

Medication-Induced Female Sexual Dysfunction

Causes, Symptoms, Diagnosis, Treatment, Fertility Considerations and an Integrative Unani Approach

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Introduction

When a woman comes to me and says, **“Doctor, my sexual desire, lubrication or ability to reach orgasm changed after I started a medicine,”** I consider the timing carefully.

Sexual functioning is influenced by much more than hormones or reproductive organs. The brain, neurotransmitters, nerves, blood flow, estrogen and androgen activity, mental health, sleep, physical health, relationship circumstances and medications all interact with one another.

A medicine prescribed for depression, anxiety, hypertension, allergy, chronic pain, cancer, contraception or another medical condition may sometimes interfere with one or more parts of this sexual-response system.

This is broadly described as **Medication-Induced Female Sexual Dysfunction**, also called **drug-induced or medication-associated female sexual dysfunction**.

A major 2026 clinical review identifies medication/substance-induced sexual dysfunction as one of the recognized categories within female sexual dysfunction, alongside disorders affecting sexual interest/arousal, orgasm and sexual pain. Modern management increasingly uses a multidisciplinary approach because several domains can be affected simultaneously.

The first message I give patients is particularly important:

Do not abruptly stop an essential medicine simply because you suspect that it is affecting your sexual function.



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The original illness may itself require continuous treatment, and sudden discontinuation of medicines—particularly antidepressants, antipsychotics, anticonvulsants, opioids or hormonal therapies—can sometimes cause serious problems. The correct approach is to identify the likely relationship, assess other possible causes and work with the prescribing clinician to find the safest solution.

What Is Medication-Induced Female Sexual Dysfunction?

Medication-induced female sexual dysfunction means that a medicine or substance **causes, contributes to, or significantly worsens a woman's sexual functioning.**

The effect may involve sexual desire, mental arousal, genital arousal, lubrication, orgasm, genital sensation, sexual comfort or pain.

ACOG recognizes sexual problems caused by medications or substances as an important category of women's sexual-health concerns and identifies several relevant medication groups, including SSRIs, hormonal medications, cardiovascular medicines and anticholinergic medications.

The diagnosis should not be made simply because a woman happens to take medication.

A more convincing pattern is seen when sexual function was previously satisfactory, a problem begins after a medicine is introduced or its dose is changed, the type of dysfunction is compatible with the medicine's known pharmacological effects, and other stronger explanations have been considered.

Female Sexual Response Is Complex

Female sexual response does not follow one identical pattern in every woman.

Desire may sometimes appear before arousal. At other times, a woman may initially feel emotionally neutral and become interested only after affectionate or sexual stimulation begins.

Sexual function depends upon interactions between the brain, neurotransmitters, hormones, genital blood flow, sensory nerves, pelvic-floor muscles, psychological state and relationship circumstances.

This explains why the same medication can affect two women very differently.

One woman taking an SSRI may have normal desire but difficulty reaching orgasm.

Another may lose sexual interest almost completely.



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A third may notice reduced genital sensation.

Another may experience inadequate lubrication, making penetration uncomfortable.

And some women experience no sexual adverse effect at all.

Mayo Clinic similarly describes female sexual dysfunction as involving problems with desire, arousal, orgasm or sexual pain and stresses that medical, hormonal, psychological and relationship factors often overlap.

What Symptoms Can Medication-Induced Female Sexual Dysfunction Cause?

Medication-related changes can affect almost every aspect of sexual response.

A woman may notice a substantial reduction in sexual thoughts or desire. She may still want emotional intimacy but rarely feel sexually interested.

Another woman may mentally desire sexual activity but notice that her body no longer responds as previously. Genital swelling and lubrication may be reduced, and more stimulation may be required.

Orgasm may become delayed, weaker or impossible despite adequate stimulation.

Some women describe a reduction in genital sensation, stating that stimulation feels less intense than before.

Others develop vaginal dryness. Friction then causes burning, irritation or pain during penetration, which can eventually lead to anticipatory anxiety and avoidance of intercourse.

ACOG notes that medication-related sexual problems can involve desire, arousal, orgasm and pain, while Mayo Clinic identifies reduced desire and difficulty reaching orgasm among well-recognized antidepressant adverse effects.

Medication-Induced Low Sexual Desire

Loss of sexual desire is one of the most common medication-related complaints.

The patient may say:

“My relationship has not changed, but I simply don't think about sex anymore.”

or:

“I still love my partner, but the interest I used to have has disappeared.”



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This is important because partners can easily misinterpret reduced sexual desire as emotional rejection.

Medicines that alter serotonin, dopamine, prolactin, gonadal hormones or central nervous-system activity may influence desire.

However, low sexual desire should not automatically be blamed on medication.

Depression, anxiety, chronic pain, fatigue, thyroid disease, menopause, relationship problems and lack of sleep can produce the same symptom.

The clinician therefore needs to establish whether sexual interest was already reduced **before** treatment began.

Medication-Induced Arousal and Lubrication Problems

A woman may remain mentally interested in sex but notice that physical arousal has changed.

She may experience less genital warmth, less vaginal lubrication or reduced clitoral responsiveness.

This can make sexual activity feel uncomfortable or emotionally frustrating.

Some antidepressants, antihistamines, blood-pressure medicines and hormonal treatments may contribute to reduced desire or arousal, which in turn can decrease lubrication. Mayo Clinic specifically notes that antidepressants, antihypertensive medicines, sedatives, antihistamines and some contraceptive pills can contribute to sexual pain indirectly through effects on desire, arousal or lubrication.

Vaginal dryness can also occur when a treatment reduces estrogen activity—for example during certain breast-cancer treatments.

Medication-Induced Orgasmic Dysfunction

Orgasm is particularly sensitive to medications that influence serotonin.

A patient may tell me:

“I can become aroused and enjoy intimacy, but I can no longer reach orgasm.”

Another may still reach orgasm but only after unusually prolonged or intense stimulation.

Others describe the orgasm as noticeably weaker.



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The terminology can include **delayed orgasm** or **anorgasmia**, depending on the pattern.

ACOG lists difficulty reaching orgasm among recognized sexual problems associated with antidepressant treatment.

This does not mean that the woman has permanently lost the ability to experience orgasm. Medication effects, psychiatric illness, hormonal factors, stress and sexual stimulation patterns all need to be evaluated.

Sexual Pain Secondary to Medication Effects

Not every medication directly causes pain.

Sometimes a medication alters another component of sexual response, and pain develops secondarily.

For example:

reduced arousal → reduced lubrication → increased friction → burning or painful penetration → fear of intercourse → pelvic-floor tightening → more pain.

Thus, what begins as a lubrication problem can evolve into a more complicated sexual-pain disorder.

In hypoestrogenic conditions caused by some cancer treatments, thinning and dryness of vulvovaginal tissues may produce significant dyspareunia.

This is why treating only the pain without identifying the medicine-related dryness or hormonal change may provide incomplete relief.

Antidepressants: The Most Important Medication Group

Among medication-related female sexual problems, **antidepressants are particularly important.**

SSRIs and SNRIs are widely used for depression, anxiety disorders and several other conditions.

SSRIs include medicines such as sertraline, fluoxetine, paroxetine, escitalopram and citalopram.

SNRIs include medicines such as venlafaxine, desvenlafaxine and duloxetine.

Mayo Clinic notes that serotonergic antidepressants can cause decreased sexual desire, difficulty with lubrication and difficulty reaching orgasm, with SSRIs generally carrying a comparatively high risk of sexual adverse effects.

SNRIs can similarly contribute to reduced sexual desire or orgasmic difficulty.

Why Do SSRIs Affect Sexual Function?

Serotonin is extremely important for mood regulation.

Increasing serotonergic activity can reduce depression and anxiety, but serotonin also influences sexual pathways.

Higher serotonergic activity can inhibit dopaminergic and other neural mechanisms involved in sexual motivation and orgasm.

The result may include:

reduced desire, reduced arousal, delayed orgasm or inability to reach orgasm.

This illustrates an important medical principle.

A pharmacological effect that is beneficial for one function may interfere with another.

The medicine may be successfully treating depression while simultaneously reducing sexual functioning.

The solution is therefore not automatically to stop the medicine. The objective is to preserve psychiatric stability while reducing the sexual adverse effect whenever safely possible.

Depression Itself Can Cause Sexual Dysfunction

This is one of the biggest diagnostic difficulties.

Depression itself commonly reduces:

- Sexual desire
- Motivation
- Pleasure
- Energy
- Confidence
- Relationship engagement



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Therefore, if a woman with depression develops sexual dysfunction, we have to determine whether it is caused by:

the depression, the antidepressant, or both.

If sexual function was already poor before starting treatment and improves slightly with improvement of depression, the medication may not be the principal cause.

If sexual function was satisfactory before treatment and marked anorgasmia begins shortly after starting an SSRI, a medication contribution becomes more likely.

This distinction is essential for accurate treatment.

Do All Antidepressants Affect Sexual Function Equally?

No.

The risk differs between individual drugs and patients.

Mayo Clinic notes that several antidepressants—including **bupropion, mirtazapine, vilazodone and vortioxetine**—are generally associated with lower rates of sexual adverse effects than strongly serotonergic antidepressants, although no antidepressant is completely free from potential sexual effects.

This information can be useful when a woman has clinically important treatment-emergent sexual dysfunction.

However, switching antidepressants must always consider the psychiatric illness, previous treatment response, other medical conditions, pregnancy plans and potential withdrawal effects.

Treatment of Antidepressant-Induced Sexual Dysfunction

Several approaches have been studied.

Depending upon the individual situation, the prescribing clinician may consider allowing time for adaptation, adjusting the antidepressant dose, switching to another antidepressant, or adding another treatment.

A 2025 systematic review and meta-analysis specifically examining pharmacological treatment of antidepressant-induced sexual dysfunction in women included 11 randomized trials involving 859 women. Among the interventions studied, bupropion showed encouraging improvements in desire, arousal and orgasm, but the authors rated the overall certainty of the evidence as **low** and called for better-quality trials.

This means bupropion should not be presented as a guaranteed antidote.



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It may be useful for selected patients under psychiatric supervision.

What About Sildenafil in Women?

Medicines such as sildenafil are well established in male erectile dysfunction, but their role in female sexual dysfunction is much less certain.

A 2024 scoping review examining PDE5 inhibitors in female sexual dysfunction found mixed results: four included randomized studies reported benefit while two did not, leading the authors to conclude that efficacy remains controversial and inconclusive.

Therefore, sildenafil is not a universal treatment for medication-induced female sexual dysfunction.

If the main problem is absent desire caused by an SSRI, simply increasing genital blood flow may not solve the central serotonergic inhibition.

Treatment needs to target the actual sexual domain affected.

Should Women Take an “Antidepressant Holiday”?

Some older strategies have involved briefly interrupting antidepressant treatment around planned sexual activity.

I do **not** recommend patients attempt this independently.

Depending on the particular antidepressant, interruptions can lead to withdrawal symptoms, mood destabilization or recurrence of depression or anxiety.

The safety and usefulness of this approach vary according to medication half-life and psychiatric history.

Any dose reduction, medication interruption or switching strategy must be planned with the prescribing clinician.

Persistent Sexual Symptoms After SSRI or SNRI Discontinuation

A small but important area of current research concerns sexual symptoms that continue after serotonergic antidepressants have been discontinued.

A 2026 clinical review concluded that persistent sexual dysfunction after SSRI/SNRI discontinuation remains **clinically debated and poorly quantified**, but that a medication-associated adverse reaction may be plausible when there is a clear change from baseline, appropriate timing, persistent characteristic symptoms and no stronger



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alternative explanation. The review emphasized that current evidence does not support reliable prevalence estimates, mechanistic certainty or established curative treatment.

Patients with persistent symptoms deserve proper evaluation rather than dismissal.

At the same time, clinicians should avoid automatically attributing every long-term sexual problem to a previous SSRI without examining hormonal, neurological, psychological, relationship and other medical causes.

Antipsychotic Medicines

Antipsychotic medications can also affect female sexual and reproductive function.

Some antipsychotics block dopamine strongly enough to increase **prolactin**.

Elevated prolactin can interfere with the hypothalamic-pituitary-ovarian axis.

Potential consequences include reduced sexual desire, menstrual disturbance, vaginal dryness or reduced arousal, galactorrhea and, in sufficiently marked cases, reproductive difficulties.

Clinical literature has long recognized hyperprolactinemia as an important mechanism of sexual dysfunction among women treated with prolactin-elevating antipsychotics.

Sedation, emotional blunting, autonomic effects and the psychiatric illness itself can also contribute.

Again, the patient should **never stop antipsychotic medication suddenly**.

What Should Be Done If an Antipsychotic Is Suspected?

The clinician may need to evaluate:

Whether sexual function changed after the medication was introduced, whether menstrual cycles changed, whether galactorrhea developed, whether prolactin is elevated, and whether other endocrine abnormalities exist.

If the medication is strongly implicated, the psychiatrist may consider dose modification, switching to a medication with a different prolactin profile or another therapeutic strategy.

Psychiatric stability remains the priority.

A sexual side effect is important, but the solution must not place the patient's mental health at serious risk.



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Hormonal Contraception and Female Sexual Function

This is an area where simplified claims should be avoided.

Some women report a clear reduction in sexual desire after starting hormonal contraception.

Others report improved sexual well-being because fear of unintended pregnancy decreases.

Many experience no meaningful change.

A 2024 review concluded that the overall relationship between hormonal contraception and female sexual function remains **inconsistent across studies and differs among contraceptive methods**.

A separate updated 2024 review noted that combined oral contraceptives reduce free testosterone but that this does not translate predictably into sexual dysfunction for every woman. Some antiandrogenic combined pills may adversely affect arousal, lubrication or orgasm in susceptible women, while evidence remains heterogeneous.

Therefore, statements such as **“birth-control pills always destroy libido”** are not scientifically justified.

What If Symptoms Clearly Began After Starting Contraception?

When the temporal relationship is strong, sexual side effects should be discussed as part of contraceptive shared decision-making.

The clinician should consider:

What contraceptive is being used, when symptoms began, whether the patient has other hormonal or psychological factors, and whether another suitable contraceptive method could meet her needs.

Stopping reliable contraception without an alternative plan may result in unintended pregnancy.

The goal is therefore not simply to stop contraception, but to find the most appropriate balance between contraceptive effectiveness and quality of life.

Recent women's-health literature specifically recommends incorporating sexual-health effects into contraceptive counselling.

Blood-Pressure Medicines



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Female sexual function and hypertension are difficult to separate because **hypertension itself can affect vascular health and sexual response.**

Studies suggest that women with hypertension experience sexual dysfunction more frequently than normotensive women, but research distinguishing the effects of the disease from those of treatment is limited and sometimes conflicting.

A review of antihypertensive therapies found comparatively stronger evidence for adverse female sexual effects with some beta-blockers, while several other antihypertensive classes appeared more neutral. However, the evidence base in women remains much smaller than that available for men.

Therefore, women should not stop blood-pressure medication because of sexual concerns.

Uncontrolled hypertension creates far greater health risks and can itself impair sexual function.

Anticholinergic and Antihistamine Medicines

ACOG includes anticholinergic medications among drugs that may interfere with sexual function. These medications are used for several conditions, including overactive bladder, motion sickness and other disorders.

Antihistamines and other drying medications may contribute to vaginal dryness in susceptible women.

ACOG specifically notes that some allergy/cold medicines and antidepressants can contribute to vaginal dryness.

If dryness is mild, appropriate lubrication may be sufficient. Persistent symptoms require evaluation for other causes such as menopause, breastfeeding, vulvovaginal disease or inadequate arousal.

Opioid Pain Medicines

Long-term opioid exposure can influence the endocrine system.

Opioids can suppress the hypothalamic-pituitary-gonadal axis and contribute to hypogonadism.

The Endocrine Society's scientific statement recognizes gonadal suppression as an established endocrine consequence of chronic opioid exposure.



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In women, possible consequences can include menstrual disturbance, hormonal changes and altered sexual function.

A 2026 review focusing specifically on women describes endocrine disruption with chronic opioid use but also stresses an important limitation: much of the existing opioid-endocrine evidence was generated in men, leaving major gaps in female-specific data.

This uncertainty means symptoms must be investigated individually rather than assuming every woman taking an opioid has endocrine sexual dysfunction.

Breast-Cancer Endocrine Therapy

Women receiving treatment for hormone-sensitive breast cancer may experience particularly significant sexual changes.

Aromatase inhibitors markedly reduce estrogen production.

Tamoxifen alters estrogen-receptor activity.

These treatments can contribute to hypoestrogenic genital changes and symptoms including:

- Vaginal dryness
- Burning
- Irritation
- Reduced lubrication
- Dyspareunia
- Reduced sexual comfort

ACOG specifically recognizes genitourinary and sexual symptoms associated with breast-cancer endocrine therapy, with aromatase inhibitors capable of producing particularly profound estrogen suppression.

These symptoms can strongly affect sexual desire secondarily because intimacy becomes painful.

Management in Women With Breast Cancer

This population requires particularly careful treatment.



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ACOG recommends nonhormonal approaches first for women with a history of estrogen-dependent breast cancer, including appropriate lubricants, vaginal moisturizers and related measures.

When symptoms remain severe, treatment becomes an individualized risk-benefit discussion.

Low-dose vaginal estrogen may be considered in selected women after appropriate counselling, including women receiving tamoxifen. For women taking an aromatase inhibitor, ACOG recommends shared decision-making involving the patient, gynecologist and oncologist.

This is clearly not an area for unsupervised hormone treatment.

Cancer Treatments More Broadly

Cancer can affect sexuality through the disease itself and through:

- Surgery
- Chemotherapy
- Radiotherapy
- Endocrine treatment
- Immunotherapy
- Premature ovarian insufficiency
- Body-image changes
- Fatigue
- Pain
- Psychological distress

A 2025 European Society for Sexual Medicine guideline on sexual dysfunction after gynecological cancer emphasizes routine sexual-health screening, counselling and multidisciplinary management because cancer-related sexual dysfunction remains commonly overlooked.

Sexual rehabilitation should be regarded as part of survivorship care rather than a luxury.

Medication Effects and Genitourinary Syndrome of Menopause



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A woman does not have to reach natural menopause to develop a hypoestrogenic vaginal condition.

Anti-estrogen treatment, ovarian suppression and some cancer therapies can create menopause-like genital changes.

Reduced estrogen can cause:

- Vaginal dryness
- Thin and fragile tissues
- Burning
- Irritation
- Painful intercourse
- Urinary symptoms

These symptoms may be part of **Genitourinary Syndrome of Menopause or treatment-induced hypoestrogenic genitourinary changes**.

This is an important differential diagnosis because a woman may initially report only “loss of interest in sex,” while the actual reason is that intercourse has gradually become painful.

Medication-Induced Sexual Dysfunction and Infertility

Medication-related female sexual dysfunction does not automatically mean infertility.

A woman can have normal ovulation and reproductive anatomy yet experience medication-related low desire or orgasmic difficulty.

However, sexual dysfunction can become a **functional barrier to conception** if intercourse becomes infrequent, painful or difficult.

Certain medicines can also affect fertility through mechanisms separate from sexual function.

For example, prolactin-elevating antipsychotics can disturb menstrual and reproductive hormonal function. Chronic opioids can suppress reproductive endocrine pathways. Gonadotoxic cancer treatments may affect ovarian reserve. Hormonal contraceptives intentionally prevent conception while they are being used.

These are different mechanisms and should not be mixed together under one label.

At Saira Health Care, when a woman presents with both sexual dysfunction and difficulty conceiving, I consider it important to evaluate **sexual function and fertility separately but together**.

How I Assess Suspected Medication-Induced Female Sexual Dysfunction

The first step is usually not a laboratory test.

It is a careful history.

I want to know:

What exactly changed?

Was it desire?

Was it lubrication?

Was orgasm previously easy but is now extremely difficult?

Has penetration become painful?

Did genital sensation change?

Then comes the second question:

When did it change?

If sexual functioning was satisfactory for years and changed soon after a medicine was introduced or increased, that timeline is important.

But I also investigate alternative explanations.

The Importance of Knowing Sexual Function Before Treatment

The most useful comparison is often not:

“How are you functioning now?”

but:

“How were you functioning before the medication?”

This is particularly important for depression.

If the patient had already lost sexual desire before starting an antidepressant, we cannot automatically attribute low desire to the drug.



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If desire improved as depression improved but orgasm disappeared only after an SSRI was started, the picture is different.

A baseline sexual history can therefore make later diagnosis much easier.

A Complete Medication Review

Patients should tell the clinician about more than prescription tablets.

The assessment should include prescription drugs, over-the-counter medicines, hormonal contraception, antihistamines, sleep medications, pain medicines, psychiatric medication, cancer treatment, herbal preparations and nutritional supplements.

This is important because patients sometimes omit a medication that they do not associate with sexuality.

For example, a woman may forget to mention an allergy medicine that worsens dryness or a contraceptive that was started several months before her sexual symptoms became noticeable.

Medical Causes That Should Also Be Considered

Medication-associated sexual dysfunction should not become a shortcut diagnosis.

Sexual problems can also result from:

- Diabetes
- Thyroid disease
- Hyperprolactinemia
- Menopause
- Premature ovarian insufficiency
- Endometriosis
- Chronic pelvic pain
- Vulvodynia
- Vestibulodynia
- Pelvic-floor dysfunction
- Cardiovascular disease



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- Neurological disease
- Depression
- Anxiety
- Chronic fatigue
- Relationship difficulties

The 2026 review of female sexual dysfunction emphasizes that contemporary management should be individualized by subtype and commonly requires a team-based approach.

Laboratory Evaluation

Laboratory testing should be targeted.

Depending on symptoms, the clinician may consider thyroid testing, prolactin, glucose/HbA1c or other endocrine investigations.

If a prolactin-elevating antipsychotic is being used and the patient has absent periods, galactorrhea or markedly reduced sexual desire, prolactin testing may be particularly relevant.

Hormonal testing is not required for every woman with sexual dysfunction.

Sexual response cannot be diagnosed by one testosterone or estrogen result alone.

The Female Sexual Function Index and Other Assessment Tools

Validated questionnaires such as the **Female Sexual Function Index (FSFI)** can help quantify several domains of sexual function, including desire, arousal, lubrication, orgasm, satisfaction and pain.

These tools can be useful before and after a medication change because they provide a more structured picture than simply asking whether sex is “better” or “worse.”

But questionnaires do not replace a clinical conversation.

The patient's distress and goals remain central.

Treatment Begins With the Cause

There is no single treatment called “medicine for drug-induced female sexual dysfunction.”



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The appropriate solution depends on the medication and the sexual domain affected.

If an SSRI is causing anorgasmia, the treatment strategy is different from treatment of vaginal dryness caused by anti-estrogen therapy.

If an antipsychotic is causing hyperprolactinemia, a lubricant alone will not correct the endocrine mechanism.

If a woman's main problem is fear of painful penetration after months of dryness, changing medication may not immediately reverse the secondary pelvic-floor guarding.

The diagnosis needs to be specific.

Never Stop an Important Medicine Abruptly

This deserves repetition.

A patient should not independently discontinue:

antidepressants, antipsychotics, blood-pressure medicine, opioids, anti-cancer treatments, hormonal medicines or other essential therapies merely because a sexual side effect is suspected.

Sexual adverse effects matter, but so does control of the original illness.

The safest approach is coordinated management.

Medication Adjustment or Switching

When the relationship appears convincing, the prescribing clinician may consider changing the dose, switching to another drug or selecting an alternative treatment with fewer sexual adverse effects.

For antidepressant-related dysfunction, Mayo Clinic describes strategies such as dose adjustment, switching to an antidepressant with fewer sexual effects or adding a treatment intended to counteract the adverse effect.

This should be individualized.

A medicine that is ideal for one patient may be inappropriate for another because of psychiatric diagnosis, cardiovascular health, pregnancy plans or other medications.

Lubricants and Vaginal Moisturizers



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When reduced lubrication is part of the problem, simple interventions can sometimes provide substantial benefit.

A **lubricant** reduces friction during sexual activity.

A **vaginal moisturizer** is generally used regularly to improve ongoing dryness.

Mayo Clinic includes both lubricants and vaginal moisturizers among supportive measures for female sexual dysfunction and vaginal discomfort.

However, persistent dryness should prompt investigation for hypoestrogenism, menopause, cancer-treatment effects or other vulvovaginal disorders.

Pelvic-Floor Physiotherapy

If repeated painful intercourse has caused pelvic-floor tightening, fixing the medication alone may not immediately solve the entire problem.

The muscles may have learned a protective response.

Specialized pelvic-floor physiotherapy can address hypertonicity, pain, coordination and fear-related muscular guarding.

This is especially relevant if penetration remains painful after lubrication and tissue health have improved.

Modern female sexual-dysfunction care increasingly recognizes the value of physical therapy as part of multidisciplinary treatment.

Psychosexual and Couple Counselling

Medication-related sexual dysfunction can quickly become a relationship problem.

A woman loses desire because of treatment.

Her partner interprets this as rejection.

She feels guilty.

Sex becomes pressured.

Anxiety increases.

A pharmacological side effect has now acquired psychological and relational components.



Psychosexual counselling can help couples understand that reduced desire or orgasmic difficulty may be physiologically influenced by medication rather than reflecting loss of love or attraction.

Mayo Clinic recommends counselling, including relationship-focused counselling when appropriate, as part of female sexual-dysfunction management.

Medication-Induced Female Sexual Dysfunction and Unani Medicine

As a physician trained in the **Unani System of Medicine**, I find one classical principle particularly relevant to medication-induced sexual dysfunction:

Izala-i-Sabab — identifying and addressing the causative factor

CCRUM describes Unani treatment as cause-oriented, with **Izala-i-Sabab**—removal or correction of the causative factor—forming part of its traditional therapeutic framework.

This is highly relevant here.

If a drug is contributing to sexual dysfunction, simply giving another medicine without first understanding the offending drug would not be a rational approach.

At the same time, Izala-i-Sabab should **not** be misunderstood as abruptly stopping an essential prescription medicine.

The cause must be addressed safely and intelligently.

The Major Therapeutic Approaches in Unani Medicine

Official CCRUM material describes the major Unani therapeutic approaches as **Ilaj-bil-Tadbir (regimental therapy)**, **Ilaj-bil-Ghiza (dietotherapy)**, **Ilaj-bil-Dawa (pharmacotherapy)** and **Ilaj-bil-Yad (surgical/procedural treatment where applicable)**.

The Ministry of AYUSH also describes Unani health maintenance through the **Asbab-e-Sitta Zarooriya**, or six essential factors, which include food and drink, physical activity and rest, psychological activity and rest, sleep and wakefulness, and other basic physiological considerations.

These principles can provide a useful supportive framework for women whose medication-related sexual difficulties coexist with poor sleep, stress, metabolic disease, fatigue or lifestyle problems.

How Unani Medicine May Be Useful



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I consider the most appropriate role of Unani medicine in medication-induced female sexual dysfunction to be **individualized and integrative rather than substitutive**.

For one woman, attention to sleep, stress, nutrition and general health may improve sexual interest.

Another may benefit from strategies aimed at improving general vitality and metabolic health.

Another woman may require management of digestive disturbance, constipation or chronic stress that is worsening pelvic-floor symptoms.

Carefully selected Unani pharmacotherapy may be considered when appropriate and compatible with the patient's conventional treatment.

However, it must be used with realistic expectations.

What Unani Medicine Cannot Replace

If an SSRI is producing severe anorgasmia, the psychiatrist's medication review remains important.

If an antipsychotic has caused hyperprolactinemia, that endocrine adverse effect requires appropriate medical assessment.

If aromatase-inhibitor treatment has produced severe hypoestrogenic vaginal symptoms in a breast-cancer survivor, treatment must be coordinated with oncology and gynecology.

If chronic opioid treatment has caused endocrine suppression, the pain and endocrine plan need to be reviewed.

A Unani medicine should not be used to hide a medication adverse effect while leaving its mechanism unexamined.

Evidence for Unani Treatment of Medication-Induced Female Sexual Dysfunction

Scientific transparency is essential.

At present, **high-quality clinical trials specifically proving that a particular Unani formulation reverses medication-induced female sexual dysfunction are lacking**.

Even for conventional treatment of antidepressant-induced sexual dysfunction in women, a 2025 systematic review rated the available pharmacological evidence as low certainty.



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Research into plant-derived products is continuing. A 2026 review found preliminary signals for some botanicals in antidepressant-associated sexual dysfunction but concluded that evidence remains investigational rather than sufficiently established for routine therapeutic claims.

Therefore, describing any herbal or Unani product as a guaranteed antidote would not be scientifically justified.

Herbal Medicines Can Interact With Prescription Medicines

This point is extremely important.

A patient may think:

“This is herbal, so it cannot interfere with my antidepressant or blood-pressure medicine.”

That assumption is unsafe.

Herbal medicines can influence drug-metabolizing enzymes, sedation, blood pressure, glucose, bleeding risk and central nervous-system activity.

When sexual dysfunction is already suspected to be medication-induced, adding multiple unreviewed products can make the clinical picture even more confusing.

At Saira Health Care, any integrative plan should therefore begin with a complete medication and supplement history.

The Saira Health Care Approach

When a woman consults me because she believes a medicine has changed her sexual function, I do not regard the problem simply as “low libido.”

I first try to identify the precise sexual domain involved.

Is sexual interest absent?

Is arousal reduced?

Is vaginal lubrication inadequate?

Is genital sensation different?

Has orgasm become delayed or absent?

Is intercourse now painful?

Was the problem present before treatment?



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Did it begin after starting or increasing a particular medication?

And importantly:

How much is it affecting the woman's quality of life and relationship?

This structured approach avoids unnecessary treatment.

My Cause-Oriented Clinical Framework

At **Saira Health Care**, an individualized assessment may include review of the complete medication history, sexual function before and after treatment, psychological health, menstrual and reproductive history, menopausal status, metabolic disease, endocrine symptoms, fertility goals and relationship circumstances.

Relevant testing can then be selected rather than performed routinely.

Treatment may involve coordination with the prescribing doctor, modification of lifestyle factors, treatment of dryness or sexual pain, pelvic-floor rehabilitation, psychosexual counselling, fertility assessment and appropriately selected Unani supportive management.

Where psychiatric, gynecological, oncological, endocrinological or other specialist treatment is required, coordinated referral should form part of responsible care.

Why This Condition Is Often Missed

Many patients are embarrassed to tell their doctor that medication has affected sex.

Doctors may also concentrate on whether the treatment is controlling the original illness and fail to ask about sexuality.

This can have consequences.

A woman may silently stop her antidepressant.

Another may discontinue her antihypertensive medicine.

Someone may stop cancer endocrine therapy because intimacy has become intolerably painful.

A sexual side effect can therefore affect **medication adherence and overall health**, not merely sexual satisfaction.

ACOG explicitly recognizes medication- and substance-related sexual problems as an important part of women's sexual health.



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Doctors should therefore ask, and patients should feel permitted to answer.

Medication-Induced Dysfunction Is Not a Relationship Failure

I regularly emphasize this point because sexual side effects are often misunderstood between partners.

If a medication reduces a woman's libido, her partner may think:

“She no longer finds me attractive.”

If orgasm becomes difficult, the partner may think:

“I am doing something wrong.”

Neither conclusion is necessarily correct.

Neurotransmitters and hormones have powerful effects on sexual response.

A biological side effect should not become a source of blame.

Sexual Dysfunction Is Also a Quality-of-Life Issue

A medicine may successfully control depression, anxiety, hypertension or another illness, yet significantly reduce quality of life through sexual adverse effects.

That does not mean the treatment has failed.

It means treatment needs to be reviewed more comprehensively.

Modern medicine increasingly recognizes that successful treatment should consider not only survival and symptom control but also **function, intimacy, relationships and quality of life**.

This is particularly clear in cancer survivorship, where current guidelines specifically recommend addressing sexual dysfunction as part of comprehensive care.

When Should a Woman Seek Professional Advice?

A woman should consider discussing the issue with her healthcare professional when there is a clear change in sexual desire after starting medication, orgasm becomes significantly delayed or absent, vaginal dryness or painful intercourse develops, sexual problems begin after a dose change, menstrual periods become abnormal while taking prolactin-elevating medication, treatment is affecting the relationship, or sexual adverse effects are making her consider stopping an important medication.



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Sexual health is a legitimate component of medical care.

There is no reason to wait until symptoms have damaged a relationship or led to medication discontinuation.

Frequently Asked Questions

Can antidepressants cause female sexual dysfunction?

Yes. SSRIs and SNRIs can contribute to reduced sexual desire, arousal difficulties and delayed or absent orgasm. SSRIs are among the medicines most consistently associated with sexual adverse effects.

Can an antidepressant affect orgasm even if desire remains normal?

Yes. Some women maintain sexual interest and arousal but develop markedly delayed orgasm or anorgasmia.

Should I stop my SSRI if sexual side effects develop?

No. Discuss the symptoms with the clinician who prescribed it. Abrupt discontinuation can cause withdrawal and may lead to recurrence of depression or anxiety.

Are there antidepressants with fewer sexual side effects?

Some medicines such as bupropion, mirtazapine, vilazodone and vortioxetine generally have lower reported rates of sexual adverse effects than highly serotonergic agents, although individual responses vary.

Can birth-control pills reduce libido?

They can in some women, but evidence is inconsistent and depends on the formulation and individual response. Current reviews do not support saying that hormonal contraception uniformly reduces sexual desire.

Can antipsychotics cause sexual problems?

Yes. Some antipsychotics can raise prolactin and contribute to reduced desire, menstrual abnormalities and reproductive or sexual dysfunction.

Can pain medicines affect sexuality?

Chronic opioids can suppress reproductive hormonal pathways and may contribute to sexual and reproductive changes. Female-specific evidence remains less extensive than male data.

Can breast-cancer medication cause vaginal dryness and painful sex?



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Yes. Tamoxifen and especially aromatase inhibitors can be associated with hypoestrogenic genitourinary symptoms. Management should be individualized with oncology involvement where necessary.

Can medication-induced sexual dysfunction cause infertility?

Usually not directly. However, painful or infrequent intercourse can interfere with conception, while some medications can separately alter reproductive hormones or fertility.

Can sexual function improve after changing medication?

Often it can, depending on the drug, underlying illness and individual patient. However, medication changes should be professionally supervised.

Can sexual symptoms remain after an SSRI is stopped?

Persistent symptoms have been reported. A 2026 review states that the phenomenon remains poorly quantified and clinically debated, and there is not currently an established curative treatment. Persistent symptoms deserve structured evaluation.

Can Unani medicine help?

Unani medicine can contribute a useful **individualized supportive approach** emphasizing cause assessment, lifestyle, sleep, diet, psychological well-being and carefully selected pharmacotherapy. However, strong clinical evidence for a specific Unani medicine that reliably reverses medication-induced female sexual dysfunction is currently lacking.

A Message to My Patients

When a woman says to me,

“Doctor, everything changed after I started this medicine,”

I take that observation seriously.

Patients often recognize changes in their own bodies before anyone else does.

But we still need to examine the complete picture.

Did the illness itself affect sexuality?

Did the medicine change serotonin or dopamine pathways?

Did prolactin increase?

Has the patient entered perimenopause?



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Is vaginal dryness causing pain?

Has repeated painful intercourse now produced pelvic-floor tension?

Is anxiety about sexual performance maintaining the problem?

Has infertility pressure changed the couple's sexual relationship?

The answers determine treatment.

I do not believe a woman should simply be told:

“Your disease is under control, so tolerate the sexual side effects.”

At the same time, she should not be told:

“Stop your medicine and everything will become normal.”

Both approaches are incomplete.

The correct objective is to protect the woman's **overall medical health while also protecting sexual health, reproductive goals, relationship well-being and quality of life.**

About Dr. Nizamuddin Qasmi

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Focused Practice in Sexual Disorders & Infertility

His professional qualifications and training, as supplied for this article, include **BUMS from Hamdard University, Delhi; MD; CGO; Certificate in Infertility from MGBIMS, Delhi; Certificate in Urology – London, UK; Masters in Male Infertility by MasterHealthPro (HealthPro); and Integrated Sexual and Reproductive Health (ISRH, UNFPA).**

At **Saira Health Care**, the focused approach to sexual disorders and infertility includes confidential assessment of male and female sexual concerns, reproductive counselling, fertility-related sexual difficulties and individualized Unani supportive care.

In medication-related sexual dysfunction, this approach is particularly valuable because the complaint may lie at the intersection of sexual medicine, gynecology, psychiatry, endocrinology, reproductive medicine and relationship health.

Conclusion



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Medication-Induced Female Sexual Dysfunction is a genuine and clinically important condition that can affect desire, arousal, lubrication, orgasm, genital sensation, sexual comfort and pain.

Among medication groups, **serotonergic antidepressants have particularly strong evidence for sexual adverse effects**, while antipsychotics, selected antihypertensive drugs, hormonal treatments, opioids, anticholinergic medicines and cancer therapies may also contribute through different mechanisms. Hormonal contraception deserves especially careful interpretation because current evidence is mixed rather than uniformly negative.

The most recent 2026 review of female sexual dysfunction recognizes medication/substance-induced dysfunction as a distinct diagnostic area and emphasizes individualized, multidisciplinary management.

Treatment should begin by identifying **which sexual function changed and whether the medication is truly responsible**. Depending on the situation, management can involve supervised medication adjustment, changing treatment, managing vaginal dryness or hormonal effects, pelvic-floor treatment, psychosexual counselling, couple support or selected pharmacological strategies.

From an **integrative Unani perspective**, the classical principle of **Izala-i-Sabab—identifying and addressing causative factors—** is highly relevant. Unani approaches such as **Ilaj-bil-Ghiza, Ilaj-bil-Tadbir and individualized Ilaj-bil-Dawa** can support general health, stress management, sleep, lifestyle and overall sexual well-being.

However, current scientific evidence does not justify claiming that a specific Unani formulation universally reverses medication-induced female sexual dysfunction. Responsible integrative practice should therefore combine the strengths of individualized Unani care with appropriate medication review, modern diagnosis and specialist collaboration.

At **Saira Health Care**, my preferred principle is simple:

Do not ignore the sexual side effect, but do not endanger the treatment of the original disease either. Understand the cause, protect the patient's overall health and develop an individualized solution.

Sexual health is an important part of health. A woman should feel comfortable telling her doctor when a treatment that is helping one part of her life is creating a serious problem in another.

For more information:

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Medical Disclaimer: This article is intended for general medical education and patient awareness. It does not replace an individualized medical, psychiatric, gynecological or sexual-health assessment. Do not stop, reduce or change antidepressants, antipsychotics, antihypertensive medicines, hormonal treatments, opioids, cancer treatments or other prescription medications without consulting the clinician responsible for your care. Herbal and Unani medicines can also interact with conventional drugs and should be selected under appropriate professional supervision.



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