ORIGINAL ARTICLE

The Silent Struggle: Understanding Psychological Distress in Married Men With Sexual Dysfunction in Karachi, Pakistan

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ABSTRACT

Introduction: Sexual dysfunction is an overlooked condition that severely affects the psychological health of a married male, especially in a traditionalist society, like Pakistan. For this purpose, this study aims to assess psychological distress among married men with sexual dysfunction receiving psychotherapeutic treatment in Karachi, Pakistan. **Methods:** This is a cross-sectional study with 150 married men aged between 25 and 40 years with diagnosed sexual dysfunction. Kessler-10 (K10), a self-reported psychological distress scale was used to measure psychological distress and Sexual Health Questionnaire which is a brief self-reported sexual health questionnaire based on the International Index of Erectile Function (IIEF) was used to validate the presence of sexual dysfunction in males. **Results:** Participants (N=150) were married men aged 25–40, with most (43.3%) between 31–35 years and 76% reporting satisfactory economic status. Pearson's correlation analysis revealed a significant negative association between psychological distress and sexual-dysfunction domains, including sexual desire ($r = -0.168$, $p = 0.04$) and intercourse satisfaction ($r = -0.241$, $p = 0.003$), indicating an inverse relationship without implying causation. **Conclusion:** The findings revealed a significant negative association between sexual dysfunction and psychological distress, particularly in the domains of sexual desire dysfunction (SDD) and intercourse satisfaction dysfunction (ISD). Other dimensions, including erectile dysfunction (ED), orgasm dysfunction (OD), and overall sexual dysfunction (OSD), showed weaker or non-significant associations. The result highlights the urgent need for culturally sensitive interventions and mental health support for men with sexual dysfunction in Pakistan.
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INTRODUCTION

Sexual dysfunction, including erectile dysfunction, premature ejaculation and diminished sexual desire can have profound consequences that far exceed the physical acts of intimacy. Besides interrupting sexual performance, these conditions often cause considerable psychological distress, which this study defined as emotional suffering characterized by anxiety, depression and a sense of inadequacy [1]. Due to socioeconomic factors, cultural and religious conservatism, and a low awareness, male sexual dysfunctions (MSDs) are often misdiagnosed or unrecognized in Asia, in contrast to Europe [2]. In some societies, including Pakistan and especially Karachi, cultural taboos about sex and traditional gender roles aggravate these impacts [3]. Here, men have to play not just sexual roles but also serve as primary financial providers. Not being able to meet these entangled expectations can cause an increased feeling of personal incapacity and mental burden [4].

Indeed, with too few robust insights from local research, such as Yildirimer et al. (2024), who explored

the relationship of sexual dysfunction and psychological well-being, but these were mainly conducted in developed countries and thus cannot be generalized in developing countries like Pakistan with unique cultural and socio-economic milieu [5]. In conservative, religious Karachi, where the stigma of talking about sexual health is extreme, many men opt to ignore the issue when they encounter any problems, but those who ultimately seek treatment are limited by finances and demand for specialized treatment [6]. Societal expectations, marital responsibilities, and limited healthcare resources further exacerbate a vicious circle in which sexual dysfunction and psychological distress reinforce each other through a mutually aggravating feedback mechanism [7].

Increased prevalence of sexual dysfunction and poor mental health in men across studies suggests that it is a serious concern, and while there exists literature that acknowledges the bi-directional aspect of the relationship of sexual dysfunction and mental health, few studies have focused on married men in traditional settings [8]. This study fills this gap by exploring the psychological distress among married men with sexual dysfunction in Karachi. By focusing on this population, we intend to unravel the particular cultural, social, and economic determinants that uniquely shape their experiences, which cannot be directly translated or transposed to Western conditions. Finally, this is the first research to provide CSF on how sexual dysfunction leads to psycho-distress and vice versa in a society where sex is still a taboo topic.

Unlike Western populations where sexual health is more openly discussed and addressed in clinical practice, Pakistani society is deeply influenced by religious, cultural, and social norms that often stigmatize sexual discourse. Therefore, Men with sexual difficulties may delay seeking help due to shame, limited awareness, and lack of specialized services in Pakistan. Thus, findings from Western studies cannot be generalized to Pakistan. This novelty underscores the significance of exploring sexual dysfunction and its marital impact within the Pakistani cultural framework.

MATERIALS AND METHODS

Method

Participants were recruited from a Men's Health Clinic, Karachi and the psychiatry department of Ziauddin Medical University Hospital and other health institutions in the same district of Karachi. At study entry, all subjects signed an informed consent document. Initially participants filled in the self-reported sexual health questionnaire to confirm the existence and severity of sexual dysfunction. Then, the Kessler-10 (K10) scale was applied to evaluate psychological distress [9]. The administration of all the questionnaires was done in Urdu the national language of Pakistan. Culturally and linguistically relevant versions were used, i.e. IIEF-5 [10] and K10 [11] that were validated in Urdu. The Urdu IIEF-5 and K10 can be accessed free of charge on academic usage on the Harvard National Comorbidity Survey site.

Data collection occurred over nine months, from October 2023 to July 2024. This study was approved by the institutional review boards of each institution involved and was conducted in accordance with institutional guidelines for confidentiality and ethical research conduct.

Participants

This survey was performed in Karachi, Pakistan, with inclusion of 150 married males between the ages of 25 and 40. Participants were recruited through purposive sampling from three health institutions in Karachi. Flyers, referral by clinicians, and direct approach in outpatient clinics were the primary methods of enrollment. The purposive sampling strategy was employed rather than cluster sampling. Participants were recruited intentionally from three health institutions in Karachi to ensure access to married males within the specified age group. Within these institutions, enrollment was done through three methods: (a) distribution of flyers in outpatient departments, (b) clinician referrals, and (c) direct approach during clinic visits. Thus, recruitment was guided by purposive criteria rather than random or cluster-based selection. Eligibility was determined based on screening using the modified IIEF. To ensure that any sexual dysfunction was pertinent to a marital context, participants were required to have been married at least one year. Aged between 18 and 60 years old, 150 participants were recruited; however, divorced subjects (which constituted 10% of the sample) were excluded from the analysis to adhere to inclusion criteria. Participants who fell into the category of having remarried (3.9% of the sample) were retained, but were noted as a potential factor that should be considered in the discussion.

All subjects reported having some form of sexual dysfunction (orgasmic dysfunction, delayed ejaculation, premature ejaculation, or erectile dysfunction [ED]). In an effort to cross-check these self-reports, we utilized a structured self-reported sexual health questionnaire adapted from the International Index of Erectile Function (IIEF). This was not the IIEF-5, which mainly measures erectile function, but a broader version that has been modified to take multiple domains into account including erectile function, orgasmic function, sexual desire and overall satisfaction. As a formal clinical diagnosis was not secured, results should be interpreted within the self-reported framework.

Measures

Psychological distress was assessed using Kessler-10 (K10), a validated self-reported scale to assess general

psychological symptoms [12]. Participants rated how often they had experienced exhaustion, anxiety, or hopelessness over the previous four weeks using a 5-point Likert scale (from "None of the time" to "All of the time").

We assessed sexual dysfunction via self-reported questionnaire (modified IIEF) This modified tool was developed to assess several domains of sexual dysfunction, beyond erectile function itself. Since it had been adapted for cultural relevancy, it was not a validated diagnostic measure but rather a screening tool for research.

Economic status was determined based on self-reported monthly household income relative to the median income levels of Karachi. Participants were classified as having a satisfactory economic status if they reported meeting their family's financial needs without major hardship, and unsatisfactory if they reported that financial issues compromised their quality of life. This variable was added in order to assess potential socioeconomic impacts on psychological distress and sexual dysfunction.

Ethical Approval:
Written informed consent was obtained from all participants prior to their involvement in the study. Moreover, the Ethics Committee of Universiti Putra Malaysia approved the subject study within or out of Malaysia, Men's' Health Clinic Karachi (Ref No. MHC-REC-04-2023/09) and as an independent consultant at Ziauddin University Hospital Karachi. All participants gave consent to voluntarily join the study for research purposes. Their confidentiality was maintained, and the consultant provided a pre-counseling session after the administration of survey/questionnaire. Participants with positive results on erectile dysfunction (ED) or psychological distress (PD) were informed of their status privately and they were referred to experienced mental health and medical professionals to provide additional treatment in accordance with international research ethics to safeguard the participants.

Statistical Analysis
Statistical analysis were performed with SPSS software (version 29). Demographic data were summarized using descriptive statistics. Pearson's correlation coefficient was used to investigate the correlation between sexual dysfunction and psychological distress. Since the data met the assumption of normality, the Pearson product–moment correlation test was used to assess the relationships between psychological distress and sexual-dysfunction domains.

Statistical significance was defined as p-value < 0.05. Normality of the data was examined through skewness and kurtosis statistics. Following Kline (2015), values of skewness within ±3 and kurtosis within ±10 indicate acceptable normality for behavioral-science data. All study variables including psychological distress (K10 scores) and sexual-dysfunction subdomains (ED, OD, SDD, ISD, and OSD) were within these acceptable limits, confirming that the data were approximately normally distributed. Therefore, the Pearson product–moment correlation test was applied.

Considerations & Limitations
While the K10 measures distress experienced over the last four weeks, participants experienced some form of sexual dysfunction for between 7 and 12 months. It is possible that some people had psychologically adjusted to their condition after some time and this might have affected the outcome. This limitation should be taken into account when interpreting the findings.
The influence of remarriage on sexual dysfunction and psychological distress was not the main objective of the study, but rather, this is mentioned as a confounding factor which could be addressed in future studies.

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RESULTS

Table I shows total number of Participants N=150, the age of participants was between 25-40 years. Most of them are 31 to 35 years at 43.3%, 36-40 are 31.2% and 26-30 year are 25.3%. 53.2% have been married for more than a year, while 37.7% had been married for more than 5 years and 9.1 % are married less than a year. While 61% of the participants were employed, and 23.4% in business, among employment category 8.4% are daily wage or labor and 7.1% are unemployed. 76% of the participants were reported having a satisfactory

Table I Demographic Variables (n=150)

Variables	*f*	Percent-age %	Mean	*SD*
Age				
21-25	4	2.7		
26-30	37	24.7		
31-35	65	43.3	2.9	.80
36-40	44	29.3		
Total	150	100		
Duration of Marriage				
Less than year	7	4.7		
More than a year	82	54.7	2.3	.57
More than five year	61	40.7		
Total	150	100		

CONTINUE

Table I Demographic Variables (n=150) (cont.)

Variables	*f*	Percentage %	Mean	*SD*
Age				
21-25	4	2.7		
26-30	37	24.7		
31-35	65	43.3	2.9	.80
36-40	44	29.3		
Total	150	100		
Duration of Marriage				
Less than year	7	4.7		
More than a year	82	54.7	2.3	.57
More than five year	61	40.7		
Total	150	100		
Education				
Primary-middle	27	18.0		
Matric-Intermediate	66	44.0		
Graduate	52	34.7	2.2	.87
Other	5	3.3		
Total:	150	100		
Job				
Unemployment	9	6.0		
Daily wage/labor	14	9.3		
Employment	93	62.0	3.0	.75
Business	34	22.7		
Total	150	100		
Monthly Income				
16000-35000PKR	19	12.7		
36000-55000PKR	48	32.0		
56000-75000PKR	51	34.0	2.7	1.1
76000-95000PKR	12	8.0		
96000-100000+PKR	20	13.3		
Total:	150	100		
Economic Status				
Satisfactory	114	76.0		
Unsatisfactory	36	24.0	.24	.42
Total:	150	100		
Family System				
Joint	74	49.3		
Nuclear	76	50.7	.50	.50
Total:	150	100		
Number of Child				
No Child	34	22.7		
One child	64	42.7		
More than one	44	29.3	2.1	.84
Total children	8	5.3		
Total:	150	100		

CONTINUE

Table I Demographic Variables (n=150) (cont.)

Variables	*f*	Percentage %	Mean	*SD*
Sexual Dysfunction (SD)				
Erectile Dysfunction (ED)	28	18.7		
Premature Ejaculation (PE)	74	49.3		
Delayed Ejaculation (DE)	14	9.3	2.3	1.07
Arousal Dysfunction (AD)	31	20.7		
another Dysfunction	3	2.0		
Total:	150	100		
Duration of Sexual Dysfunction				
One month	31	20.7		
Two to six months	72	48.0		
7 to 12 months	46	30.7	2.1	.72
Total duration	1	.6		
Total:	150	100		
Informed about Sexual Dysfunction				
Self	58	38.7		
Wife	72	48.0		
Friends	11	7.3	1.8	.83
Doctor	8	5.3		
Hakeem or Religious Expert	1	.7		
Total:	150	100		

economic status, and 24% were reported having an unsatisfactory economic status. All participants were under varying stages of psychotherapeutic treatment for sexual dysfunction. However, the study did not control for treatment status or measure its effect on psychological distress.

Table II presents the results of the Pearson product–moment correlation analysis between psychological distress and sexual-dysfunction domains. Psychological Distress (PD) and Sexual Dysfunction (SD): Psychological distress, Sexual dysfunctions, married male, Men sexual health, Sex therapy, Karachi, Pakistan. PD shows a small but significant negative correlation with sexual desire dysfunction (SDD) ($r = -0.168$, $p = 0.040$). The correlation between PD and ISD ($r = -0.241$) indicates a small-to-moderate negative association, suggesting a correlation between higher psychological distress and lower intercourse satisfaction, rather than a direct causal link.

The correlations between PD and erectile dysfunction (ED) ($r = -0.14$, $p = 0.088$), orgasmic dysfunction (OD) ($r = -0.127$, $p = 0.121$), and overall satisfaction

Table II: Correlation between Psychological Distress and Sexual Dysfunction

Variable	PD	ED	OD	SDD	ISD	OSD
Psychological Distress (PD)		-.140 .088	-.127 .121	-.168* .040	-.24** .003	-.072 .381
Erectile Dysfunction (ED)	-.140 .088		.647** <.001	.612** <.001	.644** <.001	.472** <.001
Orgasmic Dysfunction (OD)	-.127 .121	.647** <.001		.659** <.001	.616** <.001	.491** <.001
Sexual Desire Dysfunction (SDD)	-.168* .040	.612** <.001	.659** <.001		.754** <.001	.661** <.001
Intercourse Satisfaction Dysfunction (ISD)	-.24** .003	.644** <.001	.616** <.001	.754** <.001		.659** <.001
Overall Satisfaction Dysfunction (OSD)	-.072 .381	.472** <.001	.491** <.001	.661** <.001	.659** <.001	

dysfunction (OSD) (r = -0.072, p= 0.381) are small and not statistically significant. Therefore, results indicate negative correlations with every other variable, demonstrating an association between lower levels of dysfunction in these domains and higher psychological distress. Intercourse Satisfaction Dysfunction (ISD) has the strongest negative correlation (-0.241), indicating that higher psychological distress is associated with lower intercourse satisfaction, although no causality is implied.

Additionally, Orgasmic Dysfunction (OD), Sexual Desire Dysfunction (SDD), Intercourse Satisfaction Dysfunction (ISD), and Overall Satisfaction Dysfunction (OSD) all exhibit moderate to strong positive correlations with Erectile Dysfunction. These favorable associations demonstrate that orgasm, sexual desire, intercourse satisfaction, and general satisfaction are all issues that men with erectile dysfunction face. Orgasmic Dysfunction, like Erectile Dysfunction, has moderately positive correlations with Sexual Desire Dysfunction (SDD), Intercourse Satisfaction Dysfunction (ISD), and Overall Satisfaction Dysfunction (OSD). Additionally, there is a strong correlation between Orgasmic Dysfunction and Sexual Desire Dysfunction (0.659), indicating that problems with orgasm frequently coexist with problems with sexual desire. Additionally, there is a strong correlation between Sexual Desire Dysfunction and Intercourse Satisfaction Dysfunction (0.754) and a moderate correlation between Sexual Desire Dysfunction and Overall Satisfaction Dysfunction (0.661). This suggests that problems with sexual desire are closely linked to lower satisfaction in both intercourse areas.

DISCUSSION

The findings reveal substantial relationships between psychological distress and some aspects of sexual dysfunction, thereby confirming previous data on the mutual influence of sexual health and mental health. However, these findings should be interpreted as correlations, not causations, unless there is clear evidence showing psychological distress precedes sexual dysfunction or vice versa. It is important to note that multiple forms of sexual dysfunction often co-occur, which may compound psychological distress. For instance, ED showed moderate-to-strong positive correlations with OD and ISD, suggesting overlapping symptomatic domains. Although these results do not provide direct causal relationships, they point to the psychological factors that warrant further investigation with respect to sexual dysfunction. One unexpected key finding was the negative correlation between psychological distress (PD) and some dysfunction variables (e.g. PD and ISD, r = −0.241). Those experiencing greater psychological distress may be less likely to report sexual difficulties, possibly due to stigma, denial, or prioritization of other psychological concerns. Alternatively, the association might reflect individual differences in coping, such that some individuals prioritize sexual functioning despite elevated distress. Various other studies need to be conducted to interpret this particular trend but the interpretation is not very simple. PI-105 was also found in the form of interpretative conclusory statements.

In contrast, between various domains of sexual dysfunction (ED and ISD, r = 0.644; ED and OD, r = 0.647) the study found strong positive correlations and consistent with previous studies. These findings underscore that male sexual dysfunctions are frequently intertwined erectile difficulties can affect orgasmic function, sexual desire, and overall satisfaction [13]. Likewise, the moderate-strong association between OD and SDD (r = 0.659) adds support to the idea that stages of sexual response are closely tied to one another [14].

Sexual Desire is a significant predictor of sexual post-coital satisfaction, as indicated by its strong correlation with SDD (r = 0.754). This accords with models of sexual health that foreground desire and engagement during sex [15]. Nevertheless, the interrelations in this regard were both informative and the objective of this research study but need to be explored more insightfully in future experimental studies.

These findings have clinical implications because they underline the importance of a holistic approach in the assessment and management of sexual dysfunction. As these dysfunctions are often interrelated, treatment in one area (like ED) might also positively influence other domains, such as organismic function or global sexual well-being [16]. Likewise, due to the observed correlations between psychological distress and sexual dysfunction, mental health concerns should be addressed in conjunction with sexual health interventions [17].

This has significant clinical implications for the management of sexual dysfunction in PD, and further research is required to investigate the mechanistic explanation for the inverse relationship between PD and sexual dysfunction and also to identify whether sexual dysfunction arises as a consequence of psychological distress occurring as a result of PD or whether it occurs as a preclinical phase prior to PD, only then resulting in psychological distress long term through longitudinal assessment. Such investigations would yield clearer insights into causality and lead to more effective and targeted therapeutic options.

The management of sexual dysfunction in Pakistan differs considerably from Western contexts due to strong cultural and religious influences. While biomedical interventions such as PDE5 inhibitors, psychosexual therapy, and marital counseling are universally relevant, their acceptance and utilization in Pakistan are limited by stigma, low health literacy, and taboo surrounding sexual health. Religious leaders and community elders often influence perceptions, with some men resorting to spiritual healing or traditional remedies before seeking medical care. In contrast, Western societies typically emphasize clinical interventions supported by open communication and well-established sexual health services. Therefore, management strategies in Pakistan must integrate cultural sensitivity, include community-based awareness, engage religious leaders, and promote discreet counseling services to overcome barriers and improve outcomes.

CONCLUSION

The present study provides confirmation that the sexually dysfunctional married men experience high level of psychological distress. Holistic care for sexual dysfunction requires intervention targeting its psychological distress beyond the physical symptoms. The combination of poor mental and sexual health could be improved with the incorporation of mental health services in Pakistani General Hospital Care system.

This study emphasizes the need for culturally sensitive, multimodal interventions by highlighting the psychosocial burden of sexual dysfunction in Karachi. In addition to using culturally relevant messaging to raise awareness of mental health issues, public health campaigns should work to de-stigmatize sexual health issues by portraying them as medical conditions rather than personal shortcomings. Healthcare professionals should receive training on how to handle delicate situations with empathy, and counseling and therapy programs should honor cultural norms while promoting candid conversations. Improving access in low-income areas requires the development of subsidized health services, which are created through collaborations with NGOs, private sector stakeholders, and government authorities. Programs for marital counseling can improve communication between partners and address the dynamics of relationships that lead to psychological distress. Physicians ought to use comprehensive treatment strategies that combine medical and psychological care. In order to improve policy and interventions, more research is required to examine the connection between psychological distress and sexual dysfunction in culturally conservative societies, taking socioeconomic and cultural factors into account.

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