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Original Research Paper

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MALE SEXUAL DYSFUNCTIONS IN JAMNAGAR AND PAPAROLA: A SURVEY STUDY

Mehra BL	Institute For Post Graduate Teaching And Research Gujarat Ayurved University Jamnagar , India
Pawankumar G	Institute For Post Graduate Teaching And Research Gujarat Ayurved University Jamnagar , India
Singh G	Institute For Post Graduate Teaching And Research Gujarat Ayurved University Jamnagar , India
Prasad BS	Sri BMK Ayurveda Vidyalaya KLE University, Belagavi, India
Skandhan KP*	Sri BMK Ayurveda Vidyalaya KLE University, Belagavi, India. *Corresponding Author
Jaya V	Dell Seton Medical Centre At University Of Texas, Austin, USA

ABSTRACT

INTRODUCTION: Sexual dysfunction (SD) is present throughout the world. Male sexual dysfunction was studied in different countries. The level of SD is high in some places and low at other places. In our country the SD is not studied in detail. Here people exclude any discussion on sex. Person who suffers from SD does not disclose his disability to any. Thus even a rough estimate about SD is not possible. **MATERIALS AND METHODS:** In this study we attempted to find out the general characteristics of men on life and sexual ability. We have selected two places in our country, 1. Jamnagar North West in province of Gujarat and 2. Paparola a hilly region on North East part of our country. Married men between 21 and 30 years old were included in the study and we distributed questionnaires. Before answering they were told about normal sex organs and their functions. **RESULTS:** Response to questionnaire was around 30% from both places. **DISCUSSION:** The poor response to questionnaire is likely due to shyness on the topic or feeling that his details may be disclosed. Participants continued anxiety over sex. We studied the participants level of anxiety over sex, erectile dysfunction, then sexual experience, initial difficulty of erectile dysfunction, penile penetration, habit of masturbation, their view on masturbation, premature ejaculation, ejaculation difficulties and nocturnal emission. Experience of participants at both places, Jamnagar and Paparola differed.Similar survey studies have to be carried out at nationwide to reach on a conclusion about the level of SD.

KEYWORDS : Erectile dysfunction, Premature ejaculation, Masturbation, Nocturnal emission

INTRODUCTION

India is a vast country where different religions, cultures and languages are present. The education level of the country is below 40% and knowledge on sex is not imparted either at the level of school or college. In general, people seldom discuss about sex. When do anytime, which is not to in presence of children and members of opposite sex. This was clearly shown in a survey we conducted among girl students of schools and colleges. Many of them were not aware of the process of menstruation till they experienced it for the first time (Skandhan et al. 1988). The cause is lack of the basic knowledge on sex. In such situation sexual disability and /or dysfunction is likely to be present in both men and women. The present study is restricted to male persons.

It is essential for a person to have minimum sexual knowledge; if it is lacking he maydevelop an aversion of sex and further misconception about it. As an example, irrespective of socioeconomic classes many believed that semen loss is harmful. They considered which is an elixir of life both in the physical and in the mystical sense. They believed preserving semen as important as this helps for longevity (Malhotra 1975). "Dhat (semen loss anxiety) Syndrome" is a culture-bound sex neurosis of the Indian subcontinent (Chadda, Ahuja 1990). Which is also described historically in other cultures including Britain, the USA and Australia (Sumathipala et al. 2004). Malhotra (1975) described the clinical picture of this showing severe anxiety and hypochondriasis. A probable cause for "Dhat Syndrome" is the misconcept present in the mind of a person. In India while using squatting toilet one is tempted to look down and see the sticky substance coming out of penis which he considers as semen (Kothari 1988). In Western style toilet look is straight and does not see any. The pressure given in the abdomen during toileting is responsible for release of sticky substance which is not semen. Mind of a patient with "Dhat Syndrome" is pre occupied with the excessive loss of semen and he considers which is also mixed in urine (Malhotra 1975).

When one develops any ailment related to sex he considers it as personal and he maintains secrecy on this. In our country many times sexual disorder is revealed to clinician when he approaches for childlessness. Avasthi and Biswas (2004) pointed out sexual dysfunction (SD) in a man may change his psychological approach to life. The sexual disorder may lead to anxiety, depression or sexual phobias. SD is common (Laumann et al. 2005).

among men between the age of 40 and 70 years. A recently reported study showed male SD was on high in India (Mehra et al. 2020). Likewise in the United States it is at a high level (Braun et al. 2000). One study showed SD is more among men in rural area than urban (Kothari 1988). Globally, studies are conducted on several aspects of sex and its dysfunction (Braun et al. 2000;

Diemond et al. 1996; Fisher et al. 2005; Lendrof et al. 1994). It is known now that if not properly treated SD may badly affect relationship with partner and others (Fisher et al.

2005). Also which may lead to deterioration in the quality of life (Rosen et al.

2004). Studies showed in many cases SD ended with cardio vascular diseases (Chew et al. 2008; Feldmann et al. 1994).

In the present survey study, we aimed to understand the knowledge of people on sex and sexual disorders. Study was conducted at two different places of this vast country, Jamnagar in the Province of Gujarat in North West Coast and Paparola in the Province of Himachal Pradesh, a hilly region in Northern part of our country.

MATERIALS AND METHODS

The study was conducted at two selected places of this country, 1. Jamnagar, and 2. Paparola**.** All participants were married men. A total number of 1750 participants were from Jamnagar and 680 from Paparola. Consent of participants was taken prior to initiation of the study. They were assured about non disclosure of their identity at any level. In this study a prepared questionnaire was distributed to each one of them. Authors explained in detail about the questions placed before them. Volunteers were informed the mechanism of semen emission. Questionnaire was suitably prepared incorporating to understand their habits, general health, knowledge on sex and sexual ability (with gradation). This was also to find out if one experiences difficulty while performing sex. Details of the habit of masturbation was also enquired.

RESULTS

A total number of 528 (30.2%) participants from Jamnagar and 206 (30.3%) from Paparola responded to questionnaire. Participants age was from 21-30 years. Details of their income and general habits are given in Table 1. Participants knowledge on sex and their sexual experience including excitement on sex, difficulty in penile penetration, masturbation and their opinion on these are shown in Table 2.

Table1. Details of the study and participants.

Observation	Jamnagar	Paparola
Questionnaire distributed (number)	1750	680
Response to questionnaire	528 (30.2)	206 (30.3)
Details of participants:		
Age (years)	21 - 30	21 - 30
Income per month (Rs)	3000 - 5000	3000 - 5000
	Percentage	
Food habit		
vegetarian	39.6	14.3
non vegetarian	60.4	85.7
Consumption of alcohol	25.3	81
Smoking cigarettes and beedies	35.2	75.7
Tobacco chewing	9.9	14.3
Pan chewing*	31.9	Nil
Tea consumption	58.2	100
Hyperacidity	20.9	14.3

*A combination of betel leaf, areca nut, tobacco and essence of different flavors.

Table 2. Participants'knowledge And Experience On Sex.

Observation	Percentage	
	Jamnagar	Paparola
Anxiety over sex	61.5	23.8
Erectile dysfunction	35.2	34.44
Sexual experience		
Less excitement	33.6	14.3
Without satisfaction	39.6	7.1
Initial difficulty of penile penetration	16.0	16.6
Masturbation	43.7	61.1
Opinion – masturbation leads to sexual dysfunction	40.7	33.9
Premature ejaculation	17.2	10.2
Nocturnal emission	39.8	60.7
Ejaculation difficulties	17.2	10.2

DISCUSSION

SD is common among men and women. Which is more in women (43%) than in men (31%) (Laumann et al. 1999). A recent retrospective study showed alarming level of SD in India like in some other countries (Mehra et al. 2020). Tal (2016)[16] reported SD may appear any time during life, from puberty to old age. Andrade (2005) suggested conducting survey on this topic as essential. It is reported in US 30 million people suffer from ED (Yafi et al. 2016). Unawareness about knowledge on sex is present in our country. The best example is shown in a study where girl students understood about menstruation only after experiencing it for the first time (Skandhan et al. 1988). The reason is lack of knowledge on sex. Similarly a common belief among many people is that small size of penis leads to sexual dissatisfaction. Similar report was presented by Kothari (1988). However, size of the penis is not important for sexual arousal (Fisher et al. 1983). Considering the anatomy and sensitivity of vagina which is restricted on first one third of the organ. Our participants were informed this. All these reports prompted us to conduct the present survey study where we attempted to find out male dysfunction in our country. In this study married men from two different regions were included. They were from extreme west, Jamnagar and extreme north Paparola, of our country. Similar survey studies are conducted in other countries.

In the present survey study, people included from two places conversed in different languages, lived in different cultures and climates. This made us to understand difference in their habits, sexual attitudes and inabilities if any. We observed many participants felt embarrassed when questionnaires were distributed. As which was dealing about sex organ and its action. This was the likely reason for the limited response (30%) to distributed questionnaires (Table1). Prior to distribution of questionnaire participants were told the details of the study. Our observations on their sexual functions are discussed below.

Erectile Dysfunction (ED)

ED is defined as non erection experienced by a person to satisfactorily perform sexual function for minimum three months (Rosen et al. 2004). Which is understood that one is not able to maintain penile erection for sexual performance (NIH Consensus 1993). Reports about ED from world over are several, either from clinical studies or from hospital records. We have reported ED level as 21.03 percentage (Mehra et al. 2020). Another study from India shown ED level as 24% (Verma et al. 1998). Frank et al. (1978) reported it as

4%. Causes for ED may be Physiological or Psychological (Frank et al. 1978; Wagner, Green 1981; Lendrof et al. 1994). It may be due to anxiety over sex or mental depression or sexual phobia or ageing (Althaf, Seftel 1995) or drug addiction (Rosen et al. 2004) or anti depressant (Seidman, Roose 2000). Some systemic diseases may lead to ED. A report from UK showed ED may be due to termination of last relationship (Guest, Gupta 2002). In general, ED is associated with age and health condition. ED leads to a dissatisfied sexual life as well as poor sexual performance in case of partner also (Braun et al.

2000). ED may lead to chronic heart diseases (Chew et al. 2008).

The incidence was shown as 2.7% among Dutch (Diemond et al. 1996), 4% among Danish (Lendrof et al. 1994), and 50 to 52% among Americans (Feldmann et al. 1994). Our study showed that ED was 14.2 percentage in Jamnagar and 8.7 percentage in Paparola (Table 2). Many reported increase in ED as with advancement of age. Luo et al. (2016) reported that in the United States ED increased with age and decreased in old age. Survey conducted by Kinsey (1948) observed that ED was very rare under the age of 35 years, but increased to 6.7% at 55 years and 25% at 70 years. The more occurrence seen in our study where participants were in young age and early marriage where this was caused due to anxiety related to sex

and over exhilaration performance pressure to prove his sexual strength. Initial difficulty in penile penetration was more in Jamnagar (13.3%) than Paparola (11.1%). In India after fifty years of age sex is considered as taboo.

Premature Ejaculation (PE)

PE is one of the common SD among male (McMahon 2007). The study of Verma et al. (1998) reported from a psycho sexual clinic PE was in 77.6 % among patients. Waldinger et al. (2005) proposed a classification for PE as men with less than one minute fall under "definite" while men within 1 and 1.5 minutes as "probable". PE was either lifelong or acquired. In the present study the incidents of PE was more in Jamnagar (17.2%) when compared to that of Paparola (10.2%) (Table2). At both places people were scared of this condition and were shy to seek medical advice. This was similar to our earlier study among young females where we observed they did lack basic sexual knowledge (Skandhan et al. 1988). Studies were conducted by different authors on PE at different places and continents. PE was more in Indian subcontinent (Bhatia, Malik 1991). Generally ejaculation time was shorter among men in Asia when compared to Caucasians to Afro-Caribbens and authors concluded that men of some races are "sexually restrained" (Kinsey et al. 1948; Rushton, Bogaert

1998). Masters and Johnson (2006) considered chronic PE was due to anxiety over performance. Hassan et al. (2017) reported PE was well associated with psychological reasons like depression or anxiety which also may be due to repeated masturbation. Reports revealed probable causes of PE as either divorce, presence of social phobia or higher levels of education (Fasolo et al. 2005). Men who were treated for diabetes were less prone to PE (Perelman et al. 2004). Different studies showed PE did not reduce quality of life or sexual desire or sexual arousal (Lue et al. 2004; Perelman et al. 2004). Dapoxetine is opted for the treatment of PE (McMahon 2011).

Masturbation

Masturbation is defined as the sexual stimulation of one's own genitals for sexual arousal or other sexual pleasure, usually to the point of orgasm (Lehmiller 2017). This topic not discussed in public (Rowan 2000). The procedure of masturbation is now recognized as healthful, helpful and natural behavior (PPFA 2002) and this method does not deplete body energy or produce premature ejaculation (Strassberg et al. 2015). Masturbation becomes abnormal when done in public or when it inhibits partner-oriented behavior (Brown 2019). Incidence of masturbation was seen among participants of both places but which more practised in Paparola (Table 2). The maximum number of individuals participated in this survey were defence service personnel staying in military camps without family and which might be a probable reason, as this method alone remains as an outlet. Das (2007) reported 61% of married men in the US practiced masturbation.

Many participants of our study believed that masturbation lead to sexual dysfunction including curvature of penis at a later stage. But is proved after extensive research work that masturbation is a simple Physiological way of sexual outlet and does not necessarily cause worries. This procedure is a medically healthy and psychologically normal habit (Patton 1985). We observed a decline in the incidence as age advanced. The reason may be one attain voluntary control over ejaculation with experience. A lower probability of developing prostate cancer was reported among people who masturbated (Giles et al. 2003).

Nocturnal Emission

Nocturnal emission (night emission), informally known as a sleep orgasm, wet dream, sex dream or nightfall which is a spontaneous ejaculation during sleep. It is commonly experienced after puberty, during adolescence and early young age. Many experienced first ejaculation as a result of a nocturnal emission (Kinsey1948). Nocturnal emission is experienced till old age (Kinsey 1948). In our study participants from Jamnagar (40%) and Paparola (61%) experienced nocturnal emission (Table 2). This level was reported as 83% in the US (Kinsey, 1948), 71% in India (Verma et al. 1998) and 97% in Indonesia (Statastik 2004).

Kinsey (1948) opined men who have lower rates of masturbation experienced nocturnal emissions. Only 4 percentage of men reported sexual related dreams was leading to their orgasm (AASM 2007). Kothari (1988) reported some believed their small size of penis is responsible for NE. Size of penis is not important for sexual arousal (Fisher et al. 1983). A study conducted by Finkelstein et al. (1998) reported an important factor related to nocturnal emission as testosterone-based drugs. Drastic increase in nocturnal emission was seen while taking this drug. Meng et al. (2013) observed that equal number of sperms in semen in samples collected during nocturnal emission and routine ejaculation but motility of sperms remained high in nocturnal emission.

CONCLUSION

In conclusion in this survey we observed male sexual dysfunction a both places, Jamnagar and Paparola. Main responsible factor for this is lack of sexual knowledge. Major dysfunctions reported and discussed in this study are 1. Erectile dysfunction 2. Premature ejaculation 3. Masturbation and 4. Night emission

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