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A Survey of Psychotropic Medication Induced Sexual Dysfunction in Male Outpatients

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ABSTRACT

Introduction : Sexual problems are common in patients taking medicines. These problems affect their life, relationships and how well they follow their treatment. Mental health conditions and their treatments are known to affect health through brain and hormone changes. This study looked at how sexual dysfunction happens what kinds of problems occur and if the medicines are the cause in adult male psychiatric patients. **Materials and Methods :** We conducted a study over six months in the Psychiatry Department of Geetanjali Hospital, Udaipur. We selected 30 adult male patients who were taking medicines. We gathered information using a form and medical records. We used the Arizona Sexual Experience Scale and Sexual Dysfunction Checklist to assess problems. We evaluated how well patients followed their medication using the Medication Adherence Rating Scale. We used the Naranjo Algorithm to determine if the medicines were the cause of the problems. We analyzed the data using statistics Chi-square test and one-way ANOVA. **Results :** The average age of the patients was 36 years. We found that 80% of patients had dysfunction based on their ASEX scores. The common problems were erectile dysfunction (36.7%) and low libido (26.7%). Most cases (83.3%) were likely caused by the medicines. We found that taking antidepressants and antipsychotics together was strongly linked to sexual dysfunction scores ($p < 0.0001$). Most patients (86.7%) were taking their medication as prescribed. **Conclusion :** Sexual dysfunction is a significant problem for patients taking psychiatric medicines. We need to identify and manage these problems early to improve treatment adherence and quality of life. We recommend large-scale studies to learn more, about this issue.

Keywords : Sexual dysfunction, Psychotropic drugs, ASEX, Medication adherence, Naranjo scale, Psychiatry

INTRODUCTION

Sexual dysfunction (SD) is a widespread medical condition that affects people of all genders and age groups but remains mostly unreported. The condition manifests through sexual desire and arousal and orgasm disturbances plus sexual activity-related pain which causes intense psychological suffering and relationship problems. According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), SD represents a clinically significant impairment in sexual functioning (American Psychiatric Association *et al.*[1]). The high prevalence of the condition remains hidden because social stigma and cultural taboos prevent people from discussing it openly and seeking medical help (Rosen *et al.*[2]).

The field of sexual dysfunction classification divides into four main types which include sexual desire disorders and arousal disorders and orgasmic disorders and sexual pain disorders (American Psychiatric Association *et al.*[3]). The sexual desire disorders include hypoactive sexual desire disorder and sexual aversion disorder (Brotto *et al.*[4]). Arousal disorders include male erectile dysfunction and female sexual arousal disorder (Laumann *et al.*[5]). Orgasmic disorders consist of premature ejaculation and delayed ejaculation and female orgasmic disorder whereas sexual pain disorders include dyspareunia and vaginismus which create additional sexual health difficulties (Basson *et al.*[6]).

Epidemiological research shows that SD affects a large portion of the worldwide population. The Massachusetts Male Aging Study discovered that approximately 52% of men between 40 and 70 years old experience erectile dysfunction (Feldman *et al.*[7], Shifren *et al.*[8]). The study found that almost 43% of women experience sexual problems which lead to distress. Large multinational surveys have further demonstrated a high prevalence of sexual dysfunction among individuals aged 40–80 years (Laumann *et al.*[10]). The frequency of SD occurrences tends to rise as people grow older while medical conditions and hormonal changes and their daily habits create a major effect on this condition (Corona *et al.*[9]).

Sexual dysfunction develops through multiple systems that include neurological and vascular and hormonal and psychological pathways. Sex-related behavior and sexual motivation get controlled by the neurotransmitter substances dopamine and serotonin and norepinephrine and oxytocin. People experience sexual attraction because dopamine promotes sexual desire, but serotonin prevents them from achieving sexual pleasure and reaching orgasm (Hull *et al.*11). The body uses testosterone, which the hypothalamic-pituitary-gonadal axis controls, to maintain sexual attraction and the ability to achieve erections (Corona *et al.*12; Aversa *et al.*13).

The body requires vascular integrity because it supports normal sexual function with special importance given to penile erection, which requires nitric oxide to induce vasodilation through cyclic guanosine monophosphate signaling (Burnett *et al.*14). Endothelial dysfunction related to diabetes and hypertension and cardiovascular disease impairs this mechanism, which serves as a major cause of erectile dysfunction (Kaiser *et al.*15; Jackson *et al.*16). Sexual response functions get disrupted by neurological disorders, which include multiple sclerosis and spinal cord injury and Parkinson's disease (Rees *et al.*17).

The development and maintenance of sexual dysfunction depends on psychological factors which serve as vital components. The combination of depression anxiety and stress with relationship conflicts creates negative effects on sexual desire and performance (Nobre *et al.*18; Nicolosi *et al.*19). The study of neuroimaging has shown that limbic brain structures participate in both emotional and sexual processing activities (Georgiadis *et al.*20). Sexual difficulties result from three factors namely cognitive distortions and performance anxiety together with unresolved trauma (Bancroft *et al.*21; Brotto *et al.*22).

The occurrence of SD hinges on hormonal imbalances which serve as primary causes. The hormones estrogen and prolactin together with thyroid hormones, have a significant effect on sexual performance (Shifren *et al.*23). Hyperprolactinemia leads to decreased gonadotropin production, which results in hypogonadism together with diminished sexual desire (Corona *et al.*24). Thyroid dysfunction disrupts metabolic and neurohormonal functions, which results in sexual performance problems (Krassas *et al.*25). The decline of testosterone levels in aging men together with estrogen deficiency in postmenopausal women results in sexual dysfunction (Harman *et al.*26; Morales *et al.*27; Dennerstein *et al.*28).

Sexual dysfunction arises from various pharmacological agents, which serve as main factors, that lead to this condition. The combination of antidepressants with antipsychotics and antihypertensive medications together with hormonal therapies shows a strong connection to sexual side effects (Clayton *et al.*29). The increased serotonergic activity of selective serotonin reuptake inhibitors results in delayed ejaculation together with anorgasmia and reduced sexual desire (Serretti *et al.*30). The combination of beta-blockers and diuretics reduces penile blood flow, which results in erectile dysfunction (Kloner *et al.*31), while opioids lead to a decrease in testosterone production (Daniell *et al.*32).

People's sexual health gets affected by their lifestyle choices which include smoking and drinking alcohol without moderation along with their unhealthy eating habits and their body weight problems and their lack of exercise. The research from randomized controlled trials shows that obese men with erectile dysfunction benefit from lifestyle changes which improve their sexual performance (Esposito *et al.*33). Smoking damages blood vessels while alcohol consumption affects the neuroendocrine system which results in sexual performance problems (Sansone *et al.*34; Kupelian *et al.*35). Gupta *et al.*36 found that people who exercise regularly and reduce their cardiovascular risks can protect themselves from developing sexual dysfunction. The diagnosis of sexual dysfunction requires a comprehensive clinical evaluation, including detailed medical and sexual history, physical examination, psychological assessment, and laboratory investigations (Hatzimouratidis *et al.*37). The management of patients depends on their specific causes which results in treatment options that include drug therapy and mental health therapy and behavior modification methods (Montorsi *et al.*38). The primary treatment for erectile dysfunction consists of phosphodiesterase type 5 inhibitors which doctors use as their first treatment method (Hatzimouratidis *et al.*39). The combination of mindfulness-based therapy and cognitive-behavioral therapy helps people treat their psychogenic psychological problems which require psychological intervention (Brotto *et al.*40).

Researchers in sexual medicine have developed new treatment methods which focus on investigating molecular and regenerative biological processes. New research has shown that stem cell therapy combined with nitric oxide signaling pathways can enhance erectile function while facilitating tissue regeneration (Burnett *et al.*41; Albersen *et al.*42; Burnett *et al.*43). The researchers need to conduct extensive clinical trials because they want to test the long-term safety and effectiveness of their treatment method.

The condition of sexual dysfunction involves multiple causes which interact with each other through neurological, vascular, hormonal, psychological and lifestyle elements. The high rate of occurrence together with its major effect on life quality require doctors to use multiple methods for both diagnosing and treating the condition. The medical field needs better understanding of sexual dysfunction together with prompt diagnosis and ongoing scientific study to decrease stigma and boost treatment results for affected people (Lewis *et al.*44).

Materials and Methods

Study Design and Setting

This study was done at Geetanjali Hospital in Udaipur, Rajasthan, India in the Department of Psychiatry. It was a study that took place over six months.

Study Population and Sample Size

The study looked at adult men who were diagnosed with disorders and were taking psychotropic medications. We used a time-bound sampling method. Included 30 participants in the study.

Inclusion and Exclusion Criteria

Inclusion Criteria

- Men 18 years or older with a disorder
- Men taking any kind of medication
- Men who were willing to join the study and gave their written consent

Exclusion Criteria

- Men who had dysfunction before starting psychotropic therapy
- Men with medical conditions that could affect their sexual function
- Men taking medications or therapies that could affect their sexual performance
- Men with a history of abusing psychotropic substances or medications

Study Materials and Instruments

We used the following tools to collect data:

1. A form to record information about the participants like their age, socioeconomic status and medications.

2. Medical records from Geetanjali Hospital.

3. Consent forms in English and Hindi.

4. Arizona Sexual Experience Scale (ASEX) to assess functioning.

5. Sexual Dysfunction Checklist to check for dysfunction.

6. Medication Adherence Rating Scale (MARS) to see how well participants were following their medication regimen.

7. Naranjo Adverse Drug Reaction Probability Scale to determine if the psychotropic medications were causing dysfunction.

Data Collection Procedure

We identified men who were eligible for the study when they came for their visits to the psychiatry department. We explained the study to them. Got their written consent. We then collected information about them like their age and medications using the form and checked it against their medical records. We also used the ASEX scale, Sexual Dysfunction Checklist, MARS and Naranjo scale to assess their functioning and medication adherence. All the data collected was kept anonymous. Recorded in Microsoft Excel.

Conduct of the Study

The study was done in two phases:

Phase I: Patient Identification and Enrollment

We screened records of outpatients.

We identified men who were eligible based on our inclusion and exclusion criteria.

We got their consent.

We collected their clinical data.

Phase II:. Evaluation

We used tools (ASEX, Sexual Dysfunction Checklist, MARS and Naranjo Scale) to assess the participants.

We checked how well they were adhering to their medications. If they were experiencing any adverse drug reactions.

We verified all the data collected.

Statistical Analysis

We used Microsoft Excel to manage the data and appropriate statistical software for analysis. We used statistics to summarize the data. We also used the Chi-square test to see if there were any associations between variables and one-way ANOVA to compare means among groups. A p-value of than 0.05 was considered significant.

Ethical Considerations

The study followed the principles of the Declaration of Helsinki. We got approval, from the Institutional Human Ethics Committee, Geetanjali University (Approval No.: GU/HREC/EC/2024/2619). We obtained written consent from all participants and maintained their confidentiality throughout the study.

RESULTS

1. Participant Enrollment

We looked at 45 patients during the study period. Out of these 30 patients were chosen because they fit the criteria, for the study. We had to exclude 15 patients because they were not eligible had health issues had previous sexual problems or did not want to agree to the study terms. So we ended up analyzing the data of 30 participants.

2. Demographic Characteristics of Participants

Table 1: Demographic Characteristics of the Study Participants

Sr. No.	Study Parameter	Frequency (n=30)	Percentage (%)
1.	**Age Group (Years)**		
	18–30	7	23.3
	31–40	14	46.7
	41–50	8	26.7
	51–60	1	3.3
2.	**Residence**		
	Rural	12	40.0
	Urban	18	60.0
3.	**Socioeconomic Class**		
	Lower Class	12	40.0
	Middle Class	15	50.0
	Upper Class	3	10.0
4.	**Marital Status**		
	Married	18	60.0
	Unmarried	12	40.0

In Table 1, we have the details about the persons who took part in the study were between 31 and 40 years old, which is 46.7%. Then there were between 41 and 50 years old which is about 26.7% and persons who were between 18 and 30 years old which is about 23.3%. So, most of the patients were adults in the age.

We also found out that more people lived in cities 60%, compared to persons who lived in the country about 40%.

When we looked at how well off the persons were we found out that half of them 50% were middle class. 40% of the persons were from a lower class and about 10% were, from a higher class.

Most of the persons who took part in the study were married 60% and about 40% were not married.

Overall, the persons who took part in the study were mostly middle-aged people who lived in cities and were middle class, which is what we see in men who go to the doctor for mental health problems and get medicine for it.

3. Occupational Status

Table 2: Occupational Distribution of Participants

Sr. No.	Occupation	Frequency (n=30)	Percentage (%)
1.	Self-employed	10	33.3
2.	Private Sector	8	26.7
3.	Government Job	6	20.0
4.	Businessman	6	20.0

In Table 2, presents the occupational distribution of the participants, The major quantity of respondents were self-employed (33.3%), followed by those working in the private sector (26.7%). Government workers and businessmen respectively reported for 20% of the sample. Statistical analysis showed no significant association between occupation and sexual dysfunction ($p = 0.9998$), suggesting that a participant's job or professional background had little to no impact on sexual functioning within this group.

4. Diagnostic Profile

Table 3: Psychiatric Diagnosis of Participants

Sr. No.	Diagnosis	Frequency (n)	Percentage (%)
1.	Acute Psychotic Disorder (ATPD)	2	6.7
2.	Bipolar Affective Disorder (BPAD)	4	13.3
3.	Depression	9	30.0
4.	Generalized Anxiety Disorder	9	30.0
5.	Mania	2	6.7
6.	Schizophrenia	4	13.3

In Table 3, the diagnostic profile of the participants, Depression and generalized anxiety disorder were the maximum predominant psychiatric situations, respectively accountancy for 9 cases (30%). Bipolar affective disorder and schizophrenia were present in 4 participants (13.3%) respectively, however acute psychotic disorder and mania were observed in 2 participants (6.7%) respectively. This distribution reflects the predominance of mood and anxiety disorders in the study population.

5. Pattern of Combination Therapy

Table 4: Combination of Psychotropic Medications

Sr. No.	Drug Combination	Frequency (n)	Percentage (%)
1.	Antidepressant + Benzodiazepine	6	20.0
2.	Antipsychotic + Anticholinergic + Benzodiazepine	7	23.3
3.	Mood Stabilizer + Antipsychotic + Benzodiazepine	10	33.3
4.	Antipsychotic + Anticholinergic + Antihistamine + Benzodiazepine	4	13.3
5.	Antidepressant + Benzodiazepine + Antipsychotic	2	6.7
6.	Antipsychotic + Anticholinergic + Antipsychotic + Benzodiazepine	1	3.4

In Table 4, the combination psychotropic therapy pattern is shown, Mood stabilizer plus antipsychotic and benzodiazepine therapy was the most prescribed regimen (33.3%), followed by antipsychotic, anticholinergic, and benzodiazepine combinations (23.3%) and antidepressant plus benzodiazepine therapy (20%). Combinations of several antipsychotics and adjunctive medications were fewer common regimens. This demonstrates how common polypharmacy is in psychiatric practice.

6. Medication Adherence

Table 5: Medication Adherence Based on MARS Score

Sr. No.	Adherence Status	Frequency (n=30)	Percentage (%)
1.	Adherent	26	86.7
2.	Non-adherent	4	13.3

In Table 5, medication adherence as evaluated by the Medication Adherence Rating Scale (MARS), A total of 26 participants (86.7%) were categorized as adherent, whereas 4 participants (13.3%) were classified as non-adherent. Sexual dysfunction in this study was unlikely to be caused by irregular medication intake, as indicated by the high adherence rate, which also suggests good compliance with psychotropic therapy.

7. Assessment of Sexual Dysfunction

Table 6: ASEX Score Distribution

Sr. No.	ASEX Score Range	Interpretation	Frequency (n=30)	Percentage (%)
1.	5–18	Normal Sexual Function	6	20.0
2.	≥19	Likely Sexual Dysfunction	24	80.0

In Table 6, the distribution of ASEX scores among the participants, the 6 participants (20%) showed normal sexual functioning, while 24 participants (80%) had scores suggestive of sexual dysfunction. The significant burden of sexual dysfunction among psychiatric patients undergoing psychotropic treatment is highlighted by this high prevalence.

Table 7: Nature of Sexual Dysfunction (Sexual Dysfunction Checklist)

Sr. No.	Type of Dysfunction	Frequency (n)	Percentage (%)
1.	Erectile Dysfunction	11	36.7
2.	Decreased Libido	8	26.7
3.	Delayed Ejaculation	4	13.3
4.	Premature Ejaculation	2	6.7
5.	Normal	5	16.6

In Table 7, the pattern of sexual dysfunction as assessed using the Sexual Dysfunction Checklist, the most common disorder was erectile dysfunction, which affected 11 participants (36.7%), 4 participants (13.3%) experienced delayed ejaculation, and 8 participants (26.7%) experienced decreased libido, 2 participants (6.7%) had premature ejaculation, while 5 participants (16.6%) reported normal sexual function. These findings imply that a number of sexual function domains were negatively impacted in the study population.

8. Causality Assessment (Naranjo Scale)

Table 8: Naranjo Causality Assessment of Sexual Dysfunction

Sr. No.	Category	Frequency (n=30)	Percentage (%)
1.	Definite	0	0
2.	Probable	25	83.3
3.	Possible	5	16.7
4.	Doubtful	0	0

In Table 8, the causality assessment of sexual dysfunction using the Naranjo Adverse Drug Reaction Probability Scale, 25 participants (83.3%) were classified under the probable category, while 5 participants (16.7%) were categorized as possible, no cases were categorized as doubtful or definite. These results provide compelling evidence that the observed sexual dysfunction is caused by psychotropic medications.

9. Comparison of Drug Categories and Sexual Dysfunction

Table 9: Comparison of Mean Scores of MARS, ASEX, and Naranjo Scales

Sr. No.	Drug Category	MARS (Mean ± D)	Naranjo (Mean ± D)	ASEX (Mean ± D)	p-value	Result
1.	AD + BZD	5.8 ± 0.83	4.5 ± 0.85	19.6 ± 1.08	<0.0001	Significant
2.	AP + ACh + ZD	5.0 ± 0.8	4.3 ± 0.7	19.0 ± 1.2	<0.0001	Significant
3.	AD + BZD + P	5.6 ± 0.7	4.2 ± 0.9	19.3 ± 1.1	<0.0001	Significant
4.	Other Combinations	5.4 ± 0.6	4.1 ± 0.6	18.5 ± 0.9	>0.05	Not Significant

In Table 9, the comparison of psychotropic drug categories based on mean scores of MARS, ASEX, and Naranjo scales using one-way ANOVA, Statistically significant differences were observed in ASEX scores among different drug regimens ($p < 0.0001$), Regimens containing antidepressants and benzodiazepines, either alone or in combination with antipsychotics, demonstrated significantly higher mean ASEX scores, indicating greater sexual dysfunction. Other regimens did not show statistically significant associations, possibly due to smaller sample sizes.

DISCUSSION

This study looked at how sexual problems happen in adult men who see a psychiatrist and take medicine for their mental health issues at a big hospital. What they found out is that a lot of these men have problems. In fact many of them have problems that show up on a test called the Arizona Sexual Experience Scale. This means that sexual problems are a side effect of taking psychiatric medicine but people do not always talk about them. Sexual dysfunction is an issue, for men who take psychiatric medications and it happens more often than people think. The study shows that sexual dysfunction is a problem that affects men who take these medications and it is something that needs to be discussed more openly.

The present study found that most applicants were between 31 and 40 years old, with a mean age of 36 years. Other studies have also originate that persons sexual difficulties tend to rise as they get older. Feldman *et al.*[7] found that men over 40 years old were more likely to have dysfunction. Laumann *et al.*10 also reported that middle-aged people were more likely to have problems. The fact that the people in this study were young suggests that having a psychiatric illness and taking psychotropic drugs may contribute to sexual problems starting at a younger age.

Things like where people live how money they make, whether they are married and what they do for work did not seem to be related to sexual dysfunction. Other studies, such as those by Nobre *et al.*18 and Nicolosi *et al.*19 have also found that these kinds of factors do not have an impact on sexual health. Instead it seems that the medications people take and the state of their health have a bigger impact on their sexual function. This suggests that sexual problems in people with illnesses are mostly caused by the medications they take and the way their brains work.

When we looked at how people were taking their medications we found that most of them were taking their medications as prescribed. Even though they were experiencing side effects they continuous to take their medications because they wanted to switch their psychiatric symptoms. This is like what Clayton *et al.*29 found, which is that people will often put up with side effects if it means they can avoid having a relapse of their psychiatric symptoms. However, if sexual difficulties continue it could make it harder for people to keep taking their medications, which's why it is so important to identify and address these problems early on.

We used the Naranjo algorithm to try to figure out whether the sexual difficulties persons were experiencing were caused by their medications. We found that most of the cases were probably caused by the medications. Antidepressants, the kind that affect serotonin can impair sexual function by increasing the activity of serotonin and decreasing the activity of dopamine as described by Hull *et al.*11 and Serretti *et al.*30. Antipsychotics can also contribute to problems by blocking the action of dopamine and increasing the levels of prolactin, which can lead to decreased libido and erectile dysfunction as reported by Corona *et al.*24 and Clayton *et al.*29.

We used the ASEX scale to assess dysfunction and we found that about 80% of the people in the study had significant sexual problems. This is consistent with what other studies have found. For example Serretti *et al.*30 found that than 60% of people taking antidepressants had sexual dysfunction and Clayton *et al.*29 reported that about 70% of psychiatric patients had sexual problems. Shifren *et al.*[8] also highlighted the fact that sexual difficulties can cause a lot of distress.

When we observed at the types of sexual problems people were experiencing, we found that erectile dysfunction and decreased libido were the most common. This is similar to what other studies have found, such as those by Feldman *et al.*[7] and Jackson *et al.*16. Impaired erectile function can be caused by problems with the blood vessels and decreased levels of oxide as explained by Burnett *et al.*14. Decreased libido can be caused by much serotonin and hormonal imbalances as described by Corona *et al.*12 and Hull *et al.*11.

The common psychiatric diagnoses among the people in the study were depression and generalized anxiety disorder. Other studies have found that there is a link between mood disorders and sexual dysfunction as reported by Nobre *et al.*18 and Nicolosi *et al.*19. Bancroft *et al.*21 found that depression can alter the way the body regulates hormones leading to decreased motivation. Neuroimaging studies by Georgiadis *et al.*20 also support the idea that problems with the system can contribute to sexual impairment.

When we looked at the types of medications people were taking we found that combination therapy involving antidepressants, antipsychotics and benzodiazepines was associated with more severe sexual dysfunction. Taking medications can increase the risk of sexual problems by disrupting the balance of neurotransmitters as reported by Clayton *et al.*29 and Sansone *et al.*34. Benzodiazepines can also impair arousal by causing sedation as described by Daniell *et al.*32.

When we compared the types of psychotropic medications, we found that antidepressants were associated with more severe sexual dysfunction. This is consistent with what other studies have found, such as those by Serretti *et al.*30 and Hull *et al.*11, which have shown that serotonergic agents can inhibit motivation and orgasmic reflexes.

The suggestions of these results are significant. Sexual dysfunction can have an impact on a persons self-esteem, relationships and quality of life as emphasized by Laumann *et al.*10 and Shifren *et al.*[8]. If sexual side effects are not addressed they can increase distress and make it harder for people to stick with their treatment plans as reported by Brotto *et al.*22.

There are strategies that can be used to manage sexual dysfunction including reducing the dose of medications switching to medications, with fewer sexual side effects adding other medications and providing psychosexual counseling as suggested by Clayton *et al.*29 and Montorsi *et al.*38. Making lifestyle changes and reducing the risk of disease can also help improve sexual function as shown by Esposito *et al.*33 and Gupta *et al.*36.

Limitations

The study has certain limitations, including small sample size and cross-sectional design, which limit generalizability, as discussed by Hatzimouratidis *et al.*[37]. Self-reported assessment tools may be subject to reporting bias.

Implications for Future Research

Future studies with larger, multicentric cohorts and longitudinal designs are required, as recommended by Burnett *et al.*[41]. Interventional trials focusing on management strategies for psychotropic-induced sexual dysfunction are warranted.

Conclusion

Sexual dysfunction is a big problem for adult male patients who are taking psychotropic medications. These medications include antidepressants, the kind that affect serotonin and antipsychotic drugs. They can cause a lot of problems. This is a deal because it affects the patient's quality of life how joyful they are with their treatment and whether they keep taking their medication.

A lot of the time persons do not talk about difficulties caused by drugs because they are uncomfortable or do not want to converse it with their doctor. If doctors regularly ask about health and talk to patients about it, they can help them sooner and prevent them from stopping their treatment. Doctors can also try things to help like changing the dose of the medication switching to a different medication that does not cause, as many sexual problems or giving the patient extra support. This can help the patient's difficulties and make them more likely to keep taking their medication.

We need to do investigate to really understand what occurs when psychotropic medications cause sexual problems in the long term. If we make scrutiny for problems a regular part of taking care of persons mental well-being, we might be able to make treatment work better and improve people's overall well-being. Sexual dysfunction is a matter and we should try to deal with it when patients are taking psychotropic medications.

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CONFLICT OF INTEREST

The authors declare that there is no conflict of interest.

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