

Depression, antidepressants and female sexual dysfunction in women: Clinical approach

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ABSTRACT. *Sexual dysfunction has been found in over 40% of the general population of women. Affective disorders, including anxiety and depression, are also highly prevalent, affecting roughly a third of all women. In many cases, sexual dysfunction accompanies affective disorders. While antidepressant therapy can relieve the sexual dysfunction caused by depression, this same therapy may cause Antidepressant Associated Sexual Dysfunction (AASD). The clinician should assess for baseline sexual function before providing antidepressant therapy, and address AASD when it occurs. When treating midlife women, an assessment of changes in sexual function related to gonadal hormones should be made, with treatment provided accordingly.*

Urodynamic 14: 76-79, 2004

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INTRODUCTION

Sexual dysfunction and affective disorders are both common problems among women. This brief review will discuss the prevalence of these conditions, the association between the two, and clinical approaches to treating affective disorders with attention to sexual function.

Prevalence of female sexual dysfunction across the population

Sexual dysfunction is more common among women than men. A study of the general population in England found that 41% of women and 34% of men could report a current sexual problem (1). A population study of 1749 men and women, ages 18-59, in the United States found the prevalence of sexual dysfunction to be 43% among women and 31% among men. The most common problems among women were problems of desire, lack of interest in sex (22% and 32%, respectively), and problems with or-

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gasm (26%) (2). Another study of the American population showed that 24.4% of women reported marked distress about their sexual functioning.

Prevalence of affective and anxiety disorders across the population

Affective disorders are also very common among women. The lifetime prevalence for major depressive disorder among women is 17% (3). The prevalence of anxiety disorders in women is 30.5%. This would include all anxiety disorders: specifically phobia, social anxiety disorder, agoraphobia with panic, generalized anxiety disorder, panic disorder, and post-traumatic stress disorder (4). Women have a greater burden of affective and anxiety disorders than men. While anxiety disorders affect 30.5% of women, only 19.2% of men are affected. The prevalence of depression among women is about 21%, compared to 13% among men (3). Dysthymia, a milder form of depression, also has a greater prevalence in women, 8% compared to 5% for men (4). Depression with anxiety symptoms is quite common and is seen more often than depression alone (5). Co-morbidity of these two disorders is equally common and often makes these patients somewhat more difficult to treat (6).

Gender-specific differences also include a greater seasonal effect on mood (7), with women having approximately 80% of the cases of seasonal affective disorder (4% prevalence among women compared to 1% among men) (8). Stressful life events are more associated with depression among women as well (9). Premenstrual dysphoric disorder (PMDD), affects approximately 3-8% of women with a definition of meeting five or more DSM IV criteria (7, 10). When including severe premenstrual syndrome (PMS) or subsyndromal PMDD, this number can double (8). There are many theories that attempt to address and explain the gender differences in affective disorders; these include methodology of the research, and biological and psy-

chosocial differences between men and women. The latter include victimization, social and life stress, as well as particular issues related to socialization (9).

Failure to treat to remission of illness is an additional problem in all individuals with depression or anxiety. Patients are either not offered care or are offered care and are treated with sub-therapeutic doses of antidepressants. At times, a therapeutic dose of a particular antidepressant fails to bring the patient to remission. Some studies have defined remission as a Hamilton depression score of 7 or less, the patient no longer meets the criteria for depression, displays minimal or no symptoms, and has had a return of psychosocial/occupational functioning (11). Impairment in work appears to normalize only with remission, with incomplete return of functioning when patient has a partial response (12).

The implications of depression, anxiety, and other affective disorders along with remission issues in those treated for female sexual dysfunction and desire are significant. For women, these issues affect willingness to engage in sexual activity through distractibility of female sexual desire, fatigue, situational stress, and mood. These untreated affective disorders result in decreased desire and arousal, and thus have a great impact on female sexual function (13).

Prevalence of FSD among affective and anxiety disorders

There is a limited literature on the prevalence of female sexual dysfunction (FSD) among women with untreated affective and anxiety disorders. Kennedy et al. found that "49% of depressed women and 26% of depressed men reported no sexual activity in the preceding month" (14). Casper et al. and Hamilton et al. found decreased libido in approximately 70% of depressed patients (15, 16). Zajecka et al. found a range of problems with arousal, lubrication or orgasm, with 65% of depressed women reporting some sort of sexual problem (17).

Untoward consequences of treatment for depression and anxiety: FSD with antidepressants

Since the advent of the serotonin reuptake inhibitor class of antidepressants there has been the consistent observation that for some patients these antidepressants have an adverse impact on the patient's orgasm and/or a decline in her libido as a result of these agents (18-20). Antidepressant Associated Sexual Dysfunction (AASD) is observed soon after treatment is initiated. Its impact and the course of AASD is highly variable with some patients having mild impairment while others have significant loss of orgasm or libido. These sexual side effects may improve for some and persist for others. The most common complaints in women are decreased orgasm and libido (21, 22). In the field of psychiatry, side effects, and particularly the side effect of AASD has important implications for successful treatment of this large population of women with depression because side effects are one of the main reasons for discontinuing antidepressants, with sexual dysfunction being a primary cause for discontinuation (23).

For the midlife to post menopausal woman, this issue is confounded by the fact that many women have orgasm and libido problems related to their major affective disorder and/or may have FSD related to gonadal hormone change with menopause and age. The dynamic relationship between these two are such that both conditions may need to be serially treated or concurrently treated so as to resolve the FSD. This treatment and the establishment of the etiology of the FSD is complicated by the onset in some patients of antidepressant-induced side effects. Improvement in the major affective disorder may result in resolution of their "appetitive" problems in the sexual realm but then be confounded by the occurrence of AASD (19, 24-26). The rates of sexual side effects secondary to antidepressants vary from a conservative 14% to the less conservative estimate of 73% (27). The degree of the problem, the persistence of the problem, and

the degree of distress from the side effect are highly variable. The quality of these studies has also been questioned as many of these are observational and not prospective studies that have controlled for other pre-existing and contemporaneous variables (28). Additionally, many patients will have some degree of relief for their sexual side effects when the clinician diligently assesses pre-existing functioning, observes for new onset of FSD, and then either tries a different antidepressant, or uses some of the established augmentation strategies for amelioration of the AASD. Sildenafil has been a promising addition to these augmentation strategies (28, 29). More traditional approaches have been to augment the SSRI with bupropion or busparone (30).

CONCLUSIONS

Sexual dysfunction has been found in over 40% of the general population of women. Affective disorders, including anxiety and depression, are also highly prevalent, affecting roughly a third of all women. In many cases, sexual dysfunction accompanies affective disorders. While antidepressant therapy can relieve the sexual dysfunction caused by depression, this same therapy may cause Antidepressant Associated Sexual Dysfunction (AASD). The clinician should assess for baseline sexual function before providing antidepressant therapy, and watch for AASD. When AASD is present, the clinician should try switching to a different antidepressant, or augmenting the antidepressant with Sildenafil, bupropion or busparone. In addition, the clinician should assess whether or not any sexual dysfunction is related to gonadal hormone changes due to menopause or age, and treat accordingly.

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