

ABSTRACT

Background:

Men with genitourinary problems, infertility or sexual dysfunction usually consult andrology clinic. Previous studies have shown that psychiatric morbidity is frequently undetected in males with sexual dysfunction. The study of explanatory models or patient perspectives about illnesses is a vital but often neglected area especially among clinicians. Exploring explanatory models of patients will help clinicians to take balanced decisions regarding patient care.

Aims and Objectives:

This study aimed to determine psychiatric morbidity and explanatory models for sexual disorders in patients presenting to andrology clinic.

Methodology:

The study was conducted at the andrology clinic at Christian Medical College and Hospital, Vellore. Consecutive patients attending the andrology clinic were invited to participate in this study. All patients 18 years and above; who can speak Hindi or English and who provided informed consent were included in the study. Socio-demographic details and sexual history was collected using a specially designed proforma. Beliefs about causation, the meaning of sickness, the diagnosis, the modes of treatment, and expectations regarding treatment of the subjects were assessed using modified short

explanatory model interview (SEMI). Subjects were further assessed using Hindi version of Clinical Interview Schedule – Revised (CIS-R) to detect common mental disorders.

Results:

One hundred and thirteen patients, fulfilled criteria for inclusion and participated in the study. Prevalence of a DSM-5 sexual disorder was 83.2%. 59 (52.2%) participants had common mental disorder as per the research interview. Most common reported concerns were premature ejaculation (63.71%) and erectile dysfunction (55.75%). ‘Disease’ and ‘semen loss’ were the most commonly reported causative factor. The majority felt that consulting a doctor or a nurse would help solve their difficulties. 92.9% held a medical explanatory model and 66.4% reported a non-medical explanatory model for their sexual disorder. Participants with a common mental disorder were likely to be unemployed; and if employed, not satisfied with their current job; from a lower socio-economic status; with unsatisfactory marital life; from an urban background; having taken treatment for sexual dysfunction in the past; reported masturbatory guilt and sexual misconceptions; have multiple partners and had a diagnosis of premature ejaculation or Dhat syndrome. They were also likely to have reported that their sexual problem was due to Karma, masturbation, night falls, or a disease and believed that consulting a doctor or a nurse or taking herbal treatment will cure their sexual problem. More patients with common mental disorder also reported medical and non-medical explanatory models. Participants who held a medical model were less educated, sexually active, and more likely to have been diagnosed with PME or Dhat syndrome. Presence of masturbatory guilt, and having

taken treatment in the past were associated with holding a non-medical model. Psychiatric morbidity was under recognized by the andrologist as compared to the research interview.

Discussion:

In view of recent advances in the understanding of biological factors associated with male sexual disorders, the primary focus of management has shifted from psychiatrist to andrologist and from behavioural or psychological interventions to biological therapies. The bidirectional nature of the association between sexual disorders and psychiatric illness is well established. The course and prognosis of sexual disorders is influenced by patient explanatory models which is dependent on their cultural background. Thus a management plan for sexual disorders should take into consideration the biological, psychological and cultural factors associated with male sexual disorders. A multi-disciplinary team consisting of an andrologist, psychiatrist and a psychologist or a nurse in an andrology clinic will provide an ideal setting for management of male sexual disorders.