

EVALUATION

The Pattern of Help-Seeking Behavior Among Patients With Sexual Dysfunctions Attending in Psychiatry Outpatient Department in a Tertiary Care Hospital of Bangladesh



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ABSTRACT

Introduction: Identifying the possible pattern of help-seeking can explain the gap between care need and actual use of care.

Aim: To know the patterns of help-seeking behavior among patients with sexual dysfunction in the context of a developing country.

Methods: This was a cross-sectional, qualitative study using criterion sampling among the diagnosed patients of sexual dysfunction attending the psychiatry outpatient department. Based on data saturation, 18 in-depth interviews were done. For method triangulation, 1 key informant interview, 1 informal interview, and 1 focus group discussion were performed. Data were analyzed manually using the thematic analysis method.

Main Outcome Measure: Using an interview guideline, face to face interview was performed and the participants reported their pattern of help-seeking regarding their sexual problems.

Results: The majority of the participants were male, within 20–35 years of age range, literate, and from an urban background. Premature ejaculation and female sexual interest/arousal disorder were the most common disorders. After the identification of the problems, help-seeking was done mostly from close and intimate relationships, although a few of the participants choose a self-search strategy. The complementary and alternative medicine approach was mostly used where traditional healers played a major role. The biomedical approach was the last to seek help and most of the participants visited the dermatology and venereology department. Self-help techniques and internet use were found as emerging ways to seek help.

Conclusion: Sex education is necessary to improve general awareness because surrounding people were found as the primary source of information. **Acharjee P, Mullick MSI. The Pattern of Help-Seeking Behavior Among Patients With Sexual Dysfunctions Attending in Psychiatry Outpatient Department in a Tertiary Care Hospital of Bangladesh. Sex Med 2021;XX:XXXXXX.**

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Key Words: Sexual Dysfunctions; Help-Seeking Behavior; Developing Country; Bangladesh

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INTRODUCTION

Sexual dysfunctions are common and their negative impact on the quality of life is now widely recognized.¹ The Global Study of Sexual Attitudes and Behaviors found that 43% of men and 49% of women respondents worldwide have at least one sexual problem.² In some Asian countries, more than 20% of men and 30% of women were complaining about at least one sexual dysfunction, while in India, the rate was 1 in 5 males (21.15%) and 7 females (14%).^{3,4} In Bangladesh, the prevalence of sexual

dysfunctions was found as 6.8% among patients with diagnosed sexually transmitted diseases.⁵ Whatever the prevalence, sexual dysfunctions contribute significantly to the reduction in quality of life along with mild depression (30%), generalized anxiety disorder (26%), mixed anxiety-depression (22%), and nicotine dependence (28%) and may lead to divorce seeking (22%).^{6,7,8}

But a little portion of people with sexual dysfunctions seeks medical help.¹ The term help-seeking refers to communication with someone to seek help through the process of understanding, advice, information, treatment, and general support for a problem or distressing experience.⁹ So, identifying the possible pattern of help-seeking can explain the gap between care need and actual use of care.¹⁰ It would also assist in making plans for service delivery toward the target population. But there is a scarcity of evidence-based knowledge regarding this issue, especially in the context of a developing country. Bangladesh is a country with a Muslim majority population along with people with a belief in Hinduism, Buddhism, and Christianity. Irrespective of religion, people are too conservative and sex is taboo here and not openly discussed usually.^{11,12,13} Even clinicians feel embarrassed to discuss or to make a query with the patients regarding sexual issues.¹⁴ For these, different patterns of help-seeking behavior are only assumed, without any evidence-based information in favor of these. Therefore, we set out the research question as what is the pattern of help-seeking behavior for sexual dysfunction among such patients in Bangladesh? This study was aimed to explore the usual patterns of help-seeking behavior among patients with sexual dysfunction attending a tertiary care hospital in Dhaka city. The findings of this first-time study in Bangladesh on this issue will fill up the knowledge gap as well as explicit the possible strategies to improve the scenario.

MATERIALS AND METHODS

This was a phenomenological, qualitative study; done in the Outpatient Department (OPD) of Psychiatry, Bangabandhu Sheikh Mujib Medical University (BSMMU), Dhaka, from January 2016 to September 2017. Talking about sex is a highly sensitive issue in Bangladesh. So, one to one or private conversation type approach was revealed more appropriate to collect data. Again, qualitative studies can drill down more than the questionnaire-based studies to investigate the type of assistance that was sought or received.¹⁵ More freedom and flexibility, made the approach good enough for exploratory and discovery-oriented research.¹⁶ So, a qualitative study with rigorous description was chosen.

We used criterion sampling among the patients, who were diagnosed as a case of sexual dysfunction according to Diagnostic and Statistical Manual of Mental Disorders—5th edition, irrespective of their marital status, aged above 18 years, and attending in the OPD of psychiatry. Ethical clearance was taken from the Ethical Review Board of BSMMU. Initially, we targeted 30 participants to be interviewed.¹⁷ Thirty-two people were invited and 4 of them refused because of the shortage of time and

hesitation about talking about sexual matters in detail, which is very normal from the Bangladesh context. All interviews were done in private except the interview of 1 female participant, where her husband was present during the interview. We did not carry out any repeat interviews. All the interviews were audio-recorded with a smart mobile phone (Moto-G, 3rd generation mobile, Motorola Company, made in China, data storage capacity 32GB) using free apps named “Voice Recorder” downloaded from Google Apps. The data were recorded as high-quality MP4 format files and immediately transferred to the personal laptop of the researcher. Based on data saturation, 18 in-depth interviews (IDIs) were kept for analysis discarding 4 IDIs done further to confirm the data saturation. Pretested structured questionnaires for sociodemographic variables and an “Interview guideline” were used by the first author while interviewing the participants. At first, the first author made a rapport with the participants to be interviewed. Then, he explained the aim of research as well as, ethical matters in detail; like the autonomy to participate and to withdraw any time, audio-recording, the confidentiality of identity and audio-records, and no financial interactions. A blend of an interview and an informal conversation was incorporated to get rich information starting from the onset of sexual problems and ending with the coming to the researcher. IDIs took 15–20 minutes on average. During the interview, field notes were taken in the format of the inclusion of specific words or sentences or hints only. Later, these were elaborated and finalized by the first author within a short interval.

For triangulation, 1 key informant interview, 1 informal interview with a key person, and 1 focus group discussion (FGD) with 4 participants were performed. The key informant was an associate professor of psychiatry at the time of the interview with 10 years of experience in conducting the only psychiatric sex clinic in Bangladesh. The informal interview was done with an assistant professor of psychiatry and was then the only psychiatrist with the credentials of the Fellow of European Committee for Sexual Medicine and ESSM/EFS Certified Psycho-Sexologist. Both of them described their experiences in this field, clarified, and add to the obtained data with their answers to the question of the first author. The key informant interview and the informal interview took 30 and 10 minutes, respectively. The FGD was 1 hour in length which was performed as the last interview to get a wider view and triangulate the total findings. Four participants from different social and cultural contexts participated. The first author moderated the discussion, with the help of a colleague as the assistant moderator having experience in conducting FGDs. Both the first author and assistant moderator took field notes separately, clarified the information from different angles, and finalized the field notes jointly after the interview was done. Thus, a total of 24 participants were included finally.

The first author thoroughly checked and verified all the collected data several times to reduce inconsistency and transcribed verbatim in written form to get a general sense of the whole and ideas presented. Finally, the data were analyzed manually using

the steps of the thematic analysis method, as this method is suitable for any format of qualitative data.¹⁸

Triangulation from different data sources was used to build a coherent justification for the themes. Three types of interviewing techniques were used as method triangulation. Participants from different sociocultural backgrounds, educational statuses, etc. were included to explore the help-seeking pattern from different contexts. The first author re-examined the coded data and themes at different time intervals for better understanding and to increase accuracy. The second author analyses 2 of the interviews separately, while another resident of the same department oriented in the qualitative research method, peer-reviewed another 2 of the interview analyses. Both of them found no major discrimination with those codes and themes of the first author, though some modifications were made based on their analysis. The data and findings were regularly shared with the colleagues. Based on these, one senior colleague gave comments throughout the study period regarding the accuracy of interviews, analysis, and so on. We explored deviant cases critically and included them in a separate theme. The whole study things were documented accordingly. One of the key informants checked his interview summary, as well as codes and themes, emerged from his interview after analyses. He made some minor clarification. No transcripts were returned to the participants for member checking, though this was performed partially by summarizing the information given by them before closing the interview. This was done to avoid the complexities of the procedure in the context of Bangladesh.

RESULTS

A. Context

A1. About the researchers. The first and corresponding author was a resident of psychiatry at the time of the study with frequent exposure to male, female, and transgender patients with sexual problems. Thus, he developed some insight into their help-seeking behavior, their views to and sufferings about sexual problems, as well as, the problems in the service delivery system. He felt an evidence-based knowledge gap in the context of Bangladesh and so opted to study this topic. Later, he attended a basic training course on qualitative research to enrich him. He conducted all the interviews including the FGD by him. Though this was the first-time experience, he tried his level best to have the best outcome. Moreover, he was always supervised by the second author. As a professor, the second author had a huge experience in the research field, in both national and international sectors, during his long academic career. He was involved in planning this study and supervised the first author throughout the study. He also did analyses of several interviews.

A2. Health care delivery system in Bangladesh. The World Health Organization declared Bangladesh as one of the 58 crisis countries facing an acute human resource for health crisis. For per 10,000 population, there were 5 physicians, 2 nurses, 12 unqualified village doctors, 11 salespersons at drug retails outlets, 7.7

formally qualified registered health care professionals, 3 qualified homeopaths, 2.5 unqualified homeopaths, 31 “Kabiraj,” and 33 other traditional healers.¹⁹ In this scenario, patients, especially the poor and the disadvantaged, mostly seek health care from the unqualified and nonregistered providers in the informal sector. The popular perception of lower charges and being more effective than allopathic medicine influence this attitude.²⁰ This informal sector includes unqualified allopathic providers like village doctors or drugstore salespeople. The village doctors, also known as a rural medical practitioner or “Palli Chikitsok” in Bangla, mostly received a few weeks to a few months of training on some common illnesses, from unregistered and unregulated private institutions. The drugstore salespeople usually have no training, even on dispensing; but regularly provide health care. This informal sector also includes the traditional healers mostly known as the “Kabiraj” and nonsecular faith healers, usually called “Hujur,” “Pir,” or “Baba.” They give talisman, “Panipora” (water with sacred ayah or mantras), etc. to cure health problems. The homeopaths are mostly self-educated, though some of them possess a recognized qualification from the government or private homeopathic colleges.¹⁹

B. Sociodemographic characteristics

Excluding 2 key personals (participant no 18 and 20), a total of 22 participants participated in this study. The majority (86%) of them were within the 20–35-year age group. All the participants were Muslim. Most of them were male (86%), educated up to secondary level (27%), from an urban background (72%), married (72%), and from middle-income groups (45%). All 3 female participants (100%) were housewives (Table 1).

C. Types of sexual dysfunctions

Most among the male participants (72%) were suffering from premature ejaculation, while 2 of the female participants (67%) were suffering from female sexual interest/arousal disorder. The highest duration of illness was 16 years while the lowest was 7 months (Table 2).

D. Help-seeking behavior

Identification of the problem was the first thing to seek help. Most of the participants (73%) done this by themselves. Then most of them (77%) talked to close and intimate ones for a decision about their problems. And a few tried to solve their problems based on their own decisions, which is here termed as a self-search group. When a practice not included in main-stream is used along with or instead of mainstream treatment practice, it is called complementary or alternative medicine respectively.²¹ This includes homeopathy, chiropractic, naturopathy, Ayurveda, or faith healing.²² Here, complementary and alternative medicine (CAM) was the most common choice for help-seeking, followed by the biomedical approach. It was observed that most participants used both approaches. Switching often occurred between biomedical and CAM approaches. But overall biomedical help was sought at the last stage. Again, those who emphasized self-help usually avoided the CAM approach. All the participants, except one, came to the psychiatry outdoor through

Table 1. Sociodemographic characteristics of the participants (n = 22*)

Participant no.	Age (yrs)	Sex	Religion	Education	Habitat	Marital status	Occupation	Income group	Interview type
01	33	Male	Islam	Secondary	Rural	M	Day laborer	Low	IDI
02	45	Male	Islam	Postgraduate	Urban	M	Businessman	High	IDI
03	19	Male	Islam	Secondary	Urban	UM	Others	Low	IDI
04	36	Male	Islam	HSC	Urban	M	Service holder	Middle	IDI
05	25	Male	Islam	Secondary	Rural	UM	Currently unemployed	Low	IDI
06	25	Male	Islam	Primary	Urban	M	Others (pharmacy owner)	Middle	IDI
07	38	Male	Islam	Illiterate	Rural	M	Currently unemployed	Low	IDI
08	30	Male	Islam	SSC	Urban	M	Currently unemployed	Middle	IDI
09	35	Male	Islam	Primary	Urban	M	Farmer	Low	IDI
10	27	Male	Islam	Illiterate	Rural	M	Day laborer	Low	IDI
11	29	Male	Islam	HSC	Urban	D	Service holder	Middle	IDI
12	39	Male	Islam	Graduate	Urban	M	Service holder	Middle	IDI
13	36	Male	Islam	Secondary	Urban	M	Businessman	Middle	IDI
14	35	Male	Islam	Primary	Urban	M	Others (tailor)	Low	IDI
15	22	Female	Islam	Primary	Urban	M	Housewife	Middle	IDI
16	20	Female	Islam	Primary	Rural	M	Housewife	Low	IDI
17	20	Female	Islam	HSC	Urban	M	Housewife	Middle	IDI
19	45	Male	Islam	Postgraduate	Urban	M	Service holder	High	IDI
21	32	Male	Islam	Graduate	Urban	UM	Businessman	High	FGD
22	31	Male	Islam	Secondary	Rural	M	Others (tailor)	Low	FGD
23	21	Male	Islam	SSC	Urban	UM	Service holder	Middle	FGD
24	23	Male	Islam	Graduate	Urban	UM	Student	Middle	FGD

*Excluding participant no. 18 (key informant interview) and 20 (informal interview).

D = divorced; FGD = focus group discussion; IDI = in-depth interview; M = married; UM = unmarried.

referral by other disciplines, mostly from the dermatology department. Only 1 participant came directly to psychiatry outdoor having information about this clinic through the internet. Only 1 participant went for psychological management that was for psychotherapy. The whole process has shown in [Figure 1](#).

D1. Problem identification. Sixteen participants identified the problem by themselves (73%), while 3 identified this from their partners complaining (13%), 2 (9%) by comparing and sharing with friends, and only 1 (4.5%) was identified by the physician. Like:

"I just went to my girlfriend (for a physical relationship). Then, I felt it the first time, I mean, finished before the (physical) contact. I did not worry, that, it could happen for the first time. Then, passed out within a second, two months later the condition was the same. Now, I got married, (but) passing out (quickly) is a problem yet." (P-6, male, 25 yrs)

"I mean, mine, there are many more friends with me. Theirs (semen) did not pass out (early) during their turns. But it (semen) passes out very quickly in case of mine. They told me; you have some problems". (P-5, male, 25 yrs)

"After arriving at the Mitford Hospital (a tertiary hospital), they (physicians) asked whether there is any other problem. Then I said, yes, I have this (sexual) problem (Husband's affirmation with head nodding). Due to other problems, this came out. Then I told them about this problem." (P-16, female, 20 yrs)

D.2.1. Search through a close and intimate relationship. Seventeen of the participants (77%) talked to others to have some sort of advice or help, including friends, close relationships, family members, partners, and relatives. Only 1 participant (4.5%) talked to the family members while friends were the main source of help (45%).

Friends, especially the married or having a medical background, played a major role in help-seeking and advice-giving regarding sexual problems. One participant stated:

"Just, as usual, discussed now and then (with friends), those (friends) who are married, how is theirs (condition), what is the condition, what, they can, (etc.)." (P-21, male, 32 yrs.)

Some of the participants talked to some of their close persons other than family members, like- colleagues, roommates about their problems.

"Then I told to an uncle, uncle means supervisor (at the workplace) of mine, what to say about, actually I felt shy (to talk with supervisor), but I questioned him being a little bit anxious, he gave me some answers." (P-3, male, 19 yrs.)

D.2.2. Self-search group. Five among all participants (23%) took all the decisions themselves based on the self-searched data throughout the whole process, and are termed as the "self-search

Table 2. Types of sexual dysfunctions and total duration of illness among participants ($n = 22$)

Participant no.	Type of sexual dysfunctions	Total duration of illness
01	Premature ejaculation, erectile dysfunction	16 years
02	Premature ejaculation, erectile dysfunction	10 years
03	Premature ejaculation	2 years
04	Premature ejaculation	1 year
05	Premature ejaculation	7 years
06	Premature ejaculation	4 years
07	Premature ejaculation, erectile dysfunction	10 years
08	Premature ejaculation	8 years
09	Premature ejaculation	6 years
10	Premature ejaculation	4 years
11	Erectile dysfunction	5 years
12	Premature ejaculation, erectile dysfunction	11 years
13	Erectile dysfunction	7 months
14	Premature ejaculation	3 years
15	Female sexual interest/arousal disorder	1½ years
16	Genito-pelvic pain/penetration disorder	1½ years
17	Female sexual interest/arousal disorder	1 year
19	Premature ejaculation	1 year
21	Premature ejaculation	1 year
22	Premature ejaculation	4 years
23	Premature ejaculation	3 years
24	Premature ejaculation	2 years

group.” The usual options were searching the internet, reading books, following the writings on various posters, banners, or signboards, watching the advertisement in newspapers or on television, and joining a seminar. Some of them joined with discussions of other people, gathered information, and sought help from various sources accordingly. But they did it without sharing anything about their problems. This group mostly (80%) went for biomedical management, while only 1 went for psychological management. Again, those who talked to others also used self-searching occasionally but did not stick to it.

An increasing tendency to use the internet for these problems was observed among young and literate participants. They searched through Google with or without specific keywords or watched YouTube.

“But, recently, I, from the internet, ya, getting help on different topics, on these topics (sexual problems), and no (not from other’s laptop), I have a laptop of my own. I (learned) how to take a long time (holding ejaculation) with my laptop (from the internet). This, how to do, what to do, and whatnot. These were given to different websites, which you all know better than me; recently

I am taking help from there, from the internet.” (P-8, male, 30 yrs.)

D.3. Complementary and alternative medicine. Sixteen of the participants (73%) sought help from CAM which included traditional healer, religious healer, canvasser, herbalist (Unani/Ayurveda), the village doctor, homeopath, pharmacy owner, and local remedy.

D.3.1. “Kabiraj.” Thirteen participants (59%) went to the “Kabiraj” and took their treatment termed as “Kabiraji.” The word “Kabiraj” was used to describe the traditional healers, religious healers, and herbalists.

The traditional healers usually sell different herbs as medication, locally termed as “banaji” (herbs), “gach-gachali” (roots of different herbs). Like:

“Some ‘gachgachali’, those (kabiraj) at villages you know give medicines and others, those, ‘gachgachali’ are there, those were taken.” (P-1, male, 33yrs.)

Some locally known religious persons with the title of “Hujur,” “Pir,” “Fakir,” or “Imam” were also called “Kabiraj.” Their healing methods include- giving “tabij” that is a talisman; “jharajhari” or “jhar-fuk” that is mild beating with some shrubs and blowing to the sick person while uttering some religious words; “halua” a paste-like medication, which is prepared on various food bases like “semolina” with a mixture of some chemical or herbal ingredients; “salsa” which is a local term, indicating a liquid format of medicine made by traditional healers mainly, containing various known and unknown chemicals, powder or juice of herbs within the water and the religious healers demand that, these have the unnatural power of “mantra” or “verses”; “panipora” which means water in a bottle or coconut having the power of verses or unnatural forces; and honey. For example:

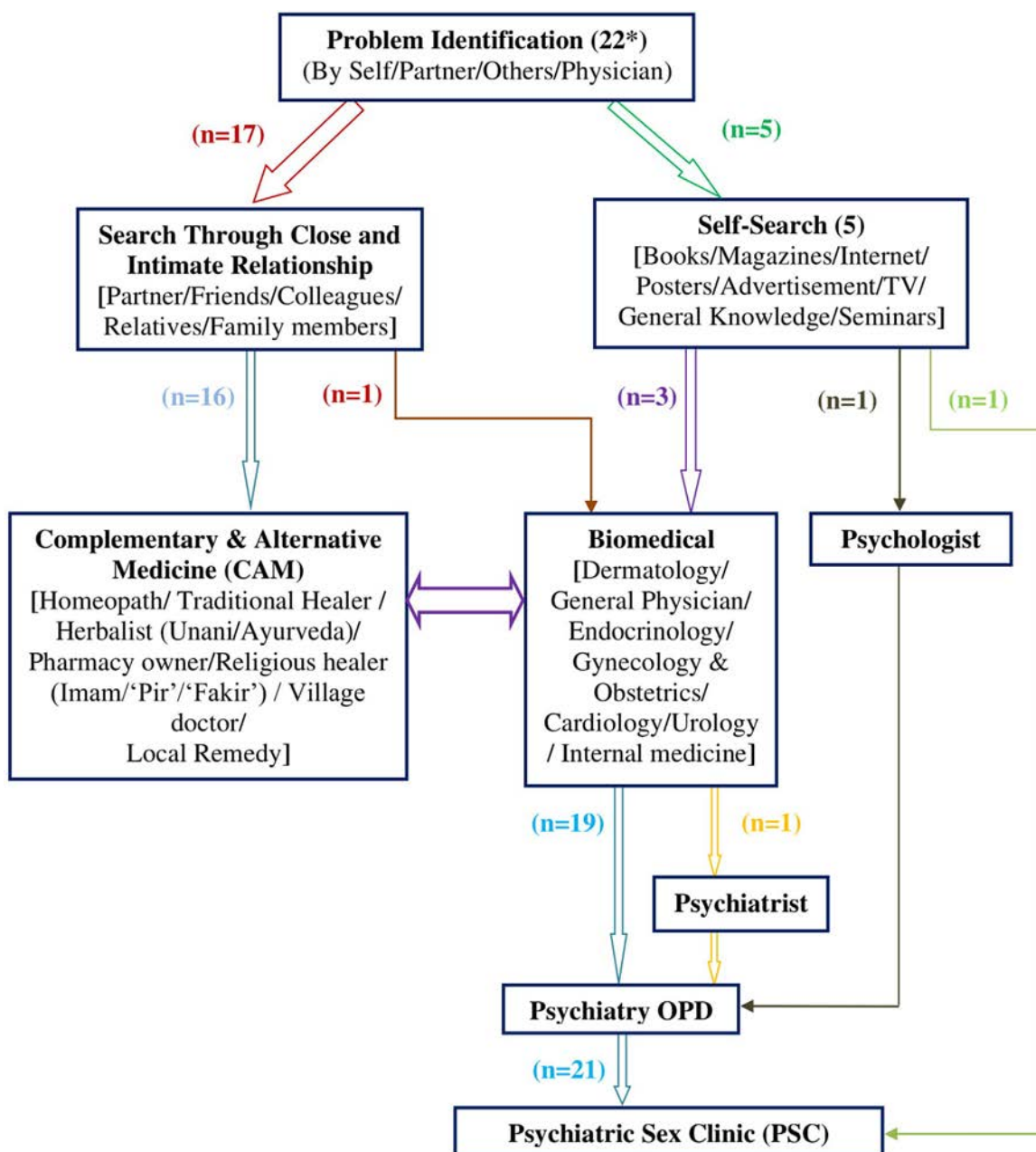
“A ‘kabiraj’ came to our home. I discussed with him, ‘kabiraj’ means native ‘fakir, like fake ‘pir’ etc. Went to him, (he) gave some ‘halua’. There (I) ate ‘halua’, tasted tasty, only this, came to no other use.” (P-7)

Many of the participants visited an herbalist, mentioning them as “kabiraj” at various locally renowned herbal treatment centers. Some of the centers are Unani-based like- “Hamdard,” while others are Ayurveda centers, like “Sadhana.”

“Yes, as I told, went to ‘Hamdard’. Visited, visited one time (at Hamdard). In the beginning, ‘Hamdard’ and (then went to) ‘Sadhana’.” (P-2, male, 45 yrs.)

There are also some locally popular herbal centers with no specific format. To attract more people, they use “Indian,” “modern,” “German,” “Kolkata,” “VIP,” etc. words. For example, “Kolikata herbal,” “modern homeopathy,” “Indian herbal,” “VIP herbal,” etc. According to a participant

“Then there is herbal, went to herbal, went to ‘Indian herbal’, and took (their) medicine.” (P-5, male, 25 yrs.)



* Participants number in total (Except Key Informant Interview & Informal Interview)

Figure 1. Process diagram showing pattern of help-seeking behavior among the participants.

An interesting statement came from a participant, which also can be labeled as an irony of fate. This participant, the owner of a pharmacy, followed the self-help strategy, and actively avoided any sorts of CAM because of his lack of faith in these. But, when he visited the dermatology outdoor of a tertiary hospital as well as a center of excellence, he had prescribed some Unani medicines including some hormonal preparation. The participant took these Unani medications at that time but got no improvement after 1 month. According to him:

"Visited at the outdoor (of dermatology). Here, those they prescribed were Unani medicine. (Also) Gave two to three types of

hormone-like medicines. I took those for a long month. (But they) Did not work." (P-6, male, 25 yrs.)

D.3.2. Canvassers. Five participants (23%) went to the canvassers. They use various formats of medications, like "molom," "halua," or "malish," which are paste of different so-called herbs to be used orally or by massaging on the penis; "file" that is some liquid preparations in a bottle, and mushrooms. People usually get allured by their speech and the relatively low cost of medications. According to one of the participants:

"Suppose, one of them, gave 'molom' of, you know, 'molom' for the gross top and lean shaft (of the penis), 'malish', 'malish'.

Again, to have a long time (during intercourse) gave 'halua'." (P-7, male, 38 yrs.)

D.3.3. Pharmacy owner. In Bangladesh, any person having no training or academic knowledge about medicine can sell drugs of any category in a pharmacy without any restriction or any authentic prescription. Surprisingly, the pharmacy owner is called a "doctor" and they give medications as treatment. 6 participants (27%) went to some pharmacy owners for help.

"When understood (the problem) went to a doctor (pharmacy owner), I mean to a dispensary of (my) village." (P-1, male, 33 yrs.)

D.3.4. Village doctor. Sometimes "Palli Chikitsok" which means village doctors was also an option for help-seeking. According to a participant:

"One of my elder brothers came to (my) home, after coming, one of his brothers-in-law is a doctor, 'Palli Chikitsok', and he (Palli Chikitsok) gave medicine of those (for sexual problems)." (P-9, male, 35 yrs.)

D.3.5. Homeopath. Many participants took homeopath at different times for a long time because of their problem. According to one of them:

"Took this homeopathy, visited a homeopath. Nearly for two to three years." (P-1, male, 33 yrs.)

D.3.6. Local remedy. One participant took some local remedy which was suggested by his friend, which was a mixture made by blending the milk of goat, coconut water, and the root of the bombax. He took it for several months but got no permanent cure. Later, he added about taking healthy foods, like—milk, egg; regularly for the improvement of sexual problems. According to him:

"When understood, someone suggested that (if you) blend milk of goat, coconut water, and the root of bombax at once and eat it (the mixture, you will get the benefit. So, I got more or less improvement after taking it. Lasted for nearly ten minutes. Then gradually found that, after taking for two or three times, I found (it) not that much benefit." (P-13, male, 36 yrs.)

One participant, being advised by friends and informed through YouTube, took garlic, black cumin, and various foods perceived as healthy, took these for his sexual problems. According to him:

"Then, again I also took garlic, then, yours, black cumin, taking healthy foods, so then noticed, (my) health improved, but no improvement in this (sexual problems)." (P-24, male, 24 yrs)

Another participant took some energy drinks, locally made, as per the suggestion of some of his friends. Though he could not mention the actual nature of that energy drinks belonged to, he confirmed somehow that, these were mainly some beverage,

neither alcohol nor any other kind of illegal drugs. Three of them including him took 1 bottle each time. According to him:

"Took those energy drinks two or three, did not take more. Energy drinks two, three, or at best four. Differently made (than usual energy drinks found at the market), those are, available at shops, available at any grocery. No (not herbal medicine). No, those are sold at the canned bottle, those, at the plastic bottle, those like the ye, locally made. I cannot recall the name. We took one bottle three to four in together... No sir (not abusive drugs), no no (not Yaba)." (P-12, male, 39 yrs)

D.3.7. Did not take CAM. Six of the participants (27%) did not take any form of CAM, in their lifetime. The causes were disbelief, temporary effect & fear of possible side effects in the long run. According to a female participant:

"The reason behind not going (for CAM) is, I don't believe in those things. That, what will be happened with (taking) those? Maybe some (improvement will occur), if give some treatment, (but) it will last for someday, will remain for a while, but will not be permanent at all. That is what it seemed like to me." (P-15, female, 22 yrs.)

D.4. Biomedical. Except for the self-search group, participants (77%) usually sought biomedical help at the last stage from specialist doctors. Nonspecialist doctors practicing in the local area often termed as "simple MBBS" were visited for the physical problems mainly. Like one said:

"Did not go (to MBBS doctors) for these (sexual problems), sometimes went for fever or so other matters (at Thana Health Complex)." (P-1, male, 33 yrs.)

Among the specialists, dermatologists were in the highest position. As because venereal diseases are translated as sexual diseases here, dermatologists are publicly known as the doctor of skin and sexual diseases. 10 participants (45%) sought help from them. As 1 participant stated:

"He was a skin and sexual disease specialist (dermatologist)." (P-2, male, 45 yrs.)

But, help is also sought from other specialists including endocrinologists, gynecologists, internists, neurologists, and cardiologists. Female participants usually talked to a gynecologist, as they are publicly entitled to any sort of health problems among females. They went there either by themselves or by being advised by others. One female participant stated:

"I, myself, went to see the gynecologist. My sister (also) was the one who told me about the gynecologist, that let's go, visit any female doctor expert in gynecology at a place somewhere, see what she (the gynecologist) would say." (P-15, female, 22 yrs.)

Except for one, all the participants came to the psychiatry department only after being referred by someone. For example, 1 participant went to the endocrine department thinking that his

sexual problems were due to some hormonal problems. But after evaluation, he was referred to psychiatry outdoor. As the participants told:

“Maybe, maybe due to hormonal problems my sex (libido) decreased and it comes out (ejaculation) early. For this, I went there (endocrinology outpatient department). I told there everything. (The endocrinologist) told that then go to a psychiatrist, he referred me to, you (at Psychiatry out-patient department).” (P-4, male, 36 yrs.)

The only participant, who came directly to the psychiatry department, came because of his prior knowledge about the scope of different specialties.

“I came here (by self). Actually, I have more or less knowledge about the medical system or some knowledge about what is there in which departments (scope of different specialties).” (P-21, male, 32 yrs.)

Dependency on tertiary or specialist care for sexual problems was very obvious regarding biomedical help-seeking. With or without a referral, the participants visited some tertiary care center of Bangladesh, like BSMMU locally known as “PG hospital”; Sir Salimullah Medical College & Hospital, locally known as “Mitford Hospital”; Bangladesh Institute of Research and Rehabilitation for Diabetes, Endocrine and Metabolic Disorders (BIRDEM), locally called as “diabetic hospital”; and National Institute of Mental Health (NIMH).

“After that, now, I came to PG (BSMMU), at your side.” (P-2, male, 45 yrs.)

D.5. Psychological. Only 1 participant went for psychological management that is psychotherapy at an institution-based psychotherapy center but returned as there were no same-sex psychotherapists. As he told:

“It was seen that I communicated with them (psychotherapy center at a public university), but there was no male, mean the counselors, were there, (all were) female. So, you know that I will not talk about this (sexual problems) with females.” (P-21, male, 32 yrs.)

DISCUSSION

The principal objective of this qualitative study was to find out the pattern of help-seeking behavior among patients with sexual dysfunctions before attending the psychiatry OPD. Here, most of the participants were between 20 and 35 years of age, which indicated that the impact of the sexual problem is high among this age group. The age group is more or less similar to the 26–35 years age range found in a previous study in the same setting or to the 20–39 years age range in a sex clinic in India.^{23,24} This can also be explained by the assumed average age of marriage in Bangladesh, which is possible in and around this age group. So, the sexual problems in the early years of conjugal

life or the anxiety related to upcoming marriage in the future drove them for seeking help.²⁵ Again, this may be an indicator of increasing awareness regarding sexuality over time.²⁴ The low rate of female patients in the study can be explained by the presence of stigma, playing a passive role in sexual activity, or due to strong cultural influence; which is very common in this part of Asia.²⁴ This is also may be due to the reluctance to seek medical treatment because of a lack of privacy, lack of a female doctor at the health facility, the cost of treatment, and their subordinate social status.²⁶ The majority was literate and from an urban background which was consistent with the previous findings.^{23,25} The presence of the study site in an urban area, which made access problematic for rural people, might be the possible cause. This also indicates that possibly the rural people are not aware of where to seek help and this led to the use of alternative methods of treatment for sexual problems.²⁴ This can make a huge change from the clinical point of view if properly addressed. All the participants were Muslim. A possible explanation is the low rate of attendance at the study site from other communities and unintentional noninclusion of them in the study. This is a limitation of this study, though the findings might be the same. Because a relatively similar format of help-seeking attitude was found in this region despite their religious difference.²⁷ Most of the male participants were suffering from premature ejaculation followed by Erectile Dysfunction while females were suffering mostly from female sexual interest/arousal disorder. The findings were matched with the findings of some other studies from both national and international backgrounds.^{8,23,24,25,28,29}

Recognition and evaluation of the presenting symptoms is the key factor of healthcare-seeking behavior.^{20,30} In this study, it was also found that participants sought help only after their problem was identified and then the help-seeking behavior followed some patterns. This study established that friends and close persons played a huge role in the identification of the problem. Here, awareness of sexual issues might play a great role in help-seeking from clinical settings.

Next to problem identification, the participants tried to seek help by gathering information almost invariably through informal help-seeking. Participants in this category were termed as help-seeking from others; relied mainly on others for decision making and so sought help from others. This is an important pattern of help-seeking in this study. Friends were the most common source, followed by colleagues and close persons, for sharing and gathering information as well as suggestions. Among friends, those who were married or have some medical background got special attention. This can be explained by some background factors, like prevailing trust, local availability, mentioned in a study in India, because both countries possess nearly the same culture.³¹ This is also consistent with the studies which highlighted social support as an important factor in help-seeking.^{30,32} This is in contrast to the findings in a literature review with a high rate of formal help-seeking but can be explained by the cultural variation.¹⁵ In a country like Bangladesh, dependency-oriented help-

seeking, which is asking a helper to fix the problem, is the main-stream of help-seeking.³³ Again, talking to family members was relatively low and only a few male participants talked to the partner regarding this problem. This was mainly due to shyness or shame in the case of family members which is also supported by the cultural difference in Asia by comparing the study findings between China and the USA.^{28,34} It can be concluded that the participant used to seek help from those, whom they feel as closer or freer, where there is no fear of future complications. This finding is very much important from the clinical point of view while providing or planning a service. It also refutes the importance of awareness of sexual issues among general people, as they are playing the main role in decision making.

A few participants, mostly literate and from middle socioeconomic status, fell under the second category, termed as “self-help” group. They gather information from various sources and then use available resources solely based on their own decisions. In this group, the internet was identified as an emerging source of help-seeking. Both of the key persons also admitted this. This may be due to the recent increase in the availability of, as well as, the use of the internet in Bangladesh. The anonymity and lack of embarrassment while searching or communicating with others about sexual problems might play a role also.³⁴ A study highlighted that the information found online made some impact on the process of diagnosis of a disease, that is, on the appraisal, the help-seeking, and the diagnostic interval stages of a disease.³⁵ So, in clinical practice regarding sexual problems, the role of the internet might be huge in the future if addressed appropriately. Another important source was the newspaper. Some participants got help from the advertisement and articles written there. Besides these, books, magazines, posters, banners, signboards, television, and seminar were the other sources to seek help. Female participants used to gather information indirectly that is through their husbands. Interestingly, young participants relatively better educated had contact with various resources, used self-help practice more and most of them sought biomedical treatment only. The possible cause might be awareness regarding sexual issues. In this study, this self-help group was found as an emerging pattern of help-seeking, which is consistent with the statement in a review article.³⁵ While developing the future delivery system, this pattern is very much important and needs to be addressed. And this is high time to create public awareness through the development of an adequate information system to entertain this emerging group with special attention to electronic media, mostly the internet and television.

Then, the participants went for formal help-seeking. Most of the participants sought help from CAM. Among the various forms of CAM; traditional healers, herbalists, and canvassers were relatively more used than others. Several studies also found the same high rate of taking treatment from the traditional healer in these premises.^{20,25,31} This may be due to the more availability, suggestion by others, perceived cost-effectiveness, and dissatisfaction with western therapy.²⁰ This might be also the

reflections of the ignorance and the pattern of belief and attitudes toward the illness in this culture.²⁵ These are reinforced and perpetuated through the traditional healers, by demanding themselves as so-called “sex healers,” and by giving self-made explanations to the common queries of the people regarding their illness and the cause of treatment failure.^{20,25} So, this is another point to get special attention from the clinicians during their practice. Regarding help-seeking from the canvassers, the canvassing of the canvassers allured the participants all of a sudden, which is very common in this subcontinent.³⁶ Many a participant took homeopathic medicine, medicine from the pharmacy, and village doctors. Three of the participants used some local remedies being advised by others, which indicates some strong social beliefs regarding the treatment of sexual dysfunctions. Some of the participants did not take CAM and the reasons behind this were the lack of faith, fear of temporary positive effects with possible side effects in the long run, and lack of their institutional base. All of these can be summarized as awareness about the side effects of CAM. Using this belief system and awareness in a positive way can improve the help-seeking from clinical settings.

The biomedical approach was the last to seek help for most of the participants. This indicates that a large portion of the population with sexual dysfunctions remains out of the biomedical services. But those who were relatively more aware and conscious about the side effects of the CAM sought help directly to the biomedical approach. This summarizes that the most possible cause of reluctance to take biomedical help is the lack of awareness. Here, a strong tendency to take help from a specialist and tertiary care center for sexual problems was found. This tendency also observed in an Australian study, where the people of the Indian subcontinent including Bangladeshi men living in Australia, were found significantly more likely to present to the Sexual Health Clinic than other groups of people.³⁷ The other possible causes might be the lack of a referral system and easy access to a specialist in Bangladesh. That's why when a patient decided to take biomedical help, they can directly visit a specialist. Here, a visit to the dermatology department or a dermatologist was the principal way to seek help. This highlighted the common perception among Bangladeshi people that, sexual problems are mainly treated by dermatologists.³⁶ Most of the participants went for general physical problems but not for sexual problems to a general physician. Again, almost all the participants felt uneasiness, shyness while sharing with a physician. This indicates the existing imbalance of the doctor-patient relationship. This study recommends conducting extensive research on this area and the application of early interventions based on the research findings, especially in Bangladesh. Because it was highlighted that, future help-seeking, as well as treatment use, are highly connected with comfortable sharing with professionals.³⁸

Among the participants, only 2 thought these problems as of mental origin. One of them, searching by self, came to know about the psychological help that is psychotherapy and sought

psychological help. Based on this, it might be inferred that there is a usual tendency of taking sexual problems as only physical problems as well as, the lack of awareness about psychological help. Ultimately, these influence the help-seeking pattern.

The major limitation of this study is the relatively short period of IDIs. This is because of the cultural context behind talking about sexual topics and the first-time experience of the first author. But the quality of data is ensured by a large number of interviews, gradual upgrading in the quality of interviewing, and method triangulation. Again, the study gave emphasis more on the identification and description of the usual pattern of help-seeking rather than explaining the cause behind it, which was nearly fulfilled by these interviews. Despite these, the researchers suggest that this study, conducted for the first time in this arena, will fulfill the knowledge gap and will serve as a baseline study for future researches in this field.

CONCLUSION

This study likes to highlight the lack of proper awareness about sexual dysfunctions and their ideal treatment leading to the low rate of help-seeking from appropriate clinical settings. Those who are suffering and those who are suggesting, all have a lack of awareness regarding this issue. Again, from a clinical point of view, the service delivery system for sexual dysfunction patients is not well established and proper information is not also easily available. So, there is an immense need for proper sex education as well as service development through the training of the physicians.

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