RELATIONSHIP OF SEXUAL DYSFUNCTION AND ANXIETY DISORDER

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Summary

Fifty married men seeking help for sexual dysfunctions were interviewed for a period of three months to see the level of anxiety associated with dysfunction. Forty patients (80%) fulfilled the criteria for anxiety disorder, according to DSM III-R diagnostic criteria. Anxiety was manifested more in age group below 35 years with mean age 30. Manifestation of anxiety was found more in patients having pre and extramarital sex, homosexual experiences, masturbation habits associated with guilt feeling. Premature ejaculation is the most frequent (50%) sexual dysfunction. But patients having both premature ejaculation and erectile impotence manifested more anxiety.

Introduction

Sexual dysfunction either psychogenic or organic is a source of distress to men. Anxiety is the most important factor associated with onset of psychological dysfunction. From a questionnaire given to 100 normal couples in a prominent study in the USA, it is found that 50% of the males and 77% of the females reported atleast some dissatisfaction with their sexual life[1]. From a report on the experience of a sexual dysfunction clinic at Oxford, it is found of 289 presentations of the males, 53% had erectile impotence, 15% premature ejaculation, 7% ejaculatory impotence and 7% low libido[2]

Sex-stress immediate or remote may led to different psychosomatic response including sexual dysfunction[3] Most men have had erectile impotence on some occasion but anxiety and embarrassment, however, will make the episode significant to them[4]. Performance anxiety following initial erectile failure in most cases limit the capacity for sexual arousal thereafter[4]. Performance anxiety is the final common pathway of dysfunction may be induced by anxiety, fear, anger or guilt[5]. Some men do present with the erectile problems accompanied by premature ejaculations, more often they do not, and when they do, anxiety often reached such proportions that all effective functions have been impaired.

The prevalence of sexual dysfunction in Bangladesh is not exactly known. The present study was designed to find out the relationship between sexual dysfunction and anxiety disorder and the socio-demographic characteristics of the patients coming for help with dysfunctions. The different observations about the extent of anxiety in sexual dysfunction may ultimately be useful in management of these patients.

Materials and Methods

Fifty married men complaining of sexual dysfunction were interviewed during the period of October, 1989 to December, 1989 from a private chamber of a Venereologist in Dhaka city to see the level of anxiety associated with dysfunction. Only erectile problem and premature ejaculation were considered for the present study. A random selection of 30 male patients matched in age and education from Medical and ENT ward of the Institute of Postgraduate Medicine and Research were taken as control. All the patients were male and were above 18 years of age, came voluntarily for treatment. Patients with history of taking drugs, alcohol or heavy smoker for long time were excluded. Patients with diabetes were also not included. All patients were interviewed separately in privacy taking informed consent. A semi-structured questionnaire which includes all socio-demographic and relevant information associated with dysfunction used for the purpose. After collecting information about dysfunction, relevant questions were asked to elicit specific anxiety symptoms according to DSM III-R criteria for anxiety disorder[7]. The relevant data was represented in tabulation form and statistical analysis was done where needed.

Results

Fifty married sexual dysfunctional men between 22 and 50 years of ages with mean age of 33.2 years (SD±9.38) were included in the present study. The age distribution of these subjects with manifestation of anxiety is shown on the Table-I.

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Table-I: *Age distribution of dysfunctional subjects with manifestation of anxiety.*

Age group	No.of subjects with dysfunction	No of Subjects manifested anxiety
21-25	2	2
26-30	21	18
31-35	12	10
36-40	7	4
41-45	4	3
46-50	4	3
Total	50	40

Mean age = 33.2 years (SD±9.38) 30.5 years (SD±12.3)

Twenty five patients complained of premature ejaculation. 22 both premature ejaculation and erectile dysfunction and 3 erectile dysfunction only (Table-II).

Table-II: *Patients with anxiety manifestation according to type of dysfunction.*

Type of dysfunction	No. of subjects manifested	No. of subjects manifested anxiety (%)
Erectile impotence	3	2 (66.67)
Premature ejaculation	25	20 (80)
Both	22	18 (81.82)

In 25 patients, dysfunction started few months to few years after marriage, in 16 patients it started immediately following marriage and in 9 patients sometimes before marriage. Forty patients (80%) with dysfunction fulfilled the criteria for anxiety disorder in DSM III-R, where as 16.67% in the control group are found to suffer from anxiety disorder (Table-III). The difference in presence o anxiety is highly significant (P<0.001).

Table- III: *Anxiety manifested in dysfunctional and control group*

Group	No.of subjects	No. of subjects manifested anxiety (%)
Dysfunctional	50	40 (80)
Control	30	5 (16.67)

X^2 =30.56, df=1,P<0.001.

Thirty six patients admitted premarital sex, 14 extramarital sex, 12 homosexuality and 43 masturbation habit for variable period. Majority of patients had no guilt feelings for their acts but those who admitted it manifested more anxiety (Table-IV).

Tabel-IV: *Dysfunctional subjects having guilt feelings about sexual experiences with manifestation of anxiety.*

Experiences	No.of subjects	Guilt feeling	Anxiety (%)	No guilt feelings	Anxiety (%)
Premarital sex	36	9	8(88.89)	27	20(74.07)
Extramarital sex	14	4	4(100)	10	9(90)
Homosexuality	12	6	6(100)	6	4(66.67)
Masturbation	43	16	15 (93.75)	27	21(77.78)

It was also found that patients who admitted masturbation habit manifested more anxiety (83.72%) with or without guilt feelings.

Discussion

Sexual dysfunction (erectile impotence and premature ejaculation) is common and overlooked problem in younger and middle aged men. In the present study anxiety was found to be more common in patients below 35 years of age with mean of 30.5 years (SD ±12.3) which is consistent with findings of other report8. Probably the people of younger age group are more concerned about their problem or they consider it more seriously.

Premature ejaculation was the most common sexual dysfunction (50%) appeared in the present study. Anxiety was manifested more by patients (81.82%) having erectile impotence accompanied by premature ejaculation. Martin Cole has observed that Premature ejaculation was more common than erectile impotence among asian patients. He also observed that anxiety is proportionately more in men who present with erectile problem accompanied by premature ejaculation[8].

Forty patients (40%) with dysfunction significantly manifested anxiety symptoms compared to that of control (16.67%), which is statistically highly significant (p>0.001). This signifies the importance of anxiety as a probable etiological factor in sexual dysfunction.

It is surprising to note that premarital sex, extramarital sex and homosexual expriencesd are quiet prevalent in our country and patients having such experiences with guilt feelings for their acts predispose to manifest more anxity.

Psychoanalytic theory, learning theory and theories of underlying sex therapy have all emphasized anxiety as an etiological factor for sexual dysfunction[9]. Fear of failure, performance anxiety, ignorance etc. may be etiologically important for dysfunction developing before or soon after marriage. On the other hand, marital conflicts, prolonged abstinence from any reason and other psycho-social factors may be etiologically important for dysfunctions developing sometimes after marriage.

Conclusion

From the present study it is evident that anxiety may be a cause and a factor in the maintenance of sexual dysfunction. Various interpersonal, intrapsychic or psychosocial factors have been identified to have possible linkage in the generation of anxiety with subsequent development of dysfunction. So anxiety reduction by encouragement of good verbal and sexual communication, correction of ignorance etc. may produce significantly good results in dysfunctional men.

References

1. Frank E, Anderson C and Robinstein D. Frequency of sexual dysfunction in "Normal couples" N Engl J Med 1978; 299:111-115.
2. Hawton K: The behavioral treatment of sexual dysfunction. Br j Psychiatry 1982; 140:94-101.
3. Pervin LA and Leiblum SR. Conclusion : Overview of some critical issues in the evaluation and treatment of sexual dysfunction. Principles and practice of sex therapy. London. Tavistick, 1980.
4. Morse Wl and Morse JM. Erectile impotence precipitated by organic factors and perpetuated by performance anxiety. C M A Journal 1982;127:599.
5. Levine SB. Marital sexual dysfunction: Erectile dysfunction. Ann Int Med 1976; 85: 342-350.
6. Martine C. Sex therapy- A critical appraisal. Br J Psychiatry 1985; 147; 337-351.
7. Diagnostic and statistical manual of mental disorders (Third edition-revised). American Psychiatric Association. Washington D.C. 1987.
8. Cooper AJ. Ismail A A A, Smith CG and loraine JA. Androgen function in psychogenic and constitutional type of impotence . Br J psychiatry 1970;3:17.
9. Kaplan HS and Norick A. The treatment of sexual phobia: the combined use of antipanic medication and sex therapy. J Sexual & Marital therapy 1982: 8: 3-28.