Introduction

Treating Sexual Dysfunction: Psychiatry's Role in the Age of Sildenafil

Steven P. Roose, M.D., Guest Editor

From the time of Freud, psychiatry and sex have been linked. In the early stages of its formation, psychoanalysis focused on the importance of libido in mental life, the role of sexual fantasies in psychological development, and, to a lesser degree, sexual perversions. As researchers in the field of psychiatry developed alternative explanations and motivations for human behavior, psychiatrists' interest in sex waned over the years, and, in general, psychiatry has paid insufficient attention to either normal sexual behavior or the diagnosis of sexual dysfunction. The study of sexual behavior has been pursued primarily by behavioral sexologists, and the diagnosis and treatment of sexual disorders have been the domain of urologists or sex therapists. Perhaps, until recently, clinical psychiatry's disinterest was related to the difficulty of treating sexual dysfunctions and the lack of a safe, consistently effective, and easy-to-use pharmacologic therapy.

A recent resurgence of psychiatrists' interest in sexual dysfunction has been prompted mainly for 2 reasons. First, the effectiveness of selective serotonin reuptake inhibitors (SSRIs) for the treatment of a variety of affective and anxiety disorders has heightened awareness of SSRI-associated sexual side effects. Clinical trials to establish the safety and efficacy of SSRIs relied on patient self-report of adverse events and did not prospectively and systematically assess treatment-emergent adverse events. Evidence is presented in this supplement that initial studies may have underreported the frequency of adverse sexual side effects. The second factor that has awakened psychiatrists' interest in sexual dysfunction is the advent of a highly effective oral treatment for erectile dysfunction: sildenafil.

Although interest in sexual function has been rekindled, most psychiatrists are not familiar with the field of sexual dysfunction—either its definitions, terminology, or the specific disorders. As a group, we have not developed a common language with which to discuss the issues or the rigorous methodology necessary to study the problems.

From the Depression Research Unit, New York State Psychiatric Institute, New York.

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CRITICAL ISSUES FOR DIAGNOSIS AND MANAGEMENT OF SEXUAL DYSFUNCTION

Sexual dysfunction is common. One type of sexual dysfunction—erectile dysfunction—occurs to some degree in approximately 30 million men in the United States.[1] Human sexual response is determined by complex interactions between neurophysiologic systems, individual psychological makeup, and social factors. The ability to respond to sexual stimuli and to have a satisfying sexual experience can be diminished by a variety of diseases and medications, as well as personal stresses and difficulties within relationships. For example, the psychiatrist treating a patient with depression who also complains of sexual dysfunction is faced with the challenge of determining the etiology of the sexual problems. To develop an effective treatment strategy, the clinician must determine, if possible, whether the sexual dysfunction existed prior to the development of depression, whether it is a symptom of depression, or whether it is a treatment-emergent side effect (Table 1).

Sexual dysfunction can be a preexisting condition that is independent of depression. A recent article in *JAMA*[2] reported a 31% and 43% prevalence of sexual dysfunction in men and women, respectively, with decreased sexual desire being the most frequent complaint for women and premature ejaculation the most frequent complaint for men. The men in this study experienced erectile dysfunction at a rate of 7% to 18%; another study[3] documented that the frequency of either moderate or complete erectile dysfunction increases significantly as men age from 40 to 70 years.

Sexual dysfunction can be a symptom or a consequence of depression. Decreased interest in sex has long been recognized as a core symptom of depression. However, it also has been documented that some men have a degree of erectile dysfunction during the depressive episode that normalizes with effective treatment. In his article in this supplement, Stuart N. Seidman, M.D., discusses the relationship between erectile dysfunction and depression. In some men,

decreased desire and erectile dysfunction may be residual symptoms of a partially treated depression, and increasing the dosage of antidepressant may be the appropriate treatment option. Seidman also discusses evidence that erectile dysfunction may cause a depressive condition in some men.[4]

Sexual dysfunction can be a treatment-emergent side effect of antidepressant therapy. As Maurizio Fava, M.D., and Meridith Rankin observe in their article, this issue is particularly important for patients taking SSRIs.[5] If a psychiatrist assumes the sexual dysfunction to be a symptom of the depression when it actually is a treatment-emergent adverse event, then increasing the antidepressant dosage may exacerbate the sexual dysfunction. Fava and Rankin review the advantages and disadvantages of pharmacologic approaches to the treatment of SSRI-induced sexual dysfunction. They also present evidence from a recent open trial of successful treatment of SSRI-associated sexual dysfunction with sildenafil.[6] Failure to treat sexual dysfunction, whether it represents a partially treated depression or a treatment-emergent event, increases the risk of patient noncompliance.

SOCIAL READJUSTMENT AFTER SUCCESSFUL TREATMENT OF SEXUAL DYSFUNCTION

Most sexual activity occurs not in isolation but in the context of a relationship, and successful treatment of erectile dysfunction may create a new set of problems for the couple. Sandra R. Leiblum, Ph.D., addresses the marital/couple problems that may arise following the return of sexual functioning in the male partner after months or even years of having little or no sexual relations. Psychiatrists should anticipate that return of sexual function in their patients may require significant social and relationship readjustment in both partners.

Table 1. Critical Issues for Psychiatrists in the Diagnosis and Management of Sexual Dysfunction in Their Patients With Depressive Symptoms

Determine whether sexual dysfunction is
a preexisting condition or symptom of depression
a treatment-emergent side effect
When treating sexual dysfunction, anticipate the need for relationship and social readjustment following return of sexual functioning

The articles in this supplement present new and exciting research and clinical experience. They are intended primarily to raise awareness among professionals in the psychiatric field of the need to diagnose and treat sexual dysfunction and to develop the methodology required to conduct research on this problem.

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