Sexual Dysfunction in married Female patients on Antidepressants in Kashmir Valley

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ABSTRACT

Introduction: Sexual dysfunction commonly occurs during antidepressant treatment. However, the reported rates of sexual dysfunction vary across antidepressants and are typically underreported in Kashmir especially in females. The Objective of the present study was to study the characteristics of sexual dysfunction in married female patients taking antidepressants.

Material and Methods: Female patients who were on antidepressants for more than 4weeks with or without benzodiazepines were administered PRsexDQ-SALSEX (Psychotropic Related Sexual Dysfunction Questionnaire) scale along with their Sociodemographic data was noted.

Results: Majority of the patients were of the patients were sexually active (65%). Around 61% of the interviewed felt a change in sexual activity after taking antidepressants. Just 12% reported their problem spontaneously. Problems of sexual dysfunction included decreased sexual desire (62%), orgasmic delay (34%), difficult vaginal lubrication (20%). Among 20 patients who were on TCA's (Tri-cyclic Antidepressants), 75% reported decrease in sexual desire and among 66 patients who were on SSRI's (Selective Serotonin Reuptake inhibitors), 80.30% had reported orgasmic delay.

Conclusion: whereas most of the patients taking antidepressants suffer from sexual dysfunction but majority of people don't report it because of cultural factors. There is a need for asking about the sexual dysfunction after antidepressants are given so that treatment can be initiated for better quality of life.

Keywords: Sexual Dysfunction, Antidepressants, PRsexDQ-SALSEX.

INTRODUCTION

Female sexual dysfunction is experienced as a difficulty by an individual or a couple during any stage of a normal sexual activity, including physical pleasure, desire, preference, arousal or orgasm, causing various distressing sexual health problems like female sexual interest or arousal disorder, female orgasmic disorder, and genito-pelvic pain or penetration disorder[1]. Sexual dysfunction is common in women and can have a profound impact on an individual's perceived quality of sexual life and medication adherence[2,3]. Sexual dysfunctions are multifactorial including biological, psychological, physical, sociocultural and emotional factors[4]. The emotional causes include interpersonal problems or psychiatric problems like depression, anxiety disorders, panic disorders, etc.[5] and physical factors that can lead to sexual dysfunctions include the use of drugs, such as alcohol, nicotine, narcotics, stimulants, antihypertensives, antihistamines, and some psychotherapeutic drugs (antidepressants, antipsychotics)[6]. Several factors influence a women's perception of her sexual life, these include: race, her gender, ethnicity, educational background, socioeconomic status, sexual orientation, financial resources, culture, and religion[7]. About one third of the women experienced sexual dysfunction, which may lead to women's loss of confidence in their sexual life. Since women have sexual problems, their sexual life with their partners become a burden but not pleasure, and eventually, women may lose their interest in sexual activity[8].

Due to increasing occurrence of psychiatric disorders like depression, obsessive compulsive disorder, somatoform disorder, anxiety disorders, etc, clinicians prescribe diverse number of antidepressants for the treatment. But the regular use of antidepressants is restricted by their side effects, one of which is sexual dysfunction. This problem affects the patient's quality of life and can lead to therapeutic non-compliance in long-term treatments[3]. Sexual dysfunction is recognized as a potential side effect of all classes of antidepressants (MAOIs, TCAs, SSRIs, SNRIs and newer antidepressants)[9]. Sexual dysfunction commonly occurs during antidepressant treatment. However, the reported rates of sexual dysfunction vary across antidepressants and are typically underreported in Kashmir especially in females.

Current research aimed to study the characteristics of sexual dysfunction in female patients taking antidepressants.

MATERIAL AND METHODS

The study was done in Postgraduate Department of Psychiatry, Government Medical College Srinagar, the known tertiary care hospital catering majority of the population of Kashmir and Ladakh and some parts of Jammu, from June 2015 to December 2016. A total of 100 married female patients participated in the study. It was a Cross-sectional observational study. The patients were

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selected by convenient sampling. Female patients who were on Antidepressants for more than 4weeks with or without Benzodiazepines, with normal sexual function prior to treatment were explained about the purpose of the study and were given freedom of choice, to accept or refuse to participate in the study. They were also informed that if they were found to have sexual dysfunction, then depending on their willingness will be provided help through their treating psychiatrists. Those who provided written informed consent were included in the study. Female patients who were on concomitant antipsychotics, mood stabilizers and other drugs causing sexual dysfunction, patients who have history of comorbid substance abuse, prior sexual dysfunction, organic brain disorder, medical disorder endocrinopathies and moderate to profound mental retardation, were excluded from the study.

Instruments

After fulfilling the inclusion criteria, written informed consent was taken from patients keeping in view their privacy. The patients were diagnosed in a separate room by consultant psychiatrist using DSM-IV-TR and all Sociodemographic correlates were noted for each patient. The patients were assessed for sexual dysfunction by using PRsexDQ-salsex scale[10]. The Psychotrophic-Related Sexual Dysfunction Questionnaire (PRsexDQ-salsex) consists of 7 items pertaining to sexual dysfunction. The first item is a screening item to assess any sort of sexual dysfunction. The second item assesses whether patient reports sexual dysfunction to physician spontaneously or not. The next items assess 5 dimensions of sexual dysfunction including decrease in sexual desire, delay in orgasm or ejaculation, unable to attain orgasm or ejaculation, difficulty in attaining vaginal lubrication and patient's tolerance of the sexual dysfunction according to severity or frequency. The good tolerance is defined by patient's lack of concern even though some type of sexual dysfunction is present. The fair tolerance is used when the sexual dysfunction provokes concern or distress but patient does not intend to discontinue treatment because of it. The poor tolerance is applied when the patient is very concerned by the adverse effects and seriously considers discontinuing treatment.

STATISTICAL ANALYSIS

The data was described in frequency distribution and percentages. The chi-square goodness of fit test was used to find significant differences across various Sociodemographic correlates and other variables and at p-value 0.05 differences was taken significant.

RESULTS

Majority 69% of patients club in the reproductive age group of 25-45years with mean age 37.85 and p-value (0.0007) was found to be statistically significant. All the patients were married, mostly unemployed (84%), illiterates (71%), belonging to nuclear family (82%), from class IV socioeconomic status (57%) and differences were statistically significant (p-value= 0.0001).

64% of patients on treatment qualify for diagnostic criteria (DSM-TR-IV) of Major depressive disorder followed by Somatization disorder 23%, panic disorder 07%, OCD 05% and others 01% with p-value=0.0001.

65% of the females were sexually active (p-value=0.003) with frequency of sexual activity more than 4 times per

Sexually active yes/no	Percentage (N=100)	Chi-square value	P value
Yes	65	9.00	0.003
No	35		
Frequency of sexual activity per month			
1-2	14	10.55	0.005
3-4	34		
>4	52		
Sexually active among Postmenopausal females yes/no	**Percentage (N=15)**		
Yes	73.33%(11)	21.16	0.0001
No	26.66%(04)		

Table-1: Sexual Activity

Type of anti-depressants	Percentage (N=100)	Chi-square value	P value
SSRI's	66	48.560	0.0001
TCA's	20		
Others	14		
Antidepressant with or without benzodiazepines			
With benzodiazepines	17(10 lorazepam+ 07 clonezepam)	43.56	0.0001
Without benzodiazepines	83		
Duration of treatment			
>1month to 6 months	36	6.80	0.08
>6months to 1year	19		
>1year to 2years	22		
>2years	23		

Table-2: Antidepressant used

SSRI'S	N=66	Change in sexual activity (Yes)	No Change in sexual activity
Escitalopram	21	18(85.71%)	03
Sertraline	15	11(73.33%)	04
Fluoxetine	12	08(66.66%)	04
Fluvoxamine	10	07(70%)	03
Paroxetine	08	07(87.5%)	01
TCA'S	N=20		
Prothiaden	05	01(20%)	04
Imipramine	05	01(20%)	04
Clomipramine	03	01(33.33%)	02
Amitriptyline	02	00	02
Nortriptyline	05	00	05
OTHERS	N=14		
Mirtazapine	08	02(25%)	06
Desvenlafaxine	05	04(80%)	01
Venlafaxine	01	01(100%)	00

Table-3: Sexual dysfunction on antidepressant used

Change in Sexual activity Yes/No	Percentage (N=100)	Chi-square value	P value
Yes	61	4.84	0.03
No	39		
Spontaneously reported Yes/No			
Yes	12	57.76	0.0001
No	88		
Decrease in sexual desire			
0	38	29.68	0.0001
1	09		
2	14		
3	39		
Delay in orgasm			
0	66	93.02	0.0001
1	08		
2	07		
3	19		
Unable to attain orgasm			
0	83	179.92	0.0001
1	08		
2	03		
3	06		
Difficulty in attaining vaginal lubrication			
0	80	163.04	0.0001
1	12		
2	04		
3	04		
Tolerance			
0	38	16.16	0.001
1	28		
2	24		
3	10		

Table-4: Nature of sexual dysfunction

month in 52% of females (p=0.005). 15% of the females have attained menopause, among those 73% were sexually active (p=0.0001) and differences were statistically significant (table 1).

66% of patients were on selective serotonin reuptake inhibitors (SSRI'S), 20% were on tricyclic antidepressants (TCA'S) and only 14% were on other drugs like mirtazapine, desvenlafexine, etc (p=0.001). Only 17% of the patients were on combination drugs antidepressants plus benzodiazepines (p=0.0001) the differences were statistically significant. 36% of patients were on treatment for less than 6months, and 22% were for more than 2years (p=0.08), however difference was statistically insignificant (table 2). Sexual activity is decreased higher in patients taking Venlafaxine (100%), followed by Paroxetine (87.5%), Escitalopram (85.71%), Desvenlafaxine (80%), Sertraline (73.33%), Fluvoxamine (70%), Fluoxetine (66.66%), Clomipramine (33.33%), Mirtazapine (25%), Prothiaden and Imipramine 20% each. Among TCA's (N=20), 75% reported decrease in sexual desire, among SSRI's (N=66), 80.30% had orgasmic delay and in SNRI's (N=14), 66.66% had difficulty in attaining vaginal lubrication (table 3).

61% of patients have reported change in sexual activity (p=0.03), but only 12% presented it spontaneously (p=0.0001). 62% have reported decrease in sexual desire (p=0.03), out of them 39% have severe decrease, 14% have moderate decrease and only 09% have mild decrease in sexual desire (p=0.0001). 34% of patients have reported delay in orgasm, out of them 19% have severe delay, 07% have moderate delay and 08% have mild delay in orgasm (p=0.0001). 17% of patients were unable to attain orgasm. 20% of patients have difficulty in attaining vaginal lubrication (p=0.0001). Out of 62%, 28% have tolerated the problem well, 24% complainted that dysfunction bothers them although they continued their medication as usual and only 10% of patients have not tolerated the dysfunction hence discontinued or insisted to change the medication with p-value= 0.001 (table 4).

DISCUSSION

The study was conducted in Postgraduate Department of Psychiatry Government Medical College Srinagar among married females who were sexually active (65%) or inactive (35%). Sexual dysfunction has been reported to occur in approximately 61% of female patients receiving antidepressant medications and similar results have been found in other studies[10,11,12]. But only 12% have reported the dysfunction spontaneously while majority reported it only after asking questions about sexual dysfunction using a validated sexual function-specific instrument and results coincide with previous studies[10] may be because of cultural reasons[13] as all patients were females, married, unemployed, with mean age 37.85 years, illiterates, belonging to nuclear family, from class IV socioeconomic status. Among the various domains, dysfunction in sexual desire was most common, followed by orgasmic dysfunction, and difficulty in attaining vaginal lubrication. This is consistent with the findings by Sandeep Grover et al 2015[14]. These findings provide credence to the fact that antidepressants impair

sexual functioning in all phases of sexual response cycle[14]. The highest incidence of sexual dysfunction is seen primarily in patients receiving serotonin reuptake inhibitors (SSRIs) where up to 80.35% of the patients have been shown to have decrease in sexual dysfunction which resembles with the results of similar studies[15]. Sexual dysfunction was reported higher among patients taking Venlafaxine, followed by Paroxetine, Escitalopram, Desvenlafaxine, Sertraline, Fluvoxamine, Fluoxetine, Clomipramine, Mirtazapine, Prothiaden and Imipramine and Montejo et al 2001 had shown similar results[9]. Among TCA's, majority reported decrease in sexual desire, among SSRI's orgasmic delay was mostly found and in SNRI's difficulty in attaining vaginal lubrication was frequently reported. Similar studies have found that selective serotonin reuptake inhibitors and serotonin noradrenaline reuptake inhibitors inhibit desire, cause erectile dysfunction and decrease vaginal lubrication. They also impair orgasm in patients[16,17,18]. This adverse effect is used therapeutically to delay premature ejaculation. Tricyclic antidepressants inhibit sexual desire and orgasm[19,20].

CONCLUSION

It is clear that most of the patients taking antidepressants suffer from sexual dysfunction but majority of people don't report it, because of cultural factors. Therefore, there is a need for asking about the sexual clinical history before and after antidepressants are given so that treatment can be initiated for better quality of life. Since antidepressants need to be continued for pretty long time, it is better to use drugs with less severe side effects to improve patients sexual life.

REFERENCES

1. Nolen-Hoeksema, Susan (2014). Abnormal Psychology. 2 Penn Plaza, New York, NY 10121: McGraw-Hill. pp. 366–367.
2. Eden, K.J., and Wylie, K.R. Quality of sexual life and menopause. Women's Health 2009; 5:385-396.
3. Montejo AL, Llorca G, Tzquierdo JA, Rico-Villademoros F. Incidence of sexual dysfunction associated with antidepressant agents: A prospective multi-centre study of 1022 outpatients. J Clin Psychiatry 2001;62:10-22.
4. Michetti P M, Rossi R, Bonanno D, Tiesi A, Simonelli C. Male sexuality and regulation of emotions: a study on the association between alexithymia and erectile dysfunction (ED). International Journal of Impotence Research 2005; 18: 170–4.
5. Coretti G and Baldi I. The Relationship Between Anxiety Disorders and Sexual Dysfunction. Psychiatric Times 2007; 24:23-29.
6. Saks BR. Common issues in female sexual dysfunction. Psychiatric Times 2008; 25:23-26.
7. Kingsberg, S.A. The impact of aging on sexual function in women and their partners. Archives of Sexual Behaviour 2002;31:431-437.
8. Womens_health_issues/sexual_dysfunction_in_women/overview_of_sexual_dysfunction_in_women.
9. Montgomery SA, Baldwin DS, Riley A. Antidepressant medications: A review of the evidence for drug-induced sexual dysfunction. J Affect Disord 2002;69:119-40.
10. Montejo, A. L., and Rico-Villademoros, F. Psychometric properties of the Psychotropic-Related Sexual Dysfunction Questionnaire (PRSexDQ-SALSEX) in patients with schizophrenia and other psychotic disorders. Journal of Sex and Marital Therapy 2008; 34:227-239
11. Clayton AH, Pradko J, Croft H. Prevalence of sexual dysfunction among newer antidepressants. J Clin Psychiatry 2002;63:357-66.
12. Zajecka J, Mitchell S, Fawcett J. Treatment-emergent changes in sexual function with selective serotonin reuptake inhibitors as measured with the Rush Sexual Inventory. Psychopharmacol Bull 1997;33:755-60.
13. Avasthi A, Kaur R, Prakash O, Banerjee A, Kumar L, Kulhara P. Sexual behavior of married young women: A preliminary study from North India.Indian J Comm Med 2008;33:163-7.
14. Sandeep Grover, Ruchita Shah, Alakananda Dutt, Ajit Avasthi. Prevalence and pattern of sexual dysfunction in married females receiving antidepressants:An exploratory study, Journal of Pharmacology and Pharmacotherapeutics 2015, IP: 14.139.240.146.
15. Outhoff K. Antidepressant-induced sexual dysfunction. SA Fam Pract 2009;51:298-302.
16. Werneke U, Northey S, Bhugra D. Antidepressants and sexual dysfunction.Acta Psychiatr Scand 2006;114:384-97.
17. Bostwick JM. A generalist's guide to treating patients with depression with an emphasis on using side effects to tailor antidepressant therapy. Mayo Clin Proc 2010;85:538-50.
18. Williams VS, Baldwin DS, Hogue SL, Fehnel SE, Hollis KA, Edin HM. Estimating the prevalence and impact of antidepressant-induced sexual dysfunction in 2 European countries: a cross-sectional patient survey. J Clin Psychiatry 2006;67:204-10.
19. Montgomery SA, Baldwin DS, Riley A. Antidepressant medications: a review of the evidence for drug-induced sexual dysfunction. J Affect Disord 2002;69:119-40.
20. Philipp M, Kohnen R, Benkert O. A comparison study of moclobemide and doxepin in major depression with special reference to effects on sexual dysfunction. Int Clin Psychopharmacol 1993;7:149-53.

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