Original Article

A study of factors associated with common sexual disorders presenting at marital and sex clinic

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Abstract : *Myths are prevalent in the society regarding dhat syndrome, nightfall and masturbation. That leads to anxiety, restlessness, wrong treatment seeking patterns and wastage of finance on the unscientific and ineffective treatment. Hence, to understand this common phenomenon 100 consecutive male patients coming to the marital and sex clinic, in the department of psychiatry, GMCH were included in the study. Control group comprised of 100 age matched normal males who accompanied the patients. Socio demographic data was also taken. Chi square and t test were used to analyze the results. Significantly more patients believed that dhat, masturbation and nightfall were not a normal activity. Significantly more patients as compared to control had unsatisfactory first sexual experience.*

Keywords: Dhat, myths, nocturnal emission, masturbation

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INTRODUCTION

Sexuality has been a consistent focus of curiosity, interest, and analysis to mankind. Sexuality is determined by anatomy, physiology, the culture in which a person lives, relationships with others, and developmental experiences through out the life cycle. It includes the perception of being male or female and private thoughts and fantasies as well as behavior.[1]

Sexual disorders need to be viewed in the light of societal attitudes and beliefs. There always has been a schism in the society regarding sexuality. Messages that the society gives about sexual expressions are quite conflicting and confusing. Despite the recognition that sex is a biological need and its importance in the well being of an individual, almost all societies advocate that sexual expression is a powerful force and such energy has to be dealt and transformed by the society.[2]

Lots of myths are prevalent in the society regarding sexual issues. There is a myth that loss of semen in any form leads to draining of physical and mental energy and vitality. [3,4] It is further reinforced by the belief enshrined in religious scriptures according to which 40 meals produce one drop of blood , 40 drops of blood make one drop of bone marrow and 40 drops of bone marrow form one drop of semen. [5] It is also believed that semen preservation guarantees health, longevity and supernatural powers.[6] Similar beliefs are also prevalent for nightfall as it involves ejaculation during sleep for males. Nocturnal emissions are most common during adolescence and early young adult years. The emission may happen with or without erection, and it is possible to wake up during or simply to sleep through the ejaculation.[7] Little is known about the actual cause of nocturnal emissions, leaving explanation of phenomenon to wide speculation.

Misconceptions regarding masturbation are also common amongst general population. Even though masturbation is a normal precursor of object related sexual behavior and no other form

of sexual activity has been more frequently discussed and more universally practiced, even then it carries with it lots of myths and taboos. Research by Alfred Kinsey into the prevalence of masturbation indicated that nearly all men and three fourths of all women masturbate sometime during their lives.[1] Common moral taboos against masturbation are that it causes mental illness or decreased sexual potency.

It is also seen that urbanization and industrialization, has led to early exposure of males and females towards sexual issues. An early exposure can be seen in terms of early age at which masturbation is started. Increased exposure and high sexual drive can also be one of the reasons due to which indulgence in sexual activities comes early in life now.

Even though dhat syndrome, nightfall and masturbation have been an important topic of research, till now, myths and misconceptions relating to sex and sexuality are still a part of our society. Poor knowledge about dhat syndrome, nightfall and masturbation leads to anxiety, restlessness, wrong treatment seeking patterns and wastage of finance on the wrong treatment etc. Hence, it is imperative to understand these common phenomenons which are otherwise normal.

Keeping the above review in mind, the aim of the present study was firstly, to see the profile of patients attending marital and sex clinic; Secondly, to compare study group and control group on socio demographic variables and sexual knowledge and practices.

METHOD

100 consecutive male patients coming to the marital and sex clinic, in the department of psychiatry, GMCH with the complaints of premature ejaculation, erectile dysfunction, dhat, masturbation and nocturnal emission were included in the study. Control group comprised of 100 normal age matched males from the relatives of patients accompanying the patient. On the basis of the experience from the psycho sexual clinic as well as from the review of existing literature and the related tools, the authors designed a semi structured interview schedule for assessing sexual knowledge and attitude. Socio demographic data was taken. In both the groups, individuals with any chronic medical disorders like diabetes, hyperthyroidism, hypertension, head injury, spinal cord injury; surgical, mental disorder were excluded. Chi square and t test were used to analyze the results.

RESULTS

In our study, results revealed that the mean age of patients coming to the marital and sex clinic was 31.30(SD=9.67) and that of the control group was 33.65(SD=7.17) (Table 1). Significant differences were found for marital status, education and occupation in two groups. In control group, 90% patients were married, 45% patients were graduate or higher and 91% patients were employed and the difference was significant.

There were significant differences between both the groups in relation to economic status, locality and residence. The mean age of married patient's spouse was 28.98(6.61) for the patients and 35.10(8.63) years for the control group. There were no significant differences between both the groups on spouse age and spouse education.

94% of patients coming to the clinic and 86% of individuals in control group reported having done masturbation and there was significant difference on age at which masturbation was started. The mean age at which masturbation was started in study sample was 15.87(2.66) years and that of control group was 16.78(2.70) years.No differences were found among both the groups on doing masturbation currently. Significant differences were found among both the groups on perception of masturbation and nightfall as

Table 1

Socio demographic profile of study group and control group (n=100 each)

	Study group	Control group	t-test p values
Age Mean(S.D.)	31.30(9.67)	33.65(7.17)	.052
Marital Status Single Married Divorced	 43 56 1	 10 90 0	 .001
Education Illiterate Upto matric Inter/Diploma Graduate or higher	 14 41 24 21	 6 41 8 45	 .001
Occupation Employed Unemployed/Idle Student	 88 1 11	 91 7 2	 .005
Economic Status 0-3500 3501-7000 >7000	 53 29 18	 16 18 66	 .001
Locality Urban Rural	 55 45	 82 18	 .001
Residence Chandigarh Punjab Haryana Others	 32 28 11 29	 81 11 6 2	 .001
Spouse Age Mean(S.D)	 28.98(6.614)	 35.10(8.63)	 .001**
Spouse Education Illiterate Upto matric Inter/Diploma Graduate or higher	 15 23 12 2	 13 39 2 35	 .001**
Spouse Occupation Employed Unemployed/Idle	 10 42	 15 74	 .721

being a normal activity and 58% of the study sample said that nightfall is not a normal activity. No difference was found on thinking as dhat being a normal activity. The mean age of first sexual experience was 21.93(4.56) for study sample and 22.56(4.06) for control group and the differences was not significant. Significant difference was evident on first sexual experience being satisfactory. 78% control group patients reported it to be satisfactory as against 55% in study group.

DISCUSSION

The findings of this study reveal that the misconceptions related to sexual issues like masturbation and nightfall are very common among Indian patients coming to the marital and sex clinic. Despite indulging into masturbatory practices, significantly more individuals in the study group believed that masturbation was not a normal activity. Even though the large number of individuals in both the groups had received more than ten years of formal education, still myths related to masturbation were prominent. Thus, education does not alter firmly held misbelieve regarding masturbation. Since, formal educations in India completely excludes information on sex and sexuality, people lack scientific information on the subject and are still influenced by unscientific sources of information on sex.

Though a number of studies in the last fifteen years indicate that attitudes towards masturbation have relaxed a bit compared to earlier times, but carryovers still remain. Unfortunately, some physicians are no better informed on this subject than the public.[8] In a study, authors reported that feelings of guilt are present after masturbation.[9] As most of the patients in our study reported that masturbation is not a normal activity, currently majority of them were not practicing masturbation. Individuals in both the groups reported certain reasons for why they thought that masturbation was not a normal activity and the reasons reported by the patients were: leads to physical weakness; size of penis

Table 2

Clinical profile of study group and control group (n=100 each)

	Study group	Control group	t-test p values
Age			
Have you ever done masturbation?			
Yes	94	86	
No	6	14	.059
At what age was masturbation started?			
Mean(S.D)	15.87(2.66)	16.78(2.703)	.025*
Are you currently doing masturbation?			
Yes	21	24	
No	73	62	.389
Is masturbation a normal activity?			
Yes	22	45	
No	67	39	
Don't know	5	2	.001
Is nightfall a normal activity?			
Yes	30	47	
No	58	34	
Don't know	12	19	.008
Is Dhat a normal activity?			
Yes	15	15	
No	61	44	
Don't know	18	27	.122
Age of 1st sexual experience.			
Mean(S.D)	21.93(4.56)	22.56(4.06)	.324
Was the 1st sexual experience satisfactory?			
Yes	55	78	
No	27	22	
Never had intercourse	18	0	.001

reduces; sexual life gets disturbed as leads to decrease in frequency of sexual intercourse; leads to early discharge; semen becomes thin; leads to feelings of guilt, dhat, erectile dysfunction, impotency, decreased memory. There was no difference between patients and control. The doubts on masturbation do linger on the following

Table 3

Reasons reported for masturbation not being a normal activity (n=100 each)

Reason	Study group	Control group
Leads to physical weakness	58	45
Size of penis reduces	10	8
Sexual life gets disturbed as leads to decrease in frequency of sexual intercourse	4	1
Leads to early discharge	8	5
Semen becomes thin	6	5
Leads to feelings of guilt	41	36
Dhat	2	-
Erectile Dysfunction	4	-
Impotency	4	-
Decreased memory	4	-

issues like: *masturbation is sinful* and *unnatural*. If naturalness refers to what occurs in nature, then this statement is incorrect. Since masturbation has been observed in many animal species also; *masturbation maybe a part of growing up, but adults who masturbate are psychologically immature*. Freudian theory generally supports this view point, suggesting that adult masturbation is a symptom of psychosexual immaturity except when it is used as a substitute for heterosexual intercourse when no partner is available. Yet no studies show that adults who masturbate are less mature than those who do not; and that *masturbation tends to be habit forming and may prevent the development of healthy sexual functioning*. In fact, it needs to be promoted that masturbation can provide a viable and pleasurable sexual outlet for people without partners, including the elderly. Masturbation can also be beneficial to persons whose drives are greater than their partners' at a particular time.

In our study significant differences were present on whether 'nightfall' is a normal activity or not. Most of the patients in our study group

reported that nightfall is not a normal activity. Authors of another study [9] reported that 71.3 percent patients reported to a sex therapy clinic with a complaint of nocturnal emission and 19.5 percent of these patients reported excessive worry about nocturnal emission. Kinsey and his co workers [8] found that 83 percent of all males experience nocturnal ejaculation at one time or the other, with the highest incidence and frequency of this phenomenon occurring during the late teens. Some of the hazards of nightfall reported by our patients were: physical and mental weakness; increases anger, irritation, tension, laziness; sexual weakness, poor sexual performance; decreases size of penis; poor erection and impotency.

Both the groups in our study reported that 'dhat' is not a normal activity. In an other study, dhat was reported in 64.6% patients and the common presenting symptoms of dhat included weakness, fatigue, palpitations and sleeplessness.[10] The dhat syndrome is a culture bound symptom complex in which the patient is preoccupied with the fear of excessive loss of semen through urine secondary to infection. Therefore, due to this reason these patients prefer to visit STD clinics, urologists and physicians rather than approaching psychiatrists.[11] Subjects in our study reported that dhat led to: physical weakness, decrease size / weakness of penis, erectile dysfunction, premature ejaculation and impotency.

The authors also attempted to investigate the first sexual experience (FSE) in both the groups and result showed that significantly more patients as compared to control had unsatisfactory FSE. It is possible that this experience occurred in unnatural circumstances because of social factors and it affected subsequent performance because of fear of failure again, thus setting a vicious cycle. The unsatisfactory early experience was described in the form of early discharge, did it illegally, fear of being caught, ED, uncooperative partner, increased excitement/ anxiety and mentally not prepared for the act.

It is possible that unsatisfactory first sexual experience, can lead to decrease in self esteem resulting in doubts about own sexual performance. Many patients start attributing failure during FSE to nightfall and masturbation. The younger age and lower education of the spouses might further complicate the problem due to her unrealistic expectations and poor participation during sex. The excessive performance anxiety might maintain the sexual disorder. The visits to traditional practitioners and faith healers further complicate the problem through reinforcement of misconceptions and unscientific treatment methods.

The result of this study suggests that sexual dysfunctions in our patients result from multiple misconceptions associated with normal sexual activities which can be due poor sex education. Early indulgence in sexual activities with limited sex knowledge and unsatisfactory FSE together can lead to sexual dysfunctions in our patients.

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