6.3)
Low sexual desire	2 (4.2)
Relationship issues	1 (2.1)
Schizophrenia	1 (2.1)
Internet porn addiction	1 (2.1)

Table 4 shows how association between presenting problems (categorized as stage of sexual response cycle) and presence and absence of depression.

The most common diagnosis was Erectile Dysfunction (29.2%), closely followed by Premature Ejaculation (27.1%) and Depression (23 %). A query has been placed in front of Vaginismus as it was directly diagnosed only in the case of the solitary female in this group. In the other two cases the diagnosis was made provisionally on the basis of the husband's account.

Table 4

Association between presenting problem (Categorized as Stages of Sexual Response Cycle) and Depression

	Depression		Total
	Yes	No	
Desire	2	3	5
Arousal	7	10	17
Orgasm	3	8	11
Pain	0	3	3
Other	2	5	7
None	0	2	2
	14	31	45

About 23 % (11) of attendees were diagnosed as suffering from depression. Of these four had depression comorbid with ED, depression was the only diagnosis in 3 people, two had depression comorbid with premature ejaculation, and two people who had presented to get their sexual orientation changed had depression.

Table 5 shows the treatments that were prescribed at the end of the initial assessment.

Table 5

Treatments Prescribed

Treatment	Number (% of cases)
SSRIs	28 (64.4)
Sex therapy	13 (28.9)
Sex education	8 (17.8)
Psychotherapy	7 (15.6)
Sildenafil	3 (6.7)
Urology referral	2 (4.4)
Referred for vaginal dilatation	1 (2.2)

Most of the patients (64%) were prescribed SSRIs. This was not only for treatment of depression but they are also a mainstay treatment for premature ejaculation [17]. Sex therapy refers to Masters & Johnson's technique[18]. Sex education was provided in every case but in the table sex education category refers to those cases where it was the only remedy that was provided. Psychotherapy category refers to those cases in which in it was felt the patients needed individual psychotherapy unrelated to sexual problems.

DISCUSSION

In this study of patterns of sexual dysfunction presenting at a psychiatric outpatient clinic in a tertiary care university hospital was assessed. Most of the attendees were young, well educated married males who were either professionals or businessmen. The largest diagnostic group was erectile dysfunction (29%), closely followed by premature ejaculation (27 %) and depression (23 %).

Our sample was almost exclusively male. This is in accordance with a similar though much larger study from this region in which the proportion of males among people presenting to a marriage and sex clinic in India was around 98 %[10]. There could be several explanations for this male preponderance. The sexual health clinic from which these data are reported is run by a male psychiatrist. Females may have been inhibited from seeking help from a male on sexual issues because of cultural reasons. There is also a dearth of female psychiatrists in Pakistan. It is possible that Pakistani females may be more comfortable seeking help regarding sexual health from gynecologists who are overwhelmingly female in Pakistan.

In our sample ED was the most common presenting problem as well as the working diagnosis reached after complete assessment, followed by premature ejaculation. This is in contrast to the Kendurkar study [10] in which the prevalence were exactly the opposite though the percentages are very close in both the studies.

Depression was the 3rd most common diagnostic category in our sample. This is in concordance with several other studies rates of sexual dysfunction in patients with depression as high as 78 % in patients treated with antidepressants [8], and 90 % in women suffering from depression [7]. However, surprisingly in the Kendurkar study [10] none of the 1,242 cases were diagnosed as suffering from depression.

There have been few studies from this part of the world that have reported data on sexual behaviour of the population. There have been two studies which have reported data on sexual behaviour of Pakistani population but both have restricted themselves to frequency of sexual thoughts and acts, one in women [15] and the other in different ethnic groups of Punjab[16]. In our study almost 95 % of people admitted having engaged in masturbation at some time during their life though many of them considered it to be against their religious beliefs. Twenty-nine percent of people had engaged in sexual experiences outside of wedlock. Thirteen percent of people described their sexual orientation as exclusively homosexual and 8 % as bisexual. Alfred Kinsey, in his landmark surveys, had reported rates of exclusive homosexuality of about 4 % in both males[19] and females [20]. Our rates may be higher as this was a clinical sample coming to seek help for sexual problems, unlike Kinsey's figures which come from general population surveys.

Limitations

In this study we have presented a retrospective collection of data from case notes. As data collected for

clinical purposes is many times incomplete or insufficient for research purposes it is a limitation of this study.

The number of participants in the study was very small. Therefore, the findings are unlikely to be generalisable. However, considering the prevalence of sexual dysfunction as high as 90 % reported in some studies from Pakistan [7] it does beg the question why only less than 50 people came to seek help for sexual problems while about 3500 initial patients had attended the same clinics for general psychiatric problems over the same year.

The sample was self-selected and is therefore unlikely to be representative of the real prevalence of sexual health issues in the Pakistani community. However, at this time we were only attempting to describe who comes to seek help regarding sexual health issues from a psychiatrist in Pakistan.

CONCLUSION

In Pakistan neither the doctors nor the patients feel comfortable talking about sex[21]. Surveys done in Pakistani clinical populations have shown quite significant numbers being affected by sexual problems but at least at this hospital the numbers of people presenting with sexual problems were a very tiny fraction of all the people presenting to the psychiatry clinic.

REFERENCES

1. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, 4th ed. Washington DC: American Psychiatric Association; 1994.
2. Laumann EO, Paik A, Rosen RC. Sexual dysfunction in the United States. JAMA 1999;281:537-44.
3. Feldman HA, Goldstein I, Hatzichristou DG, Krane RJ, McKinlay JB. Impotence and its medical and psychosocial correlates: results of the Massachusetts Male Aging Study. J Urol 1994;151:54-61.
4. Simons JS, Carey MP. Prevalence of sexual dysfunctions: results from a decade of research. Arch Sex Behav 2001;30:177-219.
5. Shaeer KZM, Osegbe DN, Siddiqui SH, Razzaque A, Glasser DB, Jaguste V. Prevalence of erectile dysfunction and its correlates among men attending primary care clinics in three countries: Pakistan, Egypt and Nigeria. Int J Impot Res 2003;15:S8-14.
6. Perlman CM, Martin L, Hirdes JP, Curtin-Telegdi N, Perez E, Rabinowitz T. Prevalence and predictors of sexual dysfunction in psychiatric inpatients. Psychosomatics 2007;48:309-18.
7. Taj R, Khan S. A study of sexual dysfunction in depressed women. J Coll Physicians Surg Pak 2002;12:277-2.
8. Osvath P, Fekete S, Voros V. Sexual dysfunction among patients treated with antidepressants: a Hungarian retrospective study. Eur Psychiatry 2003;18:412-4.
9. Wirshing DA, Pierre JM, Marder SR. Sexual side effects of novel antipsychotic medications. Schizophr Res 2002;56:25-30.
10. Kendurkar A, Kaur B, Agarwal AK, Singh H, Agarwal V. Profile of adult patients attending a marriage and sex clinic in India. Int J Soc Psychiatry 2008;54:486-93.
11. Petrak J, Keane F. Cultural beliefs and the treatment of sexual dysfunction: an overview. Sex Dysfunct 1998;1: 13-7.
12. Shah F, Sultan A, Dar SI. Depression and prevalence of sexual dysfunction. Pak J Med Res 2004;43:104-7.
13. Taj R, Mufti M, Khan A, Rehman G. A study of sexual dysfunction in depressed males. Ann Pak Inst Med Sci 2005;1:37-9.
14. Khawaja MY. Sexual dysfunction in male patients taking antipsychotics. J Ayub Med Coll Abbottabad 2005; 17:73-5.
15. Sheikh MA. Sexual behaviour of women - Perspective from Pakistan. Pak J Med Sci 2001;17:21-5.
16. Iqbal Z, khan AA, Subhani GM, Mahmood S, Abbasi A, Khan JH, et al. Sexual activity in relation to age and PSA levels in different ethnic groups of Punjab. Biomedica 1999;15:112-5.
17. Gregoire A. ABC of sexual health. Assessing and managing male sexual problems. BMJ 1999;318:315-7.
18. Masters WH, Johnson VE. Human sexual inadequacy. London: Churchill; 1970.
19. Kinsey AC, Pomeroy WB, Martin CE. Sexual behaviour in the human male. Philadelphia: W.B. Saunders; 1948.
20. Kinsey AC, Pomeroy WB, Martin CE. Sexual behaviour in the human female. Philadelphia: W.B. Saunders; 1953.
21. Afsar HA, Sohani S, Younus M, Mohamad S. Integration of sexual and reproductive health in the medical curriculum in Pakistan. J Coll Physicians Surg Pak 2006;16:27-30.