



PREVALENCE AND CORRELATES OF SEXUAL DYSFUNCTION AMONG TREATMENT-NAÏVE MALE PSYCHIATRIC OUTPATIENTS: A CROSS-SECTIONAL STUDY.

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Abstract

Background: Sexual dysfunction is common among individuals with psychiatric disorders but is often difficult to distinguish from treatment-related adverse effects because most studies include patients receiving psychotropic medications. **Objectives:** To determine the prevalence of sexual dysfunction among treatment-naïve male psychiatric outpatients and evaluate its association with selected sociodemographic and clinical variables. **Methods:** This cross-sectional observational study included 84 treatment-naïve male psychiatric outpatients at a tertiary care centre. Psychiatric diagnoses were established using ICD-10 criteria. Sexual dysfunction was assessed using the Arizona Sexual Experience Scale (ASEX), with a total score >19 indicating sexual dysfunction. Associations between sexual dysfunction and sociodemographic and clinical variables were analysed using appropriate statistical tests. **Results:** Sexual dysfunction was identified in 19 of 84 participants (22.6%). The highest prevalence was observed among patients with depressive disorders (50.0%), followed by anxiety disorders (18.2%), psychosomatic disorders (15.0%), and obsessive-compulsive disorder (12.5%). A significant association was found between sexual dysfunction and primary psychiatric diagnosis ($p=0.014$) as well as medical comorbidities ($p=0.017$). No significant associations were observed with age, marital status, education, occupation, socioeconomic status, residence, family history of psychiatric illness, or substance use. **Conclusions:** Sexual dysfunction is a common clinical problem among treatment-naïve male psychiatric outpatients, particularly in patients with depressive disorders and those with medical comorbidities. Routine assessment of sexual functioning before initiating psychotropic treatment may facilitate early identification, appropriate management, and improved patient care.

Keywords: Sexual dysfunction; Treatment-naïve; Psychiatry; Depression; Arizona Sexual Experience Scale; ASEX.



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INTRODUCTION

Sexual health is an integral component of overall health and well-being. According to the World Health Organization (WHO), sexual health encompasses physical, emotional, mental, and social aspects of human life and contributes significantly to quality of life and interpersonal relationships.¹ Sexual dysfunction can adversely affect self-esteem, intimate relationships, treatment adherence, and overall functioning.^{2,1} Despite its clinical importance, sexual health remains an under-recognized and under-discussed aspect of routine psychiatric practice because patients often hesitate to report symptoms due to embarrassment, stigma, or cultural beliefs, while clinicians may not routinely inquire about sexual functioning.^{3,4}

Psychiatric disorders are frequently associated with disturbances in sexual functioning.³ Depression, anxiety disorders, obsessive-compulsive disorder, and stress-related disorders have all been linked to varying degrees of impairment in sexual desire, arousal, erection, ejaculation, orgasm, and sexual satisfaction.^{4,5,6} The underlying mechanisms are multifactorial and include psychological distress, neurobiological alterations, interpersonal difficulties, and lifestyle factors.^{3,7} In addition, psychotropic medications, particularly antidepressants and antipsychotics, are well-known contributors to sexual dysfunction, making it difficult to distinguish illness-related sexual dysfunction from treatment-emergent adverse effects in many clinical studies.^{8,9}

Most available studies evaluating sexual dysfunction among psychiatric patients have included individuals already receiving psychotropic medications, thereby introducing treatment-related confounding.^{8,9} Information regarding sexual

dysfunction among treatment-naïve psychiatric patients remains limited, particularly in the Indian setting.⁴ Assessment of sexual functioning before initiating pharmacological treatment provides a more accurate estimate of dysfunction attributable to the psychiatric illness itself and may facilitate better treatment planning, patient counselling, and monitoring during follow-up.^{7,9}

This study was undertaken to estimate the prevalence of sexual dysfunction among treatment-naïve male psychiatric outpatients attending the Department of Psychiatry at a tertiary care centre. The study also aimed to evaluate the association between sexual dysfunction and selected sociodemographic and clinical variables.

MATERIALS AND METHODS

Study Design

This cross-sectional observational study was conducted in the Department of Psychiatry at a tertiary care centre over a period of six months.

Objectives

1. To determine the prevalence of sexual dysfunction among treatment-naïve male psychiatric outpatients.
2. To assess the association between sexual dysfunction and selected sociodemographic and clinical variables

Source of Data

The study included treatment-naïve male patients attending the Psychiatry Outpatient Department at a tertiary care centre in Kalaburagi. Consecutive eligible patients presenting during the study period were recruited after obtaining written informed consent.

Inclusion Criteria

- Male patients aged 18 years and above.
- Newly diagnosed with a psychiatric disorder according to the International Classification of Diseases, Tenth Revision (ICD-10) criteria.¹⁰
- Treatment-naïve patients with no previous exposure to psychotropic medications.
- Patients willing to provide written informed consent.

Exclusion Criteria

- Patients with a previous history of psychiatric illness or prior psychotropic medication use.
- Patients with a primary diagnosis of erectile dysfunction, premature ejaculation, or orgasmic dysfunction.
- Patients with psychotic disorders, as reliable assessment of sexual functioning may not be feasible due to active psychotic symptoms and impaired insight.
- Patients unwilling to participate or who withdrew consent.

Data Collection

After obtaining written informed consent, sociodemographic and clinical information including age, marital status, educational status, occupation, socioeconomic status, residence, family history of psychiatric illness, medical comorbidities, substance use history, and psychiatric diagnosis were recorded using a predesigned semi-structured proforma. Psychiatric diagnoses were made according to ICD-10 diagnostic criteria by consultant psychiatrists.¹⁰

INSTRUMENTS AND SCALES USED

Semi-structured Sociodemographic and Clinical Proforma

A predesigned semi-structured proforma was used to collect sociodemographic characteristics and relevant clinical information of all participants.

Arizona Sexual Experience Scale (ASEX)

Sexual functioning was assessed using the Arizona Sexual Experience Scale (ASEX), a validated five-item instrument that assesses sexual drive, psychological arousal, penile erection, ability to reach orgasm, and satisfaction from orgasm.¹¹ Each item is rated on a six-point Likert scale, with total scores ranging from 5 to 30. Higher scores indicate greater impairment in sexual functioning.¹¹ The scale was administered by the investigator through a structured interview. A total ASEX score greater than 19 was considered indicative of sexual dysfunction.¹¹

Ethical Considerations

Institutional Ethics Committee approval was obtained prior to commencement of the study. Written informed consent was obtained from all participants before enrolment.

Statistical Data Analysis

Data were entered into Microsoft Excel and analysed using the Statistical Package for the Social Sciences (SPSS) version 20.0. Continuous variables were expressed as mean $\pm$ standard deviation, while categorical variables were expressed as frequencies and percentages. The Chi-square test or Fisher's exact test was used to analyse associations between categorical variables. The independent samples t-test was used to compare continuous variables between groups. A p value of <0.05 was considered statistically significant.

RESULTS

A total of 84 treatment-naïve male psychiatric outpatients were included in the study. Sexual dysfunction was identified in 19 participants (22.6%) based on the Arizona Sexual Experience Scale (ASEX), while 65 participants (77.4%) did not have sexual dysfunction.

The sociodemographic and clinical characteristics of participants according to sexual dysfunction status are presented in Table 1. No statistically significant associations were observed between sexual dysfunction and age ($p = 0.191$), marital status ($p = 0.830$), educational status ($p = 0.194$), occupation ($p = 0.173$), socioeconomic status ($p = 0.378$), place of residence ($p = 0.318$), family history of psychiatric illness ($p = 0.939$), or substance use ($p = 0.706$). However, a statistically significant association was observed between medical history and sexual dysfunction ($p = 0.017$), with participants having medical comorbidities demonstrating a higher prevalence of sexual dysfunction than those without medical comorbidities.

The prevalence of sexual dysfunction according to primary psychiatric diagnosis is presented in Table 2. Sexual dysfunction was most frequently observed among participants with depressive disorders (50.0%), followed by anxiety disorders (18.2%), psychosomatic disorders (15.0%), and obsessive-compulsive disorder (12.5%). No participants with stress-related disorders or substance use disorders met the criteria for sexual dysfunction. The association between primary psychiatric diagnosis and sexual dysfunction was statistically significant ($p = 0.014$).

Table 1. Sociodemographic and Clinical Characteristics of Study Participants According to Sexual Dysfunction Status (N = 84)

Variable	Overall (N=84)	Sexual Dysfunction Present (n=19)	Sexual Dysfunction Absent (n=65)	p value
Age (years), Mean $\pm$ SD	35.21 $\pm$ 10.61	37.89 $\pm$ 11.24	34.43 $\pm$ 10.37	0.191
Marital status				0.830
Unmarried	26 (31.0)	5 (26.3)	21 (32.3)	
Married	58 (69.0)	14 (73.7)	44 (67.7)	
Educational status				0.194
Primary school	5 (6.0)	1 (5.3)	4 (6.2)	
High school	13 (15.5)	6 (31.6)	7 (10.8)	
Higher secondary	11 (13.1)	3 (15.8)	8 (12.3)	
Graduate	43 (51.2)	8 (42.1)	35 (53.8)	
Postgraduate	12 (14.3)	1 (5.3)	11 (16.9)	
Occupation				0.173
Skilled	19 (22.6)	1 (5.3)	18 (27.7)	
Semiskilled	42 (50.0)	13 (68.4)	29 (44.6)	
Unskilled	13 (15.5)	3 (15.8)	10 (15.4)	
Unemployed	10 (11.9)	2 (10.5)	8 (12.3)	
Socioeconomic status				0.378
Lower	4 (4.8)	1 (5.3)	3 (4.6)	
Lower middle	45 (53.6)	13 (68.4)	32 (49.2)	
Middle	3 (3.6)	1 (5.3)	2 (3.1)	
Upper middle	32 (38.1)	4 (21.1)	28 (43.1)	
Residence				0.318
Rural	38 (45.2)	11 (57.9)	27 (41.5)	
Urban	46 (54.8)	8 (42.1)	38 (58.5)	
Family history of psychiatric illness				0.939
Absent	70 (83.3)	15 (78.9)	55 (84.6)	
Depression	7 (8.3)	2 (10.5)	5 (7.7)	
Substance use disorder	4 (4.8)	1 (5.3)	3 (4.6)	

Other psychiatric illness	3 (3.6)	1 (5.3)	2 (3.1)	
Medical history				0.017*
Absent	72 (85.7)	13 (68.4)	59 (90.8)	
Diabetes mellitus	5 (6.0)	2 (10.5)	3 (4.6)	
Hypertension	4 (4.8)	1 (5.3)	3 (4.6)	
Other medical illness	2 (2.4)	2 (10.5)	0 (0.0)	
Diabetes mellitus + Hypertension	1 (1.2)	1 (5.3)	0 (0.0)	
Substance use				0.706
Nil	61 (72.6)	14 (73.7)	47 (72.3)	
Alcohol dependence syndrome	5 (6.0)	2 (10.5)	3 (4.6)	
Nicotine dependence syndrome	17 (20.2)	3 (15.8)	14 (21.5)	
Alcohol + Nicotine dependence	1 (1.2)	0 (0.0)	1 (1.5)	

*Statistically significant ($p < 0.05$).

Table 2. Prevalence of Sexual Dysfunction According to Primary Psychiatric Diagnosis (N = 84)

Primary Psychiatric Diagnosis	Total, n	Sexual Dysfunction Present, n (%)	Sexual Dysfunction Absent, n (%)
Depressive disorders	22	11 (50.0)	11 (50.0)
Anxiety disorders	22	4 (18.2)	18 (81.8)
Obsessive-compulsive disorder	8	1 (12.5)	7 (87.5)
Stress-related disorders	10	0 (0.0)	10 (100.0)
Psychosomatic disorders	20	3 (15.0)	17 (85.0)
Substance use disorders	2	0 (0.0)	2 (100.0)
Total	84	19 (22.6)	65 (77.4)

Chi-square test: $p = 0.014$

DISCUSSION

This cross-sectional study assessed the prevalence of sexual dysfunction and its associated sociodemographic and clinical correlates among treatment-naïve male psychiatric outpatients. By restricting the study population to newly diagnosed patients who had not received psychotropic medications, the present study minimized medication-related confounding and provided an opportunity to evaluate sexual dysfunction associated primarily with psychiatric illness itself rather than treatment-related adverse effects.^{12,5}

Sexual dysfunction was identified in 22.6% of treatment-naïve male psychiatric outpatients. This finding indicates that sexual dysfunction is a common clinical problem even before the initiation of psychotropic treatment and supports the growing body of evidence suggesting that psychiatric disorders themselves contribute substantially to disturbances in sexual functioning.⁵

The prevalence observed in the present study is lower than that reported in many studies involving patients receiving antidepressants or other psychotropic medications, where rates of sexual dysfunction frequently exceed 30–70% among patients receiving antidepressant treatment.^{8,12} This difference is likely attributable to the additional burden of medication-induced sexual dysfunction superimposed on dysfunction associated with the underlying psychiatric illness. By exclusively including treatment-naïve patients, the present study provides a clearer estimate of baseline sexual dysfunction attributable to psychiatric disorders alone.

The relationship between psychiatric illness and sexual dysfunction is likely multifactorial. Neurobiological alterations involving serotonergic, dopaminergic, and noradrenergic pathways, dysregulation of the hypothalamic-pituitary-adrenal axis, psychological distress, impaired self-esteem, interpersonal difficulties, and reduced quality of life have all been implicated in the development of sexual dysfunction among individuals with mental illness.^{12,5} Consequently, sexual dysfunction should be regarded as an integral component of psychiatric assessment rather than solely as a potential adverse effect of psychotropic medications.

In the present study, age was not significantly associated with sexual dysfunction, although participants with sexual dysfunction had a slightly higher mean age than those without sexual dysfunction. Although advancing age is a recognized risk factor for sexual dysfunction in the general population owing to age-related physiological changes and increasing medical comorbidities, its influence appears less pronounced among treatment-naïve psychiatric patients, where the underlying psychiatric illness may play a more dominant role.^{13,14}

Similarly, no significant associations were observed between sexual dysfunction and marital status, educational status, occupation, socioeconomic status, place of residence, family history of psychiatric illness, or substance use. Previous studies have reported inconsistent findings regarding the influence of these factors on sexual functioning, with observed differences often reflecting variations in study populations, cultural backgrounds, assessment instruments, diagnostic profiles, and sample sizes.^{2,14} The absence of significant associations in the present study suggests that sexual dysfunction among treatment-naïve psychiatric patients may be more closely related to illness-related factors than to sociodemographic characteristics.

Medical history, however, demonstrated a statistically significant association with sexual dysfunction. Participants with coexisting medical illnesses had a higher prevalence of sexual dysfunction than those without medical comorbidities. This finding is biologically plausible, as chronic medical conditions such as diabetes mellitus and hypertension are well-established contributors to sexual dysfunction through vascular impairment, autonomic neuropathy, endothelial dysfunction, hormonal alterations, and psychological distress.^{14,2} Although only a small proportion of participants in the present study had medical comorbidities, this observation highlights the importance of comprehensive physical health assessment while evaluating sexual dysfunction in psychiatric practice.

The present study demonstrated a statistically significant association between primary psychiatric diagnosis and sexual dysfunction, with the highest prevalence observed among participants with depressive disorders (50%). Comparatively lower rates were observed among participants with anxiety disorders (18.2%), psychosomatic disorders (15.0%), and obsessive-compulsive disorder (12.5%), while no cases of sexual dysfunction were identified among participants with stress-related disorders or substance use disorders. These findings suggest that the burden of sexual dysfunction differs across psychiatric disorders and may reflect disorder-specific pathophysiological and psychological mechanisms.⁵

The high prevalence of sexual dysfunction among patients with depressive disorders is consistent with previous literature. Depression has been consistently associated with reduced sexual desire, impaired arousal, erectile dysfunction, delayed ejaculation or orgasm, and diminished overall sexual satisfaction.^{12,8} Several mechanisms have been proposed to explain this relationship, including neurobiological alterations, anhedonia, fatigue, low self-esteem, and impaired interpersonal relationships, all of which may adversely affect sexual functioning.^{12,5}

An important strength of the present study is that all participants were treatment naïve. Consequently, the observed sexual dysfunction is less likely to represent an adverse effect of psychotropic medication and more likely to reflect the underlying psychiatric illness itself. This distinction is clinically relevant because sexual dysfunction in psychiatric patients is frequently attributed to antidepressants and other psychotropic medications, potentially overlooking pre-existing dysfunction present before treatment initiation.^{8,9}

Clinical Implications

The findings of the present study highlight the importance of routinely assessing sexual functioning during the initial psychiatric evaluation, even before the initiation of psychotropic treatment. Because a substantial proportion of treatment-naïve patients exhibited sexual dysfunction, baseline assessment can help clinicians distinguish pre-existing dysfunction from treatment-emergent sexual adverse effects. Early identification of sexual dysfunction also facilitates appropriate patient counselling, individualized treatment planning, and informed selection of psychotropic medications, particularly in patients with depressive disorders and those with coexisting medical illnesses, who may be at greater risk of impaired sexual functioning.^{12,8,9} Incorporating sexual health assessment into routine psychiatric practice may improve therapeutic alliance, treatment adherence, overall quality of life, and long-term clinical outcomes.²

STRENGTHS

The exclusive inclusion of treatment-naïve male psychiatric outpatients minimized the confounding effects of psychotropic medications and enabled assessment of sexual dysfunction attributable primarily to the underlying psychiatric illness. Furthermore, psychiatric diagnoses were established using standardized ICD-10 criteria, and sexual dysfunction was assessed using the validated Arizona Sexual Experience Scale (ASEX), enhancing the reliability and consistency of the study findings.

LIMITATIONS

- The cross-sectional study design precludes establishing causal relationships between psychiatric disorders and sexual dysfunction.
- The study was conducted at a single tertiary care center with a relatively small sample size, which may limit the generalizability of the findings.
- Only male participants were included; therefore, the findings cannot be generalized to female psychiatric patients.
- Potentially relevant factors such as the severity and duration of psychiatric illness, relationship quality, hormonal status, and other psychosocial variables were not evaluated.

CONCLUSION

Sexual dysfunction affected nearly one-quarter of treatment-naïve male psychiatric outpatients. Depressive disorders were associated with the highest prevalence of sexual dysfunction, while medical comorbidities also showed a significant association. These findings emphasize that sexual dysfunction may be an intrinsic manifestation of psychiatric illness rather than solely a consequence of psychotropic treatment. Routine assessment of sexual functioning during the initial psychiatric evaluation may facilitate early identification, appropriate management, and individualized treatment planning. Further multicentric longitudinal studies are warranted to better elucidate the temporal relationship and determinants of sexual dysfunction across different psychiatric disorders.

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