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Manuscript Type- Clinical Practice Guidelines

Title: Assessment and Management of Sexual Desire Disorders

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Conflict of Interest- Authors report no conflict of interest

Assessment and Management of Sexual Desire Disorders

EXECUTIVE SUMMARY

Clinical diagnosis of Sexual desire disorders (SDD) is established by detailed clinical history of persistent low sexual desire, associated distress and impairments. The laboratory assessments may be needed as per the available information by clinical evaluations. The clinical condition should not be better explained by any other psychiatric disorder, medical illness, medication or substance use and relationship situations. The clinician should also differentiate whether it is lifelong vs acquired and generalised vs situational as these have important etiological and treatment considerations.

Sexual disorders, psychiatric disorders, medical comorbidities and substance use disorders are commonly associated with sexual desire disorders and it should be included in assessments. The medications used for psychiatric disorders and medical conditions can affect sexual desire disorders and need a careful review. Relationship quality, developmental experiences, cultural and religious factors may influence diagnosis and treatment hence should be carefully assessed. Additionally, clinicians should also enquire about masturbation practices, pornography use, atypical arousal patterns, sexual orientation, and past sexual trauma, which may masquerade as primary desire disorders. The management should follow biopsychosocial approaches. The initial management starts with psychoeducation and sex education. Other nonspecific treatment approaches include optimization of psychiatric and medical treatment, modification of offending medications, and lifestyle interventions. This is followed by other indicated non pharmacological treatment approaches like sex therapy, cognitive behaviour therapy, relationship focussed therapy and trauma focussed therapy.

The pharmacological treatments are individualised and should be used as per clinical needs of the patients. Testosterone replacement is recommended only for men with laboratory confirmed hypogonadism. In postmenopausal women with hypoactive sexual desire disorder, transdermal testosterone has the strongest evidence among hormonal therapies, whereas local estrogen may improve desire indirectly by treating vulvovaginal atrophy and dyspareunia. Flibanserin and Bremelanotide provide modest benefit in carefully selected premenopausal women but have limited availability and experience of use in India. Bupropion and Buspirone may be considered, particularly when depression, anxiety, or antidepressant-induced sexual dysfunction coexist. PDE-5 inhibitors should not be used for isolated low desire but it may improve desire secondary in men whose low desire results from erectile dysfunction.

Key words: Sexual desire disorders; Hypoactive sexual desire disorder; Sexual dysfunction; Psychosexual assessment; Pharmacotherapy

Introduction and Definition

Sexual desire is defined as the subjective experience of motivation, interest or willingness toward sexual activity. It represents one of the most prevalent yet underrecognized clinical concerns in psychiatry. Unlike many psychiatric phenomena, Sexual Desire Disorders (SDD) exist at the intersection of brain, body, relationship, and culture, demanding an integrative biopsychosocial approach from clinicians.^[1-3] These guidelines by Indian Psychiatric Society provide evidence-based recommendations for the assessment, diagnosis and management of sexual desire disorders in men and women, incorporating biological, psychological, relational and sociocultural factors relevant to clinical practice in India. They are intended to support clinical decision-making and should be applied in accordance with the individual patient's clinical condition, preferences and available resources. These recommendations are advisory in nature and are not intended to constitute an absolute or legally binding document governing the clinical practice of psychiatrists in India; clinical judgement and individual patient needs should guide their application.

Epidemiology

Recent meta-analyses provide robust prevalence estimates. A 2024 meta-analysis found pooled female sexual dysfunction prevalence of 47.81%, with sexual desire disorder specifically ranging from 8.0% to 91.0% depending on assessment methodology. For women ages 18–44, clinically distressing low desire affects 8.9%; prevalence rises to 12.3% till age 45–64, plateauing at 7.4% over 65. Male hypoactive sexual desire remains underrecognized, with self-reported prevalence of low desire ranging from 4.8% to 17% across countries.^[1] A European multi-country study found 14.4% of men with distressingly low sexual interest over at least two months^[3]. When DSM-5^[4] morbidity criteria are applied, population prevalence plummets i.e only 4.2% of men and 3.6% of women meet full diagnostic criteria, though 38.2% of men and 22.8% of women report at least one sexual concern^[4]. An Indian community sample from South Indian rural population reported prevalence of sexual desire disorder in 2.56% males and 8.87% in females.^[5] Large Indian population studies are conspicuously absent from the epidemiological datasets.

Clinical Relevance in Psychiatric Practice

SDD can emerge as primary or secondary manifestation of psychiatric illness.^[6] Major depression causes anhedonia which affects sexual reward circuits; anxiety disorders generate hypervigilance which is incompatible with sexual focus and history of trauma may cause avoidance of sexual stimuli.^[7-9]

Psychotropic medications represent the leading iatrogenic cause of sexual dysfunction. SSRIs produce sexual side effects in 30–60% of users; antipsychotics cause desire suppression often proportional to dopamine D2 receptor blockade.^[8]

Nosology and Diagnostic Framework

International Classification of Diseases, 11th Revision (ICD-11) criteria

The sexual dysfunctions have been relocated to a new chapter entitled “Conditions related to Sexual Health.” The ICD-11 have include desire related disorders in a category entitled “Hypoactive Sexual Desire Dysfunction (HSDD)” which is defined as ***persistent or recurrent reduction or absence of sexual thoughts, fantasies, spontaneous desire, responsive desire, or motivation to engage in sexual activity, resulting in clinically significant distress.*** Symptoms should not be better explained by another medical condition, severe relationship difficulties, medication effects, substance use, or another mental disorder. It also provides sex-specific diagnostic guidance for better diagnostic clarity and to accommodate gender related differences in presentation. ^[10]

Consideration of age, cultural norms, relationship context, and duration of symptoms are needed before assigning the diagnosis. Importantly, ICD-11 explicitly recognizes that sexual desire in women and even in men in long standing relationships may be predominantly responsive rather than spontaneous. This may help in overdiagnosis and over-pathologizing normative variations in sexual functioning. There is no fixed duration criteria or frequency threshold and clinician makes a diagnosis based on chronicity, persistence, severity, and contextual factors surrounding the clinical presentation. ^[9,11]

DSM-5-TR Diagnostic Criteria

The DSM-5 (2013) and DSM-5-TR (2022) introduced significant conceptual changes from DSM-IV-TR. Sexual dysfunction is now defined as a ***'clinically significant disturbance in a person's ability to respond sexually or to experience sexual pleasure.'*** DSM-5 introduced explicit morbidity criteria: symptoms must be experienced 75–100% of the time, persist at least for six months, and cause clinically significant distress. This reflects growing recognition that sexual symptoms without clinically significant distress do not constitute a disorder. DSM-5 separated the male and female diagnosis in desire disorder as follows, ^[4,9]

Male Hypoactive Sexual Desire Disorder (MHSD) is characterized by persistently or recurrently absent/deficient sexual desire, manifesting as: reduced frequency of sexual thoughts, fantasies, and urges; reduced initiation of sexual activity; or markedly diminished receptivity to partner sexual advances. The symptoms must be present for minimum six months and cause clinically significant distress or impairment. ^[4,12]

Female Sexual Interest/Arousal Disorder (FSIAD) combines previous two separate categories, reflecting that women frequently experience desire and arousal as interdependent rather than a sequential phenomenon. The diagnosis requires reduction in interest or arousal with at least three of six specific symptoms for a minimum of six months: reduced frequency of sexual thoughts/fantasies, reduced interest in sexual activity, reduced responsiveness to erotic stimuli, reduced physical pleasure during sexual activity, reduced responsiveness to partner sexual initiation, or reduced sexual motivation. ^[4,13-15]

Hyperactive sexual desire remains formally unrecognized in DSM-5-TR as a disorder category. However, the DSM-5 Section III proposed 'Hypersexual Disorder,' which is characterized by recurrent and intense sexual fantasies, urges, or behaviours lasting a minimal of six months,

with continued engagement despite adverse consequences, and causing significant distress or functional impairment.^[16]

Clinical Distinctions: Essential Classification

Clinical assessment must distinguish desire presentations along two dimensions: temporal course and contextual specificity, as each carry distinct etiological and therapeutic implications.

Lifelong versus Acquired: Lifelong presentations (desire disturbance since sexual maturation) suggest constitutional-developmental factors. Acquired (decline from previously normal baseline) implicate medical conditions, medications, psychiatric illness, or relational deterioration—all potentially reversible with targeted intervention.^[17]

Generalized versus Situational: Generalized hypoactivity (reduced desire across all contexts, partners, stimuli) indicates systemic biological or intrapsychic dysfunction. Situational presentations (desire preserved with some partners or contexts, absent with others) implicate relational, contextual, or partner-specific factors.^[18-20]

Cultural and Relational Modifiers

DSM-5-TR explicitly requires consideration of cultural and relational factors: religious injunctions against sexual pleasure, family honour systems restricting sexual agency, gender role expectations conflicting with authentic desire, partner relationship quality, and individual vulnerability factors. In Indian contexts, these may be fundamental to the etiology.^[11]

Research documents high prevalence of anxiety-based sexual concerns in Indian males stemming from cultural myths (masturbation causing 'weakness,' penis shrinkage). Female sexuality, particularly outside reproductive contexts, faces systematic devaluation in conservative settings, and may modify sexual motivation in long term also. Diagnostic formulation must explicitly evaluate these cultural issues and should avoid pathologizing normative responses to cultural constraint.^[21]

Etiology and Risk Factors: The Biopsychosocial Model^[9]

Medication-Induced Dysfunction

Selective serotonin reuptake inhibitors (SSRIs) remain the leading iatrogenic cause of sexual dysfunction. SSRIs affect 30–60% of users through multiple mechanisms: increased serotonin at 5-HT₂ and 5-HT₃ receptors reduces dopamine in mesolimbic pleasure centers; decreased dopamine directly suppresses sexual motivation; SSRIs inhibit tuberoinfundibular dopamine neurons, elevating prolactin which suppresses desire and arousal; blockade of cholinergic and alpha-1 adrenergic receptors impairs erectile mechanisms; inhibition of nitric oxide synthetase reduces vasodilation essential for genital engorgement. Paroxetine demonstrates highest incidence of sexual side effects, followed by Fluvoxamine, Sertraline, and Fluoxetine. The relationship between sexual dysfunction and SSRIs is dose-dependent.^[28-30]

Antipsychotics produce desire reduction proportional to antipsychotic potency through dopamine D₂ antagonism and prolactin elevation. Classical antipsychotics, Risperidone, and Amisulpride elevate prolactin significantly, particularly in women compared to men.

Aripiprazole (dopamine D2 partial agonist) demonstrates relatively fewer sexual side effects.^[31]

Mood stabilizers (Valproate, Lithium) impair testosterone synthesis and produce weight gain-related body image effects. Antihypertensives, particularly thiazide diuretics and beta-blockers, reduce vascular supply to genital tissues. Antihistamines and anticholinergics impair parasympathetic function essential for erectile physiology.^[32]

Substance Use Disorders

Chronic alcohol use produces testicular atrophy and hepatic estrogen metabolism dysfunction, yielding hypogonadism and gynecomastia. Alcohol also inhibits the hypothalamic-pituitary-gonadal axis, reducing gonadotropin release. At lower doses, alcohol may acutely enhance desire through anxiety reduction but higher doses can decrease arousal and impair ejaculation.

Cannabis acutely enhances desire through cannabinoid receptor activation and anxiety reduction, but chronic use produces amotivational syndrome and dopamine dysregulation.^[33, 34]

Opioid use demonstrates biphasic effects: initial use delays male ejaculation and decreases vaginismus in women, giving false impression of improvement. However, chronic use of opioids (Morphine, Heroin) reduces luteinizing hormone release, decreasing testosterone and estradiol while increasing free sex hormone binding globulin resulting in severe hypogonadism. Opioid-induced hypogonadism affects 21–86% of chronic users, with sexual dysfunction affecting 76% of males and 64% of females. Hypothalamic-pituitary-gonadal axis suppression is immediate and dose-related. Methadone and Buprenorphine maintenance therapy produce sexual dysfunction in 14–83% and 36–83% of patients respectively.^[33–35]

Stimulants (Cocaine, Amphetamines) acutely enhance desire through dopamine elevation and sympathomimetic effects, but chronic use produces tolerance, sensitization, and ultimately desire suppression. Nicotine produces vascular disease and endothelial dysfunction, contributing to erectile dysfunction and potentially desire suppression through vascular mechanisms.^[33]

Psychological and Psychiatric Factors

Major depressive disorder causes anhedonia affecting sexual reward processing through dopaminergic dysregulation and reduced mesolimbic responsiveness.^[36] Patients often report sexual thoughts and fantasies as 'not occurring to them' a manifestation of motivational deficit rather than mere pleasure loss.^[9]

Anxiety disorders produce hypervigilance and enhanced threat appraisal which is incompatible with sexual engagement. Performance anxiety creates conditioned fear responses to sexual stimuli. Generalized anxiety produces persistent cognitive interference with sexual focus. Obsessive-compulsive disorder produces intrusive sexual content (unwanted sexual urges, fears of harming partner sexually, taboo sexual thoughts) that creates cognitive interference preventing hedonic engagement. The intrusive thoughts are experienced as ego-dystonic hence may generate shame and avoidance.^[9,11]

Trauma-related conditions, particularly post-traumatic stress disorder (PTSD) and complex trauma, systematically produce sexual avoidance through multiple mechanisms. PTSD

patients demonstrate heightened amygdala activation and anterior insula engagement to sexual threat cues (whether trauma-related or unrelated).^[37,38] Sexual trauma specifically produces elevated emotional numbing and avoidance symptoms compared to non-sexual trauma. The neurobiology creates automatic defensive mobilization when sexual stimulation is encountered, a state neurobiologically incompatible with reward processing. Body image disturbance and shame associated with trauma create additional psychological distance from sexual desire. Survivors frequently report loss of pleasure in previously enjoyed sexual activity, reflecting anhedonia-like mechanisms and conditioned fear associations.^[39]

Relational and Partner Factors

Unresolved marital conflict, consistent criticism, and contempt systematically suppress sexual desire through threat appraisal and emotional disconnection. The accumulation of relationship grievances produces sexual avoidance as metaphorical relationship withdrawal, a protective strategy reflecting deeper relational dysfunction. Research in couples demonstrates that conflict engagement patterns predict subsequent sexual dysfunction.^[40] Partner sexual dysfunction creates secondary desire reduction through frustration and performance pressure. Women whose partners experience erectile dysfunction frequently report reduced desire through identification, anxiety, and reduced partner attunement. Emotional intimacy, trust, quality of communication, and partner responsiveness substantially influence desire expression, particularly in women and long-term relationships:^[41,42] Rosemary Basson's research demonstrates that many women's desire shifts from spontaneous (new relationship phase) to responsive (dependent on partner contact and intimacy cues) as relationship duration extends.^[20] Failure to recognize this normative shift creates misdiagnosis i.e. women become concerned about 'losing desire' when they are actually experiencing a developmentally appropriate transition from spontaneous to responsive desire.

Sociocultural and Religious Factors

Sexual desire expression reflects profound cultural influence. Certain religious and cultural beliefs produce guilt associations with sexual pleasure which results into enduring desire inhibition. Female sexuality, particularly outside reproductive contexts, faces systematic cultural devaluation in conservative Indian settings. Female modesty norms, family control over partner selection, and reproductive-only sexual ideologies generate psychological conflicts that may manifest as desire inhibition.^[23] Religious/cultural prohibitions against premarital sex are particularly stricter for women, create internalized shame and approach-avoidance conflicts around sexual desire expression. Gender role expectations particularly female passivity and male sexual initiation imperatives produce incongruence between authentic desire and performance demands.^[20,23] Family honour systems restricting female sexual autonomy, emphasis on virginity and chastity, and collectivist frameworks subordinating individual sexual desire to family obligation all create systematic psychological suppression of desire, particularly in women.^[23] Indian research documents high prevalence of anxiety-based sexual concerns in males stemming from cultural myths about masturbation, penis anatomy, and semen loss, beliefs

creating performance anxiety and conditioned fear responses incompatible with desire. A cross-sectional study of Indian males found anxiety affected 23–100% of men with sexual dysfunction, with particularly high rates in West India, reflecting regional cultural variation in sexual stigma and anxiety tolerance.^[11,27]

Clinical Assessment

The clinical assessment of desire disorder begins with a structured and detailed clinical interview, followed by physical examination and laboratory testing, wherever indicated. The evaluation should be comprehensive and follow a biopsychosocial and relational framework. The subject with desire disorder may commonly have comorbid sexual, psychiatric and medical disorders. Therefore, clinical assessment should also include assessment of sexual comorbidities, psychiatric, medical, and endocrinological comorbidities.^[9]

Developmental experiences, attachment style, personality traits, relationship dynamics, cultural and religious beliefs, moral values, and ethical concerns may influence sexual desire and should be explored in a sensitive and non-judgmental manner.^[11]

Evaluation of medications being used is essential as many medications may impact sexual functioning.

A detailed clinical history should also extend beyond presenting complaints. Clinicians should enquire about having a secret sexual life, sexual orientation, variant (atypical) arousal patterns, preference for masturbation over partnered sexual activity, and sexual trauma that is unresolved and not shared with partner. These factors are not very uncommon in clinical population.^[38]

Assessment should preferably involve both partners. The desire disorder affects the couple as a whole rather than individual alone. The partner should be encouraged to express concerns, expectations and emotional responses. They should also be offered support during this process. Unaffected partners might feel offended due to lack of desire in affected partner. Feelings of blame, guilt, sense of betrayal and hostility are not uncommon and may influence treatment engagement and outcome. Unaffected partner may also have an intent of punishing/shaming affected partner which needs assessment and clinical management. The unaffected partner is encouraged to participate as intimately and erotically in developing a new couple sexual style. However, if unaffected partner is uncooperative/uninterested initially which is common in Indian settings, it is advisable to start working with treatment seeking partner with continuing efforts to engage unaffected partner, wherever possible.^[17]

The clinical interview should also differentiate whether the disorder is lifelong vs acquired and generalized vs situational subtypes. Identifying individual distress as well as impact on relationship are necessary for diagnosis. Attempting to categorize risk factors in modifiable vs non-modifiable risk factors is meaningful in planning management^[21]

The clinician should explore the patient's intentions and motivation for change. The individual may seek help for diverse reasons such as due to family pressure, last attempt to preserve the relationship before separation or divorce, partner's insistence, or for planning conception rather than genuine wish to improve. Hence, clarifying expectations, strengthening motivation, and establishing mutually agreed treatment goals at the outset are essential for improving engagement and long-term outcomes.^[42] (See Table 1 and 2)

Table 1: Assessment Schedule for Sexual Desire Disorder in Men/Women: History taking
[5,12,32]

Domain	Key Components of history and physical examination	Clinical Interpretation	Important Clinical Considerations
Presenting Complaint and Diagnostic Clarification	Nature of low desire; reduced spontaneous and/or reduced responsive desire; diminished erotic thoughts/fantasies; avoidance/aversion of sexual activity; inability to maintain desire during sexual activity; associated distress; duration (>6 months); frequency and severity	Establish diagnostic type and differentiate normative low desire from clinically significant disorder	Clarify whether symptoms meet DSM-5-TR criteria for male hypoactive sexual desire disorder or female sexual interest/arousal disorder or ICD 11 diagnosis
Chronology and Course	Lifelong vs acquired; generalized vs situational; sudden vs gradual onset; episodic vs persistent course	May help in identifying psychogenic, relational, endocrine, medication-related, or neurobiological etiological contributions	Sudden onset may suggest medication/substance effect or relationship stressor; gradual decline may suggest endocrine or chronic medical contributors; Situational type is mostly psychogenic/relational
Detailed Sexual History	Frequency of sexual activity; masturbation; fantasies; porn use; arousal capacity both in masturbation vs partnered sex; orgasmic function; erectile function; lubrication; pain; sexual orientation; preferred sexual practices; sexual satisfaction; discrepancy between partners related to sexual activities	Distinguish primary desire disorder from secondary avoidance due to pain, erectile dysfunction, or orgasmic dysfunction; distinguish if any partner prefer porn related solo sexual activity	In women, dyspareunia/genitourinary syndrome of menopause may suppress desire; in men, erectile dysfunction or premature ejaculation commonly reduces desire

Relational Assessment, contextual factors	Partner availability; emotional intimacy; marital conflict; mutual attraction; communication difficulties; infidelity concerns; sexual compatibility; caregiving burden; parenting stress; job related stress	Identify relational contributors and guide couple-based interventions or appropriate psychological support	Relational discord is one of the most common perpetuating factors in desire disorders; chronology of relationship discord vs sexual dysfunction; desire discrepancy; infidelity related concerns are especially challenging to treat.
Assessment of Distress and Motivation	Degree of distress- Personal and partner's distress; motivation for treatment by both partners; expectations from treatment	Distress is essential for diagnosis	Some individuals may have constitutionally low but non-distressing desire hence may not have motivation for the treatment
Psychiatric History	Depression; anxiety disorders; Obsessive Compulsive Disorder; Post Traumatic Stress Disorder; bipolar disorder; psychosis; substance use disorders; personality traits; body image disturbance; eating disorders	Psychiatric disorders commonly impair sexual functioning through neurobiological and psychological pathways; associated stigma and residual symptoms of psychiatric disorder may cause sexual difficulties	Psychiatric disorders and psychopharmacological treatment may be a significant contributor
Psychosocial and Developmental History	Childhood attachment; sexual education; guilt/shame; childhood physical abuse or emotional neglect; restrictive sociocultural beliefs; religious conflict;	Identify psychodynamic and sociocultural contributors	Trauma-informed interviewing is essential

	performance anxiety, taboo related to sexuality		
History of Sexual Trauma or Abuse	Childhood abuse; coercion; assault; painful first intercourse; marital sexual violence	Sexual trauma may contribute to avoidance, dissociation, or aversion	Sensitive, nonjudgmental inquiry is recommended; childhood sexual abuse often creates one or other sexual problems
Substance Use Assessment	Alcohol; nicotine; opioids; cannabis; stimulants; recreational drugs	Substance use may suppress desire directly or indirectly	Chronic opioid use strongly suppresses gonadal axis
Medication Use history	SSRIs/SNRIs; antipsychotics; mood stabilizers; benzodiazepines; antihypertensives; hormonal contraception; antiandrogens; opioids; finasteride etc.	Medication-induced sexual dysfunction is common and often reversible, hence careful attention to medication use is essential	Particular attention to serotonergic antidepressants and prolactin-elevating antipsychotics
Medical and Endocrine History	Diabetes; obesity; metabolic syndrome; cardiovascular disease; neurological disorders; chronic pain; renal/hepatic disease; endocrine disorders	Identify systemic contributors to impaired desire	Sexual symptoms may precede overt cardiometabolic disease; penis is metaphorically called a " cardioscope " or a " window to the heart " because Erectile Dysfunction (ED) is often the earliest visible symptom of underlying, silent cardiovascular disease
Reproductive and Gynaecological History (Women)	Menstrual history; menopause; postpartum status; infertility; pelvic surgery; endometriosis; contraception; Genitourinary Syndrome of Menopause (GSM)/vulvovaginal atrophy	Hormonal transitions and genital pain syndromes are common contributors	Menopause-associated vulvovaginal atrophy may indirectly reduce desire; hormonal changes also influence desire. However, post-menopausal desire changes experience is highly variable. A significant portion of women experience no change , and others experience a notable increase in sexual desire.
Comorbid sexual	Erectile dysfunction; ejaculatory disorders;	Clarify overlap with other male	Erectile dysfunction frequently coexists with

dysfunctions (Men)	Peyronie disease; infertility; hypogonadism symptoms; androgen deprivation	sexual dysfunctions	reduced desire; comorbid sexual dysfunctions are often rule rather than exception
Sleep and Lifestyle Assessment	Sleep deprivation; shift work; sedentary lifestyle; stress; obesity; exercise; nutrition	Lifestyle factors significantly influence sexual functioning	Sleep disorders and chronic stress may reduce testosterone and motivation to engage in sexual activities
Sociocultural and Gender Considerations	Cultural prohibitions; gender norms; sexual scripts; stigma; minority stress	Sexual experiences are significantly influenced by sociocultural; gender and orientation related issues	Particularly important in India and other sexual conservative societies

Table 2: Assessment Schedule for Sexual Desire Disorder in Men/Women: Physical Examination and laboratory testing

General Physical Examination	BMI; waist circumference; blood pressure; metabolic signs; gynecomastia; body hair distribution, neurological assessment	Screen for systemic illness and endocrine dysfunction	Obesity and metabolic syndrome strongly correlate with sexual dysfunction
Physical Examination for Endocrine Assessment	Testicular size; secondary sexual characteristics; thyroid enlargement; galactorrhoea	Detect hypogonadism, hyperprolactinemia, thyroid disease	Useful in antipsychotic-treated patients
Genital Examination (Men)	Penile abnormalities; Peyronie plaques; testicular atrophy; varicocele, Digital Rectal Exam (DRE) to assess for prostate tenderness	Identify structural contributors affecting sexual confidence/function	Recommended when clinically indicated
Pelvic and Genital Examination (Women)	Vulvovaginal atrophy; vestibulodynia; pelvic floor tenderness; infection; dermatologic lesions	Detect pain disorders and estrogen-deficient states contributing to low desire	Examination may not be mandatory in all cases but is indicated when pain/genital symptoms are reported

Baseline Laboratory Testing	Fasting glucose/HbA1c; lipid profile; CBC; renal and liver function tests	Screen for metabolic and systemic illness	Particularly important in middle-aged and older adults
Hormonal Testing in Men*	Morning total testosterone; free testosterone (if indicated); LH/FSH; prolactin; thyroid function	Evaluate hypogonadism and endocrine causes	Morning testosterone should ideally be repeated if low
Hormonal Assessment in Women*	Thyroid function; prolactin; estradiol (selective use); testosterone and SHBG if androgen therapy considered	Identify endocrine contributors	Routine androgen testing is not universally recommended unless clinically indicated
Additional Investigations (Only if clinically indicated)	Sleep study; pituitary imaging; vascular assessment; specialized endocrine evaluation	Use selectively in complex or refractory cases	Avoid unnecessary investigations unless needed on case-to-case basis
Differential Diagnosis	Asexuality; normative aging; relationship dissatisfaction; medication adverse effects; psychiatric disorders; pain disorders; endocrine disease	Differential diagnosis helps in correct diagnosis	Distress and impairment remain central diagnostic requirements

**Androgen serum levels do not correlate with sexual desire and are currently not recommended routinely.*

Standardized tools for assessment of desire disorder

A variety of rating scales are available for assessment of sexual dysfunctions. Most of the scales are multidimensional and include assessment of several domains of sexual function. Below given table summarizes most commonly used rating scales. (See Table 3).

Table 3: Standardized tools for assessment of desire disorder ^[43-49]

Name of tool	Population	Format	Key points
Sexual Desire Inventory (SDI)	Both males and female	14 items, both dyadic and solitary desire is assessed	Most widely used, useful for baseline as well as outcome evaluations
Arizona Sexual Experiences Scale (ASEX)	Both males and females	5 items, Domains include Desire, arousal,	Brief and commonly used rating scale

		erection/lubrication, orgasm, satisfaction	
Changes in Sexual Functioning Questionnaire	Both males and females	14 and 36 items versions, Self-reported assessment of sexual functioning domains Desire/frequency, desire/interest, arousal, orgasm, pleasure	Especially useful in psychiatric patients including psychotropic induced sexual dysfunctions
Sexual Function Questionnaire (SFQ)	Both males and females	34 items, Domains include Desire, arousal, orgasm, pain, enjoyment, partner-related factors	Comprehensive assessment of multiple domains of sexual functioning
Female Sexual Function Index (FSFI)	Females	19 items, domains include Desire, arousal, lubrication, orgasm, satisfaction, pain	Most widely used female sexual function scale
Decreased Sexual Desire Screener (DSDS)	Females	5 items, Diagnostic screening for acquired generalized HSDD	Specifically developed for HSDD in premenopausal women

Management

Management strategies should be individualized and incorporate biopsychosocial model which accepts multicausal and multidimensional nature of desire disorders. The treatment planning should consider patient's age, sex, as well as sexual, medical, and psychiatric comorbidities. Relationship factors and individual context of the patient like cultural factors and relevant moral/ethical values are additional important information for treatment planning. As sexual desire is always influenced by interpersonal dynamics, interventions involving both partners are often associated with better and more sustained outcomes. Depending on the clinical presentation, the following components may be incorporated into the treatment plan.^[9,11]

Managing medical comorbidities

Making a thorough assessment to identify medical comorbidities, if any, is essential. Particular attention should be paid to cardiovascular illness, metabolic syndrome, diabetes and endocrine dysfunctions like thyroid and prolactin related disease. Treatment of obesity, diabetes, cardiovascular disease, and sleep disorders is important. Selection of pharmacotherapy that have facilitatory or are atleast devoid of negative impact on sexual functioning should be preferred ^[50-51]

Managing Psychiatric comorbidities

Psychiatric disorders commonly impact sexual functioning and especially sexual desire may be adversely impacted by it. Many psychotropic medications negatively influence sexual functioning due to side effects. Careful selection of medications is essential to balance the response and sexual side effects.

Medication review- Many patients use medications for medical and/or psychiatric conditions. Careful review and change in medications is needed if they adversely impact sexual functioning. (See Table 4) ^[28]

Table 4: List of commonly used medicines categorized as per the risk of sexual side effects

Disease	Higher Risk of Sexual Dysfunction	Lower Risk / Sexually Neutral or Potentially Favorable	Comments
Hypertension	Thiazide diuretics (especially hydrochlorothiazide), non-selective β -blockers (propranolol), older β -blockers (atenolol), centrally acting agents (methyldopa, clonidine)	Angiotensin-Converting Enzyme (ACE) inhibitors (enalapril, ramipril, perindopril), Angiotensin II Receptor Blockers (ARBs) (losartan, telmisartan, valsartan), calcium channel blockers (amlodipine, diltiazem), Nebivolol	ARBs and Nebivolol have the best evidence for preserving or improving erectile function. Nebivolol increases nitric oxide availability and may improve erectile function.
Heart failure / ischemic heart disease	High-dose loop diuretics, spironolactone, digoxin (occasionally), non-selective β -blockers	ACE inhibitors, ARBs, Nebivolol, mineralocorticoid receptor antagonist Eplerenone, SGLT2 inhibitors (when indicated)	Spironolactone may reduce libido through anti-androgenic effects; Eplerenone has substantially less endocrine toxicity.
Diabetes Mellitus	Older sulfonylureas (limited evidence), chronic insulin use (indirectly through disease severity rather than drug effect)	Metformin, Dipeptidyl peptidase-4 (DPP-4) inhibitors or Gliptins (sitagliptin, linagliptin), Glucagon-Like Peptide-1 (GLP-1) receptor agonists (semaglutide, liraglutide), Sodium-Glucose Cotransporter 2 (SGLT2) inhibitors (empagliflozin, dapagliflozin), pioglitazone	Good glycaemic control itself is associated with better sexual function. GLP-1 receptor agonists and SGLT2 inhibitors may improve sexual function through weight loss and cardiometabolic benefits.
Dyslipidemia	Older reports suggest possible effects with statins, but current	Statins (atorvastatin, rosuvastatin), ezetimibe	Statins are generally considered sexually neutral and may

	evidence does not support a clinically important adverse effect		improve erectile function by improving endothelial function.
Antiplatelet / Anticoagulants	No established adverse effect	Aspirin, clopidogrel, ticagrelor, rivaroxaban, apixaban	Generally, do not adversely affect sexual desire or erectile function.

Lifestyle modification- The overall physical and mental health is very important for sexual health. Hence, life style modifications focused at regular physical exercise, management of stress, stopping tobacco/other psychoactive substances use, stopping or minimizing alcohol use, and improving dietary habits are useful adjuvants in management. ^[3,6]

Relational focused intervention- Each individual should be offered strategies to improve romantic relationship and emotional intimacy with their partner. Good communication, spending quality time together, learning to respectfully resolve conflicts, continue to maintain focus on intimacy and physical touch, reminding playful/involve safe new mutually agreed experiences and bringing novelty to sexual scenario can add in improving sexual desire. Where significant relationship distress, communication difficulties, or longstanding interpersonal conflicts are identified, structured couple therapy or sex therapy should be considered as part of comprehensive management. ^[40,42]

Specific interventions

Non-Pharmacological Management

Psychoeducation and Sex Education

Psychoeducation is an important therapeutic intervention. Patient and partner should be educated regarding normal variations in desire.^[20] Aging-related changes, responsive versus spontaneous desire, impact of stress and fatigue, and effects of relationship dynamics on sexuality are important issues to be included in psychoeducation.^[52] Unrealistic expectations and performance-focused sexual scripts should be addressed. Concept of Good Enough Sex (GES) should be incorporated, wherever relevant. The GES model focuses more on intimacy, touch and mutual emotional acceptance as well as accepting natural variability, age-appropriate changes as well as occasional dysfunctional sexual encounters as normative. ^[42,52] Porn use and its impact need assessment also. Many people substitute porn and masturbation as preferred sexual activity despite being in a relationship. Management includes remaining non-judgmental and focusing on restoring healthy partnered intimacy by gradual reduction of porn use, improving communication, increase partner based joint activities and sensate focus techniques. ^[53,54]

Sex Therapy

Sex therapy remains a commonly used treatment modality, particularly in cases where psychological and relational factors are dominant and/or coexist with organic contributors.^[39] Treatment is individualized and commonly include sensate focus exercises, enhancing erotic communication, expanding erotic repertoire, guided fantasy and behavioural techniques.^[55]

Sensate Focus (SF) remains one of the most widely used therapeutic techniques, particularly for patients with performance anxiety, avoidance, or spectatoring. SF reduces pressure of performance by banning sexual intercourse in initial phases, increasing focus on awareness of bodily sensations by touching or being touched, reduces anxiety, and promotes emotional and physical intimacy by shifting attention away from intercourse and performance goals. The focus is on sensuality (pleasure) rather than sexuality (performance). This devalues perfectionistic, totally predictable sexual response and encourages variable, flexible couple sexuality that embraces GES.^[56,57]

Couple-based approaches are especially useful if discordant desire and relationship conflict is identified. The sex therapy treatment approaches can be commonly integrated with pharmacotherapy and medical management.^[41]

Cognitive Behavioural Therapy (CBT)

Cognitive dysfunctions like poor sexual esteem, body image issues, and perfection based sexual scripts may result in behavioural avoidance. CBT targets maladaptive beliefs, anxiety, guilt, shame, body image concerns, trauma-related cognitions, and avoidance behaviours during therapy. CBT in sexual desire disorder often incorporates sensate focus, directed masturbations and coital alignment techniques as behavioural component of therapy.^[58]

Mindfulness-based CBT (MBCBT) has demonstrated benefit particularly in women with female sexual interest/arousal disorder (FSIAD). MBCBT aims at improving awareness of one's body, sensations, emotions and ability to pay attention in a particular way as well as accepting oneself in a nonjudgmental and compassionate way. It also addresses negative sexual schema and negative expectations about sexual outcome. CBT targets avoidance by gradual exposure to threatening situations (sexual intercourse) and teaching patients to remain in the present moment during the act rather than being distracted.^[59]

The research evidences of successful use of both the CBT and MBCBT for sexual dysfunctions are stronger in females in comparison to males. Additionally, the psychological interventions have been mostly tested in patients who have comorbid sexual dysfunctions like ED, PME and orgasmic dysfunctions in both men and women. Psychological interventions have global effects on sexual functioning and frequency of sexual activity irrespective of specific sexual dysfunction.^[61-63]

Relationship-Focused Interventions

Marital dissatisfaction, unresolved conflict, emotional disengagement, and poor communication are common perpetuating factors of sexual dysfunction. Couple therapy may improve emotional intimacy, responsiveness, and overall sexual satisfaction.^[6] Relationship building exercises like scheduling time for physical and sexual intimacy, and communication training (talking about personal sexual needs and concerns) are often incorporated in the treatment. Teaching nonjudgemental and respectful methods to listen to partner's sexual concerns as well as discussing own sexual concerns in an open and comfortable manner

without feeling shame, guilt or embarrassment are helpful in improving sexual self-confidence in couple settings.^[9,11]

Partner involvement improves treatment adherence and outcomes. Where concerns regarding infidelity, betrayal, resentment, or unresolved interpersonal conflicts are identified, these should be addressed before initiating interventions primarily directed at sexual functioning.^[62]

Trauma-Informed Psychotherapy

In patients with histories of sexual abuse, coercion, painful sexual experiences, or PTSD, trauma-focused psychotherapy is useful. Therapy should initially focus on safety, emotional stabilization, affect regulation, and processing trauma-related beliefs.^[36] Restoration of trust, bodily autonomy, and healthy sexual intimacy should proceed gradually according to the individual's readiness. The therapist emphasizes that past cannot be changed and power to change is in the present and future only. Individual can process the themes from past and learn to handle it in the present.^[64]

Pharmacological Management

Pharmacotherapy is usually considered when potentially modifiable psychosocial and medical contributors have been addressed. However, clinically significant symptoms as well as distress persists. The decision for simultaneous pharmacotherapy can be taken on case-to-case basis depending on the needs of the situation and it should complement rather than replace psychological interventions. The quality of evidence for pharmacological treatment of low sexual desire varies considerably.

Management in Men

Testosterone Therapy^[24,25]

Men having low sexual desire associated with confirmed hypogonadism may benefit from testosterone replacement therapy (TRT) (*Level of evidence- High*). Patients having symptoms suggestive of low testosterone along with low morning serum testosterone levels are treated with TRT (low testosterone levels is preferably confirmed on at least two separate occasions before starting testosterone). TRT can improve libido, sexual thoughts, erectile function, mood, and energy. Monitoring for TRT includes haematocrit, haemoglobin, prostate specific antigen, Digital Rectal Examination (DRE) for prostate enlargement, and testosterone levels. TRT is not recommended in men with normal testosterone levels for enhancement of sexual desire.

Commonly used preparations include intramuscular testosterone enanthate (100–250 mg every 2–3 weeks), intramuscular testosterone undecanoate (1000 mg at baseline, followed by a second dose after 6 weeks and subsequently every 10–14 weeks), or transdermal testosterone gel (usually 40–60 mg applied once daily).

Treatment response should be reviewed after 3–6 months by assessing changes in sexual desire, overall sexual function, mood, energy levels, serum testosterone concentrations, and treatment-related adverse effects. Men who experience meaningful clinical improvement and tolerate therapy well may continue testosterone replacement for long term with periodic monitoring, usually at 6–12-month intervals. In contrast, the need for continued treatment should be reconsidered in individuals who fail to show symptomatic benefit despite achieving mid-range testosterone levels.

The duration of therapy depends on the underlying cause of hypogonadism. Men with irreversible hypogonadism often require long-term replacement. Patients with functional or potentially reversible hypogonadism like obesity, diabetes or sleep apnea should be reassessed periodically to determine whether testosterone therapy can be tapered or discontinued following correction of the underlying condition.

Treatment of Erectile Dysfunction

Low desire in men may be secondary to erectile dysfunction (ED). Management of ED with Phosphodiesterase-5 inhibitors such as Sildenafil or Tadalafil may indirectly improve sexual confidence and desire (*Level of evidence for use of PDE5i when ED is contributing to low desire-High*).

Pharmacotherapy in Women

Pharmacotherapy for desire disorder in women is found to be only modestly effective.

Flibanserin^[18]

Flibanserin is approved for acquired generalized FSIAD in premenopausal women (*Level of evidence- Moderate*). It acts through serotonergic modulation with downstream dopaminergic and noradrenergic effects. However, the research data is not very strong and Flibanserin may only modestly improve sexual desire and may be associated with bothersome adverse effects like dizziness, somnolence, nausea and fatigue. Alcohol use is contraindicated with Flibanserin.

Bremelanotide^[18]

Bremelanotide is a melanocortin receptor agonist. It is administered subcutaneously before planned sexual activity. It may benefit premenopausal women with acquired generalized FSIAD (*Level of evidence- Moderate*). Nausea, flushing, and headache are common adverse effects. However, the therapeutic effects are modest and clinical significance of improvement as well as tolerability issues are not very robust resulting into a very limited use of this medicine only.

At present, Flibanserin and Bremelanotide are not routinely available in the Indian market and clinical experience with these agents in India remains limited.

Testosterone Therapy in Women^[65,66]

Transdermal testosterone therapy may be considered for postmenopausal women with HSDD after careful assessment (*Level of evidence- High*). Current guidelines support short-term testosterone therapy in carefully selected women with distressing low desire. Baseline and follow-up monitoring include testosterone levels, lipid profile, liver function. Acne, hirsutism, and voice changes are common side effects. Long-term safety data remain limited. Initially a 3–6-month trial is recommended before planning a longer use. For transdermal testosterone therapy, 300-µg/d patch has been found to be effective.

Estrogen Therapy^[66]

In peri- and postmenopausal women, vulvovaginal atrophy and dyspareunia may secondarily suppress desire. Local or systemic estrogen therapy may improve genital comfort, lubrication, and sexual functioning in women suffering from vulvovaginal atrophy (*Level of evidence- Moderate*).

Other hormonal treatments

Tibolone and other selective estrogen modulators alone or in combination of estrogen are not currently recommended due lack of sufficient evidence. Dehydroepiandrosterone (DHEA) is the most abundant steroidal hormone in women. Vaginal DHEA (approved by FDA) can improve vaginal lubrication, comfort with intercourse and can produce more intense orgasm and enhance desire (*Level of evidence- Moderate*). Daily administration of 50 mg DHEA may improve symptoms.

PSYCHOTROPIC MEDICATIONS^[9,67]

Bupropion

Bupropion is a norepinephrine-dopamine reuptake inhibitor and is an approved antidepressant. Bupropion has been found to be useful for desire in patients with comorbid depression and in non-depressed women also (*Level of evidence- Moderate to low*). The dosage most commonly used are 150 to 300 mg/day.

Buspirone

Buspirone is serotonin 1A partial agonist and is approved as a medication for treatment of anxiety disorders. It has shown to be effective in SSRI induced sexual dysfunction as well as inhibition of sexual desire due to anxiety (*Level of evidence- Low*). The usual dosage is 15 to 30 mg/day.

Both Bupropion and Buspirone should be regarded as adjunctive, off-label treatment options and prescribed after careful discussion regarding expected benefits and limitations. The pharmacotherapy of the male and female hypoactive sexual desire disorder is summarised (see table 5).^[32,65]

Table 5: Pharmacotherapy for Hyposexual desire disorder (Male) and FSIAD (Female)

Agent	Clinical Use	Dose/Route	Clinical Response	Adverse Effects	Monitoring	Precautions	Evidence
Testosterone (Men)	Men with low sexual desire and documented hypogonadism; not recommended with normal testosterone	Undecanoate 1000 mg IM every 10–14 weeks; enanthate/cypionate 75–200 mg IM every 1–2 weeks; gel 50–100 mg/day	Improves libido, sexual thoughts, erectile confidence, energy, and mood over weeks to months	Acne, erythrocytosis, edema, gynecomastia, infertility, worsening sleep apnea	Testosterone, hematocrit, PSA, lipids, cardiovascular risk	Avoid in prostate cancer, uncontrolled polycythemia, severe untreated sleep apnea, fertility-seeking men	Strong evidence in hypogonadal men
PDE5 inhibitors	Erectile dysfunction contributing to low desire	Sildenafil 25–100 mg orally as needed; tadalafil 5–20 mg orally	Improved erectile reliability may enhance desire and sexual confidence	Headache, flushing, dyspepsia, nasal congestion	BP and cardiovascular assessment in high-risk patients	Contraindicated with nitrates	Moderate
Bupropion	Antidepressant-associated low desire or comorbid depression	SR 150 mg/day → 150 mg twice daily; XL 150–300 mg/day	May improve libido, motivation, arousal, and sexual satisfaction	Insomnia, anxiety, dry mouth, tremor, headache	Mood, anxiety, sleep, BP	Avoid in seizure disorder and eating disorders	Moderate; especially antidepressant-induced dysfunction

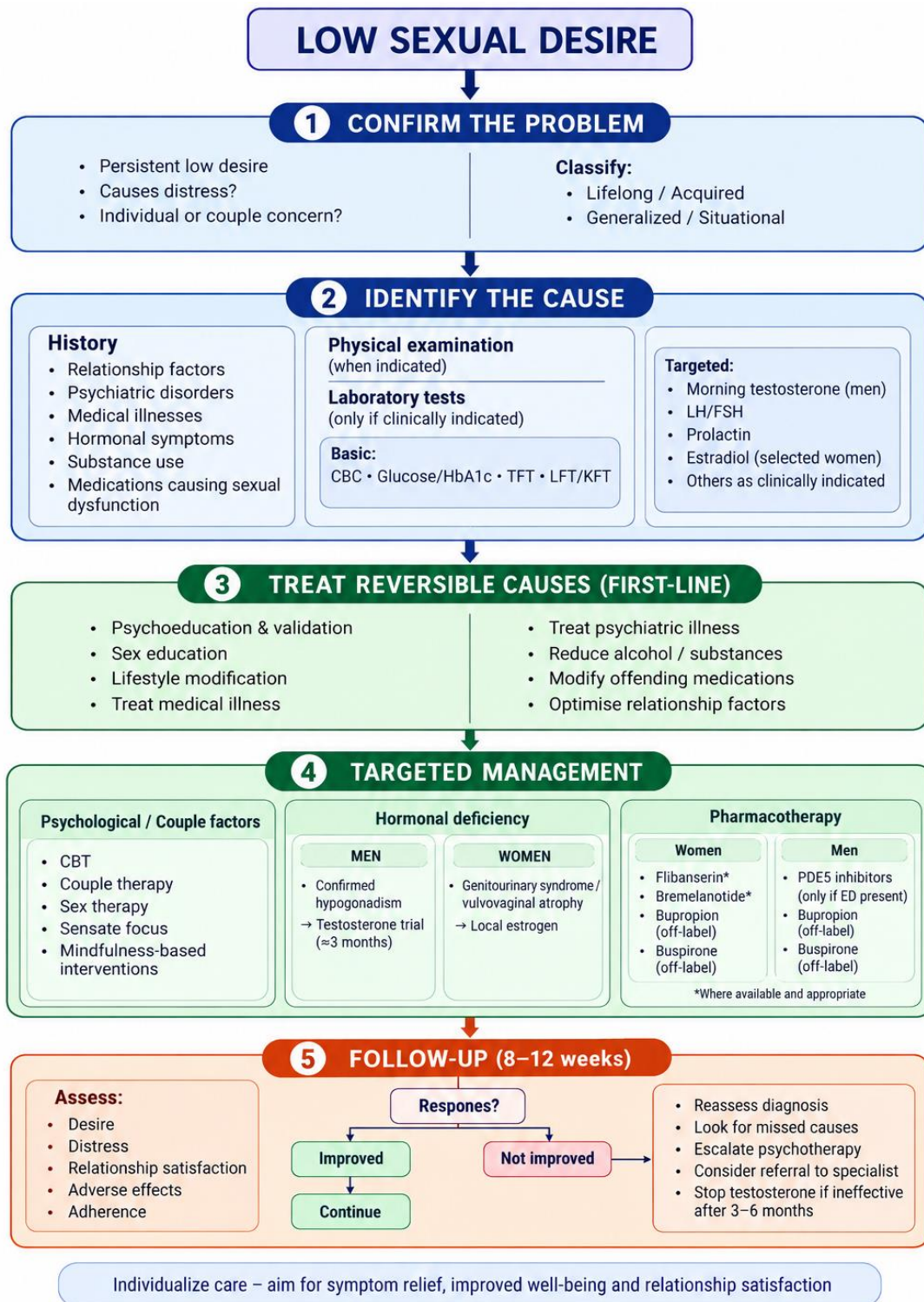
Buspirone	Anxiety-related sexual inhibition; SSRI-induced dysfunction	5 mg twice daily initially; usual 15–30 mg/day in divided doses	May modestly improve desire and reduce anxiety-related inhibition	Dizziness, nausea, headache, restlessness	Anxiety symptoms and tolerability	Limited evidence; gradual titration	Moderate to low
Flibanserin	Premenopausal women with acquired generalized HSDD/FSIAD	100 mg orally at bedtime	Modest improvement in desire and associated distress	Dizziness, somnolence, fatigue, nausea, hypotension	Sedation, BP, alcohol use, drug interactions	Alcohol and CYP3A4 interactions; caution in hepatic impairment	Moderate; phase III trials/ISSWSH
Bremelanotide	Premenopausal women with acquired generalized HSDD/FSIAD	1.75 mg SC ~45 min before anticipated sexual activity	Modest improvement in desire and distress	Nausea, flushing, headache, transient BP elevation	BP, nausea, injection tolerability	Avoid in uncontrolled hypertension/significant cardiovascular disease	Moderate
Testosterone (Women)	Postmenopausal women with carefully diagnosed HSDD	Low-dose transdermal testosterone targeting physiologic female range	May improve desire, sexual satisfaction, and distress	Acne, hirsutism, oily skin, voice change, alopecia	Testosterone, lipids, liver function, androgenic effects	Avoid supraphysiologic dosing; long-term safety limited	Strongest evidence among hormonal therapies for postmenopausal HSDD
Estrogen	Peri/postmenopausal women with vulvovaginal atrophy/dyspareunia contributing to low desire	Local vaginal or systemic estrogen depending on indication	Improves vaginal comfort/lubrication and reduces pain, potentially improving sexual interest	Breast tenderness, nausea, vaginal bleeding	Breast and gynecological evaluation were indicated	Avoid in estrogen-dependent malignancy and selected thromboembolic conditions	Moderate

Integrated and Stepped-Care Approach

Treatment should generally proceed in a stepwise manner starting from reversible causes and psychosocial interventions toward targeted pharmacotherapy where necessary.

Combination approaches integrating psychotherapy, couple therapy, lifestyle intervention, and pharmacological treatment often produce superior outcomes compared to single-modality interventions. (See Figure 1).

Figure 1



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Special Populations

Desire concerns present differently across life stages and vulnerable groups. Age, pregnancy, menopause, history of trauma, chronic illnesses and genital pain modify strategies of assessment and treatment. LGBTQIA+ individuals experience unique stressors. A uniform approach risks misdiagnosis and inadequate management. Hence, individualization in assessment and management is recommended. A summary of hypoactive and hyperactive sexual desire in special populations is presented in (See table 6 and 7).

Table 6: Decreased sexual desire in Special populations [9,18,30,66,68,69]

Special Populations	Common Contributing Factors	Important Clinical Considerations	Psychiatric Management
Male: Older adults and Andropause	Decreased testosterone, chronic illness, meds like SSRIs, Beta-blockers, fatigue and depression	Rule out organic causes: testosterone levels, TSH, metabolic syndrome. Assess relationship + performance anxiety	Psychoeducation, treat depression/anxiety, review /adjust medications, CBT for performance anxiety. Consider HRT if recommended after endocrinological assessment.
Female: Pregnant/ Postpartum/ Lactation	Oestrogen plummets, prolactin rises, fatigue, Postpartum depression (PPD)	Dryness, thinning of vaginal wall, dyspareunia. Screen for PPD and any other relationship stress	Reassure: changes are temporary. Couple counselling. Water-based lubricants. If SSRIs needed for PPD, prefer Sertraline, counsel for sexual side effects
Female: Peri and Postmenopausal	Oestrogen decline, dyspareunia, sleep disturbances, Genitourinary Syndrome of Menopause (GSM)	150+ million >45 in India. GSM causes mood changes and vaginal discomfort. Avoidance due to pain is mislabelled as “No desire”. Myth – “Sex ends at menopause.”	Hormonal/nonhormonal interventions. Local vaginal oestrogen. Transdermal testosterone for true hypoactive desire (off label after ruling out contraindications). Coordinate with gynaecology. Goal -comfort and choice, not 20-year old libido.
Both Male and female: Elderly	Widowhood, loneliness, chronic illness	Avoid assumptions and bust myths regarding “asexual aging”	Integrated biopsychosocial support including hormonal/nonhormonal interventions.
Both Male and female: Disabilities	Dependency, abuse risk, reduced autonomy	Assess decision-making capacity and abuse risk	Rights-based and ethical care psychoeducation.
Both Male and Female:	Trauma response, avoidance, shame	NFHS-5*: 29% married women report violence	If IPV is ongoing, prioritize safety planning before sex

Survivors of trauma and Interpersonal Violence (IPV)		however no data available on married men. Screen sensitively for violence and coercion. Helpline number of 181 or 1901 should be provided. Mandatory reporting POCSO Act 2012	therapy. Partner involvement may be contraindicated. Trauma-focused therapy should precede sexual interventions. Document neutrally
LGBTQIA+ individuals	Minority stress, family pressure, forced marriages, discrimination, stigma, orientation conflicts lead to low desire, Relationship distress	Evaluate as Trans women and men on hormones report reduced desire. Use affirmative and non-judgmental interviewing	Inclusive psychosexual care, hormonal treatments. Provide safety, confidentiality & affirming care. Use neutral language (Partner instead wife/husband) Never attempt conversion therapy.

* National Family Health Survey-5

Table 7: Increased Sexual Desire in Special Populations [7,9,11,18,30,69]

Special Populations	Common Contributing Factors	Important Clinical Considerations	Psychiatric Management
Female: Peri and Postmenopausal women	Hormonal fluctuations, psychological freedom	Differentiate normal variation in desire from mania or medication effects	Supportive counselling and assessment of mood symptoms. SSRIs if required prefer Sertraline.
Both Male and female: Adolescents and younger adults	Hormonal changes and identity exploration may increase sexual curiosity and desire	Assess for risky behaviour, coercion, internet sexual exposure, and distress	Psychoeducation, sexual counselling and family guidance when appropriate
LGBTQIA+ individuals	Minority stress and identity-related factors	Provide affirmative and nonjudgmental assessment	Affirmative psychotherapy and supportive care

Psychiatric comorbidities

Psychiatric illness and psychotropic medications are major contributors to sexual desire disorders in India. Depression, anxiety and substance use often reduce desire. Conversely mania, psychosis and impulse control disorders may cause hypersexuality. Anti-depressants, anti-psychotics and mood stabilizers are routinely implicated in sexual dysfunction. Psychiatrist must attempt to determine if the changes are due to the illness, the medication, or both before diagnosis and management plan. (See Table 8 and 9)

Table 8: Psychiatric Comorbidities Associated with Decreased Sexual Desire in Males and Females [7,9,18,28,66]

Psychiatric Condition	Mechanisms Affecting Desire	Important Clinical Considerations	Psychiatric Management
Depression	Anhedonia, fatigue, low self-worth	Differentiate illness-related vs medication-induced dysfunction. Core illness reduces interest in everything and SSRIs further blunt the desire, arousal and orgasm	Review Antidepressant profile. Consider dose reduction, drug holiday, or switching to Bupropion, Mirtazapine, or Vortioxetine if SSRI-induced dysfunction occurs.
Anxiety disorders	Hypervigilance, fear, performance anxiety	Assess trauma history and relationship anxiety	Cognitive-behavioural interventions. Consider dose reduction, drug holiday, or switching to Bupropion, Mirtazapine, or Vortioxetine if SSRI-induced dysfunction occurs.
OCD	Obsessions about purity and sexual harm	Evaluate and ask for sexual thoughts	SSRIs, Clomipramine, Behaviour therapies like Exposure and Response prevention (ERP). Psychoeducation
ADHD	Inattention and marital discord	Adult ADHD screen, Assess marital satisfaction and medication	Optimise ADHD treatment, Behavioural scheduling for intimacy.
PTSD/trauma disorders	Avoidance, dissociation, intimacy difficulties	Sensitive inquiry regarding abuse history	Trauma-informed psychotherapy.
Psychotic disorders	Social withdrawal, hyperprolactinemia	Monitor antipsychotic side effects	Consider prolactin-sparing atypical antipsychotics.

Substance Use disorder	Chronic alcohol suppresses hypothalamic pituitary axis. Tobacco reduces blood flow. Benzodiazepines flatten arousal. Cannabis and stimulants increase desire acutely, but decrease desire chronically	Screen non-judgementally	Integrated deaddiction and sexual medicine. Psychotherapies. Treat dependence first as desire rarely improves if substance use continues.
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Table 9: Psychiatric Comorbidities Associated with Increased Sexual Desire in Males and Females [7,9,11,18]

Psychiatric Condition	Mechanisms Affecting Desire	Important Clinical Considerations	Psychiatric Management
Bipolar Disorder	Mania/hypomania may cause excessive sexual desire and impulsivity.	Evaluate risky sexual behaviour and impaired judgment.	Mood stabilization and relapse prevention.
Obsessive Compulsive Disorder	Compulsive behaviour to relieve anxiety	Ask if sex is compulsive, Assess distress vs pleasure	SSRIs, Clomipramine, Behaviour therapies like Exposure and Response prevention (ERP). Psychoeducation
Attention Deficit Hyperkinetic Disorder (ADHD)	Impulsivity and boredom	Adult ADHD screen, Assess marital satisfaction and medication	Optimise ADHD treatment. Couples communication training
Substance Use Disorders	Alcohol and stimulants may reduce inhibition and increase sexual impulsivity.	Screen for risky, unsafe sexual practices and exploitation	De-addiction treatment, psychotherapy and sexual medicine
Personality Disorders	Emotional dysregulation may manifest as compulsive sexual behaviour.	Assess interpersonal instability and impulsivity	Dialectic Behavioural Therapy, Cognitive Behaviour Therapy, Impulse control strategies

Medical comorbidities

Comorbidities is a rule rather than an exception. Physical illness and medications commonly cause desire disorders. Endocrine, vascular, neurological and pain conditions alter desire via fatigue, mood and body image. Screen for these before diagnosing a primary sexual disorder. (See Table 10 and 11).

Table 10: Medical Comorbidities Associated with Decreased Sexual Desire in Males and Females [7,9,18,28,66]

Medical Condition	Mechanism affecting Desire	Important Clinical Considerations	Management focus
Both Male and female: Diabetes Mellitus, Chronic Kidney Disease, Chronic Vascular Disease	Vascular/Neurological damage, fatigue, depression, meds: anti-hypertensives, statins	Assess glycaemic control and depression	Multidisciplinary management. Review medications that may worsen such as beta blockers and diuretics. Aim for <7% HbA1c. SGLT2 inhibitors are weight and sex neutral.
Both Male and female: Hypothyroidism	Hormonal imbalance, fatigue, low mood, weight gain, menstrual issues. All reduce desire and energy for intimacy	Evaluate endocrine status routinely	Hormonal correction. Reassess desire every 3 months after euthyroid status is achieved. Treat even “subclinical” TSH>4.5 if hypoactive desire disorder is present.
Both Male and female: Obesity	Poor body image, metabolic disturbances	Explore self-esteem and relationship issues	Lifestyle and psychological support
Females: Polyendocrine Metabolic Ovarian Syndrome (PMOS)	Hormonal imbalance due to insulin resistance. Hirsutism, acne and infertility causing body image concerns	Assess anxiety, depression and body image concerns.	Combined endocrine-psychiatric care. Metformin and lifestyle changes improve metabolic health and mood. Address body image concerns directly
Female: Chronic pain disorders	Dyspareunia and intimacy avoidance caused by Endometriosis, PID*, vaginismus, GSM.	Evaluate fear-avoidance behaviours and undiagnosed pain disorders. Ask for deep pain during intercourse	Pain and psychosexual management. Pelvic floor therapy may help in Vaginismus. Always rule out pain including GSM before diagnosing for desire disorder.
Malignancy	Fatigue, altered body image, distress. Chemotherapy and aromatase inhibitors cause premature	Assess survivorship-related emotional burden	Supportive psychotherapy.

	menopause and severe GSM		
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*PID – Pelvic Inflammatory Disease, SGLT2- Sodium-GLucose co-Transporter 2, TSH- Thyroid-Stimulating Hormone

Table 11: Medical Comorbidities Associated with Increased Sexual Desire in Males and Females ^[9,22]

Medical Condition	Mechanism affecting Desire	Important Clinical Considerations	Management focus
Neurological Disorders	Dopaminergic abnormalities, brain injury, Kleine Levin syndrome, Kluver Bucy syndrome, Epileptic personality changes	Rule out organic causes and medication-induced symptoms.	Multidisciplinary management with Neurology
Endocrine disorders	Hormonal abnormalities in androgen production, oestradiol, testosterone may contribute to hypersexuality	Rule out organic causes and medication-induced symptoms.	Multidisciplinary management with Endocrinology

Indian cultural and regional aspects

Indian sociocultural context shapes how sexual desire is expressed, reported, and treated. Kama Sutra, Rigveda, Mahabharata, Ramayana, and Ananga Ranga, as well as temple art at Khajuraho, Konark, Ajanta, Ellora, and Modhera, reflect themes of love, desire, intimacy, and the connection between physical and spiritual life. Modern Indian society holds conservative views on sexuality, giving greater importance to marriage, procreation, and modesty. Limited sex education, myths, and the lack of open discussion about sexual health further complicate the scenario.

Indian cultural and linguistic diversity determines access to sexual healthcare. Access to health care, specifically to a sexual medicine expert or physician competent in sexual medicine and family structure vary widely across India. These factors directly impact patient's engagement in assessment or therapy. Assessment should identify which factor is influential, and intervention should be matched to the context and prevailing local conditions rather than applying Western norms uniformly. Hence, Indian psychiatrists must carefully distinguish culturally influenced sexual attitudes from true psychopathology. (See Table 12,13,14)

Table 12: Cultural Factors associated with Decreased Sexual Desire in India in Males and Females ^[9,23,27,66]

Cultural Factor	Impact on Sexual Desire	Important Clinical Considerations	Psychiatric Intervention
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Male: Masculinity norms/ "Performance pressure"	Increase anxiety, decreased desire. Fear of not "performing" can cause avoidance	Distinguish cultural expectations vs HSDD. Assess for performance anxiety, ED, depression. Check partner expectations.	CBT for performance anxiety, Cognitive restructuring of "masculinity = performance".
Female: Patriarchal norms	Suppression of sexual autonomy specific to women. As it may be viewed negatively or morally unacceptable, individuals may hide symptoms due to shame and fear of judgment	Explore gender-role expectations. Assess misconceptions	Psychoeducation to minimise internalized guilt and shame. Maintain a nonjudgmental and confidential approach.
Female: Shame and Honor	"Shame" inhibits women to disclose especially in front of husbands or in-laws and to male doctors	Ask if they want time alone. Respect their answer. More disclosure occurs once family leaves	Promote confidentiality and create safe space.
Marriage-cantered sexuality	Sex viewed as marital obligation	Assess marital satisfaction and coercion if any	Relationship counselling to avoid distress
Myths	Myths and misinformation. "Common beliefs include good women do not initiate sex or masturbation causes weakness in males"	Assess for misconceptions. Counter directly but gently. Explain responsive desire.	Challenge myths, Provide correct and adequate information
Inadequate sex education	Most never learnt body basics. No knowledge about erogenous zones	Get permission before personal questions. Explore sensitively for sexual knowledge and understanding	5-minute anatomical explanation often most powerful intervention.
Religious conservatism and Community Nuance	Shame regarding desire and masturbation. Beliefs regarding menstruation, purity, fasting, widowhood, and intimacy vary widely	Avoid judgmental communication and assumptions	Provide Psychoeducation and challenge myths and misconceptions.

Table 13: Cultural Factors associated with Increased Sexual Desire in India in Males and Females [9,30]

Cultural Factor	Impact on Sexual Desire	Important Clinical Considerations	Psychiatric Intervention
Male: Masculinity norms/ "Performance pressure"	In some contexts, pressure to initiate can increase desire but also stress	Distinguish cultural expectations and true disorder.	Couple counselling for partner expectations.
Media /Pornography norms	Increased unrealistic expectations leads to decreased satisfaction /desire with partner. Can increase desire for novelty but decrease for real intimacy.	Assess porn use pattern, distress vs addiction model. Compare real relationship vs fantasy expectations.	CBT, mindfulness, "porn literacy". Sensate focus to reduce pressure.

Table 14: Regional considerations associated with Sexual Desire in India in Males and Females [9,66]

Regional Considerations	Impact on Sexual Desire	Important Clinical Considerations	Psychiatric Intervention
Access Gap	Delayed help-seeking and treatment	Metropolitans have sexology clinics, districts don't. Psychiatrist maybe the only MHP* for 5 lakh people	Sexology services, District-level sexual health clinics, integration of sexual health services into existing mental health and reproductive health programmes
Language	Difficulty expressing sexual concerns	Check understanding "What does desire mean to them?"	To use regional language. Prefer simple local language instead of "libido".
Local Remedies or alternative medical systems	Unsafe products may worsen symptoms	Ask about Ayurvedic/Unani "sex power" medicines. Many hide Sildenafil or Steroids use	Don't shame, explain risks, monitor for drug interaction and safe guard against unsafe products.
Joint Family Systems	Reduced privacy and intimacy	Lack of locked doors prevents behavioural homework. If Sensate focus prescribed may not happen. Assess family dynamics.	Combine with Adapt therapy with communication or mindfulness exercises

MHP*- Mental Health Professional

Specific Clinical Situations

There are certain specific clinical scenarios which may present as disorders of sexual desire in clinical practice. These scenarios require different strategies for clinical assessment and management. These situations and management strategies are briefly mentioned below. (See Table 15).

Table 15. Specific Clinical Situations During Assessment of Low Sexual Desire in Males and Females [9,18,70]

Clinical situation	Clinical significance	Clinical pearls for assessment and management
Variant (atypical) sexual arousal patterns (e.g., fetishes, cross-dressing, BDSM interests)	Some individuals experience sexual arousal primarily in specific erotic contexts. This may be concealed from the partner and misinterpreted as low sexual desire.	Explore sexual fantasies, preferred arousal patterns, and masturbation practices in a non-judgmental manner. Determine whether the interest is consensual, causes distress or impairment, or affects partnered intimacy. Many variant arousal patterns are not pathological and require psychoeducation, couple counselling, or negotiation rather than attempts to eliminate the preference.
Paraphilic interests and disorders	Sexual interest in non-consenting persons or behaviours involving coercion, exploitation, or harm may coexist with apparent low desire for consensual partnered sex.	Differentiate consensual atypical sexual interests from paraphilic disorders. Assess the nature of fantasies, urges, behaviours, associated distress, impulse control, risk to others, and legal implications. Risk assessment, safeguarding, and appropriate psychiatric management should take priority where there is potential harm to others.
Preference for masturbation over partnered sexual activity	Some individuals maintain satisfactory solitary sexual function but avoid or show reduced interest in partnered sexual activity because of performance anxiety, relationship difficulties, pornography use, or conditioned masturbation patterns.	Assess masturbation frequency, pornography use, preferred methods of stimulation, performance anxiety, relationship satisfaction, and erectile or ejaculatory concerns. Treatment should focus on the underlying maintaining factors rather than advising abstinence alone. Couple-based interventions and behavioural

		exercises may help restore partnered intimacy.
Sexual orientation-related concerns	Apparent low sexual desire may reflect incongruence between an individual's sexual orientation and the current relationship rather than a true desire disorder. This is particularly relevant in societies where social or familial pressures influence marriage decisions.	Explore sexual orientation sensitively and confidentially without making assumptions. Assess self-acceptance, disclosure concerns, minority stress, and relationship expectations. Provide affirmative, non-directive counselling. Distinguish conflicts related to sexual orientation from psychopathology, and avoid any attempts at sexual orientation change interventions.
Asexuality	Sexual orientation characterized by little or no intrinsic sexual attraction and should not be mistaken for a psychiatric disorder or hypoactive sexual desire disorder.	Establish that the absence of sexual attraction is lifelong or stable, is not associated with personal distress, and is not better explained by medical illness, endocrine disorders, psychiatric conditions, medication effects, trauma, fear of intimacy, or relationship problems. Management primarily involves psychoeducation, normalization, and helping the individual or couple understand and negotiate relationship expectations rather than attempting to increase sexual desire.

Conclusion

Desire disorder patients often present with variable symptoms. They require individualised treatments that include combinations of pharmacological, psychological and behavioural approaches. Comorbidities are rule rather than an exception hence careful treatment planning is essential to cover all problems. There is a need to continue to develop safe, effective and acceptable treatment methods for desire disorders.

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