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To,
Dr Sujit Sarkhel,
Editor in Chief,
Indian Journal of Psychiatry

Dear Dr Sarkhel,

Please find herewith the article

Clinical Practice Guidelines for Psychosexual Health, Dysfunctions and Disorders:
Practice Guidelines for Forensic Issues in Clinical Practice of Sexual Medicine.

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Thanking you,

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Clinical Practice Guidelines for Psychosexual Health, Dysfunctions & Disorders

Practice Guidelines for Forensic Issues in Clinical Practice of Sexual Medicine

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INTRODUCTION AND BACKGROUND

Maslow proposed a 5-tier hierarchy of human needs. Sex is a basic human need in the first tier (physiological needs). [1] In a civilized society, sexual needs are fulfilled via the institution of marriage. Marriage is a socio-religious institution. Society has set norms (gender based) for sexual behavior. Sex outside marriage is looked down upon in society. Several legislations have been enacted from time to time to regulate marriage and sexual behavior.

Psychiatrists may often be confronted with clinically challenging situations. The main task of the psychiatrist is to treat patients' ailments within the framework of legal provisions. While practicing sexual medicine, clinicians should be aware of the laws of the land (Table 1) that may have clinical implications for proper assessment and management of the patients.

Table-1: Legislations that may be important in the practice of sexual medicine.

1. The Drug and Cosmetics Act (DCA), 1940.[2]
2. The Special Marriage Act (SMA), 1954. [3]
3. The Hindu Marriage Act (HMA), 1955. [4]
4. The Immoral Traffic (Prevention) Act (ITPA) 1956. [5]
5. Medical Termination of Pregnancy Act (MTPA), 1971. [6]
6. The Family Courts Act (FCA), 1985. [7]
1. Narcotic Drugs and Psychotropic Substances Act (NDPSA), 1985. [8]
7. Constitution of India (COI), 2004. [9]
8. The Right to Information Act (RTI), 2005. [10]
9. Protection of Women from Domestic Violence Act (PWDVA), 2005. [11]
10. The Prohibition of Child Marriage Act, (PCMA), 2006. [12]
11. The Clinical Establishments (Registration and Regulation) Act (CERRA), 2010. [13]
12. The Prevention of Child from Sexual Offences (POCSO) Act, 2012. [14]
13. The Mental Healthcare Act (MHA), 2017. [15]
14. The National Medical Commission Act (NMCA), 2019. [16]
15. The Consumer Protection Act (CPA), 2019. [17]
16. Bharatiya Nyaya Sanhita (BNS), 2023.[18]
17. Digital Personal Data Protection Act (DPDPA), 2025. [19]
18. The Law of Torts, 2022. [20]
19. Transgender Persons (Protection of Rights) Amendment Act (TPPRA), 2026. [21]

Clinical Practice in Sexual Medicine

The NMC, 2019 [18] stipulates that registered medical practitioners should practice within the limits of their education, training, competence, and experience. The physician should

practice scientific method, and should not associate professionally with anyone who violates this principle. Physicians should try continuously to improve their medical knowledge and skills and should make available to their patients and colleagues the benefits of their professional attainments. The physician shall observe the laws of the country in regulating the practice; such as DCA, 1940 [2]; MTPA, 1971 [6]; NDPSA, 1985 [10]; MHA, 2017 [15] etc. These principles are reinforced by the Code of Medical Ethics. [22]]Practicing beyond one's competence or employing unscientific methods, violates the ethical duties of beneficence and non-maleficence, exposes patients to unnecessary risk, and may result in professional disciplinary action, civil liability, or, in cases of gross negligence, criminal consequences.

A widely cited legal standard in medical negligence is the Bolam test [23]. In simple words, a professional is not negligent if he acted in accordance with a practice accepted as proper by a responsible body of medical professionals skilled in that specific field (in the present context, 'psychiatrists'). If a psychiatrist performs a procedure normally requiring a trained urologist without equivalent training, the standard of care will be assessed against that of a competent urologist. Any adverse outcome will likely constitute medical negligence, potentially exposing the psychiatrist to liability for trespass and compensation.

Confidentiality

Right to confidentiality and privacy is guaranteed under Art 21, COI, Right to life and personal liberty. The Supreme Court of India declared Right to privacy as an inherent fundamental right under article 21 COI in the landmark Puttaswamy v. Union of India case. [24] Sensitive information is to be protected from unauthorized access/ disclosure.

The right to confidentiality is also mentioned in the MHA, 2017 [15]. Mental health professionals must keep all health details private. No one can share data (photos, videos, or other details) about a patient on the internet or in the media. Anyone getting treatment in a mental health facility has the right to keep his personal life completely private from the public.

The NMC [22] mandates the right to patient confidentiality. Doctors are ethically and legally required to keep patient information private. Breaking this rule can cause doctors to lose their medical licenses; also invites strict penalties under the DPDPA Act, 2025. [19]

Maintenance of Medical Records

The CERRA, 2010 [13] states that accurate patient records must be maintained. Inpatient records should be preserved for at least 3 years.

Right to Medical Records in Practice of Sexual Medicine

Under guidelines issued by NMC [22] (which follows the Indian Medical Council Regulations (Professional Conduct, Etiquettes and Ethics) Regulations, 2002) patients have the legal right to access and obtain copies of their medical records, which doctors/ hospital must provide within 72 hours of a formal request. Refusing to do so can be treated as professional misconduct. The RTI, Act [10] and The CPA, Act [17], also gives the right to patients to access their medical records.

Marriage and sexual behaviour

The SMA, 1954 [3], and The HMA, 1954 [4], provide for the conditions of valid marriage(s). The legal age for marriage for boys is 21 and for girls 18. For Muslims, it is the age at attainment of adolescence, which is considered to be about 15 years. [25]. Adultery is a ground for divorce in SMA, 1954 [3], and The HMA, 1954 [4]. Other marriage laws have similar provisions. The PCMA. Act 2006 [12] prohibits child (girl below 18; boy below 21) marriage. However, if a child marriage takes place, it is voidable. It can be nullified on a petition, by the child, before 16 years of age. It may be noted that the PCMA, 2012 is a secular act, it overrides personal laws. The FCA, 1985 [7] was established to promote conciliation, and secure speedy settlement of, disputes relating to marriage and family affairs.

The POCSO Act, 2012 [14] is to protect children from offences of sexual assault, sexual harassment and pornography and provide for establishment of Special Courts for trial of cases. "Child" means any person below the age of 18 years. Under Section 19 of The POSCO Act 2012, mandatory reporting requires any person who has knowledge/ apprehension of a sexual offence against a child to report it immediately to the Special Juvenile Police Unit or to the local police. Failure to Report carries strict legal and punitive consequences.

In view of the rising cases in courts of consensual / romantic relationships, the Supreme Court requested the Government to lower the age of consent from 18 to 16 years, by introducing the Romeo-Juliet clause, as in some countries, so that adolescents love relationships are not criminalized. [26] However, the government has not acceded to this request because it is against constitutional provisions. [27]

Marriage and Live-in relationships

There is a strong social stigma against live-in relationships (LIRs) between consenting adults. The Judiciary has taken various stands on LIRs, from permissible only in unmarried adults of heterogeneous sex and not a crime [28]; to being a 'walk-in and walk' out relation with no rights [29]; and to being akin to marriage [30]. If any unmarried couple of right legal age "indulge in sex and gratification", it would be considered as a valid marriage and that the man and woman could be termed "husband & wife." [30]. Further, there should be a presumption of marriage if the LIR is of long duration [31]. Thereafter, the Supreme Court [32] spelled out guidelines for LIRs to fall within the expression "relationship in the "nature of marriage" under S 2(f) of PWDV Act, 2005. [11] These include, duration of cohabitation, shared household, pooling of resources, domestic arrangement, sexual relationship, children, socialization in public and common intentions. Thereafter, the Rajasthan Human Rights Commission ruled that "Women in Live-in relations are akin to concubine"; and demanded that the state government enact a law against them. [33] Recently, Delhi High court affirmed that LIRs are Akin To Marriage; parents or relatives have no right to interfere. [34]

Considering the controversial status of LIRs recently some states, Uttarkhand, Gujarat and Assam and Madhya Pradesh, have implemented Uniform Civil Code (UCC) and enacted laws to mandate registration of LIRs. [35]

It may be noted that LIRs, especially those that ignore family tradition can sometimes have adverse legal repercussions.

Transgender Persons

The TPPRAA, 2026 [21] significantly alters the original 2019 Act by removing the right to self-perceived gender identity. The Act mandates the formation of medical boards at the state or union territory level to verify an applicant's claim. The district magistrate (DM) would only issue an identity certificate after a recommendation from the medical board. The DM now has the discretion to then consult further 'medical experts' and make their decision on the application. This replaces the previous system where the DM issued certificates upon request.^[1]

The medical board comprises the Chief / Deputy Medical officer of the district, and medical specialists: A clinical psychologist/ psychiatrist, frequently an endocrinologist or other clinical specialists depending upon the specific evaluation needed for physical or mental health status.

The Ministry of Social Justice and Empowerment national portal provides the facility for transgender persons across the country to apply for certificate and identity card. [36]

Immoral Trafficking

An adult who chooses to exchange sexual services for money independently, voluntarily and privately is not committing a crime.

The ITPA, 1956 [5] strictly criminalises any form of organised commercial sex business, such as operating, managing, or renting out a property to be used as a brothel where multiple people practice sex work.

The Act also bans third-party exploitation, meaning that pimping, trafficking individuals for sex, or living off the earnings of another person's sex work carries severe criminal penalties. Additionally, soliciting clients in public spaces or near designated public institutions, such as schools, religious places, and hospitals, remains completely prohibited.

Obscene Material

Section 294 of the BNS, 2023 [18], criminalises the sale, distribution, public exhibition, or circulation of obscene material. Material may be regarded as obscene if it is lascivious, appeals to prurient interests, or has the tendency to deprave or corrupt persons who are likely to see, read, or hear it. A first conviction may attract imprisonment of up to 2 years and a fine of up to ₹2,000, while subsequent convictions may result in imprisonment of up to 5 years and a fine of up to ₹5,000.

Clinical Implications

1. Sexual Medicine and ICD-11 [37]

In the ICD-10, sexual dysfunctions were classified under "Mental and Behavioural Disorders," which reinforced the concept that sexual health issues were purely psychiatric conditions, thus stigmatizing them. ICD-11, does not include sexual problems in Chapter 6 "Mental, behavioural or neurodevelopmental disorders". It has a new Chapter 17 entitled "Conditions Related to Sexual Health." This is a major shift by the

World Health Organisation to acknowledge these conditions as medical, with a causation that is multi-factorial, thus destigmatising them and aligning its clinical approach with other major disciplines like Urology, Andrology, Endocrinology, Sexology, Gynaecology and General etc

2. Sexual Medicine and MHA 2017

A major legal and clinical consequence of this departure is that sexual medicine would be governed by the MHA 2017 [15] only when patient is admitted to a Mental Health Establishment (MHE) for treatment, not otherwise. In the context of Indian jurisprudence, this means that the stringent rules regarding the admission, treatment, and discharge of patients under the MHA would be applicable only when the psychiatrist admits a patient to a MHE (under MHA), not when the psychiatrist visits sexual health clinics run by non-psychiatrists. Standard medical consent and standard medical protocols would apply.

Furthermore, this removes the legal burden of registration of all 'sexual clinics' as MHEs with the State or Central Mental Health Authority as per the MHA 2017.

3. Confidentiality in Sexual Medicine Practice

Sexual medicine practice is inherently relational. Unlike many other areas of clinical practice, the assessment and management of sexual dysfunction frequently extend beyond the individual patient to include the intimate partner. Sexual function is influenced by biological, psychological, interpersonal, relational, and sociocultural factors, and a comprehensive evaluation often requires information from both partners. Consequently, the psychiatrist or sexual medicine practitioner is not merely treating an individual, but is also evaluating the dynamics of the relationship that contributes to the presenting problem. This unique therapeutic context creates complex ethical challenges, particularly when one partner discloses confidential information with direct implications for the relationship and requests that it be withheld from the other partner.

One of the most challenging situations arises when a partner privately reveals an ongoing or previous extramarital relationship, an undisclosed sexually transmitted infection, uncertainty regarding paternity, concealed infertility, hidden sexual orientation, or other information that is likely to influence the diagnosis, treatment, or prognosis of the couple's sexual difficulties. The clinician is then confronted with competing ethical obligations. On one hand is the duty to maintain patient confidentiality, which forms the foundation of the therapeutic alliance. On the other, is the obligation to promote beneficence, prevent harm, preserve the integrity of the therapeutic process, and protect the interests of the other partner who may be unknowingly exposed to significant physical or psychological risks.

Apart from this psychiatrist may note down certain information for clinical purpose, which is likely to be misinterpreted or have an adverse effect if disclosed.

Confidentiality is a fundamental ethical and legal obligation in sexual medicine practice. However, confidentiality has never been regarded as an absolute obligation. Across medical ethics and law, confidentiality may be limited when disclosure is mandated by law such as Sec 19 of the POCSO Act, 2012 [14] or when withholding information is likely to result in serious and foreseeable harm to an identifiable individual (such as HIV

infection of the index patient), which is governed by the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017. [38] The ethical challenge in sexual medicine lies in determining when confidential information merely represents an individual's private history and when it becomes so central to the couple's treatment or safety that continued secrecy undermines ethical clinical care.

4. Right to Medical Records in Sexual Medicine Practice

Managing medical records in sexual medicine is uniquely complex. An individual patient presenting alone is treated in accordance with standard medical ethics. However, couples therapy involving both the index patient and their intimate partner introduces distinct ethical challenges. Although couples present with shared complaints such as non-consummation or relationship distress, each partner retains independent legal rights and expectations of confidentiality. Clinicians cannot automatically grant one partner access to a joint record, as this violates the other's autonomy. Consequently, handling couple therapy records requires strict adherence to legal provisions and a careful balancing of individual privacy rights within a shared treatment framework.

Where the consultation is sought by a single individual, that person remains the index patient. The accompanying partner functions as an informant unless independently registered and evaluated as a patient. In such circumstances, the medical record belongs to the index patient, and access should ordinarily be restricted to that individual only or to persons legally authorised by the patient or by law.

The situation differs when both partners voluntarily participate in conjoint assessment and treatment. In couple's therapy, the therapeutic focus extends beyond the individual to the couple. In such situations, medical record management becomes more complex. The clinician simultaneously owes professional responsibilities to two autonomous individuals, while also treating the relationship as the unit of care. However, even in couples therapy, the individual retains an independent right to confidentiality regarding information disclosed during individual interviews. Accordingly, psychiatrists should distinguish between shared therapeutic records and individual confidential records.

The shared therapeutic record should contain information generated during conjoint sessions, including the presenting complaint, relationship history, shared treatment goals, observations made in joint sessions, agreed management plans, interventions delivered in the presence of both partners, and recommendations accepted by the couple. Since this information forms part of the conjoint therapeutic sessions, both partners may reasonably have access to these portions of the record. This issue needs to be clearly explained to the couple and incorporated into the informed consent process.

By contrast, information obtained during separate individual sessions should ordinarily be maintained in an individual confidential record. Access to these records should remain restricted to the individual concerned unless explicit consent for disclosure is obtained from the individual, or disclosure is otherwise justified under law or necessary to prevent serious and foreseeable harm.

5. Surrogate Partner Therapy (SPT)

Sex therapy pioneers Masters and Johnson introduced surrogacy in sex therapy; however, there is a lack of published evidence supporting treatment efficacy, and ethico-legal questions have limited the practice from becoming a common intervention

Sexual surrogacy, formally known as Surrogate Partner Therapy (SPT), is a specialised behavioural model used in sex therapy. It involves a trained professional who acts as a proxy partner to help a client overcome physical or emotional intimacy issues. The practice operates in a deeply complex legal and ethical grey area because it involves paid physical intimacy,

Ethical Issues: A major ethical concern is that SPT is the co-modification of intimacy. Further, it exploits the emotional vulnerabilities of clients, especially those often isolated, lonely, or struggling with deep insecurities and past trauma. Besides, therapists must ensure that the surrogate maintains strict boundaries to prevent the client from developing unhealthy romantic attachments that can cause harm after the therapy concludes. Further, there is lack of rigorous, peer-reviewed data proving that this therapy is broadly effective or safe long-term.

Legal Issues: In traditional psychotherapy, sexual contact between a licensed psychotherapist and a client is strictly illegal and unethical. In SPT, the surrogate is not the primary therapist. Instead, works under the guidance of a licensed sex therapist. This creates complex questions of legal liability if a boundary is violated, especially since the surrogates operate largely outside mainstream medical licensing boards. This in itself can warrant professional misconduct for referring the patients for Surrogate Partner Therapy.

The most prominent legal challenge is the blurry line between commercial sex work (prostitution) and therapy. Soliciting sexual services is illegal in India. SPT can easily cross legal lines if the actions of the surrogate extend beyond counselling and communication into explicit commercial sex work. At present, there are generally no specific laws regulating or prohibiting sexual surrogacy; and no state-issued licenses or dedicated regulatory boards to audit practices or protect the rights of those involved. This leaves both the surrogate and the client in a legal vacuum. Thus many professional bodies distance from such practices.

The primary legislation governing this space is the ITPA Act, 1956 [5]. In India, under the ITPA Act 1956 [7], SPT occupies a complex legal position.

6. Sexual wellness devices and accessories

The use of sexual wellness devices should be viewed through the dual lens of clinical necessity and legal accountability. Sexual dysfunction is a recognised medical condition, and evidence-based management may include psychological interventions, pharmacotherapy, behavioural techniques, and, in selected situations, the use of assistive sexual devices. For individuals with physical disabilities, neurological disorders, chronic pain, or limited mobility, certain devices may reduce physical barriers to sexual expression, facilitate masturbation, and improve intimacy, autonomy, and overall quality of life. For many individuals and couples, these devices are not merely instruments of pleasure but may also contribute to sexual rehabilitation and psychosocial well-being.

The legal position in India remains uncertain. At present, there is no specific statute that expressly prohibits the manufacture, import, marketing, sale, or possession of adult sex toys. Instead, the legal framework is largely governed by obscenity laws. From a regulatory standpoint, a limited category of products with a demonstrable diagnostic, therapeutic, or rehabilitative purpose may be eligible for regulation as medical devices under the Medical Devices Rules, 2017 [39], read with the DCA, 1940 [2]. However, the majority of commercially available pleasure-oriented sex toys do not satisfy the scientific and regulatory standards required for classification as medical devices.

Merely seeking registration or regulatory approval without establishing a genuine therapeutic indication may be viewed as an attempt to circumvent the regulatory framework. Such practices undermine the integrity of the medical device regulatory system and may expose manufacturers, distributors, and healthcare professionals to legal scrutiny. The latter may create conflicts of interest, blur professional boundaries, and expose the practitioner to allegations of unethical conduct or regulatory violations.

Child Sexual Abuse

In Indian sexual medicine practice, psychiatrists encounter severe ethical and legal dilemmas under Section 19 of the POSCO Act, 2012 [14] when a client discloses sexual urges toward children. If a client admits to actively abusing a child or has acted in the past, the psychiatrist has a strict, non-negotiable legal obligation to report the matter to the nearest police station immediately. Conversely, if the client reports only intrusive thoughts or fantasies without ever acting upon them, the clinician must tread carefully. Reporting unacted-upon thoughts presents a critical grey area where the statutory duty to report clashes directly with psychiatric confidentiality and the therapeutic goal of preventing future harm.

Potency test

In India, a potency test is a medical examination used to determine an individual's capability to perform sexual intercourse. It involves physical examinations, potency tests, and penile Doppler ultrasounds. The legality, necessity, and consent requirements for these tests differ significantly between civil and criminal cases.

Civil Cases (Matrimonial Disputes): Potency tests are primarily used in divorce or annulment petitions under the Hindu Marriage Act, 1955 [4], where one spouse alleges the other is impotent and unable to consummate the marriage. Forcing someone to undergo a potency test arguably implicates the "right to privacy" under Article 21 of the Indian Constitution. However, the Supreme Court of India, has ruled in *Deep Mukerjee vs Sreyashi Banerjee* on 5 April, 2024 [40] that courts can order a spouse to undergo a potency test. Refusal to undergo the court-ordered test without a valid reason can lead the court to draw an adverse inference against the party who refuses, which can heavily influence the outcome of the divorce.

Criminal cases: In criminal trials involving rape or POCSO offences, investigators often mandate potency tests for male(s) accused. However, forensic experts strongly argue that routine potency testing is outdated and offers limited diagnostic value for two primary reasons: a) Sexual potency is highly dependent on transient psychological factors, situation-

specific stress, and individual mental states, making a clinical test an unreliable indicator of past behaviour. b) Modern legal definitions of rape no longer require penile erection or standard intercourse; any form of non-consensual penetration qualifies, rendering proof of erection irrelevant to establishing guilt. Unless there is a strong logical reason for conducting the potency test, it is not appropriate to conduct such a test.

Clinical Practice Guidelines:

Table 2 - General: Dos for psychiatrists

1. Should practice within the limits of his education, training, competence and experience.
2. Should keep his experience certificate of specific training in sexual medicine in safe custody for retrieval when needed.
3. Should register his outpatient/ inpatient hospital for treatment of Sexual Disorders under The CERRA, 2010, if he has received specific training in sexual medicine.
4. Can be a visiting consultant to sexual clinics/ hospitals, not registered under CERRA, 2010.
5. Should update his knowledge and skills on a regular basis.
6. In case of doubt, or need, in difficult/ complicated cases he should consult professional colleagues, psychiatrists and others.
7. Should have some basic knowledge about the important laws relating to mental health/ illness and sexual medicine, and follow them in letter and spirit.
8. Should have knowledge about social norms relating to sexual behavior (sex, marriage and cohabitation), and do his best to uphold them
9. Should take informed consent on all procedures that are not a part of routine clinical psychiatric practice.
10. Should maintain medical records diligently.
11. Provide medical records of patient(s) to patient/ authority as per requirement of law.
12. Should ensure confidentiality. Keep a password to secure the data. Confidential information may be released in special circumstances for the interest of the patient, where the laws mandates, or when there are major security concerns.

Table 3-General: Don'ts for psychiatrists

1. Should refrain from advertising himself as "Sexual Medicine Expert"/ "Sexologist", if he has not received training for the same.
2. Should refrain from doing Invasive procedures eg intracavernosal injection therapy; surgical procedures (gynaecological, urological, others), which are not a part of regular PG training and if he/she has not received specific training for the same.
3. Should not cross sexual boundaries while dealing with patients/ relatives.
4. Should not embark on SST.
5. Should not embark on using sexual wellness devices/ accessories for treatment.

Table 4- Structured Pro forma for recording patients' details

1. Informant(s): Name, age, relationship to patient, duration of acquaintance, education. (Ensure at least 1 informant is a family member).
2. Identity: Name of father; name of mother; name of spouse; Sex; Age (date of birth); Religion; Education. Address (with state); Mobile No.: ID. (ID: Birth Certificate/ Adhaar card/ Voter ID Card/ Passport)
3. Marital Status:
Married (date, name of spouse)*, Unmarried, Divorced, Separated.
Proof of marriage (Adhaar card/ Marriage certificate)
4. Live-In Status:
Duration:
Partner: Name, age, education, religion, address, Father's name, Mothers name, Address
Consent of parents for Live-in: Yes/ Partial/ No
Planning to get married: Yes (When?)/ No
LIR registered: Yes (provide certificate)/ No
LIR in "Nature of Marriage" (On the basis of Supreme Court Guidelines (Indra Sarma vs V.K.V.Sarma) [32]: Yes / No
5. History and evaluation: as per pro forma (Kar et al 2022) [41]

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Table 5 - Medical Records

- 1 Document history, investigations, treatment and follow up. Maintain medical records for at least 3years
- 2 Identify at the outset whether the therapeutic contract is with an individual or with the couple jointly.
- 3 Explain the confidentiality, and take informed consent regarding the medical records policy before commencing the assessment.
4. Maintain separate confidential documentation for individual interviews whenever appropriate.
5. Distinguish shared therapeutic information from individually protected information.
6. Avoid releasing information that would inadvertently disclose confidential information relating to the other partner without consent or legal justification.
7. Document all decisions regarding confidentiality, disclosure, and access to records to ensure ethical consistency and medico-legal defensibility.
8. Give copy of medical record within 72 hours of a formal request to patient/ spouse as per legal requirement.
9. Specific information noted down by the psychiatrist, which is likely to be misinterpreted or have an adverse effect if disclosed, may be retained. It should be released only when there is a legal obligation to do so.

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Confidentiality: Multistep approach: (Table 6 and 7)

363 Clinicians must distinguish between a *patient's personal private history* and *therapy-*
364 *interfering secrets*. Personal private information includes past experiences like childhood
365 trauma, previous illnesses, or earlier relationships that do not directly impact the couple's
366 current treatment; these must remain private unless the patient gives consent.
367

368

369 In contrast, therapy-interfering secrets are ongoing issues that directly sabotage the
370 couple's assessment, block effective treatment, or place the partner at risk. As therapy-

interfering secrets fundamentally compromise the safety of the partner and integrity of the joint therapy, they cannot be kept confidential from the partner within a dyadic treatment framework.

Table - 6: Confidentiality: Multistep approach

First, the practitioner must establish clinical relevance by verifying if the information is central to the diagnosis, subsequent medical management and therapy.

Second, the clinician must perform a risk assessment to determine if non-disclosure creates a serious, foreseeable harm that triggers a statutory duty to protect or warn.

Third, the practitioner is legally obligated to assess whether voluntary disclosure can still be achieved through direct patient engagement.

Fourth, If voluntary compliance is unobtainable, the psychiatrist must identify the specific statutory mechanism or judicial order confirming that the disclosure is legally permitted or required within the applicable jurisdiction.

Fifth, any subsequent breach must strictly adhere to the principle of narrow tailoring, ensuring that the disclosure is proportionate and restricted solely to the minimum necessary information required to abate the identified danger.

Table - 7: Confidentiality: Final step

Finally, to secure absolute compliance with regulatory standards and shield the practitioner from liability, the psychiatrist must document the process undertaken, the time spent explaining the need for disclosure, the opportunity given for voluntary disclosure, and the exact information disclosed, with step-by-step disclosure documented in the medical record.

Transgenderers

A psychiatrist/ clinical psychologist can be a member of the medical board for verifying the identity, and treatment of transgender persons. The psychiatrist may be required to assess and certify as to the presence or absence, and nature of mental illness.

Certification should be based on a detailed psychiatric history (from the patient/client and other reliable informants/ relatives (1, 2, or more as needed), physical examination and necessary investigations.

The Psychiatrist should not be dogmatic when issuing a medical certificate; doubts should be stated eg "the history and examination is suggestive of a Depressive Disorder."

Child sexual abuse

Scenario: A client discloses un-acted-upon sexual urges toward children:

In such a case, the psychiatrist's primary role is to serve as a dual investigator-clinician, balancing rigorous risk assessment with immediate therapeutic intervention.

The first step is to conduct a forensic risk evaluation. The psychiatrist must determine if the fantasy carries an imminent threat of violence or enactment. This involves assessing whether the thoughts are unwanted and distressing to the patient (ego-dystonic), analysing the patient's level of impulse control, evaluating any history of substance abuse, and

determining whether the patient has unsupervised or direct access to children in their daily life.

If the clinician determines that the risk of child sexual abuse is low and the patient is genuinely seeking help, the role shifts to aggressive clinical management. In all cases psychiatrist should assess make a diagnosis regarding the presence/ absence, nature and severity of mental illness and mental health capacity

If the psychiatrist determines that there is imminent risk is high, he should 1) communicate the finding of high risk. 2) Educate the client that child sexual abuse is an offence punishable under POSCO, 2012, 3) and that if a person has apprehension that an offence of sexual abuse is likely to be committed or has knowledge that such an offence has been committed, The POSCO Act mandates reporting to the local police.

The psychiatrist should report the case to local police or Special Juvenile Police Unit.

Maintaining comprehensive documentation is essential to demonstrate that the assessment and subsequent actions were undertaken in good faith, in accordance with professional standards, and in compliance with statutory obligations.

Potency Test

Civil Cases (Matrimonial Disputes): Potency test is generally not recommended because of its limited utility. However, may it be carried in certain cases after written informed consent.

Criminal trials involving POCSCO offences: Unless there is a strong logical reason for conducting the potency test, it is not appropriate for individual practitioners to conduct the test and issue isolated opinions. The issue is complex and better dealt by a specialized medical board comprising a forensic medicine expert, a psychiatrist, a gynaecologist, an endocrinologist and a treating physician, to issue a comprehensive joint certificate.

Table 8 - Decide on whether to take up for treatment

Case Vignettes	Suggestions
1. An unmarried man contemplating marriage comes with erectile/ ejaculatory problems.	May be taken up for treatment
2. An unmarried man/ woman comes because his/ her perceived gender is not synchronous with his biological gender.	May be taken up for treatment, Sexual Orientation Conversion Effort (SOCE)
3. Unmarried couple in a LIR presents with a complaints suggestive of sexual dysfunction.	Take the couple for treatment if LIR is registered/ or is in the "Nature of Marriage" (as per SC Guidelines)
4. A man and a woman, living separately, but in a romantic relationship, present with a complaints suggestive of sexual dysfunction.	Treatment is best avoided
5. Unmarried couple in a LIR presents with intimate partner disharmony requests for couple/ 'dual therapy'.	Take the couple for treatment if LIR is registered/ or is in the "Nature of Marriage" (as per SC Guidelines).

6. A man and a woman, living separately, but in a romantic relationship, present with relationship difficulties requests for couple/ 'dual therapy'.	Treatment is best avoided
7. A man comes alone, with complaints of sexual dysfunction, dressed as female (<i>saree</i>), without ID (Adhaar Card) for identity certificate. He changed his name from male to female (from Vinod to Vini)	1) Confirm gender by records, history, examination and investigations 2) Then decide
8. A married couple (Hindu/ Muslim) presents with symptoms suggestive sexual dysfunction. Name of woman has been changed from Hindu to Muslim (Neetu Singh to Naseema Bano) (?forced conversion).	1) Confirm gender identity 2) Confirm Religious identity 3) Confirm religious conversion: Yes/ No 4) Confirm: forced/ voluntary 5) Decide.

Summary

There can be various presentations in practice of sexual medicine. Special attention should be paid to confidentiality, maintenance of medical records, providing them to patient/ authority as per NMC guidelines and legal provisions, and informed consent should be taken when special procedures are undertaken. One should refrain from carrying out invasive procedures for which one has not been trained. SST and sexual wellness devices/ are best avoided. It is important to ensure that decisions taken and treatment (s) instituted are within acceptable norms of clinical practice and do not violate major social norms or any provision of law.

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