Original Article

Assessment of sexual beliefs among "drug naive male" patients attending psychiatry OPD in a teaching institution: A cross-sectional study

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Abstract

Background: The basic objective of any civilization is to preserve a happy family. The quality of one's sexual encounters is crucial to a happy marriage. Couples' dissatisfaction in this area may be the cause of several social, psychological, and medical issues. The way reality is interpreted, which shapes behaviors and emotions, is established by beliefs. These beliefs, which are among the most frequent causes of male sexual problems, include those relating to high performance, women's sexual enjoyment, and sexual conservatism. **Aims:** To identify the misconceptions about sexuality among psychiatry patients. Method This cross-sectional study was carried out at the School of Medical Sciences and Research, Sharda University. We enrolled 200 samples and it is assessed through Sexual Beliefs Questionnaire (Male version). **Result:** Sexual beliefs were assessed in different domains as well as overall sexual belief score was also estimated. The different domains in which the sexual beliefs were scored were sexual conservatism, female sexual power, macho belief, beliefs about women's sexual satisfaction, restrictive attitude toward sex, and sex as an abuse of men's power. **Conclusion:** The development of both psychiatric and sexological care will benefit from the early identification of the intricate relationships between psychopathology, the adverse effects of antipsychotic medicines, and sexuality. However, longitudinal studies are needed to anticipate the relationship more accurately between sexual dysfunction and sexual beliefs at a larger sample size. Sexual beliefs are significant contributors to sexual dysfunction.

Keywords: Beliefs, drug naive, dysfunctional, male, sexual

Background

There is more to sexuality than just an urge or inclination. A sexual partner's bond with you is significantly more important than just satisfying the lust. Marriage is a social phenomenon in which two people cohabitate with a degree of independence so they can grow as individuals and achieve their potential. The basic objective of any civilization is to preserve a happy family.[1] The quality of one's sexual encounters is crucial to a happy marriage.[2] Couples' dissatisfaction in this area may be the cause of a number of social, psychological, and medical issues. Additionally, numerous physical and psychiatric illnesses might have an impact on a patient's ability to have sex.[3]

The sexual connection is a complicated one, and issues can arise for a variety of reasons, often with more than one contributing aspect. Physical, psychological, and relationship aspects can all be roughly categorized into these three groups. The self- and other evaluative aspects of sexual response (thus the term "performance" in relation to sexuality) are the root of many psychological sexual issues.[4] The need to contact a health

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professional has grown as a result of the significant growth in interest in human sexual function over the past several years, a change in social attitudes, and an increase in the number of people who wonder if their sexual performance is less than ideal.[5]

Sexual dysfunction in psychiatric patients is common, although it is underdiagnosed and commonly overlooked in general care.[6] It can be difficult to distinguish between treatment-emergent sexual dysfunction (TESD), a common side effect of antidepressant drugs like selective serotonin reuptake inhibitors (SSRIs) and serotonin and norepinephrine reuptake inhibitors (SNRI), and SD in patients with affective disorders as a pre-existing condition.[7] However, SD frequently results in treatment noncompliance or discontinuation, regardless of whether it is linked to fundamental diseases or the therapy for them.[8] One clinical survey revealed that SD was "very difficult to live with" and was cited as the main reason for antidepressant medication non-compliance. The selection of more effective treatment choices for SD and/or other primary illnesses with favorable side effect profiles may be made possible by the recognition of SD at numerous points of contact with the healthcare system. This may also encourage treatment compliance.[9]

The way reality is interpreted, which shapes behaviors and emotions, is established by beliefs, which are rather consistent concepts about who we are and the world around us. Numerous ideas have a direct bearing on gender and sexual issues and have an impact on relationships, friendships, and daily life in addition to sexual activity. A core belief that is more fundamental and unconditional and an intermediate belief that is more conditional are the two main levels of belief, according to cognitive theory (usually known as attitude or conditional belief). Many clinical reports and theoretical studies point to some prevalent beliefs as etiologic factors determining sexual dysfunction. These beliefs, which are among the most frequent causes of male sexual problems, include those relating to high performance, women's sexual enjoyment, and sexual conservatism.[10] Dysfunctional sexual beliefs are unfounded and unrealistic ideas about sexuality that are taken for granted despite a lack of supporting data. As a result of early exposure to the sociocultural milieu, direct information from the Internet, pornography, and sex education programs, as well as personal experiences, sexually linked views are internalized.[11]

In the past, antipsychotic medication has been widely blamed for causing sexual dysfunction.,[12] even if recent studies indicate that it might be a side effect of the illness itself and might possibly be connected to the severity of the symptoms.[13] An essential component influencing the quality of life is sexual satisfaction. Sexual issues are a rarity for patients; thus, inquiries regarding this aspect of life should not be disregarded during a medical interview. This study was, therefore, aimed to assess the prevalence, nature, and risk factors of sexual dysfunction in drug naïve or drug-free psychiatric patients using standardized diagnostic criteria and assessment tools in contrast to previous reports and also to determine the sexual beliefs among the patients with psychiatric illnesses. To the best of our knowledge, there have been no published studies from India that have looked at this topic.

Aims

To identify the misconceptions about sexuality among psychiatry patients.

Study location

School of medical sciences and research, Greater Noida, Uttar Pradesh.

Study population

All drug naïve patients with known psychiatric morbidity.

Study period

Data were collected from January 2022 to June 2022.

Study design

Cross-sectional, analytical study.

Inclusion criteria

- Written and informed consent
- Age 18–45 years
- Male patients
- Any psychiatric diagnosis except established sexual disorders and substance abuse.

Exclusion criteria

- Patients with any medical co-morbidities
- Established sexual disorder diagnosis
- Patients with co-morbid established substance use disorder
- Patients on any drug that can affect sexual functions
- Patient found to have STD will be referred for treatment.

Sampling technique

Any patient fulfilling the inclusion criteria was recruited for the study through consecutive sampling.

Study tools

It was a self-designed, pre-tested, semi-structured, interview-based questionnaire that recorded the following details:

1. **Socio-demographic and clinical data sheet (self-prepared)**

It was created specifically for recording socio-demographic information including name, age, marital status, religion, level of education, occupation, background, state, socioeconomic position, income, and clinical information.

2. **Sexual Beliefs Questionnaire (Male Version)[19]**

A 40-item survey measuring preconceptions and attitudes have been identified in the clinical literature as contributing to the emergence of various male sexual dysfunctions. The survey includes a

male version that evaluates particular gender-related views. The individuals are asked to rate the agreement of 40 statements pertaining to various sexual issues (from 1—completely disagree to 5—completely agree). The following domains are present in the masculine version:

Sexual conservatism: Masturbation, oral sex, and anal sex are viewed as deviant and sinful behaviors, and coitus is a fundamental part of human sexuality. Women have a passive, receptive sexual role, and for unmarried women, virginity is a key value.

Female sexual power/need for sexual control: Male sexual power can be harmful, and if men do not restrain their urges, they will be under the influence of women.

"Macho" belief: All women should feel satisfied by men, and they should keep their penis erect throughout any sexual action.

Beliefs about women's sexual satisfaction: It is crucial to satisfy female partners, and to satisfy women sexually, penile erection and vaginal coitus are prerequisites.

Restricted attitude toward sexual activity: Oral sex, anal sex, and sexual fantasies are unhealthy or improper experiences.

Sex as an abuse of men's power: Sex is when a man violates or mistreats a woman's body.

Study procedure

The study was conducted at the School of Medical Sciences and Research Medical College and Hospital on Out Patient Department (OPD) basis. All the patients who fulfilled their respective inclusion and exclusion criteria were enrolled in the study. A written informed consent was taken from the patients, and then the patient information sheet was handed out. The data collection proforma was then given to collect socio-demographic details, followed by filling the sexual beliefs questionnaire.

The author provided a vernacular translation for individuals who did not speak English.

Result

Sexual beliefs were assessed in different domains as well as overall sexual belief score was also estimated. The different domains in which the sexual beliefs were scored were sexual conservatism, female sexual power, macho belief, beliefs about women's sexual satisfaction, restrictive attitude toward sex, and sex as an abuse of men's power.

There were 200 patients who were enrolled in the present study. All the patients were diagnosed with case of schizophrenia and were presenting for the first time in the psychiatry OPD. There were all males. The mean age of the respondents was 29.2 (SD = 8.06) years. The mean year of education of the respondents was 13.04 (SD = 5.13) years [Table 1].

Majority of the patients were unmarried (*n* = 104), while 96 patients were unmarried [Table 2].

Figure 1 describes the marital status of the patients.

Table 3 describes the education status of the patients. Most of the patients were graduates (*n* = 65), followed by those who had studied up to the intermediate level (*n* = 40) and up to primary level (*n* = 27). Twenty-six patients had completed their education up to senior secondary level, and 21 patients had completed their education up to middle school level. Twenty patients had completed their postgraduation.

Figure 2 describes the education status of the patients.

The majority of the patients consisted of an occupation of a skilled worker (*n* = 84), followed by the unskilled worker (*n* = 73), and 43 patients were unemployed.

Figure 3 describes the occupation status of the patients.

Table 1: Mean age and duration of education of the patients (*n*=200)

	Mean	S. D
Age in years	29.2	8.06
Education in years	13.04	5.13

Table 2: Marital status of the study participants

	Frequency	Percent
Married	96	47.8
Unmarried	104	52.2

Table 3: Education status of the patients (*n*=200)

	Frequency	Percent
Graduate	65	32.4
Intermediate	40	20.1
Primary	27	13.6
Secondary	26	13.1
Middle	21	10.4
Postgraduate and above	21	10.4

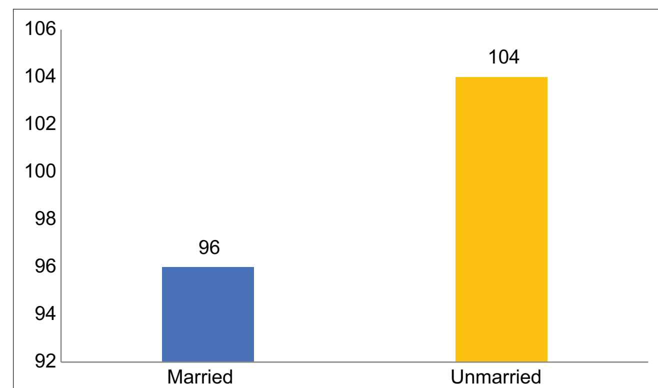

Figure 1: Marital status of the patients (*n* = 200)

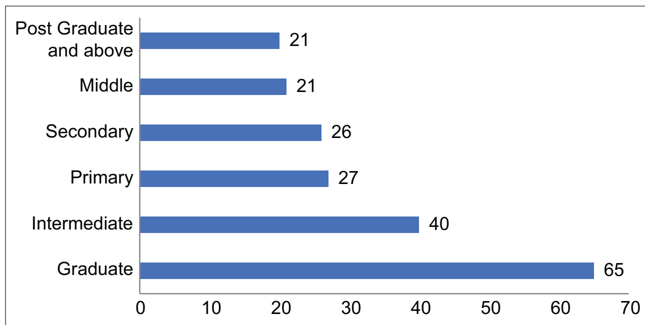

Figure 2: Education status of the patients (*n* = 200)

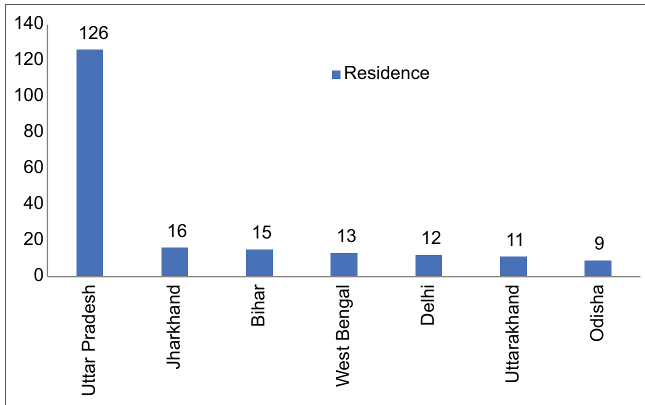

Figure 4: Residence of the patients (*n* = 200)

Most of the patients belonged to the state of Uttar Pradesh (*n* = 126), followed by Jharkhand (*n* = 16) and Bihar (*n* = 15). Thirteen patients were residents of West Bengal, 12 patients were from Delhi, 11 from Uttarakhand, whereas nine patients belonged to Odisha [Table 4].

Figure 4 describes the residential status of the patients.

Table 5 majority of individuals were Skilled workers. The majority of the patients belonged to low socioeconomic status (*n* = 98), 69 belonged to the middle socioeconomic status, whereas 33 patients belonged to upper socioeconomic status according to the BG Prasad Scale [Table 6].

Figure 5 describes the socioeconomic status of the patients.

Most of the patients belonged to the extended family (*n* = 61), whereas 139 patients belonged to the nuclear family.

Figure 6 describes the type of family [Table 7].

Sexual dysfunctional beliefs questionnaire was used in the patients to assess the sexual beliefs. Sexual beliefs were assessed in different domains as well as overall sexual belief score was also estimated. The different domains in which the sexual beliefs were scored were sexual conservatism (15.44 ± 4.76), female sexual power (18.82 ± 4.49), macho belief (14.88 ± 4.60), beliefs about women's sexual satisfaction (8.32 ± 2.72), restrictive attitude toward sex (8.32 ± 2.72), and sex as an abuse of men's power (3.86 ± 1.64) [Table 8].

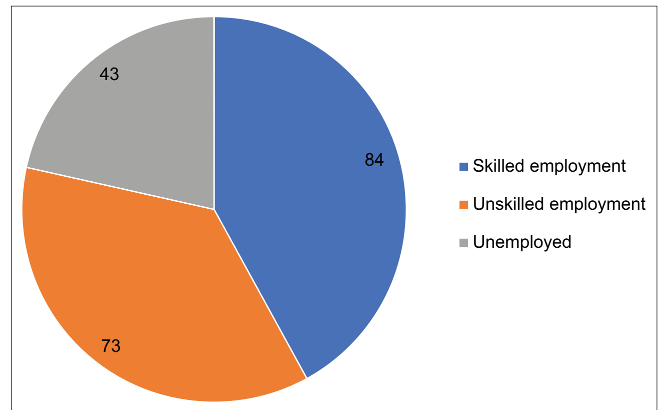

Figure 3: Occupation status of the patients (*n* = 200)

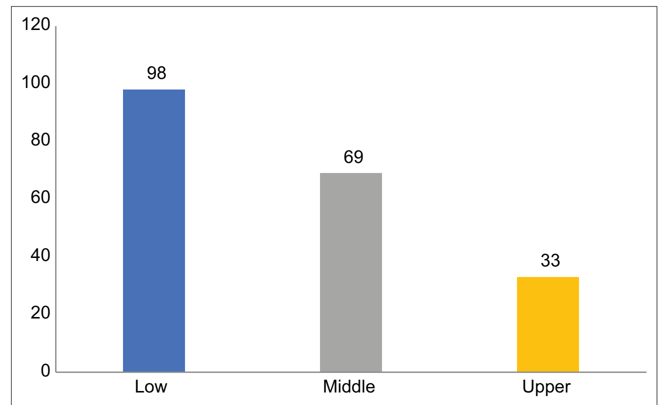

Figure 5: Socioeconomic status according to BG Prasad Scale

Table 4: Residence of the patients (*n*=200)

	Frequency	Percent
Uttar Pradesh	126	63.0
Jharkhand	16	7.8
Bihar	15	7.3
West Bengal	13	6.3
Delhi	12	5.8
Uttarakhand	11	5.3
Odisha	9	4.7

Table 5: Occupation status of the patients (*n*=200)

	Frequency	Percent
Skilled employment	84	42.1
Unskilled employment	73	36.6
Unemployed	43	21.3

Table 6: Socioeconomic status according to BG Prasad Scale (*n*=200)

	Frequency	Percent
Low	98	49.0
Middle	69	34.7
Upper	33	16.4

Table 7: Type of family (n=200)		
	Frequency	Percent
Extended	61	30.4
Nuclear	139	69.6

Table 8: Sexual dysfunctional beliefs				
Male factors	Minimum score	Maximum score	Mean	S. D
Sexual conservatism	10	50	15.44	4.76
Female sexual power	8	40	18.82	4.49
"Macho" belief	7	35	14.88	5.22
Beliefs about women's sexual satisfaction	5	25	15.38	4.60
Restrictive attitude toward sex	4	20	8.32	2.72
Sex as an abuse of men's power	3	15	3.86	1.64
Total			77.61	16.64

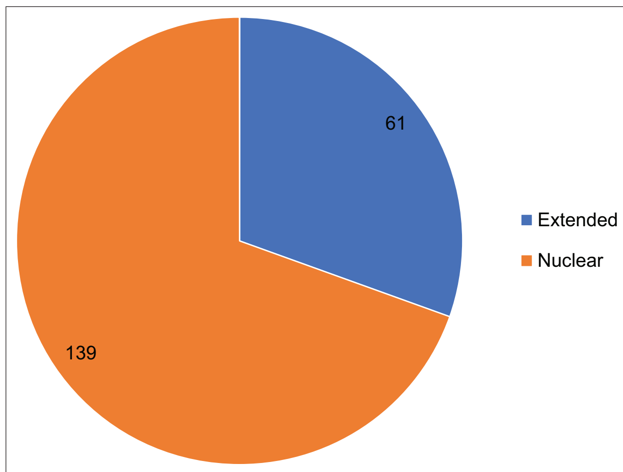

Figure 6: Type of family

Limitation and Conclusion

The development of both psychiatric and sexological care will benefit from the early identification of the intricate relationships between psychopathology, the adverse effects of antipsychotic medicines, and sexuality. However, longitudinal studies are needed to anticipate the relationship more accurately between sexual dysfunction and sexual beliefs at a larger sample size. Sexual beliefs are significant contributors to sexual dysfunction.

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Conflicts of interest

There are no conflicts of interest.

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