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To

The Editor-in-Chief

Indian Journal of Psychiatry

Subject: Submission of the manuscript entitled “*Why Clinical Practice Guidelines in Psychiatry and Psychosexual Medicine*” for consideration as a Clinical Practice Guideline

Dear Sir/Madam,

On behalf of all authors, I submit the above manuscript for consideration in the *Indian Journal of Psychiatry*. It is the opening chapter of the Indian Psychiatric Society (IPS) Clinical Practice Guidelines for Psychosexual Health, Dysfunction and Disorders, commissioned through the IPS Sub-Committee on Clinical Practice Guidelines, and is submitted for the Clinical Practice Guidelines section.

Sexual dysfunction is common among people with psychiatric illness and among those receiving psychotropic medication, yet it is rarely asked about in routine practice. Treatment-emergent sexual dysfunction remains a major and frequently unspoken reason for non-adherence. The chapter sets out the rationale for a psychiatry-led Indian guideline. It reviews the burden of sexual dysfunction relevant to psychiatric practice and the bidirectional interface between psychiatry and sexual medicine. It maps the existing international guidance and the eight related guidelines published in this journal since 2017, examines how major psychiatry guidelines approach the assessment of sexual function, and summarises the validated instruments available for that purpose. It then defines the scope and development method of the 20-chapter guideline, the role of collaboration with allied disciplines, the changes in everyday clinical practice the guideline is intended to bring about, and the research gaps that remain.

The chapter builds directly on the 2017 IPS guideline on the management of sexual dysfunction and on the related guidelines subsequently published in the journal. It addresses areas that international documents were not designed to cover: culturally shaped presentations such as Dhat syndrome, help-seeking routes specific to India, and the resource and medico-legal context in which Indian psychiatrists work. We believe it will interest the readership of the journal and will serve as the framework chapter for the remaining chapters of the guideline.

The manuscript comprises an executive summary of 279 words, a main text of approximately 4,500 words, 10 tables, 2 figures and 42 references.

We confirm that:

- (a) the manuscript is original, has not been published previously, and is not under consideration for publication elsewhere;

- (b) all authors have read and approved the final manuscript, meet the ICMJE criteria for authorship, and agree to its submission to the Indian Journal of Psychiatry;
- (c) the work received no specific funding, and the authors have no conflicts of interest to declare;
- (d) the manuscript is a narrative guideline chapter based on published literature; it involves no human participants or patient data, and ethics committee approval was therefore not required.

I will act as the corresponding author and will handle all correspondence regarding the manuscript.
We look forward to your consideration.

Thanking you,

Yours sincerely,

Prof. T. S. Sathyanarayana Rao

Corresponding author, on behalf of all authors

1 Why Clinical Practice Guidelines in Psychiatry and Psychosexual Medicine

2 Executive Summary

3 Sexual health is part of general health, yet it stays one of the least asked about areas of clinical work.
4 Psychiatry and sexual medicine are tied together in both directions: psychiatric illness and the drugs
5 used to treat it commonly disturb sexual function, and sexual difficulty in turn lowers mood, strains
6 relationships and drives patients off treatment. The reported figures bear this out, ranging from
7 about a fifth to nearly half of adults in the general population to well over half of people with
8 schizophrenia or taking serotonergic antidepressants. This opening chapter of the Indian Psychiatric
9 Society Clinical Practice Guidelines for Psychosexual Health, Dysfunction and Disorders sets out why
10 the exercise has been undertaken. It reviews the burden and the clinical consequences of sexual
11 dysfunction, the two-way relationship between psychiatry and sexual medicine, and the guidance
12 already available from urology, sexual medicine, women's health and psychiatry, both internationally
13 and within India, where the Indian Journal of Psychiatry has published eight related guidelines since
14 2017. It looks at how the major psychiatry guidelines approach the assessment of sexual function
15 and at the instruments available for that work. It then sets out what an Indian guideline adds:
16 familiarity with local idioms of distress such as Dhat syndrome, with the routes by which Indian
17 patients seek help, and with the resources and laws we work within. The chapter goes on to describe
18 the scope and development method of the guideline, the place of collaboration with the other
19 disciplines that practise sexual medicine, the changes in everyday clinical work the guideline is
20 meant to bring about, and the research questions that remain open. The guideline is written for the
21 clinical use of psychiatrists.

22 **Keywords:** psychosexual health; sexual dysfunction; clinical practice guideline; Indian Psychiatric
23 Society; sexual history; treatment-emergent sexual dysfunction; Dhat syndrome.

25 Introduction

26 Sex matters to people. It is bound up with who we are, how we relate to a partner, how we feel
27 about ourselves, and whether a marriage or a relationship holds together. None of this switches off
28 when someone falls ill, grows old or becomes disabled; it only changes shape. The World Health
29 Organization put it in much the same way, describing sexual health as a state of physical, emotional,
30 mental and social well-being in relation to sexuality, and not merely the absence of disease or
31 dysfunction.^[1] For a psychiatrist the implication is plain. The things that make up sexual health,
32 mood, thinking, relationships and self-worth, are the very things we treat every day.

Despite this, sexual health gets very little attention in routine work. It affects illness, disability and quality of life, yet most of us rarely ask about it.^[2] The reasons are not mysterious. The doctor is uncomfortable, the patient is shy, the clinic is crowded, there never seems to be a right moment, and each side assumes the other will bring it up. So nobody does, and a problem that is common, distressing and often treatable goes unrecorded.

The Indian Psychiatric Society (IPS) has taken up this gap through its Sub-Committee on Clinical Practice Guidelines, which has commissioned a full guideline on psychosexual health, dysfunction and disorders. The Society is not starting from scratch; it published guidelines on the management of sexual dysfunction in 2017.^[3] A great deal has changed since then in classification, evidence, drugs and social attitudes, and the brief this time is far wider, covering both sexes, the whole lifespan and the entire range of psychosexual problems. This first chapter explains why the exercise is worth doing: why sexual health deserves clinical attention, how psychiatry and sexual medicine depend on each other, what guidelines already exist elsewhere, what an Indian guideline adds, how the document is put together, how it sits alongside the other disciplines that practise sexual medicine, what it is meant to change in the consulting room, and where the field is heading.

Why Bother About Sexual Health at All?

Start with the numbers. Sexual complaints are among the commonest problems people have, even if they seldom volunteer them. A large international review put the figure at roughly 40 to 45 per cent of adult women and 20 to 30 per cent of adult men reporting at least one sexual dysfunction, with the rates climbing as people get older; erectile dysfunction alone appears at about 25 to 30 new cases per 1,000 men a year.^[4] Add a *chronic illness* and it gets worse. In diabetes close to two-thirds of men have erectile dysfunction, and the worldwide count of affected men now runs into the hundreds of millions.^[5]

Then there is what these problems do. They do not stay in the bedroom. They spoil quality of life, put marriages under strain and chip away at confidence. For the prescriber there is a further, very practical consequence: sexual side effects are one of the main reasons patients stop their medication. This is especially so with antidepressants and antipsychotics, because the sexual problem tends to persist rather than settle with time, and patients often stop the drug without telling anyone.^[6]

There is also a diagnostic reason to ask. Sexual symptoms point to other things. Erectile dysfunction can be the first warning of vascular disease. A sexual complaint may be the way diabetes, low testosterone, a neurological disorder, a failing relationship or an unspoken depression first comes to light. Asking about sex, done properly, is good clinical medicine, and it often tells us more than the

presenting complaint did. Table 1 sets out the burden in the kinds of patients a mental health professional actually sees.

The Role of Sexual Medicine in Psychiatry

There is a simple reason why sexual medicine is part of psychiatry. Our diseases and our drugs are themselves major causes of sexual problems. It's the disease and the therapy. The diseases come first. Depression dulls desire, arousal and pleasure. That's part of what anhedonia means. Anxiety means fear of performance and avoidance. Sexual problems are surprisingly common in psychosis. A meta-analysis of over 21,000 people with schizophrenia found that 56 per cent had a sexual dysfunction, with erectile problems, and low libido and ejaculatory difficulty in men, and orgasmic difficulty and amenorrhoea in women.^[7] Much of the damage is caused by the illness itself, but people tend to blame it all on the tablets. And then the drugs begin to pile up. Loss of desire, delayed orgasm, anorgasmia and poor arousal are common side-effects of serotonergic antidepressants. Antipsychotics that increase prolactin or block dopamine affect desire, arousal and can interfere with menstruation and fertility. Some mood stabilisers contribute hormonal effects.^[6] This treatment-emergent dysfunction is easily missed, as it is infrequently measured in trials and patients rarely report it, but it determines whether a patient tolerates and remains on treatment. Mood-disorder guidelines now take the sexual side-effect profile into account when selecting and switching antidepressants.^[9] One drug-induced emergency deserves separate mention. The classic one is antipsychotic-induced priapism, and it requires prompt recognition and combined psychiatric and urological care.^[10] So sex is no sideline of the psychiatrist. Asking about it is part of evaluating the illness, looking for sexual side effects is part of prescribing safely, and treating the dysfunction is often what keeps the patient in treatment at all.

The Role of Psychiatry in Sexual Medicine

The other way dependence goes too. Psychiatry is needed in sexual medicine, because almost all sexual problems have a psychological component, whether in the etiology, the maintenance, or the aftermath. Best example is depression and erectile dysfunction. Follow men over time and depressed mood predicts later erectile dysfunction, and erectile dysfunction predicts later depressed mood. They feed each other.^[11,12] Elsewhere the same two-way traffic is displayed. Psychological factors are as much a part of sexual problems in neurological, endocrine and kidney disease as the underlying

lesion,^[8] and a purely “organic” reading misses the treatable psychological part.

Psychiatry also encompasses the area of sexual distress where belief and culture create distress. The most obvious example is Dhat syndrome, distress associated with loss of semen: very common in our part of the world, often co-existing with depression and anxiety, and best understood as a culturally shaped way of expressing distress rather than a distinct organic disease.^[13,14] Its assessment and treatment involves psychiatric work, through reassurance, correcting myths, simple cognitive techniques and treating any underlying mood or anxiety disorder.^[2] And finally psychiatry brings the habit of asking. Sexual dysfunction is often unrecognized not because it is rare but because the clinician is mute. Surveys of specialists continue to find the same thing: most ask about sex in only a minority of patients, citing lack of time, lack of a good moment, and hope that the patient will broach the topic first, which patients almost never do.^[15] “A calm, matter of fact, non-judgmental interview is a treatment per se in sexual medicine.” Table 2 presents the two-way links.

The case for a guideline, in one picture

The clinical argument for a guideline can be drawn as a loop that the guideline is meant to break (Figure 1).

Global Guidelines: Where the Field Stands

There is no shortage of good guidance in sexual medicine and much of it is careful, well graded work. But most of it has been written from the inside of a particular specialty. Psychiatry has contributed so far a relatively small share. Urology and andrology have produced careful, evidence graded statements on male sexual dysfunction. The American Urological Association guideline on erectile dysfunction, for example, grades its evidence and works through shared decision making.^[16] Societies of sexual medicine deal with premature ejaculation and male and female dysfunction; societies of women’s health deal with desire, arousal, orgasm and pain; and depression guidelines such as CANMAT deal with sexual side effects as part of the management of the mood disorder.^[9]

Two things follow, neither of which is a complaint against the documents themselves. Each was written, first of all, for its own specialty and question, so a clinician seeing a patient who is depressed, takes an antidepressant, complains in a culturally framed way and has a distressed partner, has to work with several documents that were never meant to be read together. Secondly, most have been developed in and for the high income Western settings. They do a good job of

covering their own ground, leaving the local issues they were never meant to address – culture-bound presentations, the routes by which people in South Asia seek help and explain their problems, and the resources and laws we actually work within – to national guidelines.

Table 3 gives a rough map of what exists and shows what a psychiatry-led Indian guideline can add. Each document serves its own specialty and its own setting well. Read together, they leave room for an integrated, psychiatry-led synthesis written for Indian practice.

Set against the wider international picture in Table 3, available information suggest that Indian psychiatry has already put out substantial guidance on separate corners of the field, dysfunction, forensic evaluation, consultation-liaison work, without yet drawing them together into one document that spans the lifespan (Table 4). Closing that gap is what the present guideline sets out to do.

What the Major Psychiatry Guidelines Say About Screening for Sexual Problems

At its heart this guideline is about getting clinicians to ask. It is therefore worth looking closely at what the major psychiatry guidelines already say on the point. Most view sexual dysfunction from their own area of responsibility, as a side effect of medication to be considered when a drug is chosen and re-evaluated. All but one recommend that the clinician should ask. There is less mention of a formal method of asking, of a named instrument or a fixed timetable, leaving that practical matter to be arranged locally.

This is clear from all the guidance – if you wait for the patient to tell you about a sexual problem you will miss the vast majority of them. It is a difficult subject for both patients and clinicians, primary care recognition rates are low and reliance on spontaneous reporting badly underestimates the prevalence of these problems.^[26] They are only revealed by direct questioning or by a short questionnaire.

Depression and the antidepressant guidelines

The British Association for Psychopharmacology (BAP) guideline on treating depression is among the more explicit. It deals with sexual dysfunction under the practical business of prescribing and of managing longer-term side effects, advises that the sexual side-effect profile of a drug should help guide the choice of antidepressant, and makes the point that these effects need to be asked about because patients do not volunteer them.^[27] The Canadian CANMAT guideline frames the same issue within measurement-based care: it asks the clinician to make an individualised assessment of patient

and medication factors before starting an antidepressant, and then to monitor outcomes and tolerability regularly, with sexual side effects among the adverse events that drive non-adherence.^[28] Both put their weight on enquiry and on shared decisions about tolerability rather than on a named sexual-function scale at baseline and follow-up, leaving that choice to the clinician. Where guidance becomes concrete is on instruments. Reviews underpinning these guidelines agree that a scale cannot replace a sensitive interview, but that a brief questionnaire helps. The instruments with adequate validity, reliability and sensitivity to change — and so the ones recommended for use before and during antidepressant treatment — are the Arizona Sexual Experiences Scale (ASEX), the Changes in Sexual Functioning Questionnaire (CSFQ), the Psychotropic-Related Sexual Dysfunction Questionnaire (PRSexDQ-SALSEX) and the Sex Effects Scale (SexFX).^[6,26] Of these the ASEX is the briefest, five items covering drive, arousal, lubrication or erection, orgasm and orgasmic satisfaction, which makes it the most practical for a busy clinic.^[29]

Psychosis and the antipsychotic guidelines

For people facing severe mental illness, mainstream guidelines offer firmer ground, mostly because sexual dysfunction here is tied to a measurable culprit: raised prolactin (a hormone that, when elevated, disrupts reproductive health). There is wide agreement that these effects should be actively monitored. Ideally, this means taking a baseline inventory of a patient's libido and sexual function before starting an antipsychotic, and re-checking at every visit until the dose is stable, with prolactin levels measured when symptoms appear.^[30] If symptoms crop up, it is time to use a structured tool like the Antipsychotics and Sexual Functioning Questionnaire.^[31] The starting point for much of this monitoring is endocrine safety, with sexual well-being addressed alongside it. But this is not just about comfort; it is about survival. For young men experiencing psychosis, sexual side effects are the single biggest reason they stop taking their medication. Missing this detail can completely derail a person's recovery. Furthermore, evidence like an Indian study using the PRSexDQ-SALSEX reminds us that deep cross-cultural factors heavily shape how patients experience and report these intimate changes.^[6]

But aside from these endocrine checks, the more general psychiatric guidelines, from the American Psychiatric Association to the World Federation of Societies of Biological Psychiatry, are written at a more general level.^[32,33] They agree that sexual dysfunction should be recognised and managed and leave it to the treating clinician to choose the schedule and the tool. NICE guidance follows a similar pattern, with sexual function being part of the routine review of side effects rather than a specific structured screening issue.^[34,35] Thus the international guidelines for schizophrenia have a common

position: ask, weigh the sexual side effects when choosing a drug and monitor, the manner of screening left to local judgement.^[36]

In Asian clinical settings the clinician is asked to do a little more within that open framework. Regional algorithms such as Japanese psychopharmacology algorithm do not say much about sexual screening in particular.^[36] Meanwhile, patients in Asian countries are much less likely to raise sexual concerns unprompted than Western patients.^[37] Where the guidance leaves the initiative to the clinician, that initiative has to be taken. If the doctor does not ask the problem remains hidden and the patient suffers in silence or even stops treatment.

The psychiatric guidelines do not provide practical details (see Table 5), so the best explicit advice on this point is sexual medicine. The International Consultation on Sexual Medicine recommends a clear sexual history and validated scales before starting any psychotropic drug and at the time of follow-up.^[38] This is the standard we set here: Patient first & Proactive .

The common thread, and what an Indian guideline can add

When the guidelines are synthesized (Table 5), a consistent pattern is observed. They agree that sexual dysfunction is common, that it affects quality of life and adherence negatively, and that clinicians should ask about it rather than wait. They differ in depth. The antidepressant guidelines tend to stop at recommending enquiry and drug choice. The antipsychotic guidance includes prolactin monitoring and a rough time table. Three things across all of them remain open for understandable reasons: a routine instruction to screen every patient at baseline with a validated tool; presentations that fall outside the antidepressant and antipsychotic frame; and culture-specific complaints and non-Western routes of help-seeking that no international document could reasonably be expected to carry. This is exactly the vacuum which an India specific psychiatry led guideline attempts to fill and one of the reasons for this document.

The Wider Toolbox of Assessment Instruments

The subsections above named only the handful of scales that the antidepressant and antipsychotic guidelines themselves refer to. Sexual medicine as a field has built up a much bigger toolbox than that. One detailed review counted well over sixty instruments and sorted them by the aspect of sexual functioning each measures, running from basic sexual knowledge through every stage of the sexual response cycle to marital adjustment and problematic pornography use.^[40]

Table 6 organises this by domain instead of by diagnosis, since the same instrument, the ASEX is the clearest case, often turns up across several different psychiatric presentations. Two practical points

from that review carry over directly into this guideline. A brief, broad tool like the ASEX suits routine screening in a busy clinic, whereas a longer one such as the IIEF or the FSFI works better for a fuller assessment once a problem has already been flagged. Very few of these scales have been validated in Indian samples or Indian languages, though the SKAQ, the Dhat Syndrome Questionnaire and its variants, and the SFQ are the clear exceptions. That gap in local validation is something the present guideline has to work around rather than solve outright.

Why India Needs Its Own Guideline

International guidelines are sound pieces of work and a good deal of what they contain travels well. They cannot anticipate a setting for which they were not written, and ours is different in kind, not just in degree.

Some of the difference is in what the patient brings. Presentations like Dhat syndrome, distress organised around the fear of losing semen, are common here, rooted in old beliefs about vitality and often tied to depression and anxiety; they sit outside the frame of guidelines written for other settings and need culturally literate handling.^[2,13,14] The route by which the patient arrives is different too. Sexual complaints in India go first to informal healers, newspaper advertisements and well-meaning relatives, and reach us late, wrapped in shame and misinformation. Guidance has to expect that route rather than a tidy Western primary-care pathway.

The rest of the difference is in what we have to work with. Good population data, especially on female sexual dysfunction, are thin globally and thinner still for India, so recommendations have to say plainly where local evidence is weak and where expert consensus is filling the gap.^[4] Advice also has to be usable within real Indian limits of manpower, access and cost, and it has to engage our own medico-legal and forensic ground around sexual offences, capacity and consent.

There is continuity to keep as well. The Society laid the groundwork with its 2017 guideline on the management of sexual dysfunction; this one carries that work forward across both sexes, the whole lifespan and the full psychosexual range, with the IPS name behind it.^[3]

A guideline written by Indian psychiatrists, for Indian practice and Indian patients, is not a rival to anybody else's work but a companion to it. It is what turns evidence into advice a clinician can actually use at the bedside in this country.

Scope and Methodology of the Guideline

Scope

The guideline is meant to be comprehensive. After this introduction it runs through age-appropriate sex education and the promotion of sexual health; the assessment and management of desire, arousal, orgasmic, ejaculatory and pain or penetration disorders in both sexes; paraphilic disorders; Dhat and other culture-bound presentations; psychosexual concerns in LGBTQ+ people; sexual problems in severe mental illness, the common mental disorders, substance use disorders and old age; sexual issues in consultation–liaison work; the drugs used in sexual medicine and the dysfunctions they cause; forensic and medico-legal questions; and the fast-changing ground of virtual sex, sexual aids and newer technologies. The full list of chapters is in Table 7.

There is one point about our scope worth stating explicitly. These guidelines are intended for the clinical practice of psychiatrists. Each recommendation contained in it is intended to help the clinician in the assessment and treatment of the patient sitting in front of him, and that is the standard by which each chapter has been judged. This is not a policy brief. It does not try to advise administrators, regulators or programme planners, and makes no claim on how services should be funded or organised, although of course anyone doing that work is welcome to read it.

Methodology

The guideline is built the way the Society has built its recent ones, including its guideline on therapeutic neuromodulation^[41] and the earlier guideline on sexual dysfunction.^[3] Each chapter has a lead author and co-authors, sets out its clinical questions, and searches the peer-reviewed and scholarly literature in a structured way. The evidence is appraised, and graded wherever the literature allows, in line with guideline work internationally.^[42] Sexual medicine being what it is, good evidence is often scarce; where that happens, the chapters use structured expert consensus to reach practice points, and they state openly what each recommendation rests on so the reader can tell strong evidence from expert opinion.^[18]

The recommendations are meant to work in Indian settings, to be sensitive to culture and gender, and to respect the patient's autonomy and dignity. Drafts go through internal and external review before they are finalised. Figure 2 shows the working steps.

Working With the Other Stakeholders in Sexual Medicine

There is no monopoly on sexual medicine, no one specialty owns it and no one specialty can practice it alone. The man with erectile dysfunction may need a psychiatrist for his depression, a physician for

his diabetes and a urologist for a vascular assessment and he will do best when all three are pulling in the same direction. A woman with genito-pelvic pain may need a gynaecologist, a pelvic-floor physiotherapist and a therapist working together, not separately, over three years. This guideline is written by psychiatrists but is written in the knowledge that most sexual problems are dealt with by several hands.

Working across disciplines buys three things. It stops patients being bounced between departments, each of which believes the problem lies elsewhere, a common experience in our clinics and a common reason people give up and consult an informal healer instead. It gets the medical work right, so that a vascular, endocrine or gynaecological cause is neither missed nor assumed. And it allows the psychological layer to be worked on alongside the physical one rather than after everything else has failed.^[21]

Much of this rests on a shared vocabulary. When a psychiatrist, a urologist and a gynaecologist use the same diagnostic terms, the same short instruments and the same thresholds for referral, a referral letter carries real information instead of a vague request for an opinion. Supplying that common language is part of what a guideline does.

Referral should run in both directions. A psychiatrist should be as ready to send a patient for vascular or hormonal assessment as to accept one from a colleague who has found a psychological basis to a sexual complaint. Joint or liaison clinics, where they can be arranged, are worth the effort.^[21]

Table 8 lists the partners a psychiatrist working in this field is most likely to need, what each brings, and the kinds of patients they usually share.

One more group deserves an honest mention. In much of India the first person consulted by a patient with a sexual complaint is not a doctor at all but a practitioner found through a newspaper advertisement, a roadside hoarding or a relative's recommendation. Patients arrive having spent money and hope but often with outright misinformation. This is not to say we recommend this route. Clinically it matters, because it determines what the patient believes, what he has already taken, and how long he has waited, and a good deal of early consultation time goes on undoing what was said earlier. Part of the job is to talk to a patient about that history and not to mock it.

How This Guideline Should Change Clinical Practice

A guideline is only useful if something changes afterwards in the clinic. Its desired changes are modest in themselves, cumulative in their effect. Most of it comes down to asking. A short sexual history should be as routine a part of assessment as asking about sleep, appetite or alcohol, and most of the under-detection described earlier in this chapter is simply the question never being put.^[15,26] Recording sexual function before a psychotropic is started settles something that cannot be settled afterwards, whether the dysfunction belongs to the illness or to the drug; without a baseline the clinician and the patient are both guessing.^[30,38] A five-item measure such as the ASEX takes a minute in a busy clinic and gives a number that can be followed, with a longer instrument such as the IIEF or the FSFI kept for the problem that has already been flagged.^[29,40]

What is then done should change as well. Dhat and its relatives should be recognised as culturally shaped distress and met with reassurance, correction of myths and treatment of the underlying mood or anxiety disorder, not another round of investigations and tonics.^[2,13,14] Treatment-emergent dysfunction should be looked for and managed by dose adjustment, substitution, timing or an adjunct rather than endured; the silent choice patients now make between their sex life and their treatment has to stop.^[6] Many sexual problems are shared problems, and they improve further, and hold the improvement longer, when the couple is treated rather than one member of it.^[19] Knowing when to call in urology, gynaecology or endocrinology, and when to keep the patient, spares people the long circuit between departments described in the previous section.

Two things follow for the record and for training. The notes should show what was asked, what was found, what was explained and what was consented to, which protects the patient and the clinician alike when a medico-legal question arises.^[22,23] Postgraduate training in psychiatry has said little about taking a sexual history; a guideline gives departments a syllabus, a set of instruments and a standard to supervise against. Table 9 sets the usual practice against what the guideline asks for. None of it requires new equipment or funding; most of it requires a question to be asked and an answer to be written down.

A reasonable measure of success would be simple enough to audit in any department: what proportion of new case records contain a sexual history, what proportion of patients started on a psychotropic have a baseline note, and how often treatment-emergent dysfunction is picked up at review rather than after a patient has quietly stopped the tablets.

The Future and the Research That Is Still Needed

A guideline is a photograph of a field that keeps moving, and psychosexual medicine is moving fast. A few things are likely to shape the editions to come. Measurement comes first. Short, validated, culturally suitable questionnaires should turn sexual function into something tracked over time rather than asked about once, if at all. Treatment comes second: newer drugs, and the cautious extension of neuromodulation into sexual disorders, are opening options that did not exist ten years ago and will need careful grading as the data arrive.^[41] Distance comes third. Tele-consultation, internet-delivered sex therapy and digital education can carry scarce expertise to places that have none, though they raise real questions about privacy, consent and quality. Technology has also entered the bedroom itself. Virtual sexual experiences, apps and devices are changing sexual behaviour, and clinicians need a way of thinking about this that is neither preachy nor naive; the guideline already gives it a chapter of its own. Care will keep widening across gender and sexual diversity, ageing and disability, on the understanding that sexual wellbeing is a right for every patient. And as evidence accumulates faster, fixed editions will have to give way to a living guideline, updated openly and regularly. This chapter has also had to say, more than once, that the honest answer to a clinical question is that no one has studied it here. Those gaps are the work of the next few years, and the strength of the next edition depends on them. Table 10 sets them out.

These are questions for clinicians and researchers and are posed here in that spirit. The guideline itself is still within clinical territory: what a mental health professional should ask, look for and do.

What we are trying to create is a kind of practice where to ask about sexual health is as normal as to take a blood pressure, sexual difficulties are met with competence not embarrassment, and every patient, whatever the diagnosis, age, gender or background can expect that their sexual well-being will be treated as a real and central part of their care. This chapter is a step in that direction.

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487 **Table Legends**

488 **Table 1.** Selected prevalence estimates of sexual dysfunction relevant to psychiatric practice

489 **Table 2.** The two-way interface between psychiatry and sexual medicine

490 **Table 3.** A rough map of the existing sexual health guideline landscape

491 **Table 4.** Clinical practice guidelines touching on sexual health that the Indian Journal of Psychiatry
492 has published between 2017 and 2024

493 **Table 5.** Approach of major psychiatry guidelines to the assessment of sexual function

494 **Table 6.** Validated instruments for the structured assessment of sexual knowledge, dysfunction and
495 related difficulties^[40]

496 **Table 7.** The chapter scheme of the current IPS Clinical Practice Guidelines for Psychosexual Health,
497 Dysfunction and Disorders

498 **Table 8.** The disciplines a psychiatrist practising sexual medicine most often works with, what each
499 contributes, and the patients they usually share

500 **Table 9.** The change in everyday practice the guideline is meant to produce

501 **Table 10.** The questions this chapter leaves open, and the studies that would answer them

502 **Figure Legends**

503 **Figure 1.** The evidence–practice gap drawn as a loop. A guideline acts at the point of variable
504 practice to restore standardised, evidence-based and context-sensitive care. The dashed arrow
505 indicates the self-perpetuating loop that the guideline is intended to break.

506 **Figure 2.** The guideline development workflow, from scoping to a document that is updated from
507 time to time. The dashed arrow indicates periodic updating of the guideline.

508

FIGURES

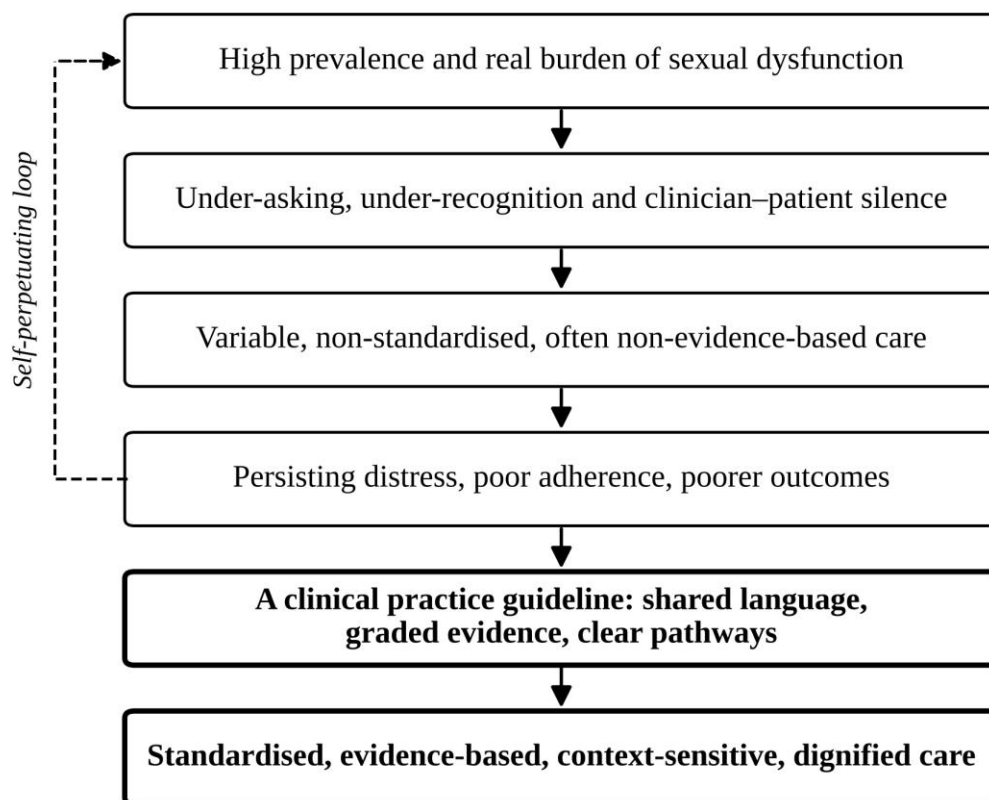


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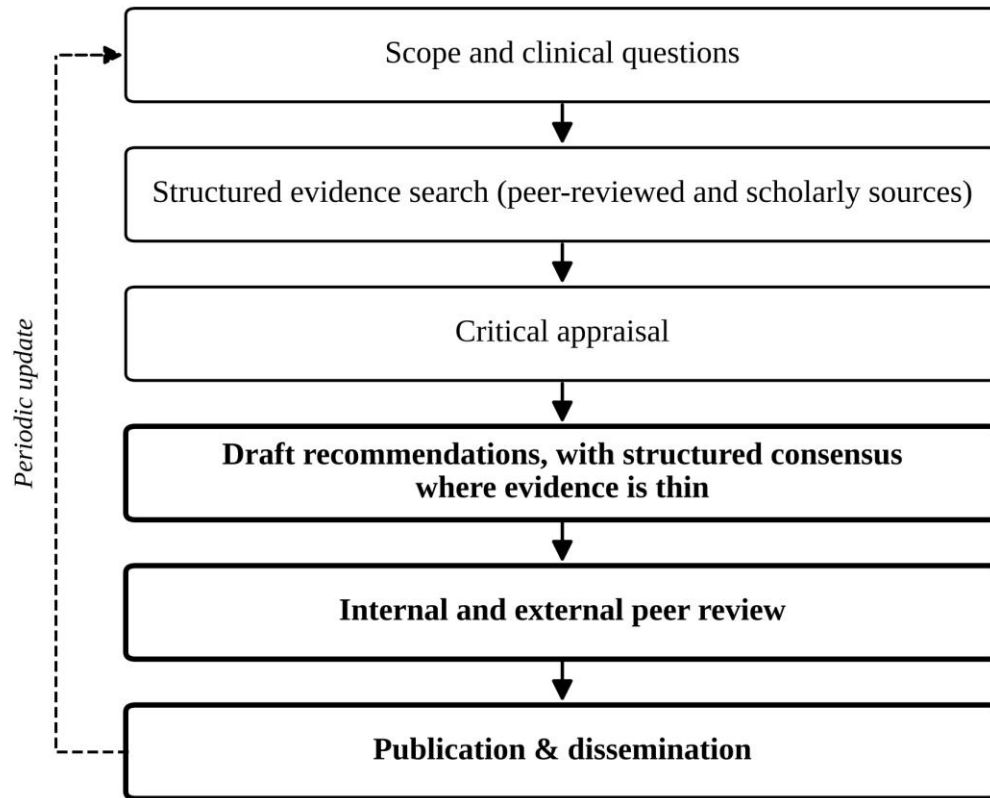


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