

Covering Letter

To
The Editor
Indian Journal of Psychiatry

Subject: Submission of Clinical Practice Guideline for Publication

Respected Sir,

We intend to publish an article entitled **“Assessment & Management of Sexual Issues in Severe Mental Illness”** in your esteemed journal as a Clinical Practice Guideline.

On behalf of all the contributors, I will act as guarantor and will correspond with the journal from this point onwards.

The paper has been read and approved by all co-authors. It has not been submitted nor has it been published or already been accepted for publication elsewhere. It is not under consideration for publication anywhere else.

Its publication has been approved by all co-authors, as well as by the responsible authorities, tacitly or explicitly, at the institute where the work has been carried out.

There is no conflict of interest declared.

To the best of my knowledge, this paper does not infringe upon any copyright or property right of any third party. This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

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Thanking you,

Yours sincerely,

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Assessment & Management of Sexual Issues in Severe Mental Illness

Executive Summary

Sexual issues are widely prevalent in individuals with severe mental illness. Hence, routine screening and assessment of sexual functioning are necessary and should be incorporated into both baseline and follow-up evaluations, as patients often do not voluntarily report sexual issues. A comprehensive evaluation should include a detailed sexual, psychiatric, medical, relationship, and medication history, along with physical examination, structured assessments, and relevant investigations.

Following assessment, clinicians should identify potential contributing factors, including the underlying psychiatric illness, psychotropic medications, medical comorbidities, substance use, psychosocial stressors, relationship difficulties, or a combination of these factors. Management should initially focus on addressing modifiable factors through optimization of medical comorbidities, treatment of substance use disorders, lifestyle modification, and appropriate adjustment of psychotropic medications, including dose reduction, switching to agents with a favorable profile or a lower risk of sexual adverse effects, or the use of adjunctive treatments when appropriate.

When sexual dysfunction persists, specific interventions should then be used according to the type of sexual dysfunction. Patients should receive psychoeducation regarding the impact of severe mental illness and psychotropic medications on sexual functioning, safe-sex practices, contraception, and the prevention of sexually transmitted infections. Stigma, body image concerns, relationship difficulties, and other psychosocial factors should be addressed through supportive interventions, and partners should be involved in assessment and management whenever appropriate. Lastly, pregnancy planning and other reproductive health concerns should be addressed routinely in individuals of reproductive age, in liaison with appropriate services when required.

Keywords: Sexuality, sexual issues, sexual dysfunction, severe mental illness, SMI

Introduction

Good sexual health requires a positive and respectful approach to sexuality, so that a person may have pleasurable and safe sexual experiences, free of coercion, discrimination, and violence. This requires access to information, awareness of risks, access to sexual health care, and an environment that affirms and promotes sexual health.

As per the National Mental Health Survey of India, 2015-16, severe mental illness includes schizophrenia, bipolar affective disorder, and major depressive disorder.^[1] This CPG covers sexual issues in these disorders.

Although individuals with Severe Mental Illness (SMI) may experience difficulties in maintaining a satisfactory sexual life because of illness and treatment-related factors, their sexual needs and desires remain largely intact. These difficulties may contribute to poorer medication adherence, reduced sexual satisfaction, lower self-esteem, poorer quality of life, and may increase psychological distress and interpersonal relationship problems.

Some of the major factors affecting sexual health in SMI include complications related to the illness itself, side effects of medications, and the frequent transitions between home and hospital environments.

Despite the high prevalence of sexual dysfunction and sexual health-related concerns in SMI, these issues largely remain underrecognized and are not addressed adequately in clinical practice. Research in this area is also limited, particularly in the Indian context. Sexual dysfunction remains a universal but often neglected concern, with nearly 80% of women with schizophrenia reporting that they had never discussed sexual functioning with their mental healthcare providers.^[2]

This guideline intends to act as a reference standard in the assessment and management of sexual health-related issues in severe mental illness. It covers schizophrenia, bipolar disorder, and depressive disorders. These guidelines should be read along with other Indian Psychiatric Society guidelines related to sexual dysfunction.^[3,4]

Classification of Sexual Dysfunction

Detailed information on the classification of sexual dysfunctions can be found in the CPG for the Assessment and Management of Desire Disorders. The classification of sexual dysfunctions according to ICD-11 is presented in Table-1. These disorders commonly co-occur and for diagnosing them, according to ICD-11, symptoms should be present for several months and cause clinically significant distress.

Table-1: Classification of sexual Dysfunctions as per International Classification of Diseases-11th Revision

Sexual Desire and Arousal Dysfunctions
• Hypoactive Sexual Desire Dysfunction
• Female Sexual Arousal Dysfunction
• Male Erectile Dysfunction
Orgasmic and Ejaculatory Dysfunctions
• Orgasmic Dysfunctions
• Delayed Ejaculation
• Early Ejaculation
Specifiers: Lifelong/Acquired; Situational/Generalized
Sexual pain disorders
• Sexual Pain–Penetration Disorder
• Female dyspareunia
Sexual Dysfunction Associated with Pelvic Organ Prolapse
• Diminished Sensation Due to Vaginal or Introital Laxity

• Obstructed Intercourse
Other Disorders
• Other Specified Sexual Dysfunctions
• Sexual Dysfunctions, Unspecified

Prevalence of Sexual Dysfunction in Severe Mental Illness

Schizophrenia

Sexual dysfunction is highly prevalent in both men and women with schizophrenia. Multiple systematic reviews and meta-analyses estimate that more than half of patients experience sexual dysfunction, with pooled prevalence rates of approximately 56% in men and 60% in women.^[5,6] Common dysfunctions include loss of libido (40.6%), erectile dysfunction (44%), ejaculatory dysfunction (38.6%), orgasmic dysfunction (28%), and genital pain (6.1%). Among women, reported rates of vaginal lubrication dysfunction range from 31% to 66%, vaginal pain from 32% to 37%, and orgasmic dysfunction from 23% to 78%. Menstrual and prolactin-related adverse effects are also common, with amenorrhea reported in 25.1% and galactorrhea in 7.7% of women. The most affected phase of the sexual response cycle is sexual desire, in both men and women.^[5,6]

Even in patients with schizophrenia who are drug-naïve, sexual functioning is significantly poorer than in healthy controls, particularly in the sexual desire domain.^[7] Poorer sexual functioning has also been associated with greater severity of disorganized symptoms in schizophrenia. Similarly, a prevalence of sexual dysfunction of 17% was reported using DSM-IV-TR criteria, with older age and later age at onset of illness identified as associated factors.^[8] These findings suggest that sexual dysfunction may be present in schizophrenia even before exposure to antipsychotic medication.

An Indian study among women aged 18–40 years with schizophrenia reported particularly high rates of sexual dysfunction, with 92.1% experiencing impaired arousal, 47.5% reporting poor lubrication, and 36.5% reporting sexual pain.^[9]

However, the true prevalence is likely higher, as sexual dysfunction is frequently underreported because of embarrassment, stigma, cultural barriers, and inadequate enquiry by healthcare professionals. Thus, despite being highly prevalent, sexual dysfunction remains an often-overlooked aspect of care.

Prevalence of sexual dysfunction appears to increase even from the first psychotic episode. Increased sexual dysfunction has been associated with earlier age at illness onset, higher lifetime number of psychotic episodes, higher number of lifetime hospitalizations, comorbid depression, and a continuous illness course. Other factors include unmarried status, unemployment, and lower socioeconomic status. Negative symptoms are commonly associated with reduced libido, while positive symptoms may affect desire, arousal, and orgasmic functioning. Antipsychotic-induced sexual dysfunction is more frequently reported with first-generation and prolactin-elevating antipsychotics.

Patients with schizophrenia often report the lowest satisfaction with sexual quality of life among all quality-of-life domains, with male gender, unmarried status, and greater affective symptom burden being associated with poorer sexual life satisfaction.^[10]

Bipolar Affective Disorder (BPAD)

Studies have reported a significantly higher prevalence of sexual dysfunction (54.6%) across all phases of the sexual response cycle, as well as increased promiscuity related to hypersexuality during manic episodes, among individuals with BPAD compared with those

with unipolar depression and healthy controls.^[11] In another study involving women with BPAD, 34.4% reported sexual dysfunction and 54.1% reported sexual distress, both rates being significantly higher than those observed in the general population.^[12]

Disorders of sexual desire appear to be the most commonly reported sexual difficulties in both men and women. Sexual dysfunction is generally more prevalent during depressive episodes than during manic episodes. However, a substantial proportion of patients continue to experience residual sexual dysfunction during euthymia or remission, which can adversely affect quality of life. In contrast, during manic episodes, due to hypersexuality and impulsivity, patients are more likely to engage in high-risk sexual behaviour.

Depressive Disorders

Sexual dysfunction is significantly more common in patients with depressive disorders and higher rates are seen in both treatment-naïve patients and also secondary to antidepressant medications. A systematic review and meta-analysis in treatment-naïve patients with depression reported the prevalence rate of overall sexual dysfunction to be 82.75% in women and 63.26% in men.^[13] In depression, sexual desire is the most commonly affected domain in both men and women. The individual dysfunction rates for women were 65.3% for desire, 47.2% for arousal, 37.0% for lubrication, 34.2% for orgasm, 33.9% for sexual satisfaction; for men, it was 40.3% for desire, 35.3% for orgasm, 32.1% for erectile dysfunction, 26.5% for arousal, and 23.1% for sexual satisfaction-related dysfunction.

Major Depressive Disorders are associated with a 50-70% increased risk of developing sexual dysfunction. Conversely, sexual dysfunction itself is associated with a 2-3-fold increased risk of developing depressive disorder.^[14]

Sexual Health Outcomes and Associated Risks

Patients with schizophrenia are considered a high-risk population for sexually transmitted infections, including HIV, although rates may be higher in Western settings than in India.^[15] Individuals with both first-episode and chronic illness remain vulnerable. Compared with the general population, patients with schizophrenia have approximately twofold higher odds of HIV and hepatitis B infection and more than fourfold higher odds of hepatitis C infection. More than half report engaging in unprotected sexual relationships.^[16]

Particularly in first-episode psychosis, as onset of severe mental illness often occurs before the age of 20 years, individuals face the developmental challenges of young adulthood, including those related to sexuality and intimate relationships. During this period, coping with the diagnosis of schizophrenia and its symptoms may overshadow sexual concerns, which makes them vulnerable to various sexual issues. Therefore, education regarding safe-sex practices, including HIV prevention, should form an integral part of routine clinical care. HIV prevention programs that promote awareness of the consequences of risky sexual behaviours, encourage condom use and other protective measures, and enhance communication and assertiveness skills have been shown to reduce risky sexual practices and improve safe-sex behaviours.^[17]

The overall incidence of criminal offending among individuals with schizophrenia is not substantially different from that of the general population. A small study examining sexual offences and antisocial sexual behaviour in individuals with severe mental illness found that such behaviour was more common among patients who were actively experiencing psychotic symptoms and non-adherent to treatment, highlighting the importance of maintaining treatment engagement and medication compliance.^[18]

Etiology and Pathophysiology

Sexual health-related issues may arise due to multiple factors, including the symptoms associated with the illness, medication side effects, comorbid medical and psychiatric conditions, substance use disorders, environmental, and social factors.

Illness-Related Factors

Both positive and negative symptoms of severe mental illness have been associated with an increased risk of decreased sexual desire and erectile, ejaculatory, and orgasmic dysfunction. Negative symptoms, particularly anhedonia, avolition, and social withdrawal, may contribute to reduced libido and impair the capacity to initiate and sustain intimate relationships. Notably, in schizophrenia, anticipatory pleasure is impaired while consummatory pleasure remains relatively intact. Cognitive symptoms and prefrontal dysfunction associated with severe mental illness may further impair the ability to plan and execute meaningful relationships.

Comorbid depressive symptoms, seen in around one-third of patients with schizophrenia, represent an additional contributing factor. In patients with depressive disorders or comorbid depression, sexual desire may be further reduced through anhedonia and diminished anticipatory and consummatory pleasure. In depression specifically, decreased energy, psychomotor retardation, and easy fatigability can limit the initiation of sexual activity, while cognitive distortions, low self-esteem, body image issues, and decreased sexual confidence can reduce the patient's willingness to engage in sexual activity. Illness severity, early age at onset, and a chronic course of illness have also been found to be significant predictors of sexual dysfunction.

Psychotropic-Mediated Mechanisms

Antipsychotic-Mediated Mechanisms

Antipsychotics are a major cause of sexual dysfunction in patients with severe mental illness, mediated through multiple mechanisms. The most prominent is prolactin elevation: dopamine normally inhibits prolactin release via D2 receptors. Antipsychotics, by blocking D2 receptors in the tuberoinfundibular pathway, increase serum prolactin levels, with the magnitude of the rise proportional to the strength of D2 blockade. Elevated prolactin can induce amenorrhea, galactorrhoea, breast tenderness, and infertility in women, while in men, prolactin suppresses GnRH secretion, leading to hypogonadism and in turn, can cause infertility. This mechanism is estimated to account for around 40% of antipsychotic-related sexual side effects. Notably, antipsychotics with fast dissociation from D2 receptors (e.g., clozapine and quetiapine) typically cause less prolactin elevation than those with slow dissociation (e.g., first-generation antipsychotics and risperidone).

Apart from prolactin-mediated effects, several receptor-specific mechanisms contribute independently to sexual dysfunction. Extrapyramidal side effects can lead to a decrease in emotional expression, mobility, and spontaneity, resulting in difficulty with sexual activity. α 1-adrenergic receptor inhibition affects contraction of the vas deferens and related organs responsible for ejaculation, which can lead to ejaculatory dysfunction. A specific manifestation of this mechanism is retrograde ejaculation, which occurs when α 1-adrenergic receptor antagonism relaxes bladder neck smooth muscle and prevents its closure during the expulsion phase of ejaculation, resulting in retrograde passage of seminal fluid into the bladder rather than anterograde passage through the urethra. Retrograde ejaculation is commonly associated with thioridazine, risperidone, quetiapine, iloperidone, clozapine, and paliperidone (further

199 details are available in the CPG for the Assessment and Management of Premature
200 Ejaculation). H1 receptor inhibition, meanwhile, can lead to sedation and fatigue, causing a
201 decrease in sexual desire, activity, and satisfaction.

202 Finally, antipsychotics contribute to sexual dysfunction through indirect and cumulative
203 pathways. Side effects including flattened affect, hypersalivation, fatigue, and weight gain may
204 negatively affect body image, sexual self-esteem, and intimacy, with excess weight gain also
205 making sexual activity physically difficult for some patients. Antipsychotics may additionally
206 contribute to other medical conditions such as obesity and diabetes, which are independently
207 associated with sexual dysfunction.

208 **Antidepressant-Mediated Mechanisms**

209 Antidepressant-mediated sexual dysfunction occurs through multiple mechanisms. Both SSRIs
210 and SNRIs primarily cause sexual dysfunction by increasing serotonergic neurotransmission,
211 which exerts a broadly inhibitory effect on sexual desire, arousal, and orgasm. This effect is
212 receptor-specific: activation of 5HT1A receptors facilitates ejaculation, whereas activation of
213 5HT2 receptors suppresses desire and inhibits orgasm and ejaculation, and activation of 5HT2C
214 receptors leads to anorgasmia and delayed ejaculation. In addition to these direct serotonergic
215 effects, increased serotonin levels indirectly suppress mesolimbic dopaminergic activity,
216 resulting in decreased sexual motivation, anticipatory pleasure, and reward value. SSRIs may
217 also inhibit nitric oxide synthase, leading to reduced nitric oxide production, impaired penile
218 smooth muscle relaxation, and consequently erectile dysfunction. In contrast, since dopamine
219 facilitates desire and arousal via the mesolimbic pathway, and bupropion acts by inhibiting
220 dopamine and norepinephrine reuptake with minimal serotonergic activity, it is associated with
221 lower rates of sexual dysfunction compared to SSRIs and SNRIs. Tricyclic antidepressants
222 cause sexual dysfunction through distinct mechanisms: an increase in serum prolactin levels
223 suppresses gonadotropin-releasing hormone, which in turn decreases serum luteinizing
224 hormone and follicle-stimulating hormone levels, leading to reduced serum testosterone levels.
225 Tricyclic antidepressants also have anticholinergic activity, which interferes with
226 parasympathetic nervous system function, leading to erectile dysfunction and decreased
227 vaginal lubrication.

229 **Mood-stabilizer-Mediated Mechanisms**

230 Mood stabilizers are associated with sexual dysfunction through distinct, agent-specific
231 mechanisms. Valproate has been associated with a relative increase in the serum testosterone-
232 to-estrogen ratio, leading to hyperandrogenism; this can manifest as hirsutism, polycystic
233 ovarian syndrome, acne, male pattern baldness, and reduced testicular volume.
234 Hyperandrogenism may be due to increased ovarian androgen production and decreased
235 conversion of testosterone to estrogen. Carbamazepine induces hepatic cytochrome P450
236 enzymes, causing increased production of sex hormone-binding globulin (SHBG); this leads
237 to a decrease in free serum testosterone levels, which can cause decreased libido,
238 hypogonadism, and erectile dysfunction. In contrast, lamotrigine has minimal effects on sex
239 hormone metabolism and SHBG levels and is therefore associated with a relatively favourable
240 sexual side-effect profile. Lithium may indirectly contribute to sexual dysfunction through
241 lithium-induced hypothyroidism, weight gain, sedation, and fatigue.

242 **Other Contributing Factors**

243 Individuals with severe mental illness (SMI) are subject to several additional psychosocial and
244 medical factors that contribute to sexual dysfunction, independent of pharmacological
245 treatment. Comorbid medical conditions are common in this population: SMI is associated with

an increased risk of diabetes, obesity, hypothyroidism, and breast cancer, all of which can adversely affect sexual functioning. Comorbid substance use disorders, particularly alcohol use disorders, can cause disinhibition and are associated with an increase in high-risk sexual behaviour and sexual dysfunction. Nicotine dependence, which is highly prevalent among individuals with SMI, is in itself an independent risk factor for sexual dysfunction.

Beyond these medical and substance use-related reasons, social consequences of the illness also play a significant role. Negative symptoms and other illness-related factors can lead to social isolation, reducing the ability and desire to establish intimate relationships and limiting opportunities for intimacy; these factors, along with stigma and repeated institutionalization, may adversely affect sexual functioning. Marital status is also relevant, with singlehood, being unmarried, or being divorced associated with greater sexual dysfunction. Although a larger proportion of persons with SMI are likely to be married in the Indian setting, intimacy issues nonetheless persist, and studies have found sexual dysfunction to be significantly associated with marital dissatisfaction and poor quality of marital life.^[19] Finally, frequent hospitalizations and institutionalization may reduce privacy, intimacy, and opportunities for sexual relationships, while unemployment and lower socioeconomic status have also been associated with poorer sexual functioning and satisfaction.

Assessment of Sexual Dysfunction

Considering the high prevalence of sexual dysfunction in severe mental illness, routine assessment of sexual health concerns and sexual functioning should be incorporated during both baseline and follow-up assessment. Comprehensive management of sexual health issues in severe mental illness requires a thorough assessment of the underlying dysfunction and its contributing factors. A non-judgmental and empathetic interviewing style should be adopted to help patients feel comfortable discussing sexual health concerns and to facilitate open communication. Clinicians should proactively try to initiate discussions about sexual health, as most patients may be hesitant to raise sexual concerns themselves but are willing to discuss them when the healthcare provider introduces the topic. (Flowchart-1)

History Taking

A detailed evaluation can help identify medical, psychiatric, medication-related, and psychosocial factors affecting sexual health. Assessment should include the current status of psychiatric illness, substance use (alcohol, illicit substances, tobacco), current medications, medical comorbidities (diabetes, cardiovascular disease, obesity, hypothyroidism), and relevant medical and surgical history. In women, relevant reproductive and obstetric history should also be inquired about, including menstrual history, contraceptive use, pregnancies, and pregnancy-related complications. It is also important to determine whether the cause of sexual dysfunction is predominantly psychosocial or organic in origin (Table-2). In many patients, psychosocial and organic factors coexist; therefore, the assessment should focus on both their independent contributions and their interactions in the development and maintenance of sexual dysfunction.

Table-2: Factors to help differentiate psychosocial and organic sexual dysfunction

Characteristic	Predominantly Psychosocial	Predominantly Organic
Age	Younger	Older
Onset	Acute/well-defined precipitant	Gradual and insidious

Cause	Psychosocial or interpersonal factors	Physiological factors (identifiable organic cause)
Circumstances	Situational (partner/context specific)	Global (all situations)
Symptom course	Intermittent or variable	Consistent or progressive
Nocturnal/ morning erections	Usually present	Absent or reduced in frequency and intensity
Organic risk factors	Absent or minimal	Presence of Diabetes, hypertension, vascular, neurological, renal or prostate-related diseases, spinal cord or pelvic trauma, operation, radiotherapy, etc.
Psychological factors	Presence of depression, anxiety, stress, relationship problems, religious beliefs, psychological trauma, performance anxiety, and major life events.	Less commonly seen
Other factors	Avoidance of sexual activity may be present due to performance anxiety	History of substance or medication use associated with sexual dysfunction
Associated ejaculatory disorder	Premature ejaculation may be present	Retrograde or absent ejaculation

A comprehensive sexual history should also be obtained, including premorbid sexual functioning, as well as the onset, duration, and progression of sexual symptoms. (Table-3) Assessment should also cover current sexual functioning, opportunities for intimacy, relationship status, environmental factors, partner-related factors, sexual practices, high-risk sexual behaviour, sexually transmitted diseases, urinary tract infection, and the patient's beliefs and attitudes regarding sexuality. Validated questionnaires relevant to the presenting sexual concern can be used during assessment. During follow-up, reassessment of sexual functioning should be done, as underlying causes and changes may only become apparent through prospective evaluation. Including assessment of the quality of marital relationship is essential in the history, as it has a significant impact on sexual functioning. Intimate partner violence, history of childhood sexual abuse are other important factors to be considered in assessment. (Table-4) Additionally, some of the key principles while assessing sexual dysfunction in SMI are shown in Table-5 (Adapted from Clinical Practice Guidelines for Management of Sexual Dysfunction of 2017).^[4]

Table-3: Sexual History Taking in Severe Mental Illness

Domain	Key Areas to Assess
Identifying Information	Age; gender; sexual orientation; relationship status (single/married/cohabiting/separated/divorced); number of previous relationships or marriages; occupation; educational attainment; religion
Premorbid Sexual Functioning	Level of sexual interest and activity prior to onset of psychiatric illness; any change from baseline; age at onset of puberty; age at menarche; prior satisfactory sexual relationships; use of pornography
Current Sexual Functioning: Desire	Frequency and intensity of sexual desire; sexual fantasies; self-reported libido; enjoyment of sexual activity; whether desire is partner-specific or generalized
Arousal	Ability to become sexually aroused; quality and duration of erection in men (including morning and nocturnal erections); vaginal lubrication and genital engorgement in women; subjective sense of excitement during sexual activity
Orgasm and Ejaculation	Ability to reach orgasm; frequency, intensity, and satisfaction of orgasm; premature ejaculation (onset, frequency, partner's reaction); delayed or absent ejaculation; retrograde ejaculation; anorgasmia in women
Pain	Presence of genital or pelvic pain during or after sexual activity; dyspareunia (superficial or deep); vaginismus or difficulty with penetration; pelvic floor tension; pain during erection
Characteristics of the Sexual Dysfunction	Lifelong vs. acquired; generalized vs. situational (partner-specific or setting-specific); onset, duration, and progression. Association with onset and change in psychiatric illness severity and psychotropic medication
Sexual Practices and Behavior	Frequency and regularity of sexual intercourse; masturbatory history and current practice; high-risk sexual behaviors (unprotected intercourse, multiple partners, unknown partners, with commercial sexual workers or under influence of substances); any compulsive sexual behavior
Relationship Factors	Current relationship status and stability; partner's sexual health, functioning, and attitudes; quality of marital or intimate relationship; level of emotional intimacy and communication; partner's response to patient's sexual difficulties; relationship disharmony or conflict
Reproductive and Obstetric History (Women)	Menstrual history including regularity, amenorrhea, galactorrhea; contraceptive use and adherence; pregnancy planning; pre- and post-pregnancy sexual functioning
Psychological Trauma	History of childhood sexual abuse or physical trauma; intimate partner violence; Sexual assault; sexual coercion; current safety within intimate relationships
Cultural factors and Sexual attitude	Cultural and religious beliefs regarding sexuality, masturbation, and sexual roles. Family attitudes toward sexuality; living situation and availability of privacy; sexual myths and misconceptions (Dhat syndrome) Knowledge and attitudes regarding normal sexual anatomy and functioning
Sexually Transmitted Infections and	History of sexually transmitted infections; HIV status and testing history; urinary tract infections; urological symptoms (urgency, frequency, hesitancy, weak stream); history of any urological or gynecological procedures

Urological History	
Impact of Sexual Dysfunction	Effect on self-esteem, body image; impact on relationship and marital satisfaction; impact on quality of life; Patient's and partner's level of distress
Patient's Expectations	Patient's and partner's expectations and motivation to engage in treatment; level of insight regarding dysfunction; psychological readiness to engage in psychosexual therapy or behavioral interventions

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Table-4: Factors to be considered during the Assessment of Sexual Dysfunction in Severe Mental Illness

Person related	Illness related (Psychiatric and Medical)	Medication related	Psychosocial
Demographic • Age • Gender • Socio-economic status • Education level • Employment Status • Relationship status Sexuality • Sexual orientation • Sexual beliefs and knowledge • Cultural and religious attitudes toward sexuality Sexual history • Premorbid sexual functioning • Frequency and quality of sexual activity • Partner's sexual health and attitudes Dysfunction • Lifelong vs. acquired • Generalized vs. situational • Phases affected: desire/arousal/orgasm	Psychiatric illness • Duration of illness • Symptomatic status • Cognitive status • Comorbid psychiatric illness • Comorbid substance use disorder Medical comorbidities • Diabetes mellitus • Cardiovascular disease • Hypertension • Obesity and metabolic syndrome • Hypothyroidism • Neurological disorders • Obstructive sleep apnea	Psychotropics • Dosage • Duration of treatment • Recent dose change • Polypharmacy • Known risk of SD with specific medication Antipsychotics • FGA vs. SGA class • Prolactin-raising vs. Prolactin-sparing profile • Medication dose • Long-acting injectable vs. Oral formulation • D2 receptor affinity and dissociation rate • Anti-α1-adrenergic and anti-h1 receptor properties Other medications • Antihypertensives (β-blockers, thiazides, clonidine) • Hormonal preparations (oral contraceptives, hormone therapy) • Opioid analgesics	Trauma • H/o childhood trauma or sexual abuse • Intimate Partner Violence Relational & environmental • Poor quality of relationship • Lack of privacy • Partner's attitude toward Sexual dysfunction • Living situation • Social isolation and opportunities for relationships Stigma • Externalized and internalized stigma related to mental illness • Body image concerns (weight gain, appearance) • Low self-esteem and reduced sexual self-confidence Sociocultural factors

• Onset, duration, progression of SD Reproductive history (women) • Menstrual and obstetric history • Contraceptive use and adherence • Pregnancy planning • Perimenopausal and menopausal history		• 5-α reductase inhibitors (finasteride, dutasteride) • Metoclopramide, Domperidone, Spironolactone • First-generation Antihistamine (chlorpheniramine) • Alpha-1 blockers (Tamsulosin)	• Cultural norms regarding sexuality • Religious beliefs • Family attitudes and pressure regarding relationships • Access to sexual health-related services
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309 SD: Sexual dysfunction, FGA: First generation Anti-psychotics, SGA: Second generation Antipsychotics.

Table-5: Important components of evaluation of Sexual Dysfunction in SMI (Adapted from Clinical Practice Guidelines for Management of Sexual Dysfunction, 2017)

Key Principles for Evaluation	
	• Evaluate in a comfortable environment while ensuring privacy and confidentiality. • Be empathetic, non-judgmental, and supportive, and normalize discussions about sexual health. • Use the language with which the patient is most comfortable, and employ neutral and non-stigmatizing terms. • Begin with general, non-threatening questions before progressing to more specific or potentially sensitive topics. • Avoid making assumptions regarding sexual orientation, gender identity, relationship status, number of partners, or sexual practices. • When evaluating a couple, obtain the sexual history from each partner separately to facilitate open and confidential disclosure, followed by a joint interview. • When examining a patient of the opposite gender, ensure the presence of a female attendant or staff member. • Determine whether the reported problem reflects true sexual dysfunction or is attributable to inadequate sexual knowledge or unrealistic expectations. • Consider the influence of cultural, religious, and societal factors on sexual attitudes, beliefs, and practices, particularly in the Indian context. • Assess the psychological maturity, insight, and motivation of both the patient and, where appropriate, the partner. • Evaluate whether the sexual dysfunction coexists with relationship difficulties, psychiatric relapse, or physical illness, and prioritize management accordingly. • Assess the patient's current psychiatric symptoms and their impact on sexual functioning. • Determine the likely etiology of the sexual dysfunction, including illness-related factors, psychotropic medications, psychosocial factors, and organic causes such as medical comorbidities. • During follow-up, monitor changes in psychiatric symptoms, medication status, and sexual functioning to help establish the contribution of individual factors and assess response to treatment.

Physical Examination

In patients presenting with sexual dysfunction or concerns, general physical examination should be done with particular attention to genital, neurological, and vascular systems. This may help identify underlying medical conditions that contribute to sexual dysfunction, including neurological disorders (e.g., stroke, Parkinsonism, and peripheral neuropathy), gynecomastia and loss of secondary sexual characteristics suggestive of hypogonadism or hyperprolactinemia, diminished reflexes, reduced peripheral pulses, hypertension, peripheral vascular disease, etc. In men, examination should include evaluation for varicocele, testicular swelling or masses, inguinal hernia, dermatological or penile abnormalities, phimosis (tight unretractable foreskin), Frenulum breve, and other scrotal pathologies. Anthropometric assessment (weight and BMI) should be recorded at baseline and follow-up visits.

In women, genital examination should preferably be performed by a gynecologist. However, when appropriate, selected parts of the examination may be done by a female psychiatrist during baseline or follow-up assessments. It should include assessment for dermatological lesions and measurement of vaginal pH to evaluate for Genitourinary Syndrome of Menopause (atrophic vaginitis), particularly in postmenopausal women and those with antipsychotic-induced hyperprolactinemia. Vaginal pH assessment may also be useful for monitoring treatment response during follow-up visits. In women with suspected vulvodynia, a Q-tip (cotton swab) test should be performed to identify localized areas of tenderness. Colposcopy or vulvoscopy may be indicated to detect anatomical abnormalities or vulvovaginal lesions. Cervical cancer screening with a Pap smear should be performed in women ≥ 25 years of age, with repeat screening every 3–5 years. Evaluation for sexually transmitted infections should be undertaken whenever clinically indicated. In women presenting with genitopelvic pain/penetration disorder, additional assessment of the pelvic floor, including pelvic floor muscle tone, tenderness, strength, and voluntary control, should be performed.

Validated Assessment Instruments

For the evaluation and monitoring of sexual functioning, validated assessment instruments may be used (for psychiatric disorders as well as sexual concerns) in addition to direct clinical enquiry. Brief screening tools can help assess specific phases of the sexual response cycle in which the patient is experiencing difficulties. While no particular tools have been developed exclusively for severe mental illness, scales such as the Antipsychotics and Sexual Functioning Questionnaire (ASFQ) and the Udvalg for Kliniske Undersøgelser (UKU) Side Effect Rating Scale may be useful for evaluating psychotropic-related sexual dysfunction, while the Arizona Sexual Experience Scale (ASEX) can be used as a brief screening tool. Some of the commonly used assessment instruments are mentioned in Table 6. Female sexual functioning Index (FSFI) is specifically used to assess sexual functioning in women, along with Female Sexual Distress Scale (FSDS), which assesses sexual distress.

Particularly in women, screening should include assessment for hypoactive sexual desire disorder (HSDD) in reproductive-age women and pain-related sexual dysfunction, including dyspareunia, in peri- and postmenopausal women. When evaluating HSDD, contributing conditions such as vaginal atrophy, vaginitis, diabetes mellitus, and lactation should be excluded.

In depressive disorders, baseline assessment of sexual functioning using standardized tools like ASEX, FSFI can help later on in differentiating illness or depression associated sexual dysfunction from antidepressant induced sexual dysfunction.

Hindi version is available for Arizona Sexual Experience Scale, International Index of Erectile Function, Sex Knowledge and Attitude Questionnaire II, Female Sexual Function Index and Sexual Function Questionnaire.^[20–22]

Table-6: Screening and assessment tools for sexual dysfunction

Domain Assessed	Recommended Instruments
Sexual desire	• Decreased Sexual Desire Screener (DSDS) • Hurlbert Index of Sexual Desire (HISD)
Erectile dysfunction / sexual arousal	• International Index of Erectile Function-5 (IIEF-5) • Erection Hardness Scale (EHS) • Sexual Encounter Profile (SEP)
Orgasmic function	• Orgasm Rating Scale (ORS) • Female Orgasm Scale (FOS)
Ejaculatory function	• Premature Ejaculation Diagnostic Tool (PEDT) • Intravaginal Ejaculatory Latency Time (IELT) • Premature Ejaculation Profile (PEP)
Sexual satisfaction	• New Sexual Satisfaction Scale (NSSS) • Index of Sexual Satisfaction (ISS)
Sexual knowledge and attitudes	• Sex Knowledge and Attitude Questionnaire (SKAQ)
Multiple domains of sexual functioning	• Arizona Sexual Experience Scale (ASEX) • Female sexual functioning Index (FSFI) • Changes in Sexual Functioning Questionnaire (CSFQ) • International Index of Erectile Function (IIEF)
Drug-related sexual dysfunction	• Antipsychotics and Sexual Functioning Questionnaire (ASFQ) • Udvalg for Kliniske Undersøgelser (UKU) Side Effect Rating Scale • Antipsychotic Non-Neurological Side Effects Rating Scale (ANNSERS)

Laboratory Investigations

Routine Investigations

While assessing sexual health issues, the primary focus should be on the clinical part rather than solely on laboratory tests. Laboratory investigations may help identify endocrinological abnormalities and other medical comorbidities contributing to sexual dysfunction. Recommended investigations include fasting blood glucose, fasting lipid profile, HbA1c, serum prolactin, and total testosterone levels.

When clinically indicated, additional investigations may be considered, including urine routine and microscopy, liver and renal function tests, serum electrolytes (sodium, potassium, chloride, and calcium), thyroid function tests (TSH), and nutritional assessments such as vitamin B12, vitamin D, and folate levels in suspected cases of nutritional deficiency and peripheral neuropathy.

Hormonal Assessment

Baseline hormonal assessment should include serum prolactin levels, particularly when antipsychotic-induced sexual dysfunction is suspected. Total testosterone level should be measured between 8–10 am on at least two separate occasions if initial levels are low, given diurnal variation and the need to confirm hypogonadism. Luteinizing hormone (LH) should be measured when serum testosterone is reduced to differentiate primary from secondary hypogonadism and clarify the underlying pathophysiology. Sex hormone-binding globulin

(SHBG) may be considered when testosterone level interpretation remains uncertain, particularly in patients receiving anticonvulsants or those with suspected endocrine abnormalities that affect hormone bioavailability.

Additional Investigations as Clinically Indicated

Additional investigations should be tailored to clinical presentation and risk stratification. Serological screening for HIV, syphilis (VDRL/Rapid Plasma Reagin), hepatitis B surface antigen, and hepatitis C antibody may be considered in patients with high-risk sexual behaviors or other clinical indications suggestive of blood-borne pathogen exposure. In women with suspected sexually transmitted infections, vaginal, cervical, and vulval discharge microscopy and cultures should be performed to identify causative organisms. When a patient reports absent or markedly reduced ejaculate volume despite preserved orgasmic sensation, retrograde ejaculation should be suspected; post-orgasmic urinalysis demonstrating spermatozoa in the urine sample helps in confirming the diagnosis. Neuroimaging and neurophysiological investigations should be reserved for cases with strong clinical suspicion of underlying neurological pathology. Nocturnal penile tumescence testing (RigiScan) may be considered in selected cases of erectile dysfunction when clinical assessment fails to distinguish between Psychosocial and organic etiologies.

Metabolic Monitoring

When Psychotropics associated with metabolic risk are prescribed, metabolic parameters should be monitored at baseline, during the early phase (1–3 months) after initiation, and annually thereafter. This should include weight, BMI, waist circumference, blood pressure, fasting blood glucose (or HbA1c), and fasting lipid profile. More frequent monitoring may be needed in patients with clinical features suggestive of metabolic syndrome.

End of Assessment: Therapist's insight

At the end of the assessment, the clinician should be able to answer the questions mentioned in table-7 before proceeding with management.

Table-7: Post-assessment checklist

1. Does the patient have a clinically significant sexual dysfunction: is it diagnosable as per ICD-11, and is it causing personal distress or interpersonal difficulty?
2. What is the current status of the psychiatric disorder, and did the sexual dysfunction predate, coincide with, or develop after the onset of the psychiatric illness?
3. Is the sexual dysfunction primarily illness-related, medication-related, comorbidity-related, psychosocial in origin, or multifactorial, and what is the relative contribution of each?
4. Is the dysfunction predominantly psychosocial, predominantly organic, or a combination of both?
5. If organic factors are primary, is there a coexisting psychological component that is perpetuating or worsening the dysfunction?
6. If the sexual dysfunction is psychotropic-induced, what is the most likely underlying mechanism? (e.g. hyperprolactinemia, α 1-adrenergic blockade, etc.)
7. If it is psychotropic-induced, is dose modification, substitution, or adjunctive treatment clinically feasible?
8. Which phase or phases of the sexual response cycle are affected? Does the pattern of phase involvement suggest a specific diagnosis that requires targeted treatment?

9. What is the status of relevant medical and surgical comorbidities and substance use, and how are these contributing to the patient's sexual dysfunction?
10. Are there significant psychosocial factors, including relationship difficulties, partner factors, stigma, body image concerns, intimate partner violence, or lack of privacy, that should be addressed before or alongside treatment?
11. What are the patient's and, where applicable, the partner's expectations from treatment, level of motivation, degree of insight into the problem, and psychological readiness to engage with therapeutic strategies?
12. Is there a culturally specific sexual concern (e.g., Dhat syndrome, masturbation related guilt, performance pressure, lack of sex education, or religious concerns) that should be identified and addressed as part of management?
13. What are the patient's reproductive health needs, including contraception, pregnancy planning, and STI risk, and do these require active intervention or referral alongside management of the sexual dysfunction?

Specialist Consultation and Referral

For a holistic assessment and management of sexual dysfunction and related sexual health concerns in severe mental illness, appropriate liaison with the concerned specialty is important. It helps in identifying the underlying etiology, and providing evidence-based treatment for the underlying conditions and any other sexual health-related concerns. (Table-8)

Table-8: Indications for referral to the concerned specialty for the management of sexual health-related concerns in severe mental illness

Specialist	Indications
Urologist	- Primary erectile dysfunction (lifelong, poorly sustained erections) - Nocturnal penile tumescence assessment (RigiScan) - Intra-cavernosal injection therapy, penile prosthesis implantation for ED - Antipsychotic-associated priapism - Retrograde or absent ejaculation due to organic conditions - Anatomic penile deformities (Peyronie's disease, hypospadias, phimosis, buried penis) - Pelvic/perineal trauma; complex vascular or neurological causes of ED
Gynecologist	- Cervical cancer screening, history of sexual violence, Sexually transmitted diseases - Preconception counselling, Pregnancy, contraceptive-related concerns. - Menstrual irregularities including amenorrhea and galactorrhea - Abnormal uterine or vaginal bleeding - Genitourinary syndrome of menopause - Vulvodynia (Q-tip and pelvic floor assessment) - Genito-pelvic pain/penetration disorder
Endocrinologist	- Metabolic syndrome, Dyslipidemia, diabetes mellitus, hypertension - Hypogonadism - Hyperprolactinemia (primary or not responding to antipsychotic adjustment) - Thyroid or adrenal disorders - Testosterone deficiency for testosterone replacement therapy
Cardiologist	- Suspected cardiovascular disease contributing to sexual dysfunction - Before initiating PDE-5 inhibitors in High-risk patients with cardiovascular diseases

Dietitian	• Metabolic syndrome, obesity, weight management.
STI Clinic	• STI screening and management in high-risk patients • HIV, Hepatitis B and C assessment and management • Contact tracing and partner notification
Social Worker	• Sexual violence, intimate partner violence, or coercive relationships • Liaison with legal and protective services • Housing instability and poverty affecting sexual health

PDE-5: Phosphodiesterase type 5; ED: Erectile dysfunction; STI: Sexually transmitted infection

Sexual Dysfunction Associated with Specific Psychotropic Medications

Psychotropic medications are the mainstay of treatment for severe mental illness and include antipsychotics, mood stabilizers, antidepressants, and anxiolytics. Many of these agents are associated with sexual adverse effects, which can be distressing for patients. Sexual side effects are among the most important reasons for treatment discontinuation and nonadherence, potentially leading to relapse and poorer illness outcomes. These adverse effects may affect any phase of the sexual response cycle, including desire, arousal, and orgasm. Therefore, each domain of sexual functioning should be systematically assessed when evaluating sexual dysfunction in patients receiving psychotropic medications. Detailed information related to psychotropics-associated sexual dysfunction can be referenced from CPG guideline for treatment-emergent sexual dysfunction.

Antipsychotics

Both first and second-generation anti-psychotics have been associated with sexual dysfunction due to various mechanisms as previously discussed.

Sexual dysfunction has been reported with several first-generation antipsychotics, particularly chlorpromazine, pimozide, thioridazine, and trifluoperazine. Commonly reported adverse effects include decreased sexual desire, erectile dysfunction, and ejaculatory dysfunction.

Among second-generation antipsychotics, the risk of sexual dysfunction increases as follows: Aripiprazole < Quetiapine < Clozapine < Olanzapine < Amisulpride < Risperidone.^[23]

Among second-generation antipsychotics, aripiprazole is associated with lower risk of sexual dysfunction and can also be used to manage antipsychotic-induced hyperprolactinemia. In contrast, risperidone is associated with one of the highest rates of sexual dysfunction, largely due to its propensity to cause hyperprolactinemia.

In cases of clinically significant antipsychotic-induced sexual dysfunction, switching to aripiprazole may be considered after careful evaluation of psychiatric symptoms, severity of sexual side effects, and the overall risk-benefit ratio. In patients with antipsychotic-induced hyperprolactinemia, adjunctive low-dose aripiprazole may be considered when dose reduction or switching of the primary antipsychotic is not feasible.

Clozapine: As clozapine has a low propensity to block dopamine receptors in the tuberoinfundibular pathway, it doesn't affect serum prolactin levels and in turn doesn't cause hyperprolactinemia. Thus, in terms of sexual functioning, it has a good profile and has minimal sexual side-effects. However, it can lead to sexual adverse effects via its common side-effects. Sedation can lead to a decrease in sexual activity, while weight gain can increase the risk of obesity, which is a known factor associated with sexual dysfunction.

Antidepressants

As serotonin plays a key role in sexual functioning, medications such as SSRIs and SNRIs are known to affect sexual function. These agents can affect all phases of the sexual response cycle and are commonly associated with delayed ejaculation, delayed orgasm or anorgasmia, and reduced libido. In men, the most commonly reported sexual adverse effects are decreased

sexual desire and orgasmic dysfunction, whereas women more commonly report decreased arousal and difficulties achieving orgasm.

As per a meta-analysis, sertraline, venlafaxine, citalopram, paroxetine, and fluoxetine are associated with the highest rates of treatment-emergent sexual dysfunction (~70–80%).^[24] Intermediate rates (~25–45%) have been reported with imipramine, phenelzine, duloxetine, escitalopram, and fluvoxamine.

When antidepressant treatment is indicated in patients with severe mental illness and comorbid sexual dysfunction, agents with a lower risk of sexual adverse effects should be preferred whenever clinically appropriate. If antidepressant-induced sexual dysfunction develops, management options include dose reduction, switching to an antidepressant with a more favorable sexual side-effect profile, or the addition of symptom-targeted treatments such as PDE-5 inhibitors, bupropion (for desire-phase), depending on the type of dysfunction, treatment response, and overall risk-benefit considerations. Drug holidays have shown mixed results and should be considered for short-acting antidepressants like paroxetine, sertraline, etc., while monitoring for SSRI-associated discontinuation symptoms and relapse. Drug holidays are not effective for long-acting SSRIs like fluoxetine. Bupropion, buspirone, trazodone, vilazodone, and vortioxetine have relatively low rates of sexual dysfunction.

Mood Stabilizers

Valproic Acid

Valproate has been associated with a range of reproductive and sexual adverse effects. In women, these include menstrual irregularities, dysmenorrhea, secondary amenorrhea, vaginitis, hyperandrogenism, hirsutism, elevated testosterone levels, galactorrhea, breast enlargement, and polycystic ovary syndrome. In men, valproate has been associated with reduced sexual desire, erectile and orgasmic dysfunction, impaired sperm parameters (reduced sperm count and motility, abnormal sperm morphology), aspermia, azoospermia, and reduced fertility.

If patients develop any sexual and reproductive adverse effects due to valproate, they are generally reversible and improve following dose reduction or discontinuation. However, any decision to reduce the dose or switch treatment should be made only after carefully weighing the benefits and risks, particularly when valproate provides adequate control of the underlying illness. When continuation of valproate is considered necessary, symptom-specific management of sexual dysfunction may be considered. As valproate is known to interfere with folate metabolism, this has been proposed as one of the possible mechanisms contributing to impaired fertility through effects on DNA synthesis and spermatogenesis. Folate supplementation may be considered in selected cases; however, evidence supporting its effectiveness in reversing valproate-associated infertility remains limited.

Because of its teratogenic potential, as per the FDA, valproate should generally be avoided in women of childbearing potential whenever suitable alternatives are available. If valproate is prescribed, effective contraception and appropriate counselling regarding pregnancy-related risks should be provided.

Lithium

Evidence regarding lithium-associated sexual dysfunction is limited. However, erectile dysfunction, reduced libido, and impaired sexual satisfaction have been reported in some patients. Proposed mechanisms include indirect effects through lithium-induced hypothyroidism, weight gain, sedation, and fatigue.

Carbamazepine and Oxcarbazepine

Evidence regarding sexual dysfunction associated with carbamazepine and oxcarbazepine is also limited. Some studies have reported decreased libido, erectile dysfunction, and impaired fertility. Proposed mechanisms include hepatic enzyme induction leading to increased metabolism of sex hormones and increased levels of sex hormone-binding globulin (SHBG), resulting in reduced free testosterone levels. Due to hepatic cytochrome P450 enzyme induction, carbamazepine can lead to a decrease in the effectiveness of oral contraceptives, so alternative contraceptive measures should be discussed with the patient.

Oxcarbazepine has also been associated with isolated reports of retrograde ejaculation and anorgasmia.

Lamotrigine

Compared with other mood stabilizers, lamotrigine has a relatively favorable sexual side-effect profile. It has minimal effects on SHBG and is generally not associated with sexual dysfunction.

General Principles of Management

General Measures

During the management of severe mental illness, patients' sexuality should be considered as an integral part of treatment. Addressing sexual health concerns can help in improving treatment compliance, building trust and rapport, facilitating identification and management of any relationship issues, minimizing medication-related side-effects, and improving the overall quality of life of the person.

Management of sexual dysfunction in individuals with severe mental illness (SMI) involves addressing both general causes of sexual dysfunction and illness-specific factors. Similar to the management of sexual dysfunction in the general population, the initial approach should focus on identifying and addressing modifiable risk factors.

These include management of comorbid medical conditions that may impair sexual functioning, such as uncontrolled diabetes mellitus, hypertension, obesity, prostatic disorders in older men, and lower urinary tract symptoms; substance use disorders like alcohol, tobacco, or other substances. Surgical conditions such as inguinal hernia, varicocele, and testicular disorders; endocrine disorders (e.g., hyperprolactinemia, hypothyroidism, low testosterone); and sexually transmitted infections. Appropriate management of these conditions should be done, including optimization of medical treatment, weight reduction, dietary modification (Mediterranean diet), regular physical activity, treatment with continuous positive airway pressure (CPAP) in obstructive sleep apnea (OSA), management of substance use disorders, and referral to relevant medical or surgical specialties when indicated.

During assessment, and when appropriate, the sexual partner should also be involved to identify any psychosocial or relationship-related factors that may contribute to, or result from, sexual dysfunction. Partner involvement may also help determine the need for couple-based interventions and assess the potential benefits of psychotherapy.

Informing and Educating Patients and Partners

During discussions about sexual health, patients and partners should be made to feel comfortable discussing their concerns with the clinician. A non-judgmental attitude, the use of open-ended questions, adequate time and opportunity to express any concerns, and maintenance of privacy help in facilitating such discussions. In case of female patients, appropriate safeguards, such as the presence of a female attendant or healthcare staff member when indicated, should be ensured for the safety and comfort of both the patient and the clinician.

Individuals with severe mental illness should be informed about the potential impact of the illness itself on sexual functioning. Attributing sexual dysfunction solely to medication may

increase the risk of treatment nonadherence. Patients should be educated about the potential sexual adverse effects of medications, their often-reversible nature, and the available management options. Education regarding sexuality, safe-sex practices, prevention of sexually transmitted infections, and HIV risk reduction should be provided to all individuals with severe mental illness.

Sexuality Education

Sexuality education is an essential and underutilized component in addressing sexual health concerns in patients with severe mental illness. It aims to normalize concerns related to sexual activity, masturbation, nocturnal emissions, sexual intercourse, sexual anatomy, and physiological sexual responses. This also helps in correcting any sexual myths and misconceptions, and in reducing any anxiety and guilt, which are commonly seen in patients with severe mental illness. By providing accurate and accessible information, sex education and involvement of partners might help empower patients in making informed decisions about their sexual and reproductive health. Detailed information on age-appropriate and culturally sensitive sex education and promotion of psychosexual health can be referenced from the CPG guideline on age-related sex education and promotion of psychosexual health.

In severe mental illness, apart from generic topics related to sex education, it should also address illness and treatment-specific concerns. This includes the effects of psychiatric symptoms and psychotropics on sexual functioning, safe sex practices, high-risk sexual behaviour, contraception, recognition and appropriate response to sexual violence. (Table 9)

Table-9: Components of Sexuality education in severe mental illness

Component	Specific considerations
Basic component	Education regarding normal anatomy, physiological sexual responses, masturbation, nocturnal emissions, and normal variation in sexual desire and functioning; correction of misconceptions regarding semen loss and related cultural beliefs
Impact of illness	Effects of the underlying psychiatric illness on sexual functioning, intimacy, and relationship capacity across illness phases, including positive and negative symptoms in schizophrenia, depressive symptoms, and manic symptoms
Medication and sexual function	Effects of psychotropic medications on sexual functioning; reversible nature of medication-induced sexual dysfunction; available treatment options; addressing adherence-related concerns arising from sexual side effects
Safe sex practices, STI prevention	Education regarding the risk of sexually transmitted infections, HIV, hepatitis B and C; early diagnosis and treatment; partner communication regarding sexual health; regular screening for sexually transmitted infection; recognition of high-risk sexual behaviors, particularly during manic episodes
Contraception and reproductive health	Information regarding available contraceptive options, emergency contraception, and family planning services; fertility; pre- and post-pregnancy care; correction of the misconception that antipsychotic-induced amenorrhea is contraceptive
Sexual violence and coercion	Helping patients and caregivers recognize and respond to their increased vulnerability to sexual violence and coercive relationships; information regarding available legal options and social services

Self-stigma and sexual rights	Addressing internalized shame and self-stigma related to severe mental illness; affirming that a diagnosis of severe mental illness does not rule out a satisfying and healthy sexual life
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HIV: Human immunodeficiency virus.

Management of Psychotropic-induced Sexual Dysfunction

For the management of psychotropic-related sexual dysfunction, it is important to obtain a history focusing on premorbid sexual functioning before the initiation of medication, as well as any variation in sexual side effects with dose initiation, escalation, reduction, or any other dose modifications. The known sexual side effects of the prescribed medication should also be kept in mind during assessment. When prescribing medications with frequent and known sexual side effects, these should be discussed openly with the patient before initiation and routinely inquired about during follow-up visits to facilitate monitoring and strengthen the therapeutic alliance.

Strategies for Management

Several management strategies have been proposed for psychotropic-related sexual dysfunction (flowchart-2).

Waiting for Tolerance to Develop

This approach may be considered in patients who have shown a significant therapeutic response to the medication. Although simple, it is often ineffective, as sexual side effects generally persist. Spontaneous remission of sexual side effects occurs in only 5-10 percent of patients and may take up to four to six months. In severe mental illness where achieving symptom control is difficult, this strategy may be considered after discussion with the patient and, when appropriate, their partner.

Dose Reduction

If sexual dysfunction appears to be dose-related, reducing the medication dose may be considered after evaluating the severity of psychiatric symptoms and the risk-benefit ratio. This approach may be particularly useful in cases of polypharmacy and with SSRIs, as sexual dysfunction associated with SSRIs is often dose-dependent. However, dose reduction carries the risk of relapse, worsening of psychiatric symptoms, and treatment discontinuation.

Rational and judicious use of medications should be done, and polypharmacy should be avoided as much as possible. Due to the side effects associated with different drugs and the drug interactions between them, polypharmacy increases risk of sexual health related concerns and relationship issues in patients. Particularly using combination of drugs which are known to cause increase in prolactin levels are associated with increased risk of sexual dysfunction, whereas addition of aripiprazole owing to its prolactin lowering effects, has been associated with improvement in sexual functioning.^[25]

Drug Holidays

This strategy involves temporarily discontinuing medication 2-3 days before anticipated sexual activity. It is generally not recommended in severe mental illness because of the substantial risk of relapse, recurrence, worsening of psychiatric symptoms, reduced treatment adherence and mixed evidence. In the case of SSRIs, there is also a risk of SSRI discontinuation syndrome.

Substitution or switching Medications

This involves replacing the offending medication with another agent that has a similar therapeutic profile but a lower risk of sexual side effects. However, if the alternative medication is less effective, there is a risk of symptom exacerbation. Therefore, switching should be undertaken only after careful consideration of the risk-benefit ratio, with close monitoring of symptoms, side effects, and patient and partner's preferences. Medications generally associated with lower rates of sexual dysfunction include aripiprazole, quetiapine, ziprasidone, bupropion, mirtazapine, desvenlafaxine, vortioxetine, lamotrigine, nefazodone and reboxetine.

Adjunctive Pharmacotherapy (Symptom-Targeted Treatment)

This is one of the most commonly used strategies when dose reduction or switching is not feasible (e.g., clozapine in treatment-resistant schizophrenia). In this approach, treatments specific to the type of sexual dysfunction are added. Although often effective, this strategy may increase polypharmacy, treatment costs, medication-related adverse effects, and the risk of nonadherence.

Among the available augmentation strategies, bupropion has the strongest evidence and has been shown to improve sexual arousal, orgasm, and sexual satisfaction in both men and women. For psychotropic-induced erectile dysfunction, phosphodiesterase-5 (PDE-5) inhibitors such as sildenafil (25–100 mg/day) and tadalafil (5–20 mg/day) may be considered along with dose adjustment of these agents in view of tolerability, efficacy, and potential drug interactions. Cyproheptadine, a 5-HT_{2A} receptor antagonist, has limited evidence for the management of SSRI-induced sexual dysfunction, particularly decreased sexual desire, anorgasmia, and delayed ejaculation. Other agents that have been studied include stimulants (methylphenidate and modafinil) for improving sexual desire and arousal. Limited evidence is also available for mirtazapine (orgasm), buspirone, antihistamines, amantadine, yohimbine, aripiprazole, bethanechol, granisetron, and various herbal preparations.

Drug interactions of medications used in sexual dysfunctions and psychotropics

While using psychotropics along with PDE-5 inhibitors and other drugs for treatment of sexual dysfunctions, their drug interactions should be kept in mind. Some of the common drug interactions are shown in table 10.

Table-10: Drug Interactions between psychotropic medications and common sexual dysfunction treatment medications

Drugs	Psychotropic medications	Mechanism	Clinical effects	Management
PDE-5 inhibitors (e.g. Sildenafil)	Antipsychotics with α 1-antagonist activity (clozapine, quetiapine, risperidone, chlorpromazine, thioridazine)	Additive effects of α 1-adrenergic blockade	↑ risk of systemic vasodilation leading to severe orthostatic hypotension and syncope	• PDE-5 dose should be kept low • Monitoring of postural hypotension and comorbid CVD
	Antipsychotics with risk of QTc-prolongation (ziprasidone, iloperidone, haloperidol)	Additive effects of QTc prolongation	↑ risk of torsades de pointes	• ECG: Baseline and follow-up • Avoid vardenafil
	Psychotropics with CYP3A4-inhibition (fluvoxamine)	↓ metabolism of PDE-5 inhibitor	• ↑ PDE-5 plasma levels • ↑ risk of hypotension, priapism	• ↓ Dose PDE-5 inhibitor (vardenafil up to 2.5 mg per day)

Drugs	Psychotropic medications	Mechanism	Clinical effects	Management
	Mood stabilisers with CYP3A4-induction(carbamazepine, oxcarbazepine)	↑ metabolism of PDE-5 inhibitor	↓ PDE5 plasma levels	- Consider ↑ dose of PDE-5 inhibitor - Consider alternative mood stabilizer
Bupropion	Clozapine, high-dose of antipsychotics	Additive effect leading to ↓ seizure threshold	↑ Seizure risk	- Combination should be avoided - Lowest effective dose should be used
	TCAs, Antipsychotics metabolised by CYP2D6 (risperidone, aripiprazole)	CYP2D6 inhibition by bupropion	↑ Antipsychotic, TCA levels	- Monitoring of side-effects - Consider dose reduction
Testosterone	Valproate	Increased burden of metabolism on liver	↑ risk of hepatotoxicity	Periodic Monitoring of liver function tests
Flibanserin	Mood stabilisers with CYP3A4-induction (carbamazepine, oxcarbazepine)	↑ metabolism of flibanserin	↓ flibanserin levels	Consider ↑ dose of flibanserin

PDE-5:phosphodiesterase type 5; TCA: Tricyclic antidepressants; ECG: electrocardiogram; CVD: Cardio-vascular disorders.

Non-Pharmacological Approaches

Non-pharmacological approaches for psychotropic-induced sexual dysfunction include individual or couples' psychotherapy, modification of sexual techniques, scheduling regular sexual activity, and engaging in physical exercise before sexual activity.

Psychotherapy can help in addressing performance anxiety, any negative beliefs regarding sexuality, relationship conflicts, and emotional distress, which are associated with sexual dysfunction. Couples therapy can be used to improve communication between the partners, to facilitate discussion of sexual concerns, and enhance intimacy and relationship satisfaction.

Behavioral interventions, such as modifying sexual techniques, experimenting with different forms of sexual stimulation, and increasing foreplay, may help compensate for medication-related sexual dysfunction related to arousal or orgasm.

Scheduling sexual activity at times when the medication-related adverse effects are least pronounced, such as before taking a sedating medication or during periods of adequate energy levels, may help overcome sexual dysfunction due to sedation. Regular planned sexual activity can help in maintaining intimacy among the partners and also reduce any avoidance behaviors.

Physical exercise performed shortly before sexual activity has been shown in some studies to improve sexual arousal and functioning, possibly through enhancement of sympathetic nervous system activity, improved cardiovascular function, and increased genital blood flow. These interventions may be used alone in mild cases but are often most effective when combined with pharmacological strategies.

Management of Specific Sexual Dysfunctions

Management of specific sexual dysfunction can be reviewed in detail from other CPG related to that specific topic (Desire disorder, Erectile dysfunction, Premature ejaculation, Female sexual interest arousal, and orgasmic disorders, Pain and penetration disorder, Dhat and koro syndrome).

Management of sexual dysfunctions in SMI patients should follow a stepwise and etiology-specific approach across the five domains. For hypoactive sexual desire disorder (HSDD) in premenopausal women, flibanserin (5-HT_{1A} agonist/5-HT_{2A} antagonist) and bremelanotide (melanocortin receptor agonist) are FDA-approved options, with bupropion and transdermal testosterone as off-label alternatives.

For sexual arousal disorder, firstly, HSDD should be ruled out before initiating treatment. As there is limited evidence for pharmacological treatments, sexual arousal disorders are primarily managed with psychological interventions like Mindfulness-based cognitive therapy, sensate-focus, individual and couples' therapy, directed masturbation, and interventions aimed at improving communication skills between partners. and for female arousal disorder, the FDA-approved EROS Clitoral Therapy Device can be considered.

Orgasmic disorder similarly relies on directed masturbation, sensate-focus, and psychotherapy, with bupropion, bremelanotide, and PDE-5 inhibitors as off-label options with limited evidence. Erectile disorder is managed in a three-tier fashion with PDE-5 inhibitors as first-line, followed by vacuum-assisted erection devices or intra-cavernosal/intraurethral alprostadil as second-line, and vascular surgery or penile prosthesis as third-line options (Table 11). Details of PDE-5 inhibitors are provided in Table 12. Testosterone replacement therapy can be used to augment PDE-5 response in hypogonadal men.

Similarly, premature ejaculation can be managed with SSRI's (paroxetine showing greatest efficacy) or topical anesthetics (lidocaine, prilocaine), with combination of SSRI and PDE-5 inhibitor therapy showing the strongest evidence among longer-term treatments. Behavioural techniques (stop-start, squeeze) have been shown to offer limited but adjunctive benefit, particularly where psychosocial factors predominate.

Table-11: Treatment Options for Erectile Dysfunction in Severe Mental Illness

First-line treatment
• Phosphodiesterase 5 Inhibitors
• Testosterone replacement (if Hypogonadism)
Second-line treatment
• Vacuum-Assisted Erection Device
• Intra-cavernosal alprostadil
• Intra-urethral Alprostadil
Third-line treatment
• Vascular Surgery (arterial bypass / venous ligation) in specific cases
• Penile Prosthesis Implantation

Adjunctive measures
Lifestyle and Psychosocial Interventions • Weight reduction and regular aerobic exercise • Mediterranean diet and cardiovascular risk factor management • Smoking and substance cessation • Continuous Positive Airway Pressure therapy if obstructive sleep apnea • Individual or couples' psychotherapy • Psychoeducation (patient and partner)
Optimization of Psychotropic medications

Table-12: Pharmacological characteristics of PDE-5 inhibitors

PDE-5 inhibitors	Available strengths	Usual dose	Time to onset	Duration of action	Precautions
Sildenafil	25mg, 50mg, 100mg	25–100 mg	30–60 min (taken 30min to 4 hrs before sexual activity)	4–6 h	Severe renal impairment (CrCl < 30mL/min), moderate-to-severe hepatic impairment
Tadalafil	2.5mg, 5mg, 10mg, 20mg	5–20 mg on-demand or 2.5–5 mg once daily	30–120 min	Up to 36 h	Renal or hepatic impairment; also approved for benign prostatic hyperplasia
Vardenafil	2.5mg, 5mg, 10mg, 20mg	5–20 mg	30–60 min (taken 1 hr before sexual activity)	4–6 h	Moderate hepatic impairment; contraindicated in congenital long QT syndrome and with Class IA/III antiarrhythmics
Avanafil	50 mg, 100 mg, 200 mg	50–200 mg	15–30 min (taken 30min before sexual activity)	~6 h	Severe renal or hepatic impairment.

PDE-5: Phosphodiesterase 5;CrCL: Creatinine clearance.

Special Clinical Considerations

Depressive Episodes

In depressive disorders and during depressive episodes in bipolar affective disorder (BPAD), decreased sexual desire is common. As part of the depressive syndrome, both men and women may be less responsive to sexual advances and less willing to engage in sexual activity, which can lead to relationship difficulties. In men, decreased sexual desire may also manifest as erectile dysfunction. Thus, during the assessment of sexual dysfunction, it is important to determine whether the dysfunction is primarily related to relationship problems or is secondary to the depressive symptoms. Effective management of depressive symptoms is therefore essential for the treatment of depression-related sexual dysfunction. If sexual dysfunction persists despite adequate management of depressive symptoms with an SSRI or SNRI and a

mood stabilizer, the possibility of medication-induced sexual dysfunction should be considered. In such cases, bupropion may be considered as an alternative or augmentation strategy.

If the patient has atypical features of depression, such as hypersomnia, increased appetite or weight gain, and mood reactivity, increased sexual drive may occur as part of reverse vegetative symptoms. In such cases, the possibility of a mixed state or bipolar spectrum disorder should be explored through a detailed review of the patient's history.

Manic and Hypomanic Episodes

During manic and hypomanic episodes, hypersexuality is an important symptom, often occurring alongside impulsivity, disinhibition, and overfamiliarity. This may result in increased sexual activity, inappropriate sexual behaviour, promiscuity, high-risk sexual practices, extramarital affairs, unplanned pregnancies, and impulsive marriages. Management should focus on adequate treatment of manic symptoms. When indicated, couples counselling and psychoeducation regarding hypersexuality as a manifestation of mania may be beneficial. In patients with a history of high-risk sexual behaviour, screening for sexually transmitted infections, along with counselling regarding contraception, family planning, and comprehensive management with timely dose adjustments should be considered.

Bipolar Disorder: Additional Management Considerations

Psychoeducation forms a key component of managing sexual dysfunction in BPAD. Psychoeducation regarding promiscuous and high-risk sexual behaviour is recommended, particularly during manic and hypomanic episodes, as well as regarding decreased sexual drive during depressive episodes. This can help reduce the psychological, interpersonal, and family-related consequences due to sexual health-related issues. Adequate control of affective symptoms with appropriate pharmacological treatment (mood stabilizers, antidepressants, and/or antipsychotics, depending on the mood episode) is essential before addressing residual sexual dysfunction. Lithium may additionally be beneficial in managing hypersexuality associated with mania, possibly owing to its modulatory effects on dopamine neurotransmission. Lastly, given that partners of individuals with BPAD frequently report dissatisfaction with sexual functioning across all phases of the illness, involvement of the partner in assessment, counselling, and psychoeducation should be encouraged.

Sexual Health and Reproductive Health Considerations

Contraception

Contraceptive nonadherence is common among individuals with severe mental illness, particularly during symptomatic phases. Consequently, long-acting contraceptive methods may be preferred when clinically appropriate and acceptable to the patient. Other general methods, include use of barrier methods (condoms), Intrauterine devices, oral contraceptive pills, and coitus interruptus, which should also be discussed on a case-by-case basis. (Table 11) Oral contraceptive pills may be associated with mood-altering effects, which can be particularly undesirable in individuals with comorbid mood disturbances. Similarly, use of implants and intrauterine devices in some patients may become incorporated into delusional beliefs, particularly delusions of control, which may affect acceptance and adherence to these contraceptive methods. Comprehensive sexual and reproductive healthcare should include rehabilitation programs, HIV education and screening, family-planning counselling, and systems for the early detection of pregnancy and sexually transmitted infections in women with

chronic mental illness. In addition, screening for high-risk sexual behaviors should form a routine component of clinical assessment in individuals with chronic mental disorders.

Collaboration with obstetric and gynecological services is important to facilitate family planning, prenatal care, prepare patients for childbirth, and support informed decision-making regarding antipsychotic treatment during pregnancy and the postpartum period. Furthermore, as sexual activity may often be unplanned, discussions regarding emergency contraception should form an important component of sexual and reproductive health counselling for patients with severe mental illness.^[26]

As clozapine is primarily metabolized by CYP1A2, potential interactions with oral contraceptive pills should be considered during prescribing. Concomitant use may increase clozapine plasma concentrations, potentially increasing the risk of adverse effects, whereas discontinuation of oral contraceptives may reduce clozapine levels and result in subtherapeutic exposure. Accordingly, changes in contraceptive use should be considered when monitoring and adjusting clozapine dosage. (We have to be careful about Venous thromboembolism with psychotropics)

Women with schizophrenia and other severe mental disorders are at increased risk of adverse sexual and reproductive health outcomes, including unplanned pregnancies, sexually transmitted infections, induced abortions, sexual violence, and intimate partner violence. These vulnerabilities arise from a complex interplay of illness-related factors, stigma, childhood trauma, poverty, homelessness, and medical and psychiatric comorbidities. Sexual health interventions should aim to promote safe, consensual, and satisfying sexual experiences, while addressing barriers related to stigma, coercion, discrimination, and violence.^[10]

In selected cases, the use of a ‘Ulysses contract’ for contraceptive care has been proposed. Under this arrangement, a woman provides consent to initiate and continue contraception while clinically stable, with the understanding that this consent remains valid during future periods of illness or impaired decision-making capacity. This approach is conceptually similar to a psychiatric advance directive and may help ensure continuity of reproductive healthcare while respecting patient autonomy.

Table-13: Contraceptive options and considerations in severe mental illness

Method	Advantages in SMI	Considerations / Cautions
Long-acting reversible: Intrauterine device (IUD)	Highly effective; no daily compliance needed	May be incorporated into delusions of control; requires insertion procedure, offers no protection from STIs
Long-acting reversible: Subdermal implant	Highly effective; no daily compliance needed; effect up to 3 years duration	As above, hormonal effects, leading to headache, mood changes
Depot injectable (Depot medroxyprogesterone acetate: DMPA)	Effective, 3-monthly administration, helpful in patients with poor compliance, no hormonal side-effects	May worsen depressive symptoms; irregular bleeding; decreases bone density with long-term use; offer no protection from STIs

Combined oral contraceptive pill (COCP)	Widely available; also treats menstrual irregularities [e.g., Polyendocrine Metabolic Ovarian Syndrome (PMOS) in patients on valproate]	Daily compliance required; mood effects; interaction with CYP3A4-inducing anticonvulsants (carbamazepine) and clozapine (CYP1A2)
Barrier methods (male/female condom)	Only method offering STI/HIV protection; no systemic effects	Compliance-dependent; requires partners' understanding
Emergency contraception	An effective way to prevent pregnancy after unprotected intercourse	Should be discussed proactively as part of routine sexual health counselling; available as an over-the-counter (OTC) medicine

STIs: Sexually transmitted infection; HIV: Human Immunodeficiency Virus

Pregnancy

Women of childbearing potential with severe mental illness should be provided routine counselling regarding sexuality, conception, contraception, sexually transmitted infections, and the effects of psychotropic medications on pregnancy and lactation. Medications with known teratogenic potential, particularly valproate, carbamazepine, paroxetine, should be avoided whenever suitable alternatives are available. Early identification of pregnancy is important to allow timely review and optimization of psychotropic treatment. Folic acid supplementation should be ensured in women planning pregnancy, and close liaison with obstetric services should be maintained throughout pregnancy. Psychotropic medication doses may require adjustment during pregnancy because of physiological changes affecting drug pharmacokinetics.

When exposure to psychotropic medications with known fetal risks has occurred, appropriate fetal anomaly screening and monitoring should be undertaken in consultation with obstetric specialists. Treatment decisions should be based on shared decision-making, balancing the risks of untreated psychiatric illness against the potential risks of medication exposure during pregnancy and lactation. In patients with chronic severe mental illness, access to rehabilitation services, regular HIV screening when indicated, and mechanisms for the early detection of pregnancy should be ensured.

STI Prevention and HIV

Patients with severe mental illness who engage in high-risk sexual behaviours should be screened for sexually transmitted infections (STIs), including HIV. HIV prevention programs should include education regarding the consequences of high-risk sexual behaviour, particularly about the increased vulnerability during manic episodes, promotion of safer-sex practices, contraceptive counselling, and assertiveness training. Open and healthy communication regarding sexual health should be encouraged between partners to facilitate early identification and management of sexual health concerns and reduce adverse outcomes. Women with severe mental illness are less likely to undergo regular cervical cancer screening than the general population. Therefore, appropriate cervical cancer screening should be actively facilitated and coordinated as part of routine healthcare.

Sexual Violence

Persons with severe mental illness, particularly schizophrenia, are at an increased risk of sexual violence compared with the general population, with even higher rates in women with SMI.^[27] Contributing factors include impaired judgment, altered reality testing, increased vulnerability, cognitive deficits, and difficulties in navigating interpersonal relationships. Clinicians should routinely assess for the risk of intimate partner violence and sexual violence, particularly when suggested by the clinical history, unexplained injuries, or sexually transmitted infections. When identified, appropriate referral to social support, legal, and protective services should be facilitated.

Psychosocial and Educational Interventions

These interventions aim to improve social, communication, coping, and problem-solving skills, enhance self-esteem, reduce high-risk behaviours, and promote overall sexual well-being and relationship functioning.

Clinician Responsibilities

Clinicians managing patients with severe mental illness should adopt a proactive and comprehensive approach to sexual health. Sexual history should be obtained routinely rather than waiting for patients to volunteer sexual concerns, and clinicians should regularly inquire about sexual dysfunction and medication-related sexual adverse effects. Reproductive plans, including contraception, pregnancy planning, and parenthood, should also be discussed, alongside screening for high-risk sexual behaviours, sexually transmitted infections, and unsafe or sexual violence in relationships. Where clinically indicated, liaison with appropriate healthcare services including obstetrics and gynaecology, medicine, surgery, HIV/STI services, and rehabilitation services should be pursued. Partners should be involved in assessment and management when appropriate. Finally, clinicians should provide psychoeducation regarding the impact of severe mental illness and psychotropic medications on sexual functioning, and encourage safe-sex practices and healthy communication regarding sexual health and intimacy.

Promoting Intimate Relationships

Individuals with severe mental illness have the same needs for intimacy and sexual relationships as the general population, and barriers to forming and maintaining intimate relationships should be identified and addressed during treatment and rehabilitation. Sexual health and intimate relationships should accordingly be considered integral components of recovery-oriented care.

To conclude, thus, asking about sexual health and the subsequent systematic inquiry paves the way towards achieving a better sexual quality of life in patients with severe mental illness. This guideline emphasizes a multifaceted management approach by integrating psychoeducation, clarifying myths, assessment and mitigation of psychosocial contributors, and optimization of pharmacological management. Along with other CPG guidelines which address various other aspects of sexual dysfunction, this guideline intends to equip practitioners with evidence-informed strategies to improve sexual functioning and overall quality of care in patients with severe mental illness.

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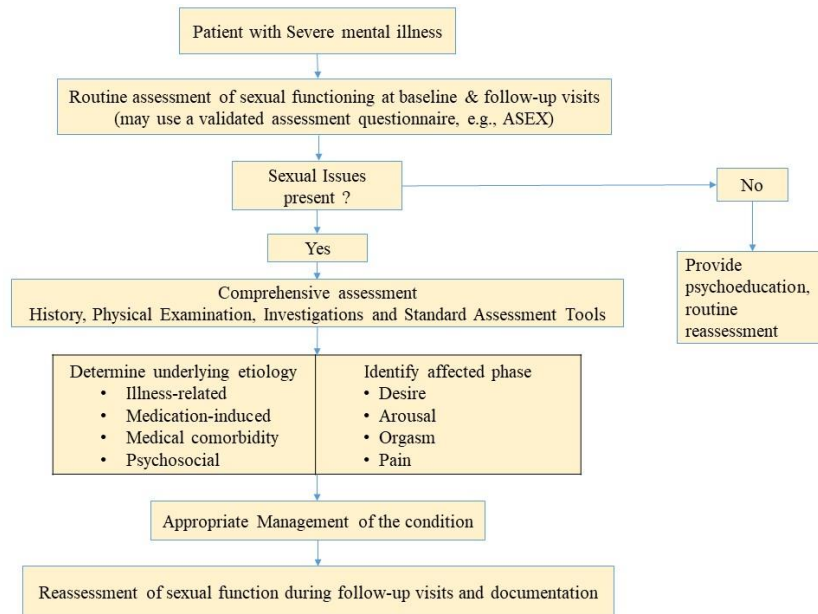
Figures

Flowchart-1: General approach of assessment of sexual dysfunction in severe mental illness.

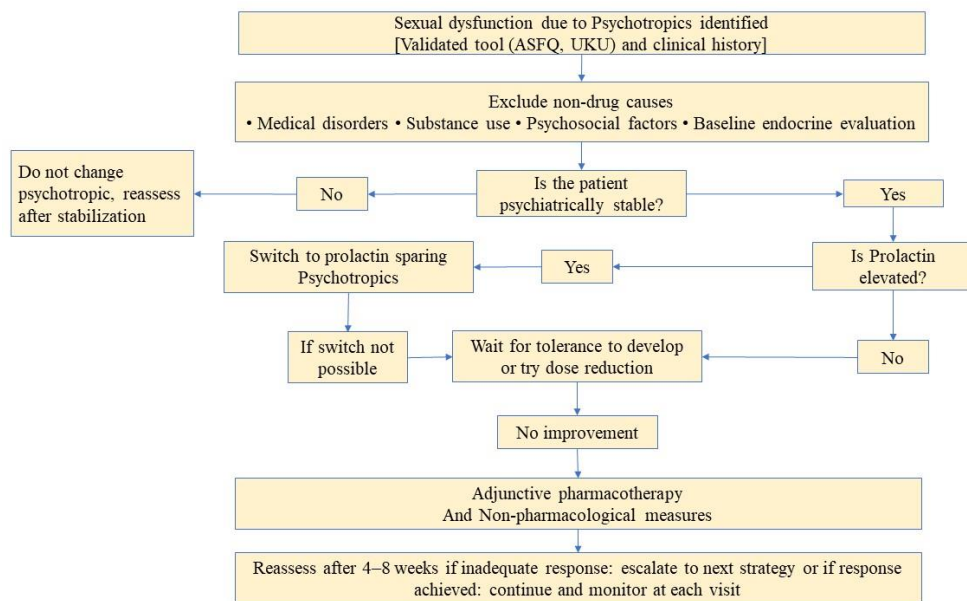
ASEX: Arizona Sexual Experiences Scale.

Flowchart-2: Management algorithm for Psychotropic-related sexual dysfunction

ASFQ: Antipsychotics and Sexual Functioning Questionnaire, UKU: Udvalg for Kliniske Undersøgelser Side Effect Rating Scale.



Flowchart-1: General approach of assessment of sexual dysfunction in SMI



Flowchart-2: Management algorithm for Psychotropic-related sexual dysfunction