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Anxiety and Depression in Men Suffering from Premature Ejaculation

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ABSTRACT

Sexual dysfunction can have an impact on both the physical and psychological well-being of men. Male erectile dysfunction (ED) and premature ejaculation (PME) are prevalent sexual disorders among the male population. In the Indian cultural context, individuals frequently encounter inhibitions when discussing matters pertaining to their sexual health, resulting in a scarcity of research in this domain. The primary objectives of this study are to investigate and analyse the levels of depression, anxiety, self-esteem and sexual quality of life among men experiencing erectile dysfunction (ED) and premature ejaculation (PME). Additionally, this research aims to compare these psychological and sexual health indicators between the two groups. To study the anxiety and depression in men suffering from premature ejaculation. A cross sectional, hospital based, single centred observational study was conducted. The study period was 6 months after approval from Institutional Ethics Committee. About 150 patients were included in this study. In the present study, a majority of the participants exhibited comorbid symptoms of Anxiety and Depression, with 51 individuals accounting for 34.0% of the sample. Importantly, this finding reached statistical significance ($p = 0.0164$). In the present investigation, the average Hamilton Anxiety Rating Scale (HAM-A) score among the participants was determined to be 15.2000 with a standard deviation of 8.4303. Similarly, the mean Hamilton Depression Rating Scale (HAM-D) score was found to be 13.6700 with a standard deviation of 8.2267. In the present study, a majority of the participants exhibited comorbid symptoms of Anxiety with Depression (34 individuals, accounting for 34.0% of the sample). Additionally, 24% of the patients presented solely with symptoms of anxiety disorder, while 23.0% of the patients displayed symptoms exclusively related to depression. The observed distribution exhibited statistical significance ($p = 0.0164$).

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Key Words
Anxiety, depression, erectile dysfunction, premature ejaculation

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INTRODUCTION

Sexuality constitutes a significant facet of an individual's overall personality. In the context of male individuals, sexual intercourse serves not only as a means of procreation but also as a significant avenue for expressing love and fostering sexual intimacy with one's partner. Similar to numerous other physiological processes, the seamless functioning of sexual activity is often overlooked and receives minimal contemplation. Nonetheless, it is important to acknowledge that any disruption in sexual function can result in significant and detrimental psychological consequences for men. In the majority of societies, the assessment of men's personal adequacy is often based on their perceived level of normal sexual function. Men who experience sexual dysfunction often feel embarrassed, confused, or depressed, which negatively impacts their sense of masculinity[1]. Erectile dysfunction (ED) and premature ejaculation (PME) are two prevalent sexual dysfunctions that frequently affect men. Among the options considered, it is observed that PME is the most prevalent, followed by ED as the second most common[2]. In general, males tend to conceal their emotions and exhibit limited expression, particularly in relation to matters of their emotional or sexual well-being. Therefore, it can be observed that sexual dysfunction in men has the potential to impact both their physical and emotional well-being. Individuals diagnosed with erectile dysfunction (ED) may experience psychological comorbidities such as anxiety, depression, diminished self-esteem and a decline in overall quality of life[3,4]. Men experiencing erectile dysfunction (ED) often exhibit a tendency to maintain a state of physical and emotional detachment from their intimate partners. Likewise, males experiencing premature ejaculation (PME) may encounter symptoms such as anxiety, depression, diminished self-worth and a decline in overall life satisfaction[5]. Previous research has primarily concentrated on evaluating depression, anxiety, self-esteem and quality of life in relation to erectile disorder and premature ejaculation as distinct entities. In the Indian cultural milieu, individuals often experience a reluctance to openly discuss matters pertaining to their sexual concerns or articulate their perceived deficiencies in sexual performance. Moreover, it is worth noting that there is a scarcity of research conducted on this particular topic in the context of Indian patients, despite the fact that culture-bound sexual disorders such as Dhat syndrome have been extensively studied. The objective of this present study was to examine and contrast the relationship between erectile dysfunction and premature ejaculation in relation to depression, anxiety, self-esteem and sexual quality of life.

MATERIALS AND METHODS

Study design: A cross sectional, hospital based, single centred observational study. Purposive sampling was done from Patient attending Psychiatry OPD in a Tertiary care teaching hospital. Study was done in 6 months after approval from health university and clearance from Institutional Ethics Committee.

Inclusion criteria:

- Patient aged 18-60 years of age
- Patient having symptoms of PME and ED to be confirmed by ICD-10 DCR
- Has given informed consent

Exclusion criteria:

- Medical conditions interfering with sexual function excluded by various departments
- Medications affecting sexual function administered within 30 days before screening
- Alcohol or substance abuse
- Presence of major psychiatric disorder and/or suicide risk prior to the symptoms of PME and/ED
- Has not given consent

Statistical analysis: For statistical analysis data were entered into a Microsoft excel spreadsheet and then analyzed by free online available software. Data had b as mean and standard deviatio count and percentages for categorical variables. Z-test (Standard Normal Deviate) was used to test the significant difference of proportions. $p \leq 0.05$ was considered for statistically significant.

RESULTS AND DISCUSSIONS

Table 1 depicts Sociodemographic profile of study participants.

Table 1: Distribution of age in group, sex, religion and SES

	Frequency	Percentage
Age in groups		
≤30	56	37.0
31-40	34	23.0
41-50	54	36.0
≥51	6	4.0
Sex		
Male	150	100.0
Religion		
Hindu	76	51.0
Muslim	74	49.0
SES		
Lower middle SES	59	39.0
LSES	82	55.0
Upper middle SES	9	6.0

Table 2: Distribution of family type

Family types	Frequency	Percentage
Joint	74	49.0
Nuclear	76	51.0
Total	100	100.0

Table 3: Distribution of anxiety and depression

Anxiety and depression	Frequency	Percentage
Anxiety disorder	36	24.0
Anxiety with Depression	51	34.0
Depression	35	23.0
None	28	19.0
Total	100	100.0

Table 4: Distribution of mean Age, HAM-A, HAM-D and ASEX

	No.	Mean	SD	Minimum	Maximum	Median
Age	150	35.6800	9.4856	12.0000	55.0000	36.0000
HAM-A	150	15.2000	8.4303	1.0000	30.0000	17.5000
HAM-D	150	13.6700	8.2267	1.0000	28.0000	15.0000

SD: Standard deviation

The study conducted was an observational study that took place in a single centre, with a cross-sectional design and was based in a hospital setting. Following the approval of the Institutional Ethics Committee , the study was conducted over a duration of 6 months. The sample size for this study consisted of 150 participants. Chepure *et al*.[6] conducted a study to investigate the prevalence of comorbid psychiatric diagnoses in adult males seeking medical care at a tertiary hospital, specifically focusing on cases of premature ejaculation (PME) and/or erectile dysfunction (ED). The median age of the sample was 35.17 years. Tsai *et al*.[7] have noted that the association between premature ejaculation (PE) and erectile dysfunction (ED) remains ambiguous. The total number of participants in the study was 937 and the average age of the participants was 41.1±10.2 years. Based on the findings of a study conducted by Pankhurst *et al*.[8], it was observed that a significant proportion 79% of the participants fell within the age bracket of 30-59 years. Among the 150 patients included in our study, 56 individuals (37.0%) were found to be below the age of 30. Similarly, 54 patients (36.0%) fell within the age range of 41-50. Additionally, 34 participants (23.0%) were identified to be between the ages of 31 and 40. Lastly, a small proportion of 6 subjects (4.0%) were observed to be above the age of 51. The statistical analysis revealed a significant association between age and the outcome variable ($p<0.00001$). The average age of the patients was calculated to be 35.68 with a standard deviation of 9.4856.The entire sample of participants in our study consisted exclusively of male individuals, totaling 150 (100.0%) in number. The group of patients identifying as Muslim constituted the second-largest proportion of the total patient population, accounting for 74 individuals or 49.0%. However, it is important to note that this observation did not yield statistically significant results, as indicated by a p-value of 0.77948. The demographic group with the largest representation among patients was Hindu individuals, a 76 individuals or 51.0% of the total patient population. Leech *et al*.[9] identified various factors for the purpose of predicting or establishing a correlation between the manifestation of depressive and anxiety symptoms in 10 year-old individuals. During the period under consideration, there was a lack of identifiable association between early onset of D/A (depression/anxiety) and socioeconomic status. Despite being statistically significant ($p<0.001$), our findings revealed that a significant proportion of the patients (82 individuals, accounting for 55.0% of the sample) were classified as belonging to the Lower Socioeconomic Status. The findings of our study indicate that a significant proportion of patients were derived from nuclear family backgrounds, comprising 74 individuals (49.0%) and 76 individuals (51.0%) respectively (Table 2). However, it is important to note that this particular observation did not yield statistically significant results ($p = 0.77948$). Chepure *et al*.[6] conducted a study to examine the prevalence of comorbid psychiatric diagnoses in adult males seeking medical care at a tertiary care hospital, specifically focusing on cases of premature ejaculation (PME) and/or erectile dysfunction (ED). A total of 23 patients, accounting for 24.21% of the sample, were diagnosed with depression, while 41 patients, representing 43.15% of the sample, were diagnosed with anxiety disorders. A significant proportion of the participants in our research, specifically 51 individuals (34.0%), exhibited symptoms of anxiety and depression (Table 3). This finding was determined to be statistically significant, as indicated by a p-value of 0.0164. The average scores for the Hamilton Anxiety Rating Scale (HAM-A) and Hamilton Depression Rating Scale (HAM-D) among the participants in our research were found to be 15.2000 and 8.4303 for HAM-A and 13.6700 and 8.2267 for HAM-D, respectively (Table 4).

CONCLUSION

The study involved the participation of 150 patients, with a significant proportion of the sample being individuals below the age of 30. The statistical significance of age is a topic of interest and investigation in various academic disciplines. The average age of the patients was calculated to be 35.68 with a standard deviation of 9.4856. Based on our research, the entire patient population consisted exclusively of male individuals. The proportion of Muslim patients was greater than that of Hindu patients; however, this observation did not yield statistically significant results. Although the statistical significance was established, it was observed that a significant proportion of the patients fell within the lower socioeconomic stratum. Based on the findings of our study, it was observed that the predominant patie originated from nuclear family structures, with

joint families representing the subsequent largest group. However, it is important to note that this disparity did not yield statistically significant results. In the present investigation, a total of 51 individuals, constituting 34.0% of the sample, were found to exhibit comorbid symptoms of anxiety and depression. This proportion was higher than the prevalence of anxiety disorder alone, which accounted for 24% of the participants, as well as the prevalence of depression alone, which accounted for 23.0% of the participants. The distribution exhibited a statistically significant result with a p-value of 0.0164. The average Hamilton Anxiety Rating Scale (HAM-A) score of the patients included in our study was calculated to be (15.2000 8.4303), while the mean Hamilton Depression Rating Scale (HAM-D) score was determined to be (13.6700 8.2267).

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