Editorial

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Depression and Female Sexual Dysfunction

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Editorial

Depression has gained importance recently especially after the WHO declared its theme for this year to be on Depression: Let's talk. It is a well-known fact that depression more common in women compared to men. Depression as such causes emotional as well as physical disturbances which impacts biological functions such as sleep, appetite, diminished libido and disinterest in sexual function. Reports show higher levels of sexual dysfunction in depressed patients as compared to non-depressed patients [1]. The prevalence of sexual problems in patients with depression was found to be approximately twice that of the controls in a Zurich cohort study [2]. A recent review from 2012 measured the bidirectional association of depression and sexual dysfunction, which confirmed that depression amplified the risk of sexual dysfunction and that sexual dysfunction increased the odds of depression [3]. Sexual dysfunction and dissatisfaction were the common symptoms associated with depression [4]. Depression was found as a risk factor for sexual dysfunction in women [5].

The incidence of sexual dysfunction in women was found to be 43% while it was 31% in men [6]. Among women, sexual dysfunction can be divided into four categories: hypoactive sexual desire disorder, female sexual arousal disorder, female orgasm disorder, and pain disorders [7]. Lauman et all identified the prevalence of the following categories of sexual dysfunction in women as follows: a low sexual desire 22%, arousal problems 14%, and sexual pain 7% whereas in men the prevalence were as follows: premature ejaculation 21%, erectile dysfunction 5% and low sexual desire 5% [8]. Montejo et al. found that greater intensity of reduced libido, delayed orgasm and anorgasmia were experienced by women as compared to men [9]. The most frequent sexual dysfunctions in women are desire and arousal dysfunctions as mentioned by McCabe et all. In addition, they stated that there are a large proportion of women who experience multiple types of sexual dysfunctions [10]. The specific types of sexual dysfunctions vary in incidence but loss of desire may be more common [11].

The predictors of sexual dysfunction may fluctuate over time, according to cultural shifts, generational and societal norms [12]. Female sexual dysfunction has attracted more interest in the past few decades [7]. Berman et all reported that female sexual dysfunction is progressive and related to age [13]. There are multiple causes for sexual dysfunction in women [14]. Some of the antidepressants medications used in clinical practice interfere with sexual functioning in all the phases of the sexual cycle [10]. Sexual problems in depressed patients may also contribute to poor compliance to anti-depressants [15]. All the classes of antidepressants available including MAO-inhibitors, tricyclic antidepressants, SSRIs (selective serotonin reuptake inhibitors) and newer antidepressants can produce sexual dysfunction as a side effect [16]. Since the launch of SSRIs, sexual dysfunctions linked with these medications has been mentioned in efficacy studies and discussed in critical reviews. Sexual desire (libido) and arousal difficulties are frequently reported, although the specific association with SSRI use has not been consistently shown [17].

A study found that 73% of the patients treated with SSRI had sexual side effects compared to only 14% of patients treated with bupropion. In addition, 77% of patients treated with bupropion reported at least one aspect of heightened sexual functioning [18]. A study by Piazza et al. suggested that after SSRI treatment, difficulties with desire and psychological arousal in depressed women tend to remit [19]. A systematic review and meta-analysis demonstrated that phosphodiesterase type 5 inhibitors could be an effective treatment modality for female sexual dysfunction [20]. Flibanserin has been approved by for the management of hypoactive sexual desire disorder (HSDD) of premenopausal women [21]. Off-label use of hormonal therapies like oestrogen and testosterone, are the most widely employed for female sexual dysfunction [22]. Female Sexual dysfunction was identified as a significant yet largely un-investigated public health problem.

There is very little population-based data available concerning the predictors, prevalence, and consequences of this disorder [23].

Although there is some data to suggest females have progressive attitude towards sex, [6] in developing countries like India discussing sexual problems is largely considered a taboo. Various lacunae remain in our knowledge about sexual dysfunction in spite of advances in treatment of sexual problems. In particular our information about female sexual dysfunction has constantly lagged behind that of male sexual disorders. In fact comparatively not much is known about relationship among sexual behaviours, sexual attitudes, sexual fantasies and marital functioning of women [24]. Research in area of sexuality is scant in India and if studied they have almost exclusively focused on male sexual dysfunction. Also, there is a lack of systematic research from India that has assessed the occurrence of sexual dysfunction in patients who are on treatment with psychotropic medications [25]. Hence, the need of the hour is to not only treat depression but also the associated sexual dysfunction which might arise out of it. Much attention should be paid on sexual health so that all aspects of functioning are covered.

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