

Covering Letter

To,
The Editor

Sub: Submission of Manuscript for publication

Dear Sir,

We intend to publish an article entitled **"Assessment and Management of Sexual Issues in Other Psychiatric Disorders"** in your esteemed journal as a Review Article.

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

Prior publication Nil

Support None

Conflicts of interest None

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Yours' sincerely,

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Manuscript Title: "Assessment and Management of Sexual Issues in Other Psychiatric Disorders"

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Name	Signature	Date signed
1 Dr Manaswi Gautam		16.10.2026
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Checklist (to be tick marked, as applicable)

Manuscript Title “Assessment and Management of Sexual Issues in Other Psychiatric Disorders”

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- ✓ Signed by all contributors
- ✓ Previous publication / presentations mentioned
- ✓ Source of funding mentioned
- ✓ Conflicts of interest disclosed

Authors

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- ✓ Author for correspondence, with e-mail address provided
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Summary of work done by the contributors All authors were involved in the development of the concept of the review. Further, Dr Ravindra Neelakanthappa Munoli, Dr Manaswi Gautam and Dr Manmeet Singh did the literature review. Manuscript was written by Dr Ravindra Neelakanthappa Munoli and subsequently it was reviewed and edited by all authors.

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Title of the article: **"Assessment and Management of Sexual Issues in Other Psychiatric Disorders"**

Abstract: Exectutive Summary

Sexual dysfunction is prevalent yet systematically neglected in patients with common mental disorders (CMDs) and other psychiatric disorders in India. Its causes are bidirectional: illness-related mechanisms, sympathetic overactivation in anxiety, negative symptoms in psychosis, Hypothalamic-Pituitary-Gonadal axis (HPG) axis suppression in eating disorders, trauma conditioning in Post-Traumatic Stress Disorder (PTSD) and psychotropic side effects (prolactin elevation from D2-blockers, serotonin-mediated inhibition from SSRIs). Untreated dysfunction harms clinical outcomes, relationships, and adherence.

Sexual dysfunction affects 25-85% of patients, yet proactive assessment occurs in <20% of South Asian psychiatric encounters. SSRI/SNRI-induced dysfunction affects 30-80; antipsychotic-induced hyperprolactinaemia occurs in 30-60% and is routinely unmeasured.

There is need to ask proactively at every encounter using ASEX. Then characterize dysfunction by domain and temporal relationship to illness and medication. Investigate with validated tools (IIEF, FSFI, GRISS) and serum prolactin, testosterone, or thyroid function as indicated. Assess trauma sensitively (PCL-5 if PTSD suspected) and include partners with consent.

Management should include a hierarchical approach (1) optimize treatment of the underlying disorder; (2) review medications via a 6-step approach (wait, dose reduce, timing, holiday, switch, augment); (3) initiate sex-specific psychological and/or pharmacological interventions for dysfunction.

The recommendations are proactive screening and baseline ASEX (Grade C); serum prolactin with D2-blockers (Grade B); CBT sex therapy for anxiety-related dysfunction (A); TF-CBT/EMDR before sex-specific work in PTSD (A); PDE-5 inhibitors for erectile dysfunction (A); bupropion augmentation for SSRI-induced dysfunction (B); switch to aripiprazole, quetiapine, clozapine, or olanzapine for hyperprolactinaemia (B); mindfulness-based sex therapy (B); DBT for impulsive sexual behaviour in borderline PD (B); tiered referral with telemedicine for non-metropolitan access (C).

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36 Key-words: Sexual disorders, Common mental disorders, Sexual dysfunctions, treatment emergent
37 sexual dysfunction, SSRI induced sexual dysfunction

38

39 Key Messages (Provide appropriate messages of about 35-50 words to be printed in centre box):

40 Sexual issues are common in common mental disorders and other psychiatric disorders. There is a
41 need to assess these objectively using disorder specific tools, hormonal assay and vascular imaging.
42 Untreated sexual dysfunctions can hamper adherence, outcome and relationships. Management is
43 personalized, and psychoeducation remains as the must form of intervention.

44

Text

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Introduction:

Sexual health is one of the determinants of overall health and quality of life. This remains neglected due to various reasons such as both doctors and patients may remain inhibited due to cultural, lack of open discussion during clinical visit, minimal formal training in psychosexual medicine for clinicians. Common mental disorders (CMDs) and other psychiatric disorders carry a hidden burden of untreated sexual dysfunctions. Sexual dysfunctions in patients with psychiatric illness erode self-esteem, impair intimate partner relationships, and worsen the psychological burden of the underlying common mental disorder. This in turn may lead to poor adherence to psychotropic medications because sexual side effects are one of the important reasons for stopping medications. This in turn leads to relapses, rehospitalization, and long-term morbidity of psychiatric disorders.

The relationship between CMDs/other psychiatric disorders and sexual function is not unidirectional. Sexual dysfunction does not merely follow from psychiatric illness and its treatment; it can also precipitate or worsen psychiatric conditions. Persistent erectile dysfunction causes significant depressive and anxiety symptoms even in the absence of pre-existing mental disorder. Vaginismus or dyspareunia drives relationship conflict, which in turn elevates anxiety and lowers mood. Unresolved sexual trauma, which underlies a substantial proportion of Post-Traumatic Stress Disorder (PTSD) cases in Indian women, perpetuates the cycle of PTSD symptoms, sexual avoidance, and relational distress.

This guideline, provides comprehensive, evidence-based guidance on the assessment and management of sexual issues arising in the context of common mental disorders and other psychiatric disorders, with particular attention to the Indian cultural, social, and healthcare context. It covers anxiety disorders, psychotic disorders, personality disorders, somatic symptom disorders, eating disorders, and adult Attention Deficit Hyperactivity Disorder (ADHD), while complementary chapters address schizophrenia, bipolar disorders, depressive disorders, substance use disorders, and organic

71 mental disorders. Scope of this article has been presented in Table 1. Definitions and terminologies
72 used in this article are provided in Table 2.

73 74 **Epidemiology**

75 The true prevalence of sexual dysfunction in patients with CMDs and other psychiatric disorders in
76 India is difficult to establish precisely, for several reasons: underreporting due to cultural taboo, the
77 absence of validated Indian epidemiological instruments in regional languages, methodological
78 heterogeneity across studies, and the systematic exclusion of sexuality from standard psychiatric
79 outcome measures. In a review 33-75% of patients with anxiety disorders had sexual dysfunctions^[1].
80 In sexual arousal disorders, the vicious circle of anxiety/dysfunction/performance anxiety has been
81 the central theme^[2]. This vicious cycle example was understood in a study as honeymoon impotence
82 in 100 patients with this problem^[3]. In a study from India sexual dysfunction was reported in 36%
83 patients with anxiety disorders, mainly affecting desire and orgasmic function^[4]. Another study
84 reported sexual dysfunction in 53.3% of OCD patients, mainly orgasmic problems related to guilt and
85 anxiety^[5]. In a case control study 85.2% of women with GAD had significant sexual dysfunction when
86 compared to controls^[6-8]. Table 3 provides a disorder-by-disorder summary of estimated prevalence,
87 predominant dysfunction types, and primary mechanisms.

88 89 **Pathophysiology**

90 Sexual response cycle involves neuro-hormonal, endocrinal and vascular pathways^[21]. Psychiatric
91 disorders/CMDs often disrupt these, which further gets complicated using psychotropics.

92

93 **Neurochemical Disruption**

94 Sexual motivation, reward and drive are linked to dopaminergic mesolimbic circuits. SSRIs elevate
95 central serotonin, which in turn suppresses dopamine release (via 5-HT_{2A} receptor activation) and
96 directly inhibits spinal sexual reflexes (via 5-HT₂ and 5-HT₃ receptors at the sacral cord), producing

97 the characteristic SSRI-induced triad of reduced desire, delayed ejaculation, and anorgasmia. SSRIs
98 also elevate prolactin via serotonergic stimulation of the pituitary, adding a hormonal dimension to
99 their sexual side effects. For premature ejaculation, state anxiety is responsible than trait anxiety^[22] .

100

101 **Autonomic Disruption**

102 Sexual arousal is predominantly parasympathetically mediated (penile erection, vaginal lubrication,
103 clitoral engorgement), while sympathetic activation is inhibitory. Anxiety disorders are characterized
104 by chronic sympathetic hyperarousal and create a physiological environment hostile to sexual arousal.
105 Tricyclic antidepressants and antipsychotics with strong anticholinergic properties further impair
106 arousal by blocking the parasympathetic pathway. Premature ejaculation is because of increased
107 sympathetic supply, during state anxiety, to the spinal generator of ejaculation^[23,24].

108

109

110 **Hormonal Disruption**

111 D2 receptor blockade by typical and several atypical antipsychotics inhibits dopaminergic suppression
112 of prolactin release from the pituitary lactotrophs, causing hyperprolactinaemia. Increased prolactin
113 suppresses the hypothalamic-pituitary-gonadal (HPG) axis. This leads to reduced gonadotropin
114 secretion, hypogonadism, and consequent sexual dysfunction: low desire, erectile failure in men,
115 menstrual irregularity and amenorrhoea in women, and reduced vaginal lubrication. In anorexia
116 nervosa, nutritional deficiency directly suppresses the HPG axis via leptin deficiency and produces a
117 similar hormonal picture.

118

119 **Psychological Mechanisms**

120 Other contributors to sexual dysfunctions in CMDs and other psychiatric disorders are performance
121 anxiety, cognitive distraction (spectatoring, worry), avoidance conditioning, shame, negative body
122 image, dissociation, and trauma re-experiencing.

123

124 **Assessment Framework**

125 **General Principles of Assessment**

126 Previous clinical practice guidelines by Indian Psychiatric Society had elaborated about the general
127 principles of assessment for sexual dysfunction^[25]. The cardinal principle of psychosexual assessment
128 in psychiatric practice is ask proactively, consistently, and at every appropriate clinical encounter.
129 Studies across cultures consistently demonstrate that patients virtually never spontaneously disclose
130 sexual concerns in the context of a psychiatric consultation, not because the concerns do not exist,
131 but because the combination of stigma (around mental illness) and cultural inhibition (around
132 sexuality) creates an almost impassable barrier to spontaneous disclosure. In India, this barrier is
133 reinforced by deeply ingrained norms that position sexuality as a private, shameful, or taboo topic.

134

135 The clinician's job is to remove this barrier. This is done not through confrontational directness, but
136 through normalization: framing the question as routine, destigmatizing, and non-judgmental. Practical
137 approaches include stating explicitly that 'I ask all my patients about this as part of routine care'; using
138 a written self-report tool (Arizona Sexual Experience Scale – ASEX)^[26], that allows patients to disclose
139 concerns without needing to voice them verbally first; ensuring absolute privacy; and reassuring the
140 patient that the information is confidential within the treating team.

141

142 Assessment of sexual function should be understood not as a separate 'sexual medicine consultation'
143 tacked onto a psychiatric appointment, but as an integral, structured component of comprehensive
144 psychiatric evaluation, as natural and expected as asking about sleep, appetite, energy, or medication
145 adherence. In the Indian context, it may be appropriate to frame this as: 'As part of understanding
146 how the condition is affecting all aspects of your life, I'd like to ask you a few questions about your
147 relationship and physical health...'

148

Overall and structured framework for psychosexual assessment in CMDs and other psychiatric disorders is provided in Table 4.

151

152

Validated Assessment Instruments

The following validated instruments are recommended in clinical practice. None are currently available in validated form in most Indian regional languages (a significant gap requiring urgent attention). The complete list of tools available for specific assessments have been reviewed in 2020^[27]

- **Arizona Sexual Experience Scale (ASEX)**^[26]: A brief 5-item instrument covering sex drive, arousal, penile erection/vaginal lubrication, ease of orgasm, and orgasm satisfaction. Rated on a 6-point scale (total score 5-30; score ≥ 19 , or any item scoring ≥ 5 , or three or more items scoring ≥ 4 , indicates significant sexual dysfunction). Takes 2-3 minutes. The most practical baseline screening tool - administer before starting any psychotropic medication and at each follow-up.
- **International Index of Erectile Function (IIEF-15)**^[28]: 15-item self-report assessing erectile function, orgasmic function, sexual desire, intercourse satisfaction, and overall satisfaction. The gold standard for male sexual function. The validated 5-item short form (IIEF-5/SHIM) can be used for rapid ED screening (score ≤ 21 indicates ED; severity graded 5-21).
- **Female Sexual Function Index (FSFI)**^[29]: 19-item instrument covering desire, arousal, lubrication, orgasm, satisfaction, and pain. Total score range 2-36; validated cut-off ≤ 26.55 indicates female sexual dysfunction.
- **Golombok Rust Inventory of Sexual Satisfaction (GRISS)**^[30]: 28-item questionnaire for couples, yielding scores across 12 subscales. Particularly useful when both partners are available and there is relational conflict contributing to sexual difficulty.

- **Changes in Sexual Functioning Questionnaire (CSFQ)**^[31]: Developed specifically for detecting medication-related sexual dysfunction; available in short form (CSFQ-14). Useful for formal TSED documentation.

Clinical Assessment Flowchart

Figure 1 provides a step-by-step guide to the structured clinical assessment of sexual issues in patients with common mental disorders and other psychiatric disorders.

Disorder-Specific Sexual Issues

Overview

Sexual issues in common mental disorders and other psychiatric disorders are heterogeneous in their presentation, mechanism, severity, and appropriate management. A single clinical approach cannot be generalized across disorders. The comprehensive disorder-specific overview in Table 5 is followed by narrative expansion of the most clinically important conditions, with emphasis on presentations and considerations specific to Indian practice.

Anxiety disorders

Anxiety disorders constitute the most prevalent diagnostic category in psychiatry globally, and their intersection with sexual function is clinically ubiquitous yet consistently under addressed. The sympathetic mediated 'fight or flight' response is at the core of problems. A patient whose nervous system is chronically primed for threat detection cannot simultaneously activate the relaxed, attentive, pleasurably focused state that sexual response requires.

In generalized anxiety disorder, the pervasive, uncontrollable worry that defines the condition invades the sexual encounter. Here, the patient starts self-observing and self-evaluating his/her sexual

199 response, termed as 'spectatoring'. The cognitive distortions here can be addressed by CBT.

200 Furthermore, mindfulness helps in managing attention and sustaining focus on the act.

201

202 In panic disorder, a particularly insidious form of sexual avoidance emerges through interoceptive

203 conditioning. The bodily sensations of panic attack may mimic physiological changes of normal sexual

204 arousal, tachycardia, increased respiratory rate, vasodilation. Due to conditioning, these may be

205 sensations during arousal may be perceived as impending or onset of panic attack, which in turn lead

206 to derailment of sexual response cycle. The treatment will involve interoceptive exposure hierarchy

207 with deliberate inclusion of sexual arousal situations.

208

209 At the core SAD is fear of negative evaluation, followed by heightened self-awareness, and avoidance

210 of socially intimate situations. These extend into sexual contexts, and shape behaviors, cognitive and

211 affective experiences. Sexual activity requires disinhibition, exposure of the body, performance of acts

212 that might be judged, the possibility of failure or rejection. The result can be complete erectile failure

213 or vaginismus in individuals with no organic pathology. This is entirely driven entirely by anticipatory

214 anxiety. Treatment targeting social anxiety cognitive distortions is essential.

215

216 OCD presents a difficult problem in: ego-dystonic sexual obsessions. At times the commonly involved

217 themes will be paedophilia, homosexuality in a person with an established heterosexual identity,

218 incest, or other taboo sexual acts. These will be ego-dystonic by definition and cause intense distress

219 and shame. They are OCD obsessions, not paraphilic desires, not sexual orientation confusion.

220 Management is ERP targeting the obsession and the compulsive avoidance/reassurance-seeking that

221 maintains it. Misidentification as paraphilic disorder is a serious clinical error with potentially

222 devastating consequences.

223

224 The 'double jeopardy' of anxiety disorders: SSRIs and SNRIs are the pharmacological cornerstone of
225 treatment for most anxiety disorders, yet cause sexual dysfunction in 30-80%^[32] of patients depending
226 on agent, dose, and individual susceptibility. A patient prescribed an SSRI for GAD may find their
227 anxiety substantially improved, while discovering their sexual desire, arousal, and orgasmic function
228 have deteriorated. This should be communicated to patients at treatment initiation, assessed at each
229 follow-up using the ASEX, and managed proactively when it occurs.

230

231 **Post-Traumatic Stress Disorder**

232 In India, sexual trauma, encompassing childhood sexual abuse, adolescent assault, domestic violence
233 including marital rape, and sexual harassment, is one of the most common precipitants of PTSD in
234 women. This creates a situation where the very domain that has been violated becomes the
235 therapeutic challenge: how does one help a survivor of sexual trauma develop or restore a healthy,
236 pleasurable sexual life without re-traumatizing them in the process of therapy? Around 69% patients
237 with posttraumatic stress disorder were found to have erectile dysfunction, problems in orgasm, and
238 reported poor sexual satisfaction^[17].

239

240 The clinical presentation is multidimensional. The most basic is avoidance, the extension of the PTSD
241 avoidance cluster to sexual situations, particularly those resembling elements of the traumatic event.
242 Specific sensory triggers may activate the trauma response, generating flashbacks, intrusive images,
243 or intense physiological distress during sexual activity. Dissociation, a protective psychological
244 maneuver, is common during sex in trauma survivors and is deeply distressing to both the survivor
245 and their partner. Partners often report feeling that the person 'goes away' or 'isn't there' during
246 sexual activity, without understanding why. There is reduction in sexual desire and pleasure because
247 of emotional numbing. Hyperarousal is not conducive to sexual response. This combination of
248 numbing and hyperarousal in PTSD emerges into a clinical picture mimicking multiple types of sexual
249 dysfunctions.

250

251 The management should follow trauma-focused psychotherapy (TF-CBT or EMDR)/Cognitive
252 Processing Therapy (CPT) which in turn bring in the changes in sexual functioning and later sex-specific
253 interventions can be considered^[33]. The treatment sequence that should be followed: stabilization →
254 trauma processing → reintegration, with sexual health explicitly included in the reintegration goals.
255 The PTST from non-sexual traumas will follow the same mechanism of sexual dysfunction and such
256 patients will also require a detailed evaluation.

257

258 **Dissociative Disorders**

259 Dissociative symptoms often hinder emotional connection, bodily awareness, sexual arousal, and the
260 ability to experience orgasm. Here, the problems are depersonalization, derealization, emotional
261 numbness, dissociative amnesia, or identity disturbance during intimate situations. These pose unique
262 challenges in assessment and management as patients may report of no memory of episodes or no
263 control. These symptoms are closely associated with emotional dysregulation and interpersonal
264 problems^[34]. CSA history is highly prevalent in dissociative disorders^[35]. Research of sexual
265 dysfunctions in dissociative disorders is scarce.

266 Management The goal in management is initial stabilization along the lines of management of sexual
267 disorders in PTSD. First target will be to decrease the dissociative episodes in intimate situations, and
268 this can be addressed by using Grounding skills. During the intimate act, dissociation can happen.
269 Patients have to be taught to become aware of their sense of touch, breath, and what they are feeling
270 in the body to help ground them in the here and now. Emotional regulations interventions will address
271 the uncomfortable feelings. The last stage in therapy is processing of the trauma.

272 The patient should be encouraged to notice early signs of dissociation, talk with their partners, and
273 practice some grounding techniques during intimate moments. Slowly introducing non-threatening
274 physical intimacy, psychosexual therapy and couple-based interventions can assist in reconnecting
275 emotionally while minimizing fear and avoidance. Partner psychoeducation can be beneficial in

educating, minimizing symptom misunderstanding, and creating a supportive environment for recovery. No drugs are directly indicated for dissociation or trauma-related sexual dysfunction; however, if there is associated depression, anxiety, insomnia or post-traumatic stress disorder, some drugs may be needed to treat these conditions. Thus, psychotherapy should be the mainstay of therapy, and pharmacological treatment should be used as an adjunct for comorbid psychiatric disorders.

Personality Disorders

Different clusters of personality have different sexual dysfunctions. Those with predominant cluster A traits/PD show higher levels of odd and eccentric behavior. They will have little or no interest in sexual experiences with other people. Cluster B personality disorder individuals will have higher levels of dramatic, emotional, and impulsive behavior and tend to express impulsive and inappropriate sexual behavior. Whereas, cluster C personality disorder individuals exhibit higher levels of anxiety, are more constrained in sexual behavior, and could have difficulties in sexual functioning^[36]. Schema therapy and CBT targeting the underlying maladaptive schemas are treatments of choice in these patients.

The core features of BPD intense emotional dysregulation, unstable identity, impulsivity, chronic emptiness, and the oscillation between idealization and devaluation, lead to harmful sexual life at times. Impulsive sexual behaviour leads to sexual risk-taking as self-harm, and rapid transitions between partners tracking the idealization-devaluation cycle. There is increased risk of Sexually Transmitted Infections, unintended pregnancy, sexual coercion. Additional measures like risk assessment and management, contraception counselling, STI screening, safety planning, should be integral part of BPD management. Dissociation during sexual activity is common in BPD. Therapeutic management requires trauma-informed approaches, grounding techniques, and explicit agreements about communication during sexual activity.

Somatic Symptom Disorders, Eating Disorders, and Adult ADHD

302 Unexplained dyspareunia, vaginismus, and pelvic pain syndromes without identifiable organic
303 pathology are well-recognized presentations. The management principle of avoiding repeated medical
304 investigations stands good here also.

305

306 Eating disorders, particularly anorexia nervosa (AN), represent one of the most biologically mediated
307 forms of sexual dysfunction. HPG axis suppression from severe nutritional deprivation creates
308 functional hypogonadism^[37]. In women: decreased sexual desire, heightened sexual anxiety, reduction
309 in sexual act, poor arousal, poor lubrication, orgasmic dysfunctions, poor sexual satisfaction, frequent
310 amenorrhoea, low oestrogen, vaginal atrophy, dyspareunia. In men: testosterone deficiency
311 producing low desire and erectile difficulties. Beyond hormones, body dysmorphia creates intense
312 shame during sexual activity even with partial weight restoration. Clinicians must communicate that
313 nutritional rehabilitation is a prerequisite for meaningful sexual recovery.

314

315 Bulimia nervosa produces binge-purge cycle, alongside body shame and self-disgust creating painful
316 ambivalence about sexual activity. CBT-E (CBT Enhanced) with explicit body image work will address
317 both the eating disorder and the sexual-body interface.

318

319 Adult ADHD creates two distinct profiles in sexual dysfunctions. Untreated ADHD is associated with
320 impulsive sexual behaviour, poor relationship communication, and novelty-seeking creating
321 relationship instability. On stimulant medication, patients may experience reduced desire and delayed
322 orgasm/ejaculation, reflecting dopaminergic and noradrenergic modulation. Timing medication doses
323 to avoid peak plasma levels during anticipated sexual activity, or using a lower weekend dose, can
324 address this without sacrificing therapeutic benefit.

325

326 **Management Principles**

327 **General Principles**

328 Management of sexual issues in common mental disorders follows a structured, staged
329 biopsychosocial approach. Three hierarchical steps should guide all management decisions:

- 330 1. Optimize treatment of the underlying mental disorder. This is always the first step. Sexual
331 function frequently improves substantially, sometimes completely, when the psychiatric
332 illness is brought to remission. Withholding effective treatment out of concern about sexual
333 side effects generally produces a worse outcome for both mental disorder and sexual
334 function.
- 335 2. Review and minimize iatrogenic contribution. A structured medication review should
336 establish whether there is a temporal association between psychotropic medications and the
337 onset or worsening of sexual dysfunction. A six-step sequential approach: watchful waiting,
338 dose reduction, timing adjustment, drug holiday, switch, and augmentation.
- 339 3. Address the sexual dysfunction directly with evidence-based psychological and
340 pharmacological interventions. This step is initiated when sexual dysfunction persists
341 despite optimal treatment of the mental disorder and optimal medication management.

342

343 Concurrently, throughout all three steps: psychoeducation should be provided to the patient and, with
344 consent, to the partner; relationship and relational factors should be assessed and addressed; and the
345 patient's cultural and spiritual context should inform communication style, goals, and intervention
346 modalities.

347

348 Management overview with evidence grade has been given in table 6.

349

350 **Treatment Emergent Sexual Dysfunctions**

351 Antidepressants are used in the treatment of common mental disorders. They may lead to various
352 sexual dysfunctions. Figure 2 shows the assessment algorithm of treatment emergent sexual

dysfunction. Figure 3 shows the management algorithm of TEDS. Table 7 shows the management strategy in different situations while on treatment with antidepressants^[39, 40].

Medication Doses and Pharmacological Management

Precise knowledge of medication dosing, indications, contraindications, and special considerations in the psychiatric population is essential for safe pharmacological management of sexual issues. Table 8 provides a comprehensive medication reference for this guideline document.

Medication Review: Switching Antidepressants

Antidepressants: Sexual Side Effect Profile

The sexual side effect burden of antidepressants varies substantially across agents and represents a critical consideration in the Indian psychiatric outpatient setting, where long-term antidepressant use for anxiety disorders is common:

- **HIGH sexual side effects:** Paroxetine (highest rate: 70-80%+), Citalopram, Escitalopram, Fluoxetine, Sertraline (20-40%), Clomipramine (very high; anticholinergic effects compound serotonergic effects), Venlafaxine, Duloxetine.
- **LOW sexual side effects** (preferred when sexual concerns present): Mirtazapine (antagonizes 5-HT₂ receptors; also improves sleep; weight gain is a concern), Bupropion (lowest sexual SE of all antidepressants; also used to reverse SSRI-induced TEDS), Agomelatine (excellent sexual SE profile; requires LFT monitoring), Vortioxetine (multimodal; not yet universally available in India).
- **MODERATE sexual side effects:** Fluoxetine (long half-life may allow drug holidays), Sertraline, Escitalopram.

378 **Clinical Approach to Switching**

379 When switching is indicated for sexual dysfunction: discuss the rationale openly with the patient and
380 family members where relevant; ensure the decision is not driven solely by sexual concerns if
381 psychiatric control is at risk; plan a gradual cross-taper for most agents; monitor psychiatric stability
382 closely during the switch period (4-8 weeks); and reassess sexual function with ASEX/IIEF/FSFI 8-12
383 weeks post-switch.

384

385 **Psychological Interventions**

386

387 **Psychoeducation**

388 Psychoeducation is the universal first-line intervention, because it lays foundation for the treatment.
389 It should cover the specific mechanism contributing to the patient's difficulty (tailored to their
390 understanding); normalization; the range of available management options; the expected timeline for
391 improvement; and the importance of partner communication. Written material in the patient's
392 preferred language allows them to revisit information and share it with their partner.

393

394 **CBT-Based Sex Therapy**

395 Cognitive-behavioural sex therapy is the most evidence-based psychological intervention for sexual
396 dysfunction in anxiety disorders and has good evidence for use in stable psychiatric patients more
397 broadly. Core components: cognitive restructuring of maladaptive sexual cognitions; behavioural
398 experiments testing the validity of these cognitions; graduated behavioural exposure to avoided
399 sexual situations; communication training; and relapse prevention. Psychiatric stability is a
400 prerequisite for this. This needs to be modified to address active psychiatric symptoms. This needs to
401 be shorter, more structured sessions, concrete homework tasks, and modest incremental goals^[25].

402

403 **Sensate Focus**

404 This involves graduated touching exercises and re-establishes the association between physical
405 intimacy and pleasure^[2]. The protocol progresses through non-genital touching, genital touching
406 without intercourse, and graduated penetration, with explicit instructions banning sexual
407 'performance' at each stage. This needs to be modified for PTSD survivors. Need to have safety
408 protocols, permission to stop, grounding for dissociation. These have to be supplemented with joint
409 family privacy solutions, cognitive simplification for high symptom burden, and more gradual pacing.

410

411 **Mindfulness-Based Sex Therapy (MBST)**

412 MBSTs reduce the symptomatology associated with sexual arousal disorder and/or sexual desire
413 disorder, provoked vestibulodynia (PVD), and sexual abuse in women, or situational ED and
414 hypersexuality in men^[41]. This has been found useful in compulsive sexual behavior disorder (CSBD).
415 The principle in this therapy is training attentional focus toward sensory experience rather than
416 evaluative cognitions. Mindfulness directly targets the proximal psychological mechanism of sexual
417 dysfunction in anxious patients.

418

419 **Trauma-Focused Psychotherapy (TF-CBT)**

420 TF-CBT and EMDR are the gold-standard, Grade A evidence-based treatments for PTSD. TF-CBT has
421 been shown to be effective for short term and long-term duration in sexual dysfunctions in PTSD^[42, 43].
422 Their application to sexual dysfunction rests on the premise that sexual dysfunction in this population
423 is frequently secondary to untreated PTSD, and successful trauma processing produces significant
424 improvement as a downstream consequence. Reintegration work should explicitly include
425 psychoeducation about the trauma's impact on sexuality, graduated re-engagement with physical
426 intimacy, couple communication training, and relapse prevention planning for sexual triggers. The
427 clinician must have formal trauma-focused therapy training.

428

429 **DBT for BPD-Related Sexual Behaviour**

430 DBT is the most robustly evidence-based BPD treatment and directly addresses the two primary
431 mechanisms of sexual dysfunction in this population: emotional dysregulation and impulsivity. The
432 emotion regulation module trains identification and reduction of emotional storms driving impulsive
433 sexual behaviour. Distress tolerance provides skills for tolerating distress without engaging in problem
434 behaviours. Interpersonal effectiveness directly addresses relationship difficulties characterizing BPD
435 relationships. It has been shown to reduce sexual impulsivity in RCT^[44].

436

437 **Management Algorithm**

438 Figure 4 provides a step-by-step visual guide to the management of sexual issues in patients with
439 common mental disorders and other psychiatric, incorporating the tiered referral model for Indian
440 practice.

441

442 **Couple and Relationship Intervention**

443 Partners carry their own burdens: grief at watching a loved one suffer; frustration and self-blame from
444 sexual rejection; caregiver exhaustion; confusion about why sexual change occurred; and sometimes
445 their own unmet needs they feel guilty acknowledging. These experiences, if unaddressed, create a
446 reciprocal cycle that maintains and worsens the patient's sexual dysfunction.

447

448 Involving the partner, with the patient's explicit, freely given, informed consent, should be the norm.
449 It serves multiple functions: psychoeducation reducing partner blame and self-blame; mobilizing the
450 partner as a therapeutic ally; identifying the partner's own sexual dysfunction; and facilitating couple
451 therapy referral when indicated.

452

453 Partners often accompany patients to hospital visits. This creates an initial paradox because the
454 presence of the person most central to the difficulty makes assessment impossible. After the

individual assessment joint consultation is essential. A careful, individual assessment of the patient's autonomy and safety must always precede partner involvement.

Tiered Referral Model for Indian Practice

Given the highly uneven distribution of psychosexual expertise across India, concentrated in major metropolitan centres with very limited availability in tier-2/3 cities and effectively absent in rural areas, a tiered model of care is essential:

- **Tier 1: Every Psychiatrist:** Proactive screening (ASEX); psychoeducation; medication timeline review; dose optimization/timing adjustment for TEDS; first-line pharmacotherapy (PDE-5 inhibitors, lubricants); basic supportive counselling. Achievable in any outpatient psychiatric setting in India.
- **Tier 2: Trained Psychiatrist or Clinical Psychologist:** Structured assessment (IIEF/FSFI/GRIS); CBT-based sex therapy; modified sensate focus; mindfulness-based sex therapy; bupropion augmentation; couple psychoeducation; TEDS management through switch/augmentation. Requires additional training via IPS workshops.
- **Tier 3: Sexual Medicine Specialist:** Management of refractory dysfunction; surgical options; complex hormonal management; paraphilias; gender identity assessment; forensic sexual medicine; complex trauma-related presentations. Telemedicine consultation is appropriate for non-metropolitan psychiatrists.

Consent, Confidentiality, and Ethical Considerations

Psychosexual assessment and management require the same rigorous standards of informed consent and confidentiality governing all sensitive clinical work, with particular attention to the Indian legal and cultural context:

- 479 • **Informed consent:** The patient should be informed sexual health questions will be part of
480 the consultation, given the option to decline specific questions, and reassured about
481 confidentiality, particularly important given family members routinely accompany patients
482 in Indian settings.
- 483 • **Confidentiality within the clinical team:** Information about sexual history, concerns, or
484 behaviour should be shared within the treating team only on a need-to-know basis, never
485 disclosed to family members without explicit written consent, even when family are
486 primary caregivers.
- 487 • **Partner involvement requires mandatory consent:** The patient's explicit, freely given,
488 revocable consent must be obtained before discussing any aspect of their sexual health with
489 a partner, even in couple therapy.
- 490 • **Mandatory reporting obligations:** If a patient discloses sexual abuse of a child, clinicians
491 have mandatory reporting obligations under POCSO 2012 and other applicable Indian
492 legislation. All psychiatrists conducting psychosexual assessments should be familiar with
493 these obligations.
- 494 • **Sexual exploitation and coercive relationships:** If assessment reveals a sexually coercive
495 relationship, including within marriage, the clinician's ethical duty is to the patient's safety
496 and autonomy, assessment of safety, discussion of options, and referral to legal aid or
497 domestic violence support should be integrated into the clinical plan.

498

499 **Clinical Practice Recommendations**

500 The following recommendations are graded using the standard evidence grading system used
501 throughout this CPG series: Grade A (consistent RCT evidence), Grade B (consistent observational
502 evidence), Grade C (expert consensus). Table 9 mentions the recommendations

503 **Gaps in Evidence and Future Research Priorities**

504 The evidence base for sexual health management in common mental disorders has significant lacunae,
505 many particularly acute in the Indian context:

- 506 • Prevalence data: Near-complete absence of large, well-designed Indian epidemiological
507 studies on sexual dysfunction across the spectrum of common mental disorders.
- 508 • Validated assessment tools in Indian regional languages: None of the major instruments
509 (ASEX, IIEF, FSFI, GRISS, CSFQ) have been formally validated in major Indian regional
510 languages, an urgent methodological priority.
- 511 • RCTs in psychiatric populations: Very few RCTs of CBT sex therapy, sensate focus, and
512 mindfulness-based sex therapy have been conducted specifically in patients with comorbid
513 common mental disorders, and almost none from India or South Asia.
- 514 • Gender equity in research: Male erectile dysfunction is massively over-represented in
515 pharmacological trials, while female sexual dysfunction in psychiatric populations remains
516 dramatically under-studied.
- 517 • LGBTQ+ populations: Individuals identifying as LGBTQ+ with common mental disorders
518 are virtually absent from global sexual health research, and entirely absent from Indian
519 research.
- 520 • Digital health interventions: The potential of app-based, internet-delivered, and
521 telemedicine-based psychosexual interventions for psychiatric patients in India has not
522 been systematically evaluated.
- 523 • Cultural adaptation research: Standard sex therapy protocols require systematic cultural
524 adaptation for Indian use; rigorous research on feasibility, acceptability, and effectiveness
525 of adapted protocols is needed.
- 526 • Longitudinal studies: Long-term studies tracking the natural history of sexual dysfunction
527 and the impact of sustained optimal psychiatric treatment on sexual function outcomes are
528 lacking.

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666 **Tables**
667 **Table 1 Scope of the Guidelines Disorders Included**

Disorders INCLUDED
Generalized Anxiety Disorder (GAD)
Panic Disorder
Social Anxiety Disorder
Obsessive-Compulsive Disorder (OCD)
Post-Traumatic Stress Disorder (PTSD)
Personality Disorders (Borderline PD; Cluster C PDs)
Somatic Symptom & Related Disorders
Eating Disorders (Anorexia Nervosa, Bulimia Nervosa)
Attention Deficit Hyperactivity Disorder - Adult

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Table 2 Definitions and Terminologies

Sexual dysfunction: A clinically significant disturbance in an individual's ability to respond sexually or to experience sexual pleasure, which causes the individual marked distress or interpersonal difficulty, and which is not better explained by a non-sexual mental disorder, the effects of a substance/medication, or another medical condition alone (DSM-5-TR). Encompasses disorders of sexual desire, arousal, orgasm, ejaculation, and sexual pain.
Treatment-emergent sexual dysfunction (TESD): Sexual dysfunction arising in temporal association with the initiation, dose increase, or continuation of a psychotropic medication, in the absence of an alternative explanation for the onset or worsening of the sexual problem.

Biopsychosocial formulation: The clinical framework underpinning assessment and management throughout this chapter, recognizing biological (neurochemical, hormonal, vascular), psychological (cognitive, emotional, behavioural), and social (relational, cultural, contextual, developmental) contributors to sexual health and dysfunction.

Sexual obsessions (in OCD): Ego-dystonic, intrusive, unwanted sexual thoughts or images that are distressing precisely because they conflict with the individual's own sexual values and identity. These are not pleasurable and are NOT paraphilias.

Prolactin-sparing antipsychotics: Antipsychotic agents that do not substantially elevate serum prolactin levels at therapeutic doses. Includes aripiprazole, quetiapine, clozapine, and olanzapine (at standard doses). Contrasted with prolactin-raising agents: risperidone, paliperidone, amisulpride, and all typical/conventional antipsychotics.

Table 3: Prevalence of Sexual Dysfunction in Common Mental Disorders and Other Psychiatric Disorders

Disorder	Estimated Prevalence	Predominant Dysfunction(s)	Primary Mechanism(s)	Indian Data?
Generalized Anxiety Disorder	30-85% ^[9] 64% ^[10]	Low desire, arousal difficulties	Sympathetic overactivation; cognitive distraction; muscle tension	Limited; small clinic-based studies
Panic Disorder	25-75% ^[11,12,13]	Avoidance; arousal difficulties	Interoceptive fear conditioning	Sparse; no large Indian RCTs
Social Anxiety Disorder	30% ^[14] premature ejaculation (47%), and retarded	Performance anxiety, arousal disorders, orgasm-ejaculation disorders, delayed ejaculation, intimacy avoidance,	Anticipatory anxiety; negative self-evaluation; shame; heightened self-awareness, and avoidance of socially intimate situations	Limited; culturally shaped presentations

	ejaculation (33%) ^[8,14]	sexual dissatisfaction, few sexual thoughts ^[15]		
OCD	25-47% ^[9] 54-73% ^[16] 25-81% ^[1]	Avoidance; desire/arousal deficits; sexual obsessions	Ego-dystonic intrusions; SSRI side effects	Few studies; under-reported due to shame
PTSD	40-60%+ (higher with sexual trauma) 69% ^[17, 18]	Low desire; arousal dysfunction; vaginismus; dissociation; erectile dysfunction, problems in orgasm, and poor sexual satisfaction	Trauma triggers; HPA dysregulation; hyperarousal/numbing	Growing data; domestic violence cohorts
Borderline PD (BPD)	30-50%	Impulsive risk-taking; dissociation; identity confusion	Emotional dysregulation; trauma history	Under-studied; BPD under-diagnosed in India
Cluster C PDs	20-40%	Avoidant: intimacy avoidance; OCPD: rigidity	Fear of rejection; perfectionism	No specific Indian data
Somatic Symptom Disorders	Not well studied 0.5% ^[19]	Dyspareunia; vaginismus; low desire	Central sensitization; somatization	Available from gynaecology OPDs
Anorexia Nervosa	-	Profoundly low desire; amenorrhoea; dyspareunia	Starvation → HPG axis suppression	Very limited Indian eating disorder data
Bulimia Nervosa	-	Impulsive sexual behaviour; low satisfaction	Impulsivity; body image disturbance	Minimal Indian data
Adult ADHD (untreated)	67% women orgasmic dysfunction 39% Premature ejaculation ^[20]	Sexual risk-taking; relationship difficulties	Impulsivity; executive dysfunction	Growing recognition; sexual dimension under-studied

Adult ADHD (on stimulants)	15-30%	Low desire; delayed orgasm/ejaculation	Dopamine/norepinephrine modulation	Clinical observation only
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ADHD=Attention Deficit Hyperactivity Disorder; BPD: Borderline Personality Disorder; ED = Erectile Dysfunction; HPA = Hypothalamic-Pituitary-Adrenal; HPG = Hypothalamic-Pituitary-Gonadal; OCD = Obsessive Compulsive Disorder; OCPD = Obsessive Compulsive Personality Disorder; OPD = Outpatient Department; PD = Personality Disorder; PTSD = Post Traumatic Stress Disorder; RCT = Randomized Control Trial; SRI = Serotonin Reuptake Inhibitor; SSRI = Selective Serotonin Reuptake Inhibitor.

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Table 4 Framework for Psychosexual Assessment in Common and Other Mental Disorders and Other Psychiatric Disorders

Domain	Assessment Focus	Tool / Method	Key Questions / Considerations
Chief Sexual Complaint	Nature, onset, duration, course; spontaneous vs partner-specific; distress level	Open-ended interview	'Has anything changed in your sexual life?' 'Does this cause distress or affect your relationship?'
Mental Disorder Profile	Diagnosis, severity, phase, comorbidities	GAD-7, PANSS, PCL-5, Y-BOCS, PHQ-9	Is the disorder currently active or undertreated? Could symptom change explain sexual difficulty?
Temporal Relationship	Predates disorder? Coincides with onset? Follows medication change?	Medication timeline; chronological history	Draw a timeline: illness onset → medication initiation → sexual symptom onset
Medication History	Current & recent psychotropics: drug, dose, duration	Structured medication list; ASEX at baseline	Which medications are known to cause sexual side effects? Was baseline documented?
Sexual Function Domains	Desire, arousal, lubrication, orgasm/ejaculation latency, pain, satisfaction	IIEF-15 (men); FSFI (women); ASEX (all); GRISS (couples)	Administer in private; offer choice of written vs verbal in regional language
Relationship & Partner	Partner's sexual health; relationship quality; communication about sex	Partner interview (with consent); couple questionnaire	Is the partner themselves dysfunctional? Relational factors independent of mental disorder?
Reproductive & Hormonal	Menstrual regularity, amenorrhoea, galactorrhoea; erection quality	Physical exam; serum prolactin, testosterone, LH/FSH, TSH, glucose, lipids	Prolactin >25 ng/mL (men) or >20 ng/mL (women) → consider prolactin-sparing antipsychotic
Sexual History	Pre-morbid function; developmental history; trauma history; orientation/gender identity	Sensitive biographical interview; PC-PTSD-5 if trauma suspected	Never assume orientation or relationship structure; use inclusive language
Psychological & Cultural	Body image, sexual self-esteem, performance	Clinical interview; culture-specific open questions	In India: ask about joint family living, privacy, in-

	anxiety, shame; religious beliefs; living situation		laws' attitudes, religious prohibitions
Risk & Safety	History of sexual abuse; high-risk behaviour; paraphilic urges	Risk assessment interview; AUDIT/DAST if substance use suspected	Mandatory reporting obligations under POCSO 2012 if child sexual abuse disclosed

736 ASEX = Arizona Sexual Experience Scale; AUDIT = Alcohol Use Disorders Identification Test; DAST =
737 Drug Abuse Screening Test; FSFI = Female Sexual Function Index; FSH = Follicle-Stimulating Hormone;
738 GAD-7 = Generalized Anxiety Disorder-7; GRISS = Golombok Rust Inventory of Sexual Satisfaction; IIEF
739 = International Index of Erectile Function; LH = Luteinizing Hormone; PANSS = Positive and Negative
740 Syndrome Scale; PCL-5 = PTSD Checklist for DSM-5; PHQ-9 = Patient Health Questionnaire-9; POCSO =
741 Protection of Children from Sexual Offences Act; TSH = Thyroid-Stimulating Hormone; Y-BOCS = Yale-
742 Brown Obsessive Compulsive Scale;

743 **Table 5: Disorder-Specific Sexual Issues: Assessment and Management Priorities**

Disorder	Key Sexual Issues	Mechanism	Treatment Priority	Clinical Pearl
GAD	Low desire, arousal difficulties, difficulty relaxing during sex	Chronic sympathetic overactivation; cognitive 'spectatoring'	CBT for GAD + mindfulness sex therapy	SSRIs used for GAD can worsen sexual dysfunction (up to 80% patients, ^[32] : assess ASEX at baseline BEFORE starting SSRI
Panic Disorder	Avoidance of sex; arousal difficulties; conditioned sexual fear	Interoceptive fear conditioning; arousal sensations misread as panic cue	Interoceptive exposure; psychoeducation	Re-exposure to sex can be incorporated into the standard panic exposure hierarchy
Social Anxiety Disorder	Sexual performance anxiety; intimacy avoidance; low confidence	Anticipatory anxiety; negative self-evaluation; shame	CBT (cognitive restructuring + behavioural experiments)	Performance anxiety in SAD can cause complete erectile failure/vaginismus without organic pathology
OCD	Ego-dystonic sexual obsessions; avoidance; desire/arousal deficits	Intrusive taboo thoughts + compulsive avoidance; SRI side effects	ERP for OCD; address SRI-induced TESD separately	CRITICAL: Ego-dystonic obsessions are NOT paraphilias, do not misidentify

PTSD	Low desire; arousal failure; vaginismus; dissociation; avoidance	Trauma triggers; HPA dysregulation; hyperarousal/numbing	Trauma-focused therapy FIRST (TF- CBT/EMDR/CPT), then sex therapy	Screen all PTSD patients for sexual impact, not only those with sexual trauma history
Borderline PD	Impulsive sexual risk-taking; dissociation; identity confusion	Emotional dysregulation; trauma history; abandonment fear	DBT; trauma- focused work; risk management	Sexual risk-taking often reflects emotional dysregulation, not sexual pathology
Cluster C PDs	Avoidant: intimacy avoidance; OCPD: rigid, joyless sex	Fear of rejection/inadequacy; perfectionism	CBT; schema therapy; gradual intimacy exposure	Distinguish from social anxiety disorder via schema-level cognitions
Somatic Symptom Disorder	Dyspareunia; vaginismus; preoccupation with body sensations	Central sensitization; somatization	Biopsychosocial approach; pelvic physiotherapy liaison	Repeated investigations without psychological formulation perpetuate illness behaviour
Anorexia Nervosa	Profound low desire; amenorrhoea; dyspareunia (vaginal atrophy)	Starvation → HPG axis suppression; body dysmorphia	Nutritional rehabilitation is prerequisite for sexual recovery	Communicate clearly: sexual function often improves with weight restoration
Bulimia Nervosa	Impulsive sexual behaviour; body shame during sex	Shared impulsivity substrate with binge- purge; body shame	CBT-E; explicit body image work	Impulsive sexual behaviour may reflect the same impulsivity driving the eating disorder
Adult ADHD (untreated)	Sexual risk-taking; poor communication; hypersexuality	Impulsivity; executive dysfunction; novelty- seeking	Pharmacological ADHD treatment + psychoeducation	Impulsive sexual behaviour may precede formal ADHD diagnosis by years
Adult ADHD (on stimulants)	Low desire; delayed orgasm/ejaculation	Dopamine/norepinephrine modulation	Timing adjustment; dose holiday; non- stimulant switch	'Medication holiday' strategy can restore function without losing ADHD control

Dissociative disorders	Decreased desire, anxiety, avoidance	H/o sexual trauma Triggers unpleasant memories	Trauma-focused therapy FIRST (TF-CBT/EMDR/CPT), then sex therapy	Usually seen in patients with trauma/PTSD
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ADHD = Attention Deficit Hyperactivity Disorder; ASEX = Arizona Sexual Experience Scale; CBT = Cognitive Behavioural therapy; CBT-E = Enhanced CBT for eating disorder; CPT = Cognitive Processing Therapy ; DBT = Dialectical Behaviour Therapy; ED = Erectile Dysfunction; EMDR = Eye Movement Desensitization & Reprocessing; ERP = Exposure and Response Prevention; GAD = Generalized Anxiety Disorder; HPG = Hypothalamic-Pituitary-Gonadal; OCPD = Obsessive-Compulsive Personality Disorder; PTSD = Post Traumatic Stress Disorder; SAD = Social Anxiety Disorder; SRI = Serotonin Reuptake Inhibitor; SSRI = Selective Serotonin Reuptake Inhibitor; TF-CBT = Trauma-Focused CBT.

Table 6: Management Interventions: Indications, Evidence, and Practical Guidance

Intervention	Target Population	Grade	Practical Guidance for Indian Settings
Psychoeducation	All patients: universal first-line	C	Normalize; simple language; written material in regional language; include partner with consent
Optimize psychiatric treatment	All patients: treat primary disorder first	A/B	Never withhold effective treatment due to sexual side effect concern alone
Medication dose optimization	TESD with temporal correlation to dose increase	B	Reduce to minimum effective dose; balance psychiatric control vs sexual function
Medication timing adjustment	SSRI-induced delayed orgasm; stimulant TSED	B	Take short-acting agent after anticipated sexual activity
Drug holiday ^[38] (Rothschild AJ, 1995)	SSRI-induced dysfunction (selected cases)	B	Only short-acting SSRIs; NOT for antipsychotics, clomipramine, venlafaxine; psychiatrist supervision mandatory

Medication switch (antidepressant)	Persistent TESD on SSRI/SNRI	B	Switch to mirtazapine, bupropion, agomelatine, or vortioxetine
Medication switch (antipsychotic)	Antipsychotic-induced hyperprolactinaemia	B	Switch to aripiprazole, quetiapine, clozapine, or olanzapine; gradual cross-taper
Bupropion augmentation	SSRI/SNRI-induced desire/arousal/orgasm deficits	B	75-300 mg/day; start 75 mg OD for 1 week; avoid in seizure-risk and eating disorders
PDE-5 inhibitor	Erectile dysfunction (any cause)	A	Widely available in India; counsel on nitrate interaction; assess cardiovascular risk
CBT-based sex therapy	Anxiety-related dysfunction; performance anxiety	A/B	Ensure psychiatric disorder is STABLE before commencing; therapist training essential
Sensate Focus (modified)	Desire, arousal, orgasm disorders; couples; post-trauma	B	Requires willing partner; modify for trauma survivors; address joint family privacy constraints
Mindfulness-based sex therapy	Female arousal disorder; PTSD-associated arousal difficulties	B	Frame as 'awareness practice' to reduce stigma; individual format preferred over group
Trauma-focused psychotherapy	PTSD with sexual trauma: TREAT PTSD FIRST – CPT/EMDR	A	Refer to trained trauma therapist; integrate sexual health at later phase
DBT	Impulsive sexual behaviour in BPD	B	Emotion regulation and distress tolerance modules directly target the behaviour
Couple therapy	Relationship discord; partner distress	B	With patient's consent only; assess partner's own sexual dysfunction
Tier 3 referral	Refractory cases; organic co-pathology; paraphilias	C	Use tiered referral model; telemedicine appropriate for non-metro settings

764 BPD = Borderline Personality Disorder; CBT = Cognitive Behavioural therapy; CPT = Cognitive
 765 Processing Therapy; DBT = Dialectical Behaviour Therapy; EMDR = Eye Movement Desensitization &
 766 Reprocessing; Grade A = consistent RCT evidence; Grade B = consistent observational evidence; Grade
 767 C = expert consensus; PDE-5i = Phosphodiesterase-5 inhibitor; SNRI = Serotonin Norepinephrine
 768 Reuptake Inhibitor; SSRI = Selective Serotonin Reuptake Inhibitor; TESD = Treatment-Emergent Sexual
 769 Dysfunction.

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Table 7: Clinical Decision Matrix based on the clinical situation

Clinical situation	Preferred strategy
Mild TESD	Watchful waiting
Near end of antidepressant course	Dose reduction → taper
Depression fully controlled	Add-on therapy
Depression partially controlled	Add-on (bupropion/mirtazapine)
Poor antidepressant response	Switch antidepressant
Long-term antidepressant needed	Switch to low-risk antidepressant
Erectile dysfunction	PDE-5 inhibitor
Low libido	Bupropion
Delayed orgasm	Bupropion ± Buspirone

PDE-5i = Phosphodiesterase-5 inhibitor; TESD = Treatment-Emergent Sexual Dysfunction.

Table 8: Pharmacological Interventions: Dosing, Indications, and Key Cautions

Drug/Class	Indication	Starting Dose	Usual Dose	Max Dose	Key Cautions

Sildenafil (PDE-5i)	Erectile dysfunction	25 mg PRN	50 mg PRN	100 mg PRN	Contraindicated with nitrates; caution in CVD, recent MI/stroke; avoid with ritonavir
Tadalafil (PDE-5i)	ED: when spontaneity needed	5 mg OD or 10 mg PRN	5-10 mg OD or 10-20 mg PRN	20 mg PRN	Same nitrate contraindication; daily dosing avoids planning
Vardenafil (PDE-5i)	ED: alternative agent	5 mg PRN	10 mg PRN	20 mg PRN	Avoid with antiarrhythmics (QT risk) - caution with thioridazine, ziprasidone
Bupropion	SSRI/SNRI-induced TESD; augmentation	75 mg OD x1 week	75-150 mg BD	300 mg/day	LOWERS seizure threshold - avoid in eating disorders, alcohol use, seizure history
Aripiprazole	Switch/adjunct for antipsychotic hyperprolactinaemia	5-10 mg/day	10-20 mg/day	30 mg/day	Prolactin-sparing even at low doses; risk of akathisia; activating
Quetiapine	Lower prolactin/ED-risk antipsychotic	25-50 mg nocte	200-600 mg/day	750 mg/day	Metabolic risk; sedating; orthostatic hypotension at initiation
Olanzapine	Prolactin-neutral antipsychotic	5 mg/day	10-20 mg/day	20 mg/day	Significant weight gain/metabolic syndrome risk; monitor glucose, lipids
Local vaginal oestrogen	Vaginal atrophy (antipsychotic/AN/menopause)	0.5 g OD x2 weeks	0.5 g twice weekly	Per gynaecologist	Minimal systemic absorption; caution in

					hormone-sensitive cancer history
Vaginal lubricants (OTC)	Vaginal dryness, dyspareunia (all causes)	PRN	PRN	No max	Safe in all patients; avoid oil-based with latex condoms
Topical lidocaine 2-5%	Provoked vulvodynia/vestibulodynia	Apply 10-15 min pre-penetration	PRN	PRN	Wash off before partner contact; not a cure - combine with physiotherapy
Buspirone	Adjunct for SSRI-induced TESD; GAD	5 mg BD	20-30 mg/day	60 mg/day	Onset 2-4 weeks; avoid with MAOIs
Testosterone (specialist)	Documented deficiency + HSDD in women	Refer to endocrinology	0.5 mg/day gel (women)	Titrate to high-normal	NOT routine without documented deficiency; monitor androgenic effects; off-label in India

AN = Anorexia Nervosa; BD = twice daily; CVD = Cardiovascular Disease; ED = Erectile Dysfunction; GAD = Generalized Anxiety Disorder; HSDD = Hypoactive Sexual Desire Disorder; MAOI = monoamine oxidase inhibitors; MI = Myocardial Infarction; OD = once daily; OTC = over the counter; PDE-5i = Phosphodiesterase-5 inhibitor; PRN = as needed; SNRI = Serotonin Norepinephrine Reuptake Inhibitor; SSRI = Selective Serotonin Reuptake Inhibitor; TESD = Treatment-Emergent Sexual Dysfunction. All pharmacotherapy should be prescribed by a registered medical practitioner with appropriate clinical monitoring.

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Table 9: Graded Clinical Practice Recommendations

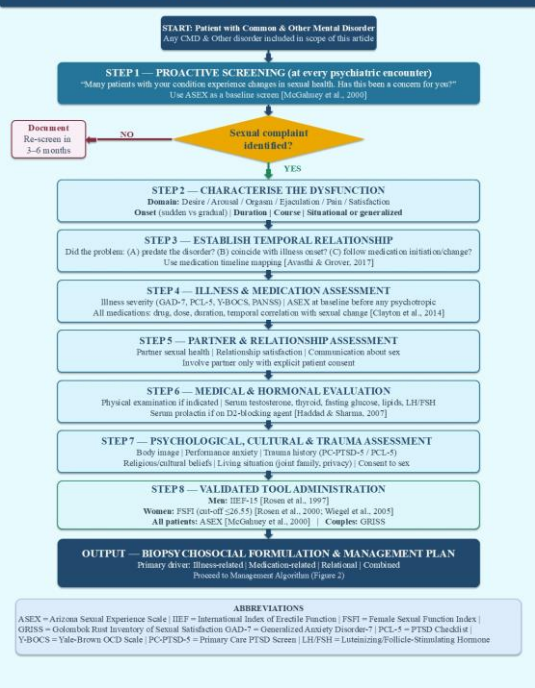
No.	Recommendation	Grade	Strength
1	Proactive screening for sexual health concerns at every psychiatric encounter, using a non-judgmental, normalizing approach.	C	Strong
2	Structured biopsychosocial assessment establishing the temporal relationship between sexual dysfunction and mental disorder/treatment.	C	Strong
3	Validated tools (ASEX, IIEF, FSFI, GRISS) to characterize and monitor sexual function; ASEX at baseline before initiating any psychotropic.	C	Strong
4	Optimise treatment of the underlying mental disorder as the primary management step.	B	Strong
5	Routine serum prolactin in patients on D2-blocking antipsychotics with sexual dysfunction, menstrual irregularity, or galactorrhoea.	B	Strong
6	Medication review (dose optimization, timing, drug holiday in selected cases, switching, augmentation) as an early management step in TESD.	B	Strong
7	CBT-based sex therapy for anxiety-related dysfunction [A]; modified sensate focus for desire/arousal/orgasm disorders [B].	A/B	Strong
8	Trauma-focused psychotherapy (TF-CBT or EMDR) must precede sex-specific interventions in PTSD-related sexual dysfunction.	A	Strong
9	PDE-5 inhibitors are first-line pharmacotherapy for erectile dysfunction, including treatment-emergent ED.	A	Strong
10	Bupropion augmentation (75-300 mg/day) for SSRI/SNRI-induced sexual dysfunction not resolved by dose/timing adjustment.	B	Moderate
11	Mindfulness-based sex therapy as adjunct for female sexual interest/arousal disorder and PTSD-associated arousal difficulties.	B	Moderate
12	DBT for Borderline PD patients with clinically significant impulsive sexual behaviour.	B	Moderate
13	Partner involvement in psychoeducation and management with explicit patient consent; couple therapy for significant relationship discord.	B	Moderate
14	Tiered referral system (Tier 1-3) for Indian healthcare infrastructure; telemedicine acceptable for Tier 3 access from non-metro settings.	C	Strong
15	Awareness of mandatory reporting obligations under POCSO 2012 when sexual abuse disclosures occur during assessment.	C	Strong (legal)

813 ASEX = Arizona Sexual Experience Scale; DBT = Dialectical Behaviour Therapy; EMDR = Eye Movement
814 Desensitization & Reprocessing; FSFI = Female Sexual Function Index; FSH = Follicle-Stimulating
815 Hormone; GRISS = Golombok Rust Inventory of Sexual Satisfaction; IIEF = International Index of
816 Erectile Function; PDE-5i = Phosphodiesterase-5 inhibitor; POCSO = Protection of Children from Sexual
817 Offences Act 2012; PTSD = Post-Traumatic Stress Disorder; RCT = Randomized Controlled Trial; SNRI =
818 Serotonin Norepinephrine Reuptake Inhibitor; SSRI = Selective Serotonin Reuptake Inhibitor; TESD =
819 Treatment-Emergent Sexual Dysfunction; TF-CBT = Trauma-Focused CBT.

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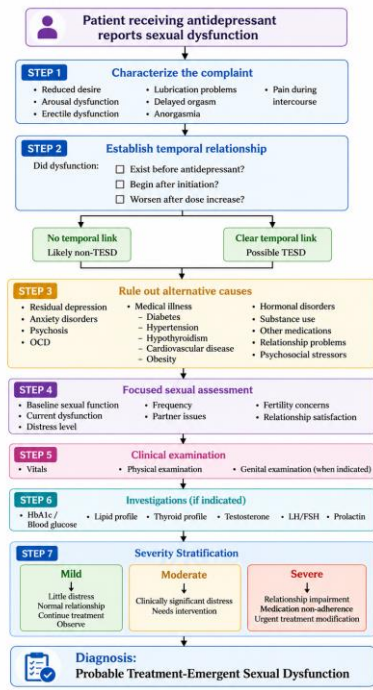
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FIGURE 1: Clinical Assessment Flowchart — Sexual Issues in Common & Other Mental Disorders



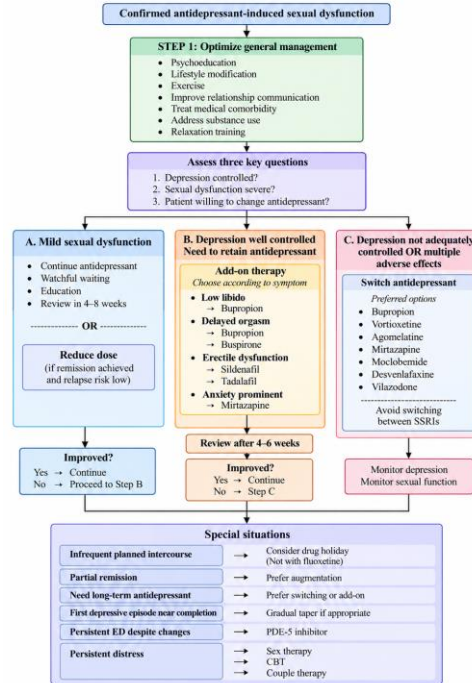
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Figure 2: Assessment of Treatment Emergent Sexual Dysfunction.



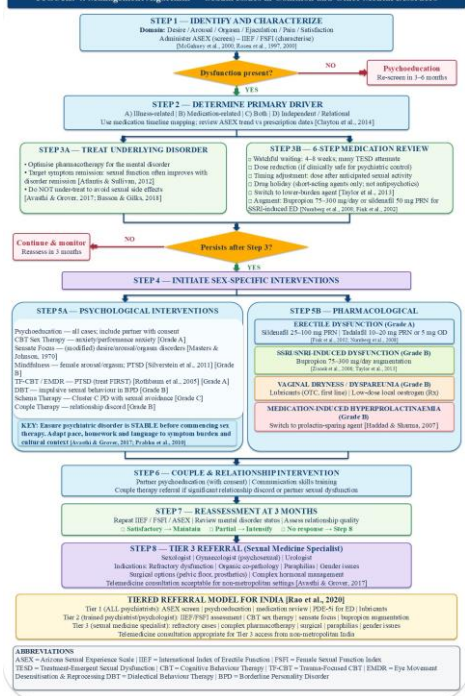
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Figure 3: Management algorithm of TESD.



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FIGURE 4: Management Algorithm — Sexual Issues in Common and Other Mental Disorders



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