
ANTIPSYCHOTICS AND SEXUAL DYSFUNCTION

Christian Jonathan Haverkamp M.D.

Antipsychotics can cause sexual dysfunction. This needs to be kept in mind when discussing medication with a patient because patients are often not asked about sexual side effects in clinical practice. Communication is important to increase the satisfaction of the patient with the treatment, the medication effectiveness and the compliance.

Keywords: sexual dysfunction, antipsychotics, communication, psychotherapy, psychiatry

Contents

Introduction	3
Antipsychotics	3
Half of Patients or More	4
Quality of Life	5
Male vs Female	5
Compliance	6
Dosage	6
Typical Antipsychotics	6
Atypical Antipsychotics	6
Risperidone vs Olanzapine	6
Management	7
Medication and Psychotherapy	7
Synergies	7
Into the Future	8
References	9

Introduction

Sexual dysfunction is a frequent problem in the general population. Large multinational studies and literature reviews indicate that approximately 40% of females and 30% of males suffer from sexual complaints. Since sexual activity is inherently a communicative activity, either with someone else or with oneself, it contributes significantly to a person's quality of life. (Haverkamp, 2017b, 2017a, 2017c, 2018b, 2018c) As it can trigger powerful feelings and emotions, which can also bring about very satisfying thoughts and mental images and a sense of happiness, satisfaction and contentment, a loss in sexual enjoyment and function is over the long-run very noticeable to a patient and can lead to an aversion of medication and failing compliance. Iatrogenic sexual dysfunction is frequent, and treatment with psychotropic drugs such as antidepressants and antipsychotics is one of the most frequent causes of sexual dysfunction. (Haverkamp, 2018a)

However, in many cases it may not be so easy to distinguish the causes of a sexual dysfunction, whether it is due to medication, to psychological factors, the underlying conditions, or, which may be easier to separate out, a somatic condition. A limited number of studies have evaluated psychiatric patients not receiving pharmacological treatment, and sexual dysfunction seems to be related not only to depression but also to several anxiety disorders and schizophrenia. It has been recently reported that 74% of men and 82% of women from a sample of 137 patients with established schizophrenia or schizophreniform disorder had a sexual problem as defined by the International Classification of Diseases, 10th revision (ICD-10). It may, of course, be not so easy to identify causality, which share can be attributed to the underlying condition and which to adverse effects of the medication.

Antipsychotics

Antipsychotic-induced sexual dysfunction seems to be frequent with

- conventional antipsychotics
- risperidone and
- sertindole

Hummer et al., in a prospective and observational study in inpatients with schizophrenia, found comparable rates of sexual dysfunction for patients treated with clozapine or haloperidol. Similarly, in a cross-sectional study of patients with schizophrenia or schizoaffective disorder there were no significant differences among

the three treatment groups (clozapine, olanzapine, and conventionals) on any of the dimensions of the sexual functioning.

However, there is also ample support for differences in the effects of sexual functioning among the various antipsychotics. Some differences may be due the timing when the effects are investigated or the communication between the investigators and the patients, but in clinical experience there seem to be differences on a daily basis.

They are probably less frequent with aripiprazole and ziprasidone. While the evidence for these differences is far from strong and consistent, in clinical praxis a switch from risperidone to aripiprazole, for example, has repeatedly shown to be useful in lowering sexual problems associated with the antipsychotic medication.

Olanzapine, though it is relatively serotonergic, and quetiapine may also cause sexual problems less frequently. But some of the effect may also be different at different points in time. In an analysis of data from the Schizophrenia Outpatient Health Outcomes study, an observational and prospective study of first time-treated patients with schizophrenia, although numerically lower with olanzapine, 6-month rates of sexual dysfunction did not differ among patients treated with olanzapine, risperidone or 'typical' antipsychotics.

Half of Patients or More

Sexual dysfunction is very common in patients receiving antipsychotics for a long period of time, and it is associated with a great impact in a substantial proportion of patients; both frequency and severity of sexual dysfunction seem higher in males. We found that 46% of the patients under treatment with antipsychotics experienced sexual dysfunction, a rate similar to that reported by Bobes et al. (38%) and Üçok et al. (53%) in two cross-sectional studies using different outcome measures. Although not statistically significant, in our study sexual dysfunction was more frequent in males than in females (50% vs. 37%). Again, Bobes et al. and Üçok et al. reported the same trend in gender differences (45% vs. 25% and 58% vs. 43%, respectively).

In a cross-sectional study in male outpatients with schizophrenia, the rate of sexual dysfunction was similar in patients receiving olanzapine, quetiapine, or risperidone (50% for each study drug) and did not differ from that of haloperidol-treated patients (40%). Finally, in another cross-sectional study in psychiatric inpatients, mostly diagnosed of schizophrenia, patients receiving prolactin-raising antipsychotics (i.e., risperidone, amisulpride, and zotepine) or prolactin-sparing antipsychotics (i.e., olanzapine, quetiapine, clozapine, ziprasidone, and aripiprazole) showed high and similar rates (75%) of sexual dysfunction [20]. Several factors may account for these discrepancies across the studies including study design, sample size, antipsychotic dose, and the evaluation tools.

Quality of Life

Sexual dysfunction has been reported to impair the quality of life of patients with schizophrenia, especially in males, although its impact seems to be less than that produced by other clinical symptoms and psychosocial factors. The important question is how relevant sex is to the individual. Sex can have various health benefits, including increased immunity by increasing the body's production of antibodies and subsequent lower blood pressure, and decreased risk of prostate cancer. Sexual intimacy and orgasms increase levels of the hormone oxytocin (also known as "the love hormone"), which can help people bond and build trust.

A long-term study of 3,500 people between ages 18 and 102 by clinical neuropsychologist David Weeks indicated that, based on impartial ratings of the subjects' photographs, sex on a regular basis helps people look significantly chronologically younger. So, there are positive effects from sexual activity, which can of course also include masturbation and other activities. Sexual activity also has shown in various studies to have a positive effect on psychological health, such as in prison inmates, for example. Sexuality is a form of intense communication (Haverkamp, 2010), which requires certain communication abilities but can also influence communication patterns. This should be seen as distinct from reproduction per se.

Sex is an emotionally strong interaction between individuals if it happens within a framework of other meaningful communication. This can include also non-verbal, such as the transmission of information through a tactile or visual channel.

Male vs Female

Interestingly, in the general population sexual dysfunction is more common in females than in males. One may thus speculate that antipsychotics affect the sexual functioning of males to a much greater extent than that of females. Men may also have a poorer tolerance to the disturbance regardless of the antipsychotic received. It is, on the other hand, also possible that these gender differences, at least the difference in the prevalence of sexual dysfunction, may reflect a selectively greater difficulty in evaluating sexual functioning in females.

In an intercontinental study of 7,655 patients with schizophrenia, Dossenbach et al. reported that there were differences between males and females in their frequency of sexual dysfunction when this adverse event was evaluated by the psychiatrist but not when it was self-reported. It has been also reported that women with schizophrenia or other severe psychiatric disorders experiencing sexual dysfunction were less likely than men to discuss or to be asked about their sexual functioning by their clinician.

As an exception, there may also be a greater incidence of sexual disorders in women than in men in the case of typical antipsychotics depots.

Compliance

Studies have found that almost half of patients stop medication because of sexual side effects, although considerably less women actually go through with stopping their medication. Thus, in the first line sexual side effects can also lead to a loss in compliance, while potentially having a negative effect on relationships.

Women and men both have often difficulties if there is a lack of a sexual outlet in the long-term. However, men have a higher pressure to reach an organism which may be due to an evolutionary necessity. If the medication would make a person completely indifferent to sex, there would be no problems, but this is not the case. The basic sex drive as opposed to libido or sexual interest is still present.

Dosage

Sexual dysfunction in typical and atypical antipsychotics seems dose related.

Typical Antipsychotics

Typical antipsychotics are significantly associated with an increased risk of sexual dysfunction, which also applies to depot formulations. Male schizophrenia patients on depots showed greater impairment in arousal and orgasm as compared with untreated patients. Female patients treated with depots may show greater severity and poorer tolerance than males.

Atypical Antipsychotics

The one factor which seems to play the most important role in whether someone had sexual side effects from an antipsychotic is which antipsychotic is being used.

Risperidone vs Olanzapine

In one study, patients treated with risperidone showed a sevenfold increased risk of sexual dysfunction as compared with olanzapine-treated patients. The literature is inconsistent in this regard, with some observational studies showing a frequency of sexual dysfunction in olanzapine treated patients that did not differ from that of risperidone or conventional antipsychotics. However, in an open-label, randomized trial, the rates of sexual dysfunction were much higher in risperidone (52% vs 12%).

Management

The majority of patients is probably never asked about sexual side effects, and particularly in psychotic patients there maybe a tendency to see this is a minor problem. Therefore, in patients receiving antipsychotics there is a need for

- greater awareness among psychiatrists about sexual dysfunction
- a systematic assessment of this side effect
- screening of prolactin levels in patients

Dose reductions are sometimes used to manage sexual side effects, although their effectiveness is probably limited. Apart from sildenafil for males with erectile dysfunction, there is no intervention of proven efficacy for the treatment of antipsychotic-induced sexual dysfunction.

Medication and Psychotherapy

Psychiatric treatments have changed over the past several decades. In the past, psychiatric patients were often hospitalized for six months or more, with some cases involving hospitalization for many years. Today, people receiving psychiatric treatment are more likely to be seen as outpatients. In many cases a combination of psychotherapy and medication can prevent relapse longer than either treatment type on its own. (Haverkamp, 2018e, 2018d) There is a substantial synergism between the two. Medication can provide the support which facilitates psychotherapy, while psychotherapy can increase the compliance with medication.

Synergies

Unfortunately, there is an increasing dissociation of the prescribing from the psychotherapy. In the past, most psychiatrists also provided psychotherapy, which no longer is the case. A psychotherapy session is usually 50 minutes long, while a medication follow-up may only need 30 minutes. Outpatient treatment involves periodic visits to a psychiatrist for consultation in his or her office, or at a community-based outpatient clinic. Initial appointments, at which the psychiatrist conducts a psychiatric assessment or evaluation of the patient, are typically 60 to 75 minutes in length, or even longer. Follow-up appointments are generally shorter in duration, i.e., about 30 minutes, with a focus on making medication adjustments, reviewing potential medication interactions, considering the impact of other medical disorders on the patient's mental and emotional functioning, and counseling patients regarding changes they might make to facilitate healing and remission of symptoms (e.g., exercise, cognitive therapy techniques, sleep hygiene—to name just a few). The frequency with which a psychiatrist sees people in treatment varies widely, from once a week to four times a year, depending on the type, severity and stability of each person's condition, and depending on what the clinician and patient decide would be best.

Into the Future

Communication is the foundation when it comes to preventing sexual side effects. Asking patients about sexual side effects is unfortunately often not done. However, it should always be on the list of questions at follow-up appointments. However, communication also plays an important role in lowering the sexual side effects. Whether psychotherapeutic or other non-medical approaches or changing or adjusting medication, understanding the patient's daily life with the antipsychotic and helping the patient understand about how it works and what the options are, increases compliance, the effectiveness of the medication and the patient's quality of life.



Dr Jonathan Haverkamp, M.D. MLA (Harvard) LL.M. trained in medicine, psychiatry and psychotherapy and works in private practice for psychotherapy, counselling and psychiatric medication in Dublin, Ireland. He also has advanced degrees in management and law. The author can be reached by email at jonathanhaverkamp@gmail.com or on the websites www.jonathanhaverkamp.ie and www.jonathanhaverkamp.com.

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