

SEXUAL DYSFUNCTION IN OBSESSIVE COMPULSIVE DISORDER AND PANIC DISORDER

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SUMMARY

Background: Clinical research has provided conflicting evidence regarding sexual dysfunction in patients with OCD and PD. This study was undertaken to assess and compare certain parameters of sexual functioning in OCD and PD patients.

Subjects and methods: The study population consisted of 80 patients between 20 and 60 years of age with a diagnosis of OCD or PD who were followed and treated at the anxiety outpatient unit of Bakirkoy Research and Training Hospital for Psychiatric and Neurological Disorders between 2005 and 2006. The total study population comprised of 40 patients with OCD, 40 patients with PD, and 40 healthy volunteers as the control group. Of the two questionnaires used for study purposes, the first provided information on demographic data and certain parameters of sexual functioning, while the second was the validated Turkish translation of the Golombok-Rust Sexual Satisfaction Inventory with transliteral equivalence.

Results: Male subjects with OCD had a lower age of first masturbation and first nocturnal ejaculation. Infrequency problem among female and male patients with OCD occurred in 63.6% and 57.1%, respectively. Corresponding figures for PD patients were 36% and 38%. Thus, infrequency problem was more frequent among OCD patients. Sexual avoidance was found in 60.6% of female OCD patients and in 64% of female PD patients. Anorgasmia was detected in 24.2% of the female subjects with OCD.

Conclusion: Sexual dysfunction unrelated to pharmacotherapy has been found to occur in OCD and PD. Assessment of sexual functioning in these individuals before treatment may help prevent deterioration of sexual function that may occur upon introduction of psychotropic medications.

Key words: sexual dysfunction - obsessive compulsive disorder (OCD) - panic disorder (PD)

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INTRODUCTION

Despite the suggestion of a link between the unconscious sexual desires and consequent development of anxiety disorders such as OCD and PD by psychoanalysis almost a century ago, sexuality and sexual functioning in anxiety disorders has largely been overlooked throughout the 20th century. Sexual dysfunction, a common problem in patients with OCD or PD, has mainly been accounted for by the effect of psychopharmacotherapy on sexual functions. A literature review on the topic reveals a relative scarcity of studies on sexual dysfunction in OCD or PD, despite apparently high incidence in up to 54 to 73% of patients (Freund & Steketee 1989, Monteiro & Noshirvani 1987, Staebler & Pollard 1993, Aksaray & Yelken 2001). This scarcity is even more pronounced in Turkey, where research on sexual functioning has traditionally been limited due to taboos surrounding sex both at an individual and societal level.

On the other hand, there are conflicting reports in the literature regarding the association between sexual dysfunction and OCD. Lower rate of marriage, sexual intercourse difficulties, and reduced sexual experience in OCD patients may be related to sexual dissatisfaction encountered during the disease process (Steketee 1997).

In a study by Monteiro & Noshirvani (1987) involving OCD patients showed that approximately 9% of female subjects had anorgasmia and 22% had sexual arousal phase problems, whereas 25% of the males had lower sexual arousal, 12% had premature ejaculation and 6% had erectile disorder, with 39% of the patients displaying sexual dissatisfaction. Orgasm phase disorder was found in 12% of the cases in another study by Freund & Steketee (1989). A Turkish study compared the level of sexual satisfaction in OCD and generalized anxiety disorder and found higher incidence of anorgasmia, sexual arousal disorder and sexual avoidance in the OCD group (Aksaray & Yelken 2000).

Sexual dysfunction in patients with OCD has been studied independently or in gender specific studies, most of which were uncontrolled and provided relatively limited evidence about sexual dysfunction in OCD (Kendurkar & Brinder 2008)

Van Minnen & Kampman (2000) found women with panic disorder and those with obsessive compulsive disorder to have lower sexual desire and lower frequency of sexual contact than controls. Hypoactive sexual desire disorder and sexual aversion disorder have also been reported to occur more frequently among anxiety patients than in controls. In addition, OCD patients were reported to experience more sexual

dysfunction overall and were less satisfied with their sex lives as compared to subjects with panic disorder and controls. Vulink et al. (2006) examined sexual satisfaction in women with OCD and found that 62% of the patients experienced reduced sexual desire, 29% had reduced sexual arousal, 33% had orgasmic phase dysfunction, 25% had problems regarding physiological arousal and 10% had lack of sexual pleasure. The same authors found no change in the frequency of sexual intercourse among the OCD patients although they seemed to avoid sexual intercourse.

In a more recent study, women with OCD reported reduced sexual pleasure, high sexual disgust, and impaired overall sexual functioning (Vulink et al. 2006).

Data on sexual dysfunction in panic disorder is somewhat conflicting. For instance, Van Minnen & Kampman (2000) found that women with PD suffered more from sexual desire disorder, while Mercan et al. (2006) observed no difference between PD patients and controls, pointing out to the lower levels of sexual desire and higher levels of avoidance in women with PD who also had coinciding signs and symptoms of depression. The latter group of investigators argued that sexual dysfunction was probably more closely associated with depression rather than PD itself.

Figueira & Possidente (2001) found sexual avoidance and decreased sexual desire in 50% and 21% of the women with PD, respectively; and their data suggested an association between decreased sexual desire and panic disorder. The same researchers also observed premature ejaculation, sexual avoidance and decreased sexual desire in 21%, 36%, and 14% of the male PD patients, respectively. Of note, only 7% had erectile problems. These data contradicted the data of three patients with panic disorder who visited the doctor due to erectile dysfunction (Sbrocco et al. 1997).

This study was undertaken to assess certain parameters of sexual functioning in OCD and PD patients, to provide a comparison with healthy controls, and to discuss our findings within the context of previous reports with somehow conflicting results.

SUBJECTS AND METHODS

Subjects and study procedures

The study sample included a total of 80 patients between 20 and 60 years of age with a diagnosis of OCD or PD (based on SCID-I) who were followed and treated at the anxiety outpatient unit of Bakirkoy Research and Training Hospital for Psychiatric and Neurological Disorders between 2005 and 2006. Patients on psychotropic medications were excluded due to sexual dysfunction associated with the use of these agents. In order to be included in the study the participants had to discontinue the treatment with psychotropic medications at least 3 months prior to study entry, have an ongoing relationship with a sexual partner, have a minimum of primary school education, be previously diagnosed with

OCD or PD, and show willingness for participation. The overall study population comprised of 40 patients with OCD, 40 patients with PD, and 40 healthy volunteers as the controls. Written informed consent was obtained from all participants before the study procedures.

Assessments

Of the two questionnaires used for study purposes, the first provided information on demographic data and certain parameters of sexual functioning, while the second was the validated Turkish translation of the Golombok-Rust Sexual Satisfaction Inventory (GRISS) (Rust & Golombok 1986) with transliteral equivalence that contains 28 items and has two versions (male and female versions). This inventory assesses sexual functions and sexual disorders under seven subtitles (frequency, communication, satisfaction, avoidance, sensuality, premature ejaculation and erectile dysfunction, vaginismus, anorgasmia). It is administered to heterosexual individuals with a regular sexual partner or couples. Transliterator equivalence, validity and reliability studies for the Turkish version of GRISS had been previously carried out by Tuğrul et al. (1993).

Statistical Analyses

SPSS for Window 16.0 was used for data analysis. Student's t test was used for the comparison of parametric data between OCD and PD groups, while Mann Whitney U test was used for the non-parametric data comparison. The overall comparisons of the three groups were performed using ANOVA and Kruskal Wallis Test, for parametric and non-parametric data, respectively. Fisher exact test and chi-square test were used for the comparison of categorical data and Pearson correlation analysis was used to test the correlations between variables. Statistical significance was set at a p level of less than 0.05.

RESULTS

A history of childhood behavioral problems was significantly more common in PD and OCD patients compared to the control group (Table 1). In addition, menarche age was lower and nocturnal ejaculation was more common in the patient groups, particularly in OCD patients (Table 1).

An assessment of GRISS subscale scores (infrequency, non-communication, dissatisfaction, avoidance and non-sensuality) revealed higher prevalence of infrequency and dissatisfaction in OCD and PD patients compared to controls ($p < 0.01$). The infrequency problem was particularly evident among males with OCD. In addition, avoidance and non-sensuality were more common in the patient groups ($p < 0.01$). The subgroup of female OCD patients in particular had more infrequency, avoidance and non-sensuality problems. However, no significant differences existed in non-communication and non-sensuality scores (Table 2).

Table 1. Age and sexual life characteristic of the three groups

	Panic disorder group		OCD group		Control group		P
	Mean	SD	Mean	SD	Mean	SD	
Age	38.11	8.64	34.17	7.62	34.58	7.59	0.078
Age of sex inform.	14.54	2.63	15.67	3.27	15.44	3.53	0.263
Menarcho age nocturnal ejaculation	13.97	1.71	13.05	1.61	14.25	2.03	0.010**
Masturbation age	15.20	2.14	15.05	4.31	15.36	1.70	0.936
Age of first intercourse	19.58	3.10	20.13	3.57	19.55	3.63	0.700

** P<0.05

Table 2. Comparison of the results of Golombok–Rust Sexual Inventory

	Panic disorder group		OCD group		Control group		P
	Mean	SD	Mean	SD	Mean	SD	
Infrequency	5.03	1.85	6.15	2.09	3.63	1.92	0.000***
Non-communic.	4.25	2.55	4.47	2.71	3.78	2.70	0.487
Dissatisfaction	4.15	1.83	3.68	1.31	2.58	1.65	0.000***
Avoidance	4.85	2.18	5.70	2.59	3.58	2.41	0.001***
Non-sensuality	4.30	2.51	5.68	2.62	3.23	2.33	0.000***

*** P<0.01

DISCUSSION

OCD is associated with marital and sexual problems that have been reported to reduce the likelihood of marriage and sexual relationships (Vulink et al. 2006, Freund Steketee 1989, Hoover & Insel 1984). However, proportion of married individuals in our OCD patients was not lower than that of controls, similar to the results reported by Steketee (1997). This finding might be explained by the characteristics of a typical marriage in Turkey, where sexual partnership can only possible in the context of a marriage for the majority of the population.

Age of first masturbation and age of nocturnal ejaculation of the male participants of OCD group was lower. First masturbation age in PD patients was 14.3 years, similar to the figures reported by Figueira & Possidente (2001).

A history of childhood behavioral problems (bed-wetting, stammering and nocturnal fears) was significantly more common among patients with OCD and PD compared to controls (Table 1). Also both OCD and PD groups experienced problems related with the frequency of sexual intercourse (i.e. infrequency) (Table 2). Figueira & Possidente (2001) did not report any differences between panic disorder and generalized anxiety disorder in terms of sexual intercourse frequency. Similarly, Aksaray & Yelken (2000) did not report any differences between with OCD or generalized anxiety disorder in terms of sexual intercourse frequency (infrequency). In this study, infrequency was observed in 57.1% and 63.6% of the male and female OCD patients, respectively. On the other hand, infrequency occurred in 36% of female PD patients, and in 38% of the male PD patients. Thus, rates in OCD group were higher.

Our findings are in agreement with those of Van Minnen & Kampman (2006) showing an increased infrequency problem in both sexes. Reporting higher incidence of infrequency among men may be related to the higher cultural pressure placed on Turkish men as the “initiator” of the sexual intercourse, probably rendering men more sensitive to infrequency and causing in higher perception rates for the problem.

Sexual avoidance was detected in 60.6% of the female OCD participants, similar to the figures reported by Aksaray & Yelken (2000) for the same patient group and gender. Avoidance occurred in 64% of female PD patients at a higher rate than that (50%) reported by Figueira & Possidente (2001). Similar findings were reported by Vulink et al. (2006).

Sexual avoidance, especially in OCD, is attributed to the absence of a partner (Freund & Steketee 1989, Monteiro & Noshirvani 1987) whereas in our patient group, similar to that of Vulnik et al. (2006), sexual avoidance may be related to sexual arousal phase problems since our participants were in a regular relationship or married.

Sexual dissatisfaction was more frequent among female patients with OCD or PD compared to healthy individuals, in contrast with the results reported by Mercan et al. (2006). However, since major depression was an exclusion criterion in our study, sexual dissatisfaction was not related to depression.

Non-sensuality was more common in the patient groups compared to controls (Table 2, p<0.05); 70% of female OCD patients had non-sensuality, similar to the study by Aksaray & Yelken (2001) who compared female patients with OCD or generalized anxiety disorder. The rate of non-sensuality was found to be 68%.

Both in OCD and PD groups, problems of the sexual desire phase were related to sexual avoidance and

clinical presentation of OCD. Sexual avoidance in panic disorder is associated with the fear of triggering panic attacks during intercourse.

In our study, percentage of female OCD patients reporting anorgasmia (24.2%) was higher compared to the figures reported by Monteiro & Noshirvani (1987) and Freund & Steketee (1989) (9% and 12%, respectively), but was similar to that reported by Vulink et al. (2006) (33%). Our data analysis suggested that female OCD patients experienced sexual problems not only involving the desire phase, but also arousal and orgasm phases, as reported by Van Minnen & Kampman (2000). Female OCD patients had higher rates of vaginismus. However, vaginismus was also present among female controls and was probably related to cultural influences.

In contrast with the results reported by Sbrocco et al. (1993) but similar to those reported by Figueira & Possidente (2001), male OCD and PD patients had increased rate of erectile dysfunction or premature ejaculation.

Patients in OCD group experienced a higher frequency of sexual arousal and orgasm phase dysfunction, while those in PD had a higher frequency of avoidance.

Sexual dissatisfaction was more common compared to healthy individuals, particularly among female patients. This is in contrast to the findings of a study by Mercan et al. (2006) that involved female PD patients. However, exclusion of patients with major depression in our study suggests that dissatisfaction was not related to the mood.

Limitations

Possible limitations of our study include the small sample size and the inclusion of subjects from culturally different backgrounds. However, the latter did not seem to have a major effect on our results, since no significant differences were found in demographic characteristics.

Absence of directly comparable studies makes it difficult to establish the validity of our findings. Another inherent limitation is the impossibility to compare the probable detrimental effect of disorder duration on sexual functions due to the cross-sectional nature of this study, limiting its ability to demonstrate a causal relationship between sexual dysfunction, OCD and panic disorder.

Therefore, further studies comparing other groups of patients with anxiety disorders from different cultural backgrounds and assessing the effect of the duration of disease on sexual functions may provide more insight into abovementioned issues.

CONCLUSION

Sexual dysfunction unrelated to pharmacotherapy has been observed in our patients with OCD and PD.

Assessment of sexual functioning in these individuals before treatment may help prevent deterioration of sexual functions that may occur upon introduction of psychotropic medications.

OCD and PD patients were more likely to report behavioral problems during childhood, and prospective studies of sexual development from childhood to the later stages of life could shed more light on these associations. Presence of vaginismus even among females in the control group suggests certain cultural influences. Higher incidence of sexual dysfunction among OCD patients were found in the domains of sexual satisfaction, frequency, sensuality and orgasm, while aversion was more common in panic disorder.

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