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To Study Erectile Dysfunction in Individuals Suffering from Severe Mental Illnesses

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Background and Objective: Sexual dysfunction is a frequently overlooked but clinically significant issue in individuals suffering from major psychiatric disorders. These dysfunctions may stem from the underlying illness itself, psychological distress, or pharmacological treatment. The objective of this study was to assess the prevalence, types, and severity of sexual dysfunction among patients diagnosed with major psychiatric disorders, including schizophrenia, Major Depressive Disorder (MDD), and Bipolar Affective Disorder (BPAD), and to explore its association with psychotropic medication use.

Material and Methods: A cross-sectional observational study was conducted at a tertiary care psychiatric facility, involving 60 patients (aged 18-60 years) diagnosed with major psychiatric disorders as per DSM-5 criteria. This study was conducted at the department of Psychiatry, Annapoorna Medical College and Hospital, Kombadipatty, Veerapandi Union, Salem, Tamil Nadu, India from April 2012 to March 2013. Sexual dysfunction was assessed using the Arizona Sexual Experiences Scale (ASEX) after obtaining informed consent. Psychiatric diagnoses were confirmed using the Mini-International Neuropsychiatric Interview (MINI). Relevant clinical details, including duration of illness, medication history, and socio-demographic profile, were collected.

Results: Out of 60 patients, 38 (63.3%) reported some form of sexual dysfunction. The prevalence was highest among patients with MDD (76.9%), followed by schizophrenia (61.1%), and BPAD (52.6%). Antidepressants, particularly SSRIs, and antipsychotics with strong dopamine antagonism (e.g., risperidone) were significantly associated with higher sexual dysfunction scores ($p<0.05$). Common dysfunctions reported were decreased libido (48.3%), difficulty in arousal (41.7%), and anorgasmia (33.3%). Female patients reported higher distress related to sexual dysfunction compared to males. A longer duration of illness and polypharmacy were also positively correlated with the severity of dysfunction.

Conclusion: Sexual dysfunction is highly prevalent among patients with major psychiatric disorders and significantly impacts their quality of life and treatment adherence. Routine screening for sexual health, psychoeducation, and individualized pharmacological strategies are essential for holistic management. This study underscores the need for greater clinician awareness and integration of sexual health in psychiatric care protocols.

Keyword: Sexual dysfunction, major psychiatric disorders, schizophrenia, depression, bipolar disorder, antipsychotics, antidepressants, ASEX

Introduction

Sexual health is a fundamental aspect of overall well-being and quality of life, yet it remains a neglected domain in the assessment and management of individuals with major psychiatric disorders. Sexual dysfunction encompasses a wide range of disturbances in sexual desire, arousal, orgasm, and satisfaction, which can be significantly distressing and may contribute to poor interpersonal relationships, decreased self-esteem, and reduced adherence to psychiatric treatment [1-3].

Patients with major psychiatric disorders such as schizophrenia, Major Depressive Disorder

(MDD), and Bipolar Affective Disorder (BPAD) are particularly vulnerable to developing sexual dysfunction. The etiology is multifactorial, involving the psychopathology of the illness, side effects of psychotropic medications, psychosocial stressors, and comorbid physical illnesses [4, 5]. Antipsychotics, mood stabilizers, and antidepressants, especially Selective Serotonin Reuptake Inhibitors (SSRIs), have been widely implicated in impairing various aspects of sexual functioning, including decreased libido, anorgasmia, and erectile dysfunction [6, 7].

Despite its prevalence, sexual dysfunction in psychiatric populations is frequently underdiagnosed and underreported. Patients may hesitate to bring up sexual concerns due to stigma, embarrassment, or lack of awareness, while clinicians may overlook these issues due to time constraints or prioritization of acute psychiatric symptoms. As a result, untreated sexual dysfunction can negatively impact therapeutic alliances, increase rates of non-compliance, and deteriorate the overall course and prognosis of psychiatric disorders [8-10].

In the Indian context, where discussions about sexuality are often culturally sensitive or taboo, the recognition and evaluation of sexual dysfunction in psychiatric settings become even more challenging. There is a pressing need to assess the extent of this problem to enhance patient-centered care [11-13].

This study aims to assess the prevalence, types, and severity of sexual dysfunction among patients with major psychiatric disorders attending a tertiary health care facility, and to explore its associations with psychotropic medication use, gender, duration of illness, and other clinical factors. The findings are expected to aid in developing comprehensive, individualized treatment plans that consider both the mental and sexual health needs of patients.

Material and Methods

This was a hospital-based cross-sectional observational study conducted in the Department of Psychiatry at a tertiary care health centre over a period of 12 months. This study was conducted at the department of Psychiatry, Annapoorna Medical College and Hospital, Kombadipatty, Veerapandi Union, Salem, Tamil Nadu, India from April 2012 to March 2013. A total of 60 patients diagnosed with major psychiatric disorders Schizophrenia, Major Depressive Disorder, and Bipolar Affective Disorder as per DSM-5 criteria were enrolled in the study.

Inclusion criteria

1. Patients aged between 18 and 60 years.
2. Diagnosed with Schizophrenia, MDD, or BPAD according to DSM-5 criteria.
3. Receiving stable psychiatric treatment for at least 8 weeks.
4. Sexually active during the past 6 months.
5. Provided informed consent for participation.

Exclusion criteria

1. Patients with a history of primary sexual dysfunction prior to psychiatric illness.
2. Presence of significant physical illness
3. History of substance dependence
4. Patients on medications known to independently affect sexual function
5. Non-consenting or severely cognitively impaired individuals unable to understand the questionnaire

Results

A total of 60 patients participated in the study, comprising individuals diagnosed with major depressive disorder (MDD), schizophrenia, and bipolar affective disorder (BPAD). Sexual dysfunction was assessed using the Arizona Sexual Experiences Scale (ASEX). The analysis included socio-demographic factors, diagnostic categories, medication profiles, and types of dysfunction.

Table 1: Socio-demographic profile of participants

Demographic Variable	Frequency (%)
Age (Mean ± SD)	36.8 ± 9.2
Gender	
Male	34 (56.7%)
Female	26 (43.3%)
Marital Status	
Married	40 (66.7%)
Unmarried	20 (33.3%)
Residence	
Urban	38 (63.3%)
Rural	22 (36.7%)

This table 1 summarizes the basic socio-demographic details of the 60 patients. The majority were male, married, and from urban areas. The mean age of the study group was approximately 37 years.

Table 2: Diagnostic distribution of patients

Diagnosis	Number of Patients (%)
Major depressive disorder	26 (43.3%)
Schizophrenia	18 (30.0%)
Bipolar affective disorder	16 (26.7%)

MDD was the most common diagnosis in this study population, followed by schizophrenia and BPAD.

Table 3: Prevalence of sexual dysfunction by diagnosis

Diagnosis	Sexual dysfunction present (%)	Mean ASEX score ± SD
Major depressive disorder	20 (76.9%)	20.3 ± 3.4
Schizophrenia	11 (61.1%)	19.1 ± 4.2
Bpad	7 (43.8%)	17.5 ± 3.7
Total	38 (63.3%)	—

Patients with MDD had the highest prevalence and severity of sexual dysfunction. BPAD patients had the lowest, but still significant, prevalence. Overall, 63.3% of patients reported sexual dysfunction.

Table 4: Association of psychotropic medications with sexual dysfunction

Medication class	Number of patients	Sexual Dysfunction present (%)
SSRIs	22	17 (77.3%)
Typical antipsychotics	14	9 (64.3%)
Atypical antipsychotics	16	10 (62.5%)
Mood Stabilizers	8	2 (25.0%)

SSRIs were most commonly associated with sexual dysfunction. Patients on mood stabilizers showed the least dysfunction, suggesting that drug class plays a significant role in influencing sexual health.

Table 5: Type of sexual dysfunction reported (n = 38 with dysfunction)

Type of dysfunction	Frequency (%)
Decreased libido	29 (76.3%)
Difficulty in arousal	24 (63.2%)
Anorgasmia	18 (47.4%)
Erectile dysfunction	11 (39.3% of males)
Premature ejaculation	6 (17.6% of males)

The most common dysfunction across all diagnoses was decreased libido, followed by difficulty in arousal and anorgasmia. Erectile dysfunction and premature ejaculation were reported among male patients.

Discussion

Sexual Dysfunction (SD) is a significant yet often underreported issue among patients with major psychiatric disorders, including schizophrenia, Major Depressive Disorder (MDD), and Bipolar Affective Disorder (BPAD). This study evaluated the prevalence, types, and medication associations of SD among 60 patients with these conditions at a tertiary health care center.

In our study, the overall prevalence of sexual dysfunction was 63.3%, with the highest occurrence observed among patients with MDD (76.9%), followed by schizophrenia (61.1%), and BPAD (43.8%). These findings are consistent with previous studies. Montejo *et al*., (2001) reported that patients with depression had significantly impaired sexual functioning, mainly due to the direct effects of the illness and the side effects of selective serotonin reuptake inhibitors (SSRIs). Similarly, Serretti and Chiesa, (2009) found that antidepressants, particularly SSRIs, are associated with higher rates of sexual dysfunction [14-16].

The high prevalence of SD in schizophrenia patients may be attributed to the illness itself, which affects motivation, emotional expression, and social functioning, in addition to the side effects of antipsychotic medications. A study by Aizenberg *et al*., (2002) showed that typical antipsychotics have a higher risk of causing SD than atypical ones, although both have an impact. In our findings, patients on SSRIs had the highest

rate of SD (77.3%), supporting existing literature reported by Clayton *et al*., (2002) [17, 18].

Interestingly, patients on mood stabilizers (such as lithium and valproate) showed the least dysfunction (25%), which aligns with findings by Gitlin *et al*., (2001), indicating a relatively lower incidence of SD with mood stabilizer therapy. Nevertheless, SD was still prevalent in BPAD patients, potentially reflecting the influence of mood states themselves on sexual behavior and interest [19].

The most commonly reported types of dysfunction included decreased libido (76.3%), difficulty in arousal (63.2%), and anorgasmia (47.4%). These results parallel those of Kennedy *et al*., (2000), who found that loss of sexual desire and orgasmic dysfunction were the most frequent complaints among psychiatric patients. Age, gender, marital status, and urban-rural residence did not show significant correlation with SD in this study, a finding similar to the results reported by Zeller *et al*., (2010). However, male patients did report a higher prevalence of erectile and ejaculatory dysfunctions, consistent with gender-specific physiological differences and sociocultural factors in reporting [20, 21].

This study highlights the need for routine assessment of sexual function in psychiatric evaluations. Despite its high prevalence, sexual dysfunction often remains undiscussed due to stigma, patient reluctance, or clinician oversight reported by Balon *et al*., (1995). Unaddressed sexual dysfunction can negatively impact treatment adherence, quality of life, and relationships. The sample size was relatively small, and the study was cross-sectional, limiting causal inference [22-24]. Self-reported data may also be influenced by social desirability bias. Additionally, hormonal profiles, which could affect sexual functioning, were not measured. Larger longitudinal studies incorporating hormonal evaluations and examining the impact of specific psychotropic dose-response relationships on sexual functioning are warranted. Interventions such as medication switching, adjunctive treatments, or psychoeducation regarding sexual side effects should be explored.

Conclusion

The present study underscores the significant prevalence of sexual dysfunction among patients with major psychiatric disorders, including schizophrenia, bipolar disorder, and major depressive disorder. The findings reveal that both the psychiatric illness itself and the psychotropic medications used in treatment play a substantial role in impairing sexual functioning. Among the domains affected, decreased libido, erectile dysfunction, anorgasmia, and overall dissatisfaction were most frequently reported. Importantly, the study highlights that sexual dysfunction is often underreported and inadequately addressed in clinical practice, which may contribute to poor treatment adherence and diminished quality of life. Routine assessment and open communication about sexual health should be an integral part of psychiatric evaluation and management. Tailored interventions, including possible adjustments in medication regimens, psychoeducation, and counseling, are recommended to mitigate these adverse effects. Further longitudinal studies with larger sample sizes are necessary to understand the long-term impact of psychiatric illnesses and their treatments on sexual health and to develop effective strategies for prevention and management.

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