

DISTRESS IN WIVES OF PATIENTS WITH PSYCHOSEXUAL DYSFUNCTION : AN EXPLORATORY STUDY

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ABSTRACT

The study was conducted with the aim of studying the wives of patients with psychosexual dysfunction with regard to the level of distress experienced and its relationship with their psychosocial dysfunction and marital adjustment. The sample comprised wives of 30 male patients with psychosexual dysfunction. Majority of the subjects was under matriculate, housewives, Hindus, and of urban background. Majority of their husbands suffered from combination of premature ejaculation and failure of genital response (60%). The subjects were found to be significantly more distressed, exhibited mild degree of psychosocial dysfunctioning. However, they had normal marital adjustment. The interrelationship between these three variables showed significantly positive correlation between distress and psychosocial dysfunction. Marital adjustment showed significant negative correlation with both the distress experienced and psychosocial dysfunctioning. These findings not only have implication for the management of these disorders, but may have prognostic value as well.

Key Words : Distress, psychosexual dysfunction, wives, marital adjustment

Human sexuality being a central core of marital relationship and adjustment, it is intuitively understandable that male psychosexual dysfunction (e.g. erectile dysfunction, ejaculatory disturbance, or both) should be distressing for the spouses of the affected men. Many women, when faced with a partner's sexual dysfunction, assume either that they are no longer attractive or the man has developed an interest in other women. This negative self-evaluation, as well as the frustration caused by the male spouse's performance difficulties can interfere with communication, and may lead to the disintegration of the couple's relationship as well as impairment in psychosocial functioning of the female spouse. Although many couples may be able to adjust to sexual dysfunction, frequently, marriages are disrupted or ended as a result of sexual problems (Osborne,

1981).

In spite of this intuitive understanding, however, there is a striking paucity of research actually documenting the distress in wives of psychosexually dysfunctional males. This deficit is glaring in the face of the reportedly appreciable 9.2% to 13% of psychiatric outpatients and 30% of males attending STD clinic presenting with sexual dysfunction in India (Kar & Verma, 1978; Kumar et al., 1983; Catalan et al., 1981).

Using both Medline and manual literature search, only one directly relevant study from USA could be identified in the previous 25 years. This study reported that wives of psychosexually dysfunctional men were significantly more distressed and symptomatic compared to wives of a normal control group (Derogatis et al., 1977).

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Even having granted the significant distress in the spouse of male with psychosexual dysfunction, other important questions remain unanswered. How does this distress relate to the level of marital adjustment of the couple, or how does it affect the level of psychosocial functioning of the female spouse? An earlier study from USA, focusing on couples seeking marital therapy vis-a-vis those seeking sex therapy, found that "just as the couples seeking marital therapy were beset with numerous sexual difficulties, the couples seeking sex therapy seemed to be experiencing considerable marital discord. Outstanding among the interpersonal difficulties experienced by the sex therapy couples were decreased interest in talking to one another, feeling that their spouse did not understand them, frequent arguments, and feeling that their spouse did not fulfil their emotional needs" (Frank et al., 1976).

In contrast, a study from Chandigarh on male potency disorders reported that "strangely, in an overwhelming majority of cases, the attitude of wife was found to be either helpful or indifferent" (Nakra et al., 1977). Unfortunately, this conclusion seems to be impressionistic as no questionnaire on attitudes or adjustment was administered to the spouses. The study from USA (Frank et al., 1976) had used a marital evaluation form, for which no further reference or its psychometric property was mentioned.

Thus, our scientific understanding of the distress generated in the wives of psychosexually dysfunctional males remains poor. Further, it is not known if the distress is associated with psychosocial dysfunction of the spouse, or with disturbed marital adjustment of the couple or both. It is important to gather data in this area, since, in the therapy of psychosexual dysfunction, not only the "affected" partner (with the dysfunction) but also the "invested" partner (who in herself is free from sexual dysfunction but has a substantial personal investment in the dyadic relationship) forms an integral component of the therapy (Masters & Johnson, 1970).

Hence, the present study had the twin objectives of: (a) documenting the degree of dis-

tress (both physical and psychological) in spouses of psychosexually dysfunctional men, and (b) exploring the relation of distress with psychosocial dysfunction and marital adjustment.

MATERIAL AND METHOD

The subjects for the study comprised wives of 30 consecutive patients of psychosexual dysfunction, who presented at Marital and Psychosexual Clinic of the Department of Psychiatry, Postgraduate Institute of Medical Education and Research, Chandigarh. The diagnosis of psychosexual dysfunction was established by the consultant psychiatrist, after detailed clinical history obtained both from the patient and his spouse, physical and genital examination, and appropriate investigations wherever required (psychometry, haemogram, blood sugar, renal and liver function tests, hormonal parameters and pharmacologically induced penile erection test etc.). The patients were diagnosed as suffering from psychosexual dysfunction i.e. failure of genital response, and premature ejaculation according to the criteria laid down by International Classification of Diseases - 10 (WHO, 1992), presenting independently or in combination.

The patient's duration of illness should have been for atleast 6 months. Only the couples living together for 6 months or longer were included in the study. It ensured an opportunity for their regular sexual contact and gave enough time for the wife to experience the distress, disruption in daily functioning, and problems in marital adjustment, if any. Moreover, the patients and their wives should have been in the age range of 20-45 years. The upper limit of 45 years ensured that age related changes of sexual functioning did not influence the study sample. The couple should have been free from any chronic physical illness and major psychiatric illness including drug dependence. In addition, the patients' wives should have been free from any sexual dysfunction.

Informed consent was obtained from the patients and their wives, and the wives were administered the following tools.

1. PGI Health Questionnaire - N1 (PGI-HQ-N1) (Verma et al., 1985)

It is a self-administered measure of distress. It is based on Cornell Medical Index Health Questionnaire (Broadman et al., 1949; Wig, et al., 1983). It consists of 38 items divided into section A (Physical distress) and section B (Psychological distress) with 16 and 22 items respectively. The answers with which the subject agreed indicated the respective score, which was then added up to get the total distress score. Higher the score, greater is the distress. The scale has been well standardized and norms are also available for different groups of population.

2. Dyadic Adjustment Scale (DAS) (Spanier, 1976)

It is a self-administered scale for measuring marital adjustment. For the present study, this scale was translated in Hindi. It has 32 items with four empirically verified components : dyadic satisfaction, dyadic consensus, dyadic cohesion & affectional expression with 10, 13, 5 and 4 items each. The scale has scoring of 0-5 for most of the items except for item No. 23 & 24 (0-4), 29 & 30 (0-1), and the item No. 31 (0-6). The scale has score range of 0-151. Higher the score, better is the marital adjustment. It has significantly high validity and reliability. However the norms are not available for Indian population.

3. Dysfunctional Analysis Questionnaire (DAQ) (Pershad et al., 1985)

It is a self-administered questionnaire which can be applied to patient or to caretaker to assess the present level of functioning in comparison with the past level of functioning i.e. before the illness. It contains ten questions in each of the five areas : social, vocational, personal, family and cognitive. Each item has five alternate answers and these are scored from 2-10 which is then converted into percentage. Psychosocial dysfunction is considered to be present only if the score is more than 40% which is then categorized as mild (40-60%), moderate (60-80%), severe (80-100%).

Higher the score, greater is the dysfunction. The total dysfunction score is arrived at by calculating the mean of scores obtained in different areas. Its reliability and validity are well established and norms are also available for different population groups.

RESULTS

The study was conducted on wives of 30 patients with psychosexual dysfunction. The mean age of patients was 29.6 ± 5.7 years. Majority of the patients were graduates (60%), employed (60%), Hindu (73%) and of urban background (63%). The mean duration of illness was 31.4 ± 28.0 months. Majority of the patients suffered from the combination of failure of genital response and premature ejaculation (60%). Premature ejaculation and failure of genital response separately comprised 13% and 27% of the patient sample respectively.

The mean age of subjects i.e. the wives of the psychosexually dysfunctional patients was 26.1 ± 5.6 years. The vast majority of the subjects were housewives (93%) and only half of them had studied above matriculation.

The wives of psychosexually dysfunctional patients were significantly more distressed as compared to the norms available for normal population (17.13 ± 7.91 vs. 7.96 ± 4.90 , $t=6.12$; $d.f.=28$; $p<0.001$). They were found to be suffering from mild degree of psychosocial dysfunction (50.46 ± 10.04). However, their scores on DAS were interestingly comparable with the norms given for western population (116.73 ± 19.44 vs. 114.80 ± 17.80), although norms for Indian population are not available.

In order to understand the relationship

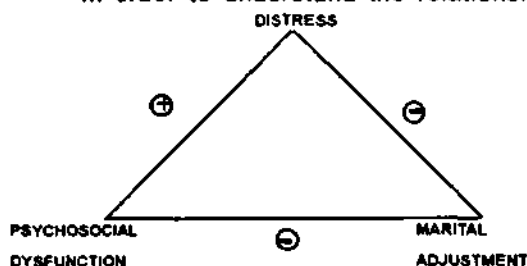


Figure 1

DISTRESS IN WIVES OF PATIENTS WITH PSYCHOSEXUAL DYSFUNCTION

TABLE 1
CORRELATION BETWEEN DISTRESS AND DYADIC ADJUSTMENT

	Dyadic adjustment				Total dyadic adjustment score
	Dyadic consensus	Affectional expression	Dyadic satisfaction	Dyadic cohesion	
Physical distress	-.3455	-.2264	-.4238*	-.5768**	-.5010**
Psychological distress	-.3322	-.1550	-.3619*	-.2668	-.4033*
Total distress score	-.4119*	-.2268	-.4739**	-.4896**	-.5434**

* p<0.05, ** p<0.01

TABLE 2
CORRELATION BETWEEN DISTRESS AND DYSFUNCTIONAL ANALYSIS QUESTIONNAIRE

	Dysfunctional analysis questionnaire					TDAQ score
	Social area	Vocational area	Personal area	Family area	Cognitive area	
Physical distress	.4648**	-.0369	.5617**	-.0107	.0075	.3630*
Psychological distress	.6013**	-.1843	.4858**	.3375	.4058*	.6100**
Total distress score	.6604**	-.1464	.6322**	.2266	.2833	.6123**

* p<0.05, ** p<0.01

between distress experience, marital adjustment and psychosocial dysfunction, the scores obtained on the three scales were then subjected to Pearson product - moment correlation.

Physical distress showed significant negative correlation with dyadic satisfaction and dyadic cohesion whereas psychological distress showed significant negative correlation only with dyadic satisfaction. Total dyadic adjustment score showed significant negative correlation with the total and components of distress score. However, total distress showed significant negative correlation with all the components of dyadic adjustment except affectional expression. Similarly, affectional expression did not show any significant correlation with the physical or psychological distress. Overall, total distress score showed significant negative correlation with total dyadic adjustment score (Table 1).

While studying the relation between distress and psychosocial dysfunction (Table 2), physical distress showed significant positive

correlation with social area and personal area of DAQ, however psychological distress in addition to these, also showed significant positive correlation with cognitive area of DAQ. The total dysfunction seen in spouses showed significant positive correlation with physical and psychological distress as well as with total distress score. Total distress score showed significant positive correlation only with social and personal area of DAQ and the total DAQ score. However no significant correlation could be found with vocational area, family area and cognitive area of DAQ. Similarly vocational and family area did not show significant correlation with either physical or psychological distress. Overall there was significant positive correlation between distress and psychosocial dysfunction.

Table 3 showed a significant negative correlation between social area of DAQ and all components of DAS including total dyadic adjustment score. Dysfunction in personal area showed significant negative correlation only with dyadic consensus, dyadic satisfaction and total

TABLE 3
CORRELATION BETWEEN DYADIC ADJUSTMENT AND DYSFUNCTIONAL ANALYSIS QUESTIONNAIRE SCORE

	Dysfunctional analysis questionnaire					TDAQ score
	Social area	Vocational area	Personal area	Family area	Cognitive area	
Dyadic consensus	-.5634**	-.0291	-.3935*	-.0877	-.0762	-.3886*
Affectional expression	-.5858**	-.2011	-.3366	-.0028	-.1671	-.1969
Dyadic satisfaction	-.5197**	-.3200	-.4062*	-.0857	-.0455	-.3832*
Dyadic cohesion	-.4302*	-.0901	-.3186	-.1531	-.0801	-.2677
Total Dyadic adjustment score	-.6341**	-.1060	-.4624*	-.1284	-.0795	-.4425*

* $p < .05$, ** $p < .01$

dyadic adjustment score. Similarly, total dysfunctional analysis questionnaire score exhibited negative correlation with dyadic cohesion, dyadic satisfaction and total dyadic adjustment score. Vocational, family and cognitive areas did not show significant correlation with either components of or total dyadic adjustment score.

DISCUSSION

Wives of 30 male patients with psychosexual dysfunction (ICD-10) were studied with regard to the level of distress experienced, psychosocial dysfunction and marital adjustment, which were assessed through the use of standardized instruments. The role of wives in the management of various physical and marital illnesses have been emphasized by a number of authors (Osborne, 1981; Nakra *et al.*, 1977; Hecht & Wittchen, 1989; Stone & Stone, 1967) which is particularly important in psychosexual dysfunctions. Osborne (1981) emphasized that wives of these patients, if involved in the assessment of these disorders, not only helped in the treatment of disorders, but also helped to bridge the communication gap between the couple, if any.

Despite an extensive review, only one study could be identified, which was conducted on the spouses of patients with psychosexual dysfunction (Derogatis *et al.*, 1977). In this study, spouses of patients with psychosexual dysfunction were studied, of which 27 were men and

21 were women. They were compared with normal subjects without dysfunctional male or female partners, and also with sexually dysfunctional patients ($n=158$). The spouses were assessed with regard to the level of distress experienced, which was measured through the use of symptom Checklist-90. The results of the study showed that invested female partners scored higher on psychological distress, when compared with females without dysfunctional husbands. However, they scored significantly lower on distress experienced when compared to sexually dysfunctional females.

The present study replicates the findings of this only available study (Derogatis *et al.*, 1977) in this area in as much that the wives of the patients with psychosexual dysfunction were significantly more distressed. However, comparison with spouses of males without any sexual dysfunction would have been desirable.

Addressing the question of relationship of distress experienced with marital adjustment and psychosocial dysfunction, it was indicated that greater the distress experienced by the wives of psychosexually dysfunctional patients, the more was the impairment in their psychosocial function and poorer was the marital adjustment. Moreover, poorer marital adjustment was also found to be associated with more psychosocial dysfunction (Figure 1). Nevertheless, it is difficult to answer as to which is primary, probably because of the design of our study.

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Certain interesting observations have been made while looking at the various components of dyadic adjustment, area of psychosocial dysfunctioning and distress experienced which may have some bearing on formulating interventional strategies. Dysfunctioning seems to be restricted to social and personal areas, sparing vocational and family spheres. Our sample comprised exclusively of housewives, who may not manifest compromised occupational functioning because of the very nature of their work which lacks strict organisational supervision. On the contrary, the call of duty towards household and family responsibilities may have compelled them to function in these areas ungrudgingly. Again in the areas of dyadic adjustment, it is the level of cohesion and satisfaction from the dyad which is seen to be affected by the distress experienced by the wives of dysfunctional males. However, the small size precludes any meaningful generalisations.

In conclusion, the most important implication of this study is that the wives' cannot be ignored in the proper assessment and management of psychosexual dysfunction in married males. The interrelationship between wives distress, psychosocial dysfunction and the marital maladjustment, may also have important prognostic implications. These aspects should be evaluated further in future prospective studies.

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