POTENCY DISORDER AMONG PATHANS

Pages with reference to book, From 12 To 14

M. F. Khan (Family Physician, D-161, KDA Scheme No. 1, Jinnah Postgraduate Medical Centre, Karachi.)
S. Haroon Ahmed (Department of Psychiatry, Jinnah Postgraduate Medical Centre Karachi.)

Abstract
In a working class industrial area of Karachi hundred consecutive Pathans presenting to a family physician with potency disorder were examined. After exclusion of those with structural or drug related conditions, a structured proforma was introduced. Their presentation, associated symptoms and background pointed to masked depression and lack of sex education. Symptoms of anxiety were noticed in 49% and depressive features in 43%. The guilt feelings were reinforced by Hakims and lay literature which stress more on masturbation (79%) and spermatorrhoea (60%) and not extra-marital intercourse (52%) or bestiality (39%) (JPMA 40:12, 1990).

INTRODUCTION

In Indo-Pakistan subcontinent sex related disorders are common in all communities irrespective of ethnicity or geographical boundaries. The variations in the manifestation may be due to socioeconomic and cultural differences, the common feature being lack of sex education. Generally the knowledge acquired is through traditional tales of sexual prowess and advertisements of magic remedies by quacks.

The Pathans living in Karachi have special features. They live away from home and work tobe able to marry and support their family. The deviation in the fulfillment of their sexual role can beverytraumatic.A studyof their sexual behaviour is expected to be revealing.

Background

The group studied consisted of working class Pathans, coming mostly from rural areas and hilly regions of North West Frontier Province. These people, robust physically, are highly volatile emotionally and tribal rivalry is prevalent. Educational facilities are meagre and the children often help the parents in the farms or grazing family sheep. Strict religious and tribal laws govern their lives. For example if a boy and girl are seen together in privacy the matter is settled through tribal laws which may be shooting the couple by their own parents.

There is no choosing of the partners, the marriages being arranged by the parents and exchange is the preferred method. If a man has a sister, he gets married easily at an early age otherwise he has to earn and wait. Child marriages are common.

Karachi is a melting pot of various cultural, ethnic and linguistic groups and religious sects. They comprise of migrants from India and immigrants from Punjab, Baluchistan and NWFP.

Since partition the population swelled from 436,000 in 1941 to 2.048 million in 1961 to over 8 million now, including about 1.5—2 million Pathans. The affluent pathans are in transport business or shopkeepers (fresh and dry fruit) but the majority are labourers in mechanized or construction industry. They are employed as manual workers, drivers and chowkidars (guards). Their work is extremely hard with no leave. A taxi or mini bus driver works from 6 in the morning till late at night. The chowkidar is on duty for 24 hours.

PATIENTS AND METHOD

Information on hundred consecutive patients belonging to working class of industrial area presenting with potency disorder was entered on proforma. All patients presenting with sex related disorders were

given thorough physical examination and those with organic basis (structural or drug-related) were excluded.

RESULTS

The mean age of the sample was 29 years. Afridi and Swabi tribes were predominant (57%). Manual workers and motor vehicle drivers were 61%. All were Muslims and majority were practic. ing religion. Seventy two percent were married (onlyfive had morethan onewife),24%weresingle and none divorced. Among married only 26 (36%) lived with their families in Karachi (Table 1).

TABLE 1. Demographic Characteristics.
N = 100

Age	Mean 29 years (Max-60, Min 18) years.
Tribe	Afridi 32, Swabi 25, Hazara 8, Others 1
Occupation	Driver 30, Manual Worker 31 Chowkidar 15, Skilled worker 9, small business 6, Others 9.
Religious Practices	Prays five times 63, Fast regularly 85, visit shrines 15, Has a regular Pir 8, Religious basis of beard 21.
Marital Profile	Married 74 (More than one wife 5, remarried 2), single 24, Separated 2, Divorce nil.
Proximity with spouse	Lives with wife 26, visit wife every year 42, visit wife occasionally 6.

Seventy four percent complained of normal or near n&mal erection which would subside on attempt at intercourse, 26% used tq have erection before but currently had no movement and 6% among them had no sexual urge at all. Premature ejaculation was complained by 11% who would ejaculate with or without erection on apprqaching the opposite sex. One case of impotentia ejacu lande is included in the

subsider groups. Average period of their sexual inadequacywas 2.6 years and they took treatment from Hakims (42%), doctors (36%) and some resorted to spiritual means. Gencralised weakness was complained by 80%, spermatorrhoea (61%), body ache (31%),

TABLE II. Sexual Experiences.

1.	Masturbation	79
2.	Heterosexual (extra marital)	52
3.	Homosexual	48
4.	Mares (she donkeys)	28
5.	Sheep & goats	05
6.	Bitch	05
7.	Cow	01

backache Masturbatory practice was accepted by 79%, pre-marital heterosexual experience by 52% and homosexuality by 48%. Bestiality was practiced by 39% but associated guilt was negligible (1%) as compared to masturbation (40%) (Table III).

TABLE III. Sex related Guilt (%).

1.	Masturbation	40
2.	Spermatorrhoea	25
3.	Homosexuality	15
4.	Premarital hetero sexual experience	05
5.	Gonorrhoea	02
6.	Intercourse with prostitute	02
7.	Intercourse during menstrual period	02
8.	Bestiality	01
9.	Blue films	01
10.	Married 5 years old child	01
11.	No child (sterility)	01

The perceived defects in tmajoritywas a small size of penis and the direction on erection (Table IV).

TABLE IV. Perceived Organ Defects (%).

1.	Size	32
2.	Direction	17
3.	Prominent Veins on penis	03
4.	Prepuce present	01
5.	Discoloration (dark colour)	01
6.	Thin at bottom or mid-shaft	02
7.	Burnt Nerves	01
8.	Small Testes	01

The preferred treatment was Hikmat by 42% followed by family physician in 36%. Fifty one percent were regular users of Niswar (combination of tobacco and lime), 21% smoked cigarette and 90%

experimented charas (none regular user). The psychiatric evaluation revealed that .49% were showing definite symptoms of anxiety. Depression was noticed in 43% though only 6% were clinically depressed. Seventy nine percent had vario Us degree of anxiety and depression. The personality of 26% wasdocilc and dependent which could be the resuit of strong parental control.

DISCUSSION

General physical weakness (80%), body ache (31%) and backache (24%) are the main presenting complaints besides potency disorder Other symptoms are equally vague. Spermatorrhoea was complained by 60% which is occasional¬ ly prostatitis but usually rectal massage of prostate due to constipation. 'Fever' not recordable on thermometer was complained by 15%. In psychiatric practice this is not unusual presentation of depression in Pathans and acceptable reason of absenteeism from work. Although only six patients were found to be clinically depressed, others denied depressed mood, but presented with fami¬liar somatic features of masked depression. Soma¬tie manifestation of depressive illness in develop¬ing countries is amply documented[1-3]. In a study on depressed patients in Karachi[4] the frequency of somatic symptoms were giddiness 82%, palpita¬tion 80%, headache 77% and general weakness 66%. Once they are conscious of their potency disorder it waS made worse through reinforcement by Hakims. Majority were practising Muslims (85%), living away from their spouse (48 out of 74 married), and sexual urges satisfied through masturbation (79%), homosexuality (45%) or heterosexual (52%) activity. This is in conformity with earlier studies on patients attending as psychiatric out patient and among male university students in Karachi[5,6]. Bestiality was admitted by 39%. It was not surprising that masturbation, spermatorrhoea and homosexualityproduced much more guilt than extramarital heterosexual contacts (52%) or bestiality (1%). The size and direction of erect penis was considered by others to be the main cause of their problems. It is concluded that masked depression and anxiety could be the main reason of potency disorder among the Pathans in Karachi. The lack of sex-education is reflected in their guilt feelings which relates closely to the popular belief that masturbation, Spermatorrhoea or intercourse during menstruation causes sexual weakness, and not bestiality.

REFERENCES

1. Binitie, A. A factor-analytical study of depression across cultures (Africa and Europe). Br. J. Psychiatry, 1975; 127: 559.
2. Murphy, H. B., Wittkower, E.D. and Chance, NA, Cross-cultural inquiry into the symptomatology of dcpression; a preliminary report. Int. J. Psychiat., 1967; 3: 6.
3. Teja, J.S., Narang, RL and Aggarwal, A.K. Depression across culture. Br.J. Psychiatry, 1971; 199:253.
4. Ahmcd, S.H. and Arif, M. Culture and Syrnptomatology in depression. PakistanJ. Med. Res., 1982; 21: 64.
5. Ahmed, S.H. Disorder of potency in males. JPMA., 1975; 25:336.
6. Ahmed, SJI. Attitude towards sex and sexual problems among male University students. JPMA., 1981; 31:59.