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Premature Ejaculationand Associated Psychological Problems: A Cross Sectional Study at District Hospital from Western India

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Abstract:
Introduction: *Premature ejaculation(PE) is most common male sexual dysfunction. Several studies have shown correlation between PE and psychological problems like depression, stressand anxiety. In this study we aim to establish this hypothesis in population of western Rajasthan(India).*
Materials &methods:*This study is a non-interventional, cross-sectional, self-reported based psychological investigation analysis that was carried out at Psychiatric OPD at District Hospital over a period of 9 months with 156 subjects. We applied DASS and BDI-II to measure the psychopathology.*
Results: *The study shows 30% subjects were depressed,35% were anxious and 47% were stressed. Subjects between 20 to 30 year of age were significantly more depressed than other age group.*
Discussion and Conclusion:*.Premature ejaculation is often associated with sense of inadequacy, guilt, disappointment, fear and embarrassment which ultimately lead to reduced satisfaction with sexual experience and anxiety. Almost one fourth of the patients suffering from premature ejaculation have significant psychopathology qualifying for the diagnosis of clinical depression.*
Key words:*Premature Ejaculation, Sexual Dysfuction,Anxiety,Depression,Stress.*

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I. Introduction

Sexual dysfunctions are cognitive, affective, and behavioral problems that prevent an individual or couple from engaging in or enjoying satisfactory intercourse[1].Male sexual dysfunctions in general and premature ejaculation in particular are condition that affects a large number of men worldwide, and likely to have an impact on couple which may lead to the low level of individual well-being and mental health.[2]Premature ejaculation (PE) is a common male sexual dysfunction[3]. Premature ejaculation (PE) is one of the most common male sexual disorders and has been estimated to occur in 4-39% of men in the general community.[4-11]. Recently studies have revealed that the prevalence of PE can be as high as 43.4% [12]. PME is broadly defined as occurrence of ejaculation prior to the wishes of both sexual partners , usually before or immediately after entering vagina. Men suffering from PE complain about decreased sexual self-confidence and psychological comorbidities. Thus, it seriously impair male health and couples' sexual relationships [13]. Early ejaculation is often disappointing and can lead to anxiety, loss of sexual confidence and low self-esteem[14]. PME has been shown to have a significant negative psychological impact on men and is often associated with low self-esteem, helplessness and increased frustration [15,16].Psychological factors of an individual such as depression, stress, anxiety, and negative cognitive processing are firmly associated with the onset and maintenance of male sexual difficulties. Several studies have shown that impaired sexual function in men with PE is significantly associated with depression[17]. Depressed persons have an increased risk of developing PME and higher prevalence of depression is found particularly in PME patients[18]. Further PME patients have decreased self-esteem, and decreased satisfaction in sexual life, which may secondarily lead to depression[19,20]. The relationship between GAD ,Depression and PME can be further explained by the fact that serotonin is the key neurotransmitter in all these conditions. [21,22]. The prevalence rate of comorbid depression in PME is also about 25%[23,24]. We tested the hypothesis that premature ejaculation can lead to neurotic and depressive disorders.

II. Material & Methods:

The present study is a no interventional, cross-sectional, self-reported based psychological investigation analysis that was carried out at the outpatient clinic in Psychiatric OPD at District Hospital during months of 1st January 2018 to 30th September of 2018 with the complaint of inability to control ejaculation

sufficiently long enough during intravaginal containment were screened for the diagnosis of premature ejaculation (PME). PME was evaluated using DSM-5 diagnostic Criteria ‘As persistent or recurrent onset of orgasm and ejaculation with minimal sexual stimulation before, on, or shortly after penetration and before the person wishes. And cause(s)marked distress or interpersonal difficulty and PE not exclusively due to the direct effects of a substance’[25,26].Before being asked the subjects to participate, a formal consent was obtained from all of them. A total 156 subjects who fulfilled the above mentioned criteria were included in the study. Demographic information was collected using a socio-demographic profile Subjects were evaluated for diagnosis of depression, anxiety and stress using DASS 21. The DASS-21 is a 21-item self-report questionnaire designed to measure the severity of a range of symptoms common to DAS. It is a generic scale that shows strong internal consistency and reliability for each subscale (DAS) and it has been prevalidated in various group of patients. In completing the DASS, the individual is required to indicate the presence of a symptom over the previous week. Each item is scored from 0 (did not apply to me at all over the last week) to 3 (applied to me very much or most of the time over the past week). There are four possible answers in terms of severity or frequency, organized in a scale from 0 to 3. The result is obtained by adding up the scores of the items for each of the three subscales.

The depression subscale assesses symptoms like inertia; anhedonia; dysphoria; lack of interest/involvement; self-depreciation; devaluation of life; and discouragement. The anxiety subscale evaluates excitation of the autonomous nervous system; musculoskeletal effects; situational anxiety; and subjective anxiety experiences. Finally, the stress subscale assesses difficulty to relax; nervous excitation; easy perturbation/agitation; irritability/exaggerated reaction; and impatience.

Calculation of extent of DAS in individual cancer patient is done with corresponding number of questionnaire which is specific (each subclass contained 7 questions) for DAS. Higher score correspond to more severe psychological disorder that is reflected in critical functioning of the DASS is to assess the severity of the core symptoms of DAS [27].Beck Depression Inventory (BDI-II,21 item, Hindi Version is a 21-item measure of depressive symptoms. For each item, participants chose the statement that best reflected how they felt. The Responses to the each items were then summed, with scores varying from 0 to 63 where scores of 0 to 13 means minimal depression, scores of 14 to 19 indicated mild depression, and scores of 20 to 29 indicated moderate and 29 to 63 indicate severe depressive symptoms. The BDI has a high coefficient of alpha (α= 0.80) and its construct validity has been established which differentiate depressed from non-depressed. The test-re-test reliability and internal consistency is .82 and .79 respectively [28,29] .Fisher’s exact test, ANOVA, chi-square test and unpaired t- test were used to analyse the data. Male patients of age 20 to 50 were included in study. Patients who are undergoing for treatment for any psychiatric illness, who have undergone any significant surgical intervention, abusing substances except nicotine and known cases of diabetes and high blood pressure were excluded from study.

III. Results

Table 1- Socio-demographic characteristics of study population

		N	%
Locality	Urban	106	67.8
	Rural	50	32.2
Religion	Hindu	134	85.9
	Muslim	22	14.1
Family	Joint	55	35.2
	Nuclear	101	64.8
Age	<20	14	8
	20-30	47	30.3
	31-40	64	41.1
	>40	31	19.6
Literacy	Illiterate	0	0
	Up to primary	8	5.3
	Matriculation	28	17.8
	Graduation	81	51.1
	Post-graduation	39	25

Table 1 is showing sociodemographic characteristic of the study population . Almost two third patients were from urban background.85.9 % were Hindu by religion,64.8% were residing in nuclear families . A 41.1% patients were in age group of 31to 40 years and half of them were educated up to graduation .

Table 2 Results of DASS Scale

DASS(subscales)	Mild	Moderate	Severe	Very Severe
DASS(D) (46)	11	26	8	1
DASS(A) (55)	19	31	14	1
DASS (S) (73)	27	31	13	2

Table 2 is showing scores on DASS subscales . Thirty percent patient of PME were having depression on DASS(D) subscale, more than half of them were moderately depressed. Thirty five percent individuals were anxious on DASS(A) subscale and sixty percent of them were having moderate level of anxiety. On stress subscale of DASS 47% of PME patients were positive for stress. Very few patients (n=4) fall in very severe category on DASS subscales. Majority were in moderate category on the score of this scale .

Table 2 Locality wise Distribution of depressed patients

LOCALITY	N	%	MEAN BDI SCORE	p value	SUBJECTS WITH CLINICAL DEP.	%	p value
URBAN	106	67.8	12.7	T=2.11 p=0.2	25	23.68	**X^2 =0.5 p=0.82**
RURAL	50	32.2	10.3		11	22.24	
TOTAL	156	100	12.39		36		

Table 3,is showing locality wise distribution of depressed patients .Though two third of patients were from urban background but we found statically non-significant difference in BDI scores .23.68% urban and 22.24 % rural patients were clinically depressed (BDI>14) ,but with a p value of .82 this difference was non-significant.

Table 4. Age wise Distribution of depressed patients

Age	N	%	Mean BDI Score		Subjects with clinical depression	P value
<20	14	8	9	***F=6.9 P=0.01***	**3**	X^2 =8.06 P=0.04
20-30	47	30.3	13.3		18	
31-40	64	41.1	9.2		11	
>40	31	19.6	7.6		5	

Table 4 is illustrating age wise distribution of depressed individual among PME patients. There is significant difference both in mean BDI scores and clinical depression with a p value of 0.01 and 0.04 respectively. Scores were higher in age group of 20 to 30 years .It seems that individuals in this age range were more depressed than others.

Table 5. Education wise Distribution of depressed patients

Literacy	N	%	Mean BDI Scores	p	Subjects with clinical depression	*p*
Illiterate	0	-	-	-	-	-
Up to primary	8	5.3	8.9	F=0.786	3	*X^2 =2.36* P=0.5
Vi-X	28	17.8	11	P=0.5	11	
Xi- grad	81	51.7	10.7		14	

Table 5 is showing education wise distribution of PME patients .Statically non-significant difference was found among different education strata.

IV. Discussion

Premature Ejaculation (PE) known as problem of the orgasm phase of the male sexual response cycle and widely believed to be the most common male sexual dysfunction[1].Male sexual dysfunctions in general and premature ejaculation in particular are condition that affects a large number of men worldwide, and likely to have an impact on couple which may lead to the low level of individual well-being and mental health[2].PME is widely believed to be the most common male sexual dysfunction that estimated prevalence range from 21 to 32.5% in men aged 18-59[3,4,5,6,7,8,9,10,11].Men suffering with PME experience frustration, anger, disappointment, insecurity, inadequacy, guilt, humiliation, fear and failure [14].PME has been shown to have a significant negative psychological impact on men and is often associated with low self-esteem, helplessness and

increased frustration [15,16].Out of 156 patients included in the study 106 were urban and 50 belonged to rural localities. The clinic is located in a urban locality and the total number of patients visiting the hospital is dominated by urban patients so is reflected by the distribution of PME patients. The mean BDI-II score of urban patients was 12.7 and that of rural patients was 10.3. no significant difference was noted between scores of the two groups. On DASS 21 (D) subscales we found 29% were having clinically depressed, on anxiety subscales 35% were significantly anxious, around 48% were stressed on stress subscales.23.68% of urban and 22.2% of rural patients were having clinical depression (BDI-II score>14) and the difference in the prevalence was not significant. Our study found out that 23.2% of all patients visiting the outpatient department for treatment of PME were suffering from depression as estimated by BDI-II score more than 14.In our study, subjects in the age group 31-40 yrs. were having most no. of PME cases (41.1%) followed by age group 21-30 yrs.(30.3%). 19.6% of subjects having age >40 yrs. who visited the clinic were having PME.Son et all (2011) found that Asian males within the age group 30-40 yrs.are most sexually active and thus the proportion of those having sexual dysfunction is higher[30].Although, the prevalence of PME increases with increasing age[14],only 19.6% of patients older than 40 yrs. reported PME in this study. In a culture where sexual activity in older age is not considered 'essential' and virtues like self-control' and indifference to materialistic pleasure are desirable, we didn't expect people more than 40 yrs. to come to psycho-sexual clinic in larger proportions. Moreover, older people tend to learn to live with such problems[31].There was no significant difference in the prevalence of depression among the groups reflecting that depression associated with PME is not related to AGE. We tried to find out any correlation with educational qualification and prevalence of depression among PME patients.51.8% of all subjects belonged to the group consisted of patients who were educated up to graduate level while up to primary level group had only 5.3% of the cases. Two possible explanations can be given, Firstly, illiterate people , due to lack of awareness about specialty facilities in the hospital were less aware about psycho-sexual clinic. Secondly more of urban patients were visiting the clinic and the literacy status of urban population is better than rural population .There was no significant difference between the prevalence of depression among the 5 groups consisted on the basis of educational status. Thus it was clear that there was no correlation between literary status of patients and prevalence of depression in patients of PME.

V. Conclusion

Premature ejaculation is the most common type of sexual dysfunction seen in male patients. Premature ejaculation is often associated with sense of inadequacy, guilt, disappointment, fear and embarrassment which ultimately lead to reduced satisfaction with sexual experience and anxiety. Almost one fourth of the patients suffering from premature ejaculation have significant psychopathology qualifying for the diagnosis of clinical depression(BDI-II>14) .Prevalence of depression in patients of PME was not associated with whether patients are rural or urban, nor it was associated with level of education.

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