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Research Article

The Pattern of Psychosexual Problems and the Prevalence of Alcohol and Nicotine Dependence among Male Patients with Psychosexual Dysfunction

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ABSTRACT
Introduction. Substance use disorders (SUDs) are often associated with a number of psychiatric conditions. Community-based research has found a substantial correlation between SUDs and male sexual dysfunction, and in the case of alcohol and nicotine, a possible cause-and-effect relationship.
Aim. To find out the pattern of psychosexual problems in patients reporting at tertiary care hospital. To determine the prevalence of alcohol & nicotine dependence among male patients with psychosexual dysfunction
Methods. This is a cross-sectional descriptive study that was carried out in a tertiary care centre with 100 male patients who came to a clinic seeking treatment for psychosexual issues. We then find out the pattern of psychosexual disorders in patients, with and without concomitant substance use disorder (SUDs) and prevalence of substance use disorder (alcohol and nicotine) in these patients. ICD-10 was used in the evaluation.
Results. 28% patients were diagnosed with erectile dysfunction. 30% patients were diagnosed with premature ejaculation and 42% patients were diagnosed with both premature ejaculation and erectile dysfunction. 60 of the 100 males had a current diagnosis of SUD. Out of the 60 with an identified substance use disorder 50% had nicotine dependence, 23.33% had alcohol dependence & 26.66% had dependence for both alcohol and nicotine. Nicotine was the most often used substances.
Conclusion. Patients with psychosexual disorders were found to be frequently co-occurring with SUDs, especially nicotine use disorders. An essential part of management in this population is recognizing and treating these illnesses.

Keywords: Premature Ejaculation (PME), Erectile Dysfunction (ED), Alcohol Dependence, Nicotine Dependence, Substance Use Disorder.

INTRODUCTION

Substance use disorders (SUDs) are a global health concern that present in various clinical scenarios. Along with causing its own physical or mental health problems, substance abuse can worsen an existing medical or psychiatric condition. Patients with psychological conditions such as schizophrenia, mood disorders, and anxiety disorders often display high levels of substance use. Those with both conditions, commonly referred to as "dual-diagnosis" patients, have been observed to experience poorer outcomes and more severe symptoms.[1]

Common risk factors associated with sexual dysfunction include overall health, the presence of non-communicable diseases such diabetes mellitus, cardiovascular diseases, genitourinary diseases, psychiatric/psychological disorders, and chronic diseases. The connection between substance misuse and sexual dysfunction is becoming more well acknowledged.[2]

Psychosexual disorders, sometimes referred to as psychogenic sexual illnesses, are anomalies of the sexual response cycle that impair a patient's capacity for sexual activity and create distress for both the patient and their partner. The human sexual response cycle consists of four phases: resolve, orgasm, plateau, and excitation (desire and arousal). There is a phase change when erotic stimulus is present. The phases are influenced by complex connections between the endocrine and neurological (central and autonomic) systems. In any of these phases, sexual dysfunction may develop.[1] Several mechanisms have been proposed to explain alcohol-induced sexual dysfunction. These include the inhibition of

hypothalamic gonadotropin-releasing hormone and/or pituitary luteinizing hormone, which disrupts the hypothalamic–pituitary–adrenal and hypothalamic–pituitary–gonadal axes, leading to reduced plasma testosterone levels. Alcohol also increases the inhibitory activity of gamma-aminobutyric acid (GABA) receptors and decreases the excitatory activity of glutamate receptors in the central nervous system (CNS). Psychological factors, such as a lack of arousal and disinterest in sex due to aversion, rejection, or retaliation against a partner's undesirable drinking behaviour, also play a role. Additionally, psychiatric comorbidities like anxiety and depression, as well as the effects of psychotropic medications, can further contribute to sexual dysfunction.[3] For male patients, hypoactive sexual desire disorder, erectile disorder, premature (early) ejaculation, delayed ejaculation are the most frequent sexual disorders.[1]

The most recent National Mental Health Survey of India found that the weighted prevalence of substance use disorders in India is 22.4%, with alcohol use disorders (4.64%) and tobacco use disorders (20.89%) having the highest rates.

Since many substances, including alcohol, opiates, and cannabis, are used with the intention of enhancing sexual performance, discussing sexual function and dysfunction is essential when discussing substance use. This may be due to the disinhibitory, anti-anxiety, and depressive effects of several of these medications, especially at lower doses and during initial use. But numerous researches have shown that long-term drug usage impairs sexual function and causes a variety of sexual dysfunctions in both men and women. [2]

There is a definite correlation between tobacco use and erectile dysfunction, however it is unclear how alcohol usage affects sexual dysfunction.[1] Although the impact of alcohol consumption on sexual dysfunction is less well-defined. Alcohol dependence is highly prevalent among the Indian population, but psychosexual issues are often overlooked in this group. This study highlights the importance of healthcare professionals addressing sexual health concerns in their patients.[4] The term "Alcohol Dependence Syndrome" (ADS), as defined by the International Classification of Diseases, 10th Revision (ICD-10), describes a problematic pattern of alcohol consumption that leads to significant impairment within a 1-12 month period.[5] While some individuals may consume alcohol to alleviate stress, this can result in additional social, emotional, and physical issues, including sexual dysfunction. Despite the widespread misconception about alcohol's aphrodisiac properties, scientific research has shown that long-term alcohol consumption can lead to sexual dysfunction.[6]

Aims and Objective

To find out the pattern of psychosexual problems among patients presenting to psychiatry department.

To determine the prevalence of alcohol & nicotine dependence among male patients with psychosexual dysfunction

Inclusion Criteria

A. Male patients aged 21years and above.
B. Married or having a partner with regular sexual activity.

Exclusion Criteria

A. Comorbid systemic illnesses including diabetes mellitus, hypertension, clinical diagnosis of endocrine disorders, history of genitourinary surgery, neurological disorders, spinal cord lesions, signs and symptoms or investigation findings suggestive of hepatic cirrhosis, and other systemic illnesses in terminal stages.
B. Mental retardation, dementia, delirium and other organic disorders, and psychotic disorders including schizophrenia, delusional disorder. Which might interfere with sexual dysfunctioning.
C. Usage of substances besides alcohol and nicotine.
D. Individuals taking drugs that could impact one's ability to perform sexual activity such as antidepressants, antipsychotics, disulfiram, antihypertensives, steroids, etc.

METHODOLOGY

The study was conducted with due permission from the scientific and the ethical committee of tertiary care hospital.

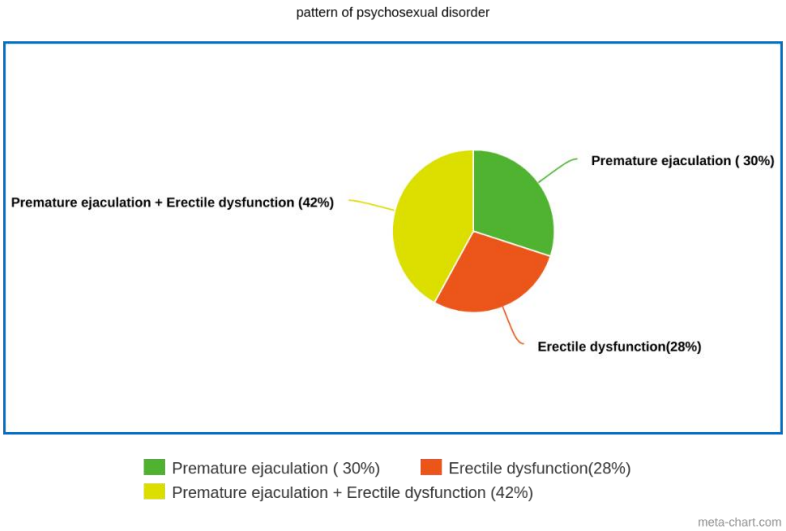
Patients who visit the psychosexual clinic in Psychiatry Department, who are married-single, or had been referred to the Psychiatry Department by the other departments within tertiary care settings, specifically urology, general medicine, general surgery, and endocrinology, or by self-referral. At the time of initial presentation who were diagnosed with premature ejaculation and erectile dysfunction were further evaluated. Patients were

diagnosed according to ICD-10 criteria. A semi-structured interview was used to assess patients, obtaining information about medical and psychiatric comorbidities, early childhood experiences, and family history of mental illness in addition to a sexual history. A pattern of psychosexual disorders was also seen between patients with and without concomitant SUDs and prevalence of different substance use disorder (alcohol and nicotine) among these patients. ICD-10 was used in the evaluation.

RESULTS

Table 1 Pattern of psychosexual disorder

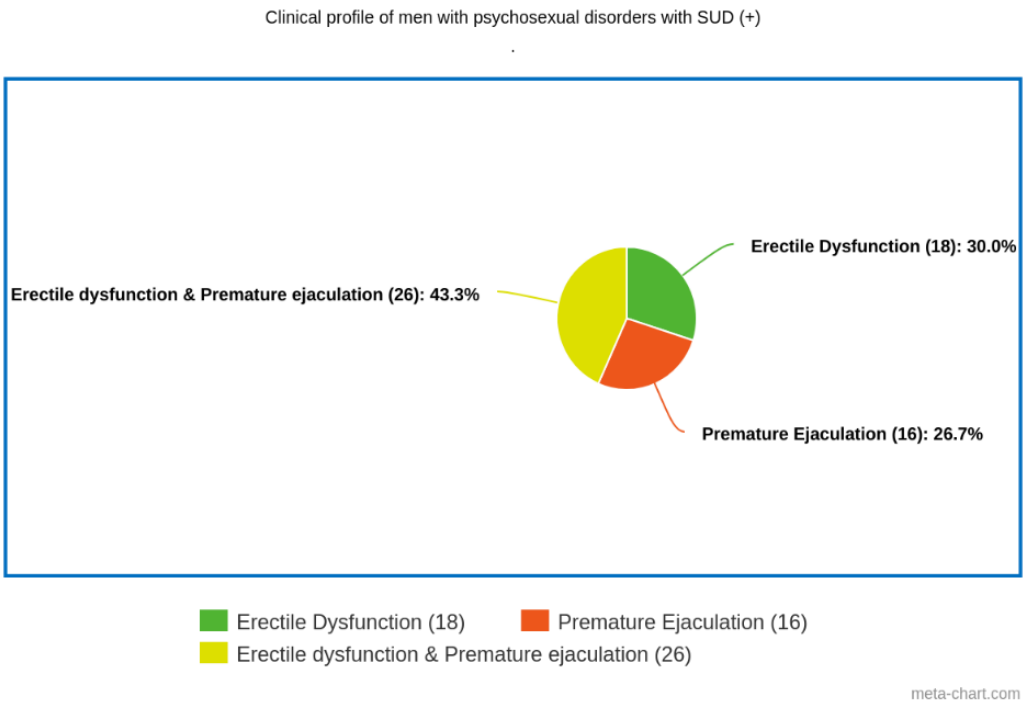
Psychosexual Disorder	Frequency (n=100), (%)
Erectile Dysfunction (ED)	28 (28%)
Premature Ejaculation (PME)	30 (30%)
Erectile dysfunction + Premature ejaculation (ED + PME)	42 (42%)



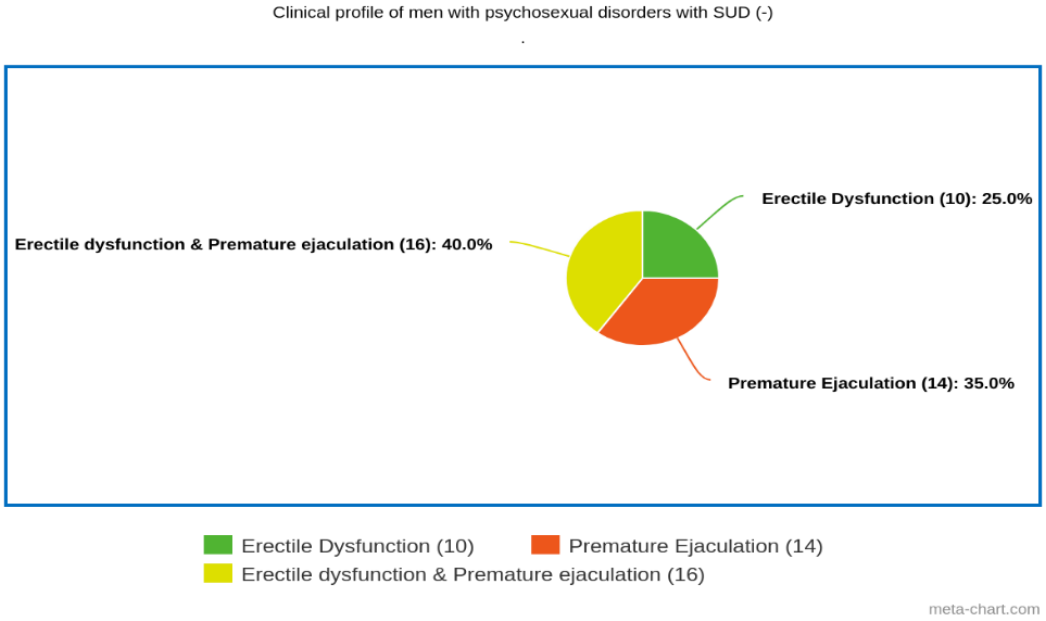
The sample consisted of 100 patients. Pattern of psychosexual disorder in patients attending psychosexual clinic was, 28% patients were diagnosed with erectile dysfunction. 30% patients were diagnosed with premature ejaculation and 42% patients were diagnosed with both premature ejaculation and erectile dysfunction.

Table 2 Clinical profile of men with psychosexual disorders, with (SUD+) and without (SUD−) comorbid substance use disorders.

VARIABLES	SUD (+)	SUD (-)
Psychosexual Disorder		
Erectile Dysfunction (ED)	18 (30%)	10 (25%)
Premature Ejaculation (PME)	16 (26.66%)	14 (35%)
Erectile dysfunction + Premature ejaculation (ED + PME)	26 (43.33%)	16 (40%)
Total	60	40



Among these 60 psychosexual disorder patients having substance use disorder, 18 (30%), 16 (26.66%) and 26 (43.33%) have diagnosis of ED, PME & ED + PME respectively.



Among those 100 psychosexual patients, 40 psychosexual disorder patients were without substance use disorder, 10 (25%), 14(35%) and 16 (40%) were having diagnosis of ED, PME & ED + PME.

Table 3 Prevalence of different substance use disorder (alcohol and nicotine) among these patients

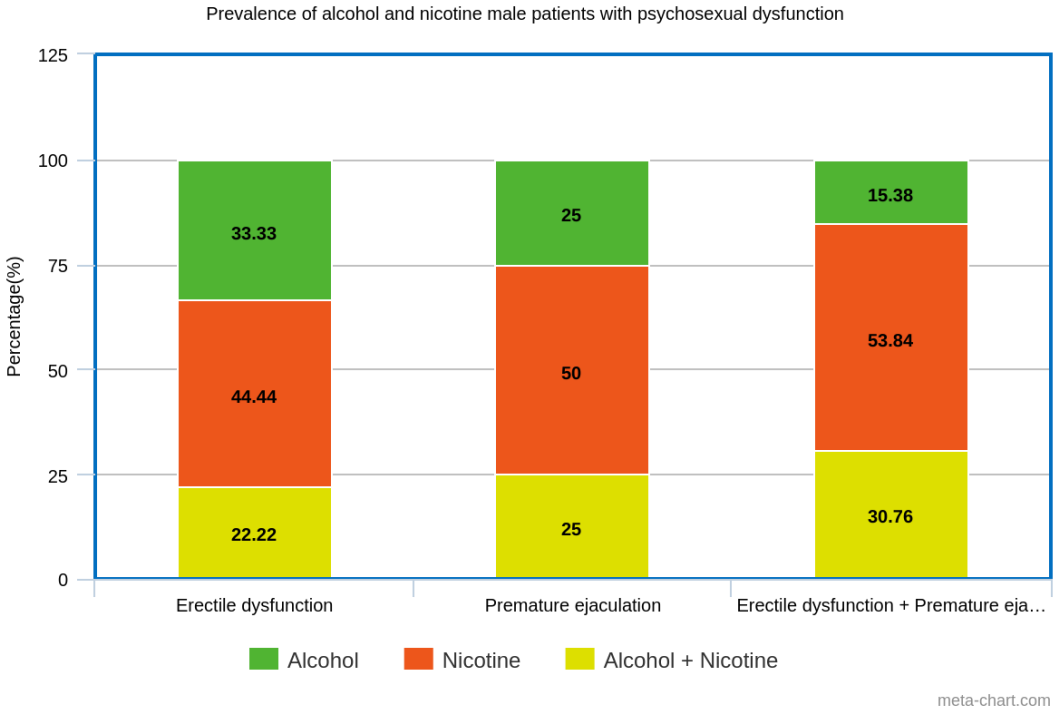
	Alcohol	Nicotine	Alcohol + Nicotine
Premature Ejaculation (PME)	4 (25%)	8 (50%)	4 (25%)
Erectile Dysfunction (ED)	6 (33.33%)	8 (44.44%)	4 (22.22%)
Erectile dysfunction +	4 (15.38%)	14 (53.84%)	8 (30.76%)

Premature ejaculation (PME + ED)			
Total	14 (23.33%)	30 (50%)	16 (26.66%)

Out of these identified substances use disorder patients, 50% had nicotine dependence, 23.33% had alcohol dependence and 26.66% patients had both nicotine and alcohol dependence.
Out of those who are diagnosed with premature ejaculation with an identified substance use disorder 50% had nicotine dependence, 25% had alcohol dependence. 25% patients had both nicotine and alcohol dependence.

Out of those who are diagnosed with erectile dysfunction with an identified substance use disorder, 44.44% had nicotine dependence, 33.33% had alcohol dependence. 22.22% patients had both nicotine and alcohol dependence.

Out of those who are diagnosed with premature ejaculation and erectile dysfunction with an identified substance use disorder. 53.84% had nicotine dependence, 15.38% had alcohol dependence and 30.76% patients had both nicotine and alcohol dependence.



DISCUSSION

In this study, nicotine emerged as the most prevalent substances misused. Due to their legality and widespread availability, they are frequently consumed by young men in India.
In our study, we observed that 60% of individuals with psychosexual disorders had a diagnosis of SUD (substance use disorder). In contrast, Rajkumar et al. (2014) [1] study found that 23.8% of individuals with a diagnosis of SUD had psychosexual disorders.

Our study identified that the most common issues were PME (Premature Ejaculation) and ED (Erectile Dysfunction), whereas Prabhakaran et al. (2018) [3] study found erectile dysfunction to be the most common. Nair et al. (2019) [4] study identified ED as the second most common issue.
In our study, we found that 60% of the psychosexual patients had substance use disorder (SUD). but Prabhakaran et al. (2018) [3]. found that 36.9% of individuals with alcohol use disorder experienced sexual dysfunction, while Nair et al. (2019) [4] study reported sexual dysfunction in 66% of alcohol-dependent individuals. Bhainsora et al. (2021) [6] study found that 48% of individuals with alcohol use disorder had sexual dysfunction.

In our study, we found that 60% of patients had SUD, Among the patients with Erectile

Dysfunction (ED), 30 (50%) were found to have nicotine dependence. Prabhakaran et al. (2018) [3] study showed that 73% of cases had a history of tobacco dependence.

Our study observed that 33.3% of patients with ED had alcohol dependence, 25% of patients with Premature Ejaculation (PME) had alcohol dependence, and 15.38% of patients with both ED and PME had alcohol dependence. In Verma et al. (2013) [7] study, among those with alcohol dependence, 29.5% had PME, 25% had ED, and 19.3% had both PME and ED.

We also found that 8(44.4%) of patients with ED had nicotine dependence, 8(50%) of patients with PME had nicotine dependence, and 14(53.8%) of patients with both ED and PME had nicotine dependence. Verma et al. (2013) [7] study, however, found that 21.3% of individuals with nicotine dependence had PME, 48.9% had ED, and 10.6% had both PME and ED.

Additionally, in our study, 15.38% of patients with both ED and PME had alcohol dependence, 53.84% of those with both PME and ED had nicotine dependence, and 30.76% of patients with both ED and PME had dependence on both alcohol and nicotine. Verma et al. (2013) [7] study found that 23.3% of those with both nicotine and alcohol dependence had PME, 34.9% had ED, and 23.3% had both PME and ED.

Limitation

Because of the cross-sectional descriptive study, it couldn't definitively establish a direct link between substance use disorders and sexual dysfunction. Additionally, the participants comprised patients primarily diagnosed with sexual dysfunction of all age, making meaningful comparisons challenging. These findings are constrained by various limitations. Diagnoses were based on clinical judgment following the ICD-10 guidelines and the cross-sectional descriptive nature of the study restricts the extent to which our conclusions can be generalized.

CONCLUSION

In men, substance use disorders are often co-occurring with psychosexual disorders. Numerous study participants had one or more sexual dysfunctions. Lack of knowledge about sexual health issues may lead to people waiting until after marriage to seek assistance when problems emerge. In India, there is still a strong stigma attached to seeing a psychiatrist in addition to a widespread inclination to keep sexual issues private. A vital component of a high-quality existence is having healthy sexual function, which is necessary for sustaining satisfying personal relationships and guaranteeing general physical, mental, and social wellbeing. To gain a deeper understanding of the extent and contributing aspects of this problem, further prospective studies involving both community- and hospital-based participants are required.

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