

## Depression as an outcome or cause of sexual dysfunctions: A review study

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### Abstract

Considerable research has indicated that there is a relationship between the occurrence of depression and sexual dysfunctions. This study aims to provide an overview of the issue of depression as an outcome or cause of sexual dysfunctions, by providing a review of results and inferences from various research works. In line with this aim, document analysis method as a qualitative research method was used in the study. Various published documents were analysed after a comprehensive literature review on the research topic. The results of the present study suggest that there are complementary research results in the literature showing that depression may be regarded both as an outcome and a cause or precedent of sexual dysfunctions. Implications for further research and practices are also provided.

Keywords : Depression, qualitative research, review, sexual dysfunctions.

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## 1. Introduction

Depression is one of the most known and debated psychological disorder nowadays, and it is a commonly familiar and striking topic among laypersons. In common parlance, depression can be defined as a mental disorder characterised by sadness, loss of interest in activities, decreased energy and not enjoying from pleasurable activities. The most common two types of depression are major depression and bipolar depression (Costello, 2016).

Depression is different from normal mood changes, with its degree of severity, enduring diagnostic symptoms and duration of symptoms. Uner and Ozcebe (2008) described depression as one of the widespread mental disorders which reduces the life quality of a person and is associated with an emotional status that includes feelings of stagnation, insignificance, decreased motivation and incapability. Uner and Ozcebe (2008) also stated that some of the etiological reasons for depression are genetic and biochemical reasons, environmental and psycho-social conditions. Depression can also appear in any stage of the life period. In general, the most widely seen typical symptoms of depression are feelings of hopelessness and moodiness, disruptions in sleep patterns, loss of appetite or eating too much, discomfort and irritability, loss of energy, chronic pain or fatigue, feelings of guiltiness and worthlessness and suicidal thoughts in severe depressive situations (Bayliss, Tipper, Wakeley, Cowen & Rogers, 2017; Karp, 2016). In addition, Murphy, Laind, Monson, Sobol and Lenghton (2000) stated that epidemiological studies show that the prevalence of depression is on the increase and it is fast becoming a common mental disorder.

Depression is a disease that can vary in severity, symptom types and disease course, and is a psychological disorder that is defined in a broad spectrum. It can be diagnosed in different situations with severe symptoms in normal sadness. From the point of view of emotions, depression is diagnosed and treated when the affects that one normally experiences are excessive, intense and time-consuming. For this reason, clinical depression is separated from the normal depression and sad emotional state that some people suffer due to a specific reason in their daily lives. According to Ozturk (1997), in a depression episode, the following symptoms usually occur:

- Depression and anxiety mood
- Slowing down in psychomotor skills
- Fatigue and reluctance
- Not enjoying things enjoyed in the past
- Limited availability
- Difficulties in getting attention, intensifying attention
- Considerations of worthlessness
- Having regrets for the past and hopelessness for the future
- Sleep disturbances
- Loss in appetite and weight
- Decreases in sexual desire
- Self-sacrifice considerations

The most important symptom of the depressed mood is a lack of interest in everything and the accompanying depression, sadness and despair. Appetite problems, changes in body weight, sleep disturbances, psycho-motor agitation, slowing, diminished energy, worthlessness, feelings of guilt, difficulty in thinking and collecting attention, death thoughts and suicide attempts. These symptoms affect a person's life (Gectan, 2006). Depression is a condition in which the desire to live and the taste for good things decrease or disappear; there is a feeling of deep sorrow, a pessimistic view of the future, the regret of the past is defined, it is a disease filled with thoughts of death, attempt of death and physiological disorders related to death, sleep, appetite and sexual desire (Aydogan et al., 2012). Changes related to emotional state, memory and thinking are also defined as an important psychological disorder, manifested by behavioural and somatic changes (Koroglu, 2012). On the basis

of depression, there is reluctance to enjoy everyday activities that you have voluntarily and fondly enjoyed, and inability to enjoy life. In addition, some changes in the depressed person develop with time, which is accompanied by a sad and sorrow emotional state. In this case, the person starts to think about the past and the future with pessimistic thoughts by considering everything as negative. The person feels sad and lonely. Interest in oneself and surroundings diminishes. There can be intense feelings of guilt. The person thinks that they are a burden on others and not fulfilling their responsibilities. It is usually accompanied by internal distress, constriction and restlessness. Sometimes the person may feel like all his/her emotions are lost. Depression also prevents our mental activities. The most common symptoms are lack of attention and forgetfulness. The effect of depression on behaviours is in the form of slowing down due to excessive fatigue in movements due to energy depletion. Even simple everyday things become a burden for the person. They avoid social relations, prefer to be alone and do not share problems and troubles. Sexual interest and desire may also diminish. Some somatic symptoms may also occur in depression. There may be a marked decrease in appetite, weight loss or, on the contrary, excessive eating. One of the common symptoms is insomnia (Finan & Smith, 2013). There may be problems with sleeping, frequent disturbed sleep, or waking up too early in the morning. Some people may tend to oversleep; however, they do not wake up feeling rested but have head, neck, back and joint pains accompanied with gastrointestinal complaints. All these symptoms last for at least two weeks. It prevents the person from carrying out the responsibilities related to his/her profession, family and himself/herself.

All of the abovementioned do not necessarily appear in the same person. Sometimes depression is manifested by only some of these symptoms. In addition, symptoms may be mild, moderate and severe, and the severity may vary from person to person. People can get depressed because of very different reasons, because each individual has different experiences and different lives (Fried, Epskamp, Nesse, Tuerlinckx & Borsboom, 2016). Many risk factors play a role in the development of depression. Some of the factors are the loss of a close relative, separation, job loss, family problems, some personality traits or other financial reasons (Phillips, Carroll & Der, 2015).

Genetic susceptibility is directly or indirectly related to gender, stressful life events, the onset of a chronic psychiatric or physical illness or lack of social support depression and a negative process. Research has shown that some people are biologically more susceptible to depression (Flint & Kendler, 2014).

Gender is also an important risk factor for depression. It is known that women are more susceptible to depression (Pallavi et al., 2015). Everyone experiences stressful events in everyday life, but each individual has different ways of thinking about and coping with these events. People who do not have well-developed thinking styles and methods of coping are more susceptible to depression. Coping with a chronic condition is also an important risk factor for depression, for example, depression among cancer patients is very common.

For an individual, the lack of social support means that the people who give importance to their own life are in favour of it and support it (Du, King & Chu, 2016; Wang, Cai, Qian & Peng, 2014). For example, supporting a woman's family in the process of divorce will reduce the risk of depression. Regardless of the problem and how depression occurs, it is possible to treat it. According to most experts, the most appropriate treatment for depression is an approach in which drug treatment and psychotherapy are carried out in parallel. Psychotherapy is very important in the treatment of depression, because the patient has to acquire and develop insights to change his or her views and illusions that lead to depression. In the course of therapy in general, the causes of depression and how to deal with these causes with more rational approaches are discussed first. The main goal is to change the patterns of incompatible thinking. Alternative thinking styles and coping strategies are the focus of therapy in achieving and realising more realistic goals. It is also important to support the positive and healthy side and positive defences of the person, to reduce stressful external factors, to increase their social support, to create a balance to adapt to everyday life and to increase its

functionality and thus to increase self-esteem and self-worth. Research shows that when psychotherapy is used in the treatment of depression, the risk of re-occurrence of the disease is significantly reduced (Lemmens, Muller, Arntz & Huibers, 2016; Mulder, Boden, Carter, Luty & Joyce 2017). However, the belief that drug treatment should always be used is also not true. How depression is treated depends on the course of the depression, the severity of the symptoms and the personal life story of the person. Only therapy can be sufficient to treat depression. As with any treatment, it is necessary for the patient to be accepted and treated for the treatment of depression. This issue is a great responsibility to the social supporters of the person, i.e., the partners (husband/wife), the family or friends.

Healthy sexual life is an essential part of many human relationships, and may enhance the quality of life and provide a sense of physical, psychological and social well-being; sexuality is a complex situation which is affected by the individuals' relations with others, life conditions and culture. A considerable amount of research indicates that there is a relationship between the occurrence of depression and sexual dysfunctions. A recent research carried out by Yee, Kanagasundram, Gill and Zainal (2016) showed that major depression especially is related with sexual dysfunctions, and most antidepressants exacerbate sexual functioning and symptoms.

Considering the potential interactive relationship between depression and sexual dysfunctions, the present study aims to provide an overview of the issue of depression as an outcome or cause of sexual dysfunctions by providing a review of the results and inferences from various research works.

## **2. Method**

In this section, information on the research model, data collection and analysis of data is presented.

### *2.1. Research model*

This study is a qualitative research in nature. Document analysis method as a qualitative research method was used in the study. Document analysis is a method used in historical and qualitative research. It is used to reach resources based on the research aims and to identify the data. It involves analysis of the written and printed documents based on a specific research aim (Cepni, 2007; Yildirim & Simsek, 2006).

### *2.2. Data collection and analysis*

Various published documents from different databases were obtained and analysed after a comprehensive literature review on the research topic. The documents were categorised as studies regarding depression as an outcome and a cause of depression. Then, the collected documents were brought together, examined and discussed.

## **3. Results and discussion**

### *3.1. Depression: Definition and risk factors*

Comorbidity, in simple terms, is any distinct additional clinical entity that has existed or may occur during the clinical course of a patient who has an index disease under study. According to Nuijen (2009), depression involves comorbidity, and in many studies, it has been shown that depression has comorbidity with many medical or mental conditions. Parkinson's disease, eating disorders, anxiety disorders and substance are some of the disorders that show comorbidity with depression.

There are many researches which try to determine the risk factors for depression and there are some typical risk factors for depression which many studies have shown in common. Commonly,

genetic and biochemical factors, negative life events, past depression, SES level and some other psychosocial factors are regarded as risk factors for depression. Specifically; for instance, Cole and Dendukuri (2003) indicated that according to their quantitative meta-analysis, bereavement and especially loss of a spouse, prior depression, sleep disturbance, disability, life stressors and female gender were found to be risk factors for depression among the elderly community.

There are many supportive evidence indicating that antidepressants such as selective serotonin reuptake inhibitors (SSRIs) and cognitive behavior therapy (CBT) are the two common forms of treatment for depression and they have been shown to be successful in many cases.

Depression is not a sign of helplessness or weakness; it is a treatable psychological disorder. As a result, a negative depression should not be perceived as an inevitable end or an uncomfortable condition. However, depression is a condition that affects one's daily life and functioning negatively and requires treatment. Anxiety or depression should be attempted to determine whether a sexual complaint is a cause or an end. If there is depression before, this should be treated along with sexual dysfunction. If the role of antidepressants and anti-anxiety drugs as factors contributing to sexual dysfunction is assessed and found to be effective, changes in treatment should be made. Loss of interest in depression, reduced energy, low self-esteem, lack of enjoyment of life, irritability and social isolation can damage the shape and continuity of interpersonal relationships. The presence of these symptoms can also damage the sexual life and relationships of people, causing CFB. Epidemiological and clinical studies show that depression has a negative effect on sexual function and satisfaction, including in untreated patients. It is reported that drugs used in the treatment of depression cause CFB. A comparison between three groups was conducted. These groups were a group that was diagnosed with depression and treated, a group diagnosed with depression but not treated and a group that did not have depression, it was determined that the group with the major sexual problems was the group that was diagnosed with depression and treated (Angst, 1998).

In a study carried out with women diagnosed with depression, women reported that they experienced a decrease in sexual desire (Kennedy & Rizvi, 2009). In psychiatry clinics, it is commonly thought that sexual dysfunctions might arise from the medications used in the treatment of depression (William et al., 2006). In addition, the frequency or occurrence of sexual dysfunctions might be related with post-traumatic stress disorder, obsessive-compulsive disorder, social phobia, panic disorder and generalised anxiety disorder (Fontenelle et al., 2007).

### *3.2. Sexual dysfunctions: Definition and risk factors*

In simple terms, any sexual dysfunction can be defined as a difficulty experienced by an individual during any stage of sexual activity, including desire, arousal and orgasm. There are four categories of sexual dysfunction disorders: sexual desire, sexual arousal, orgasm and sexual pain disorders. Hypoactive sexual desire disorder and sexual aversion disorder are the two forms of sexual desire disorders; female sexual arousal disorder and male erectile disorder are the two forms of sexual arousal disorders; female orgasmic disorder, male orgasmic disorder and premature ejaculation are the three forms of orgasmic disorders; and dyspareunia and vaginismus are the two forms of sexual pain disorders.

According to Dunn, Croft and Hackett (1998), the prevalence rate of sexual dysfunctions among the general population is higher than it is expected. In their study, they also stated that the most reported types of sexual dysfunctions are vaginismus and male erectile dysfunctions. Also, Simons and Carey (2001) supported the evidence that the prevalence rate of specific sexual dysfunctions is high among the general population and they give some statistical estimates. Some of them are 0%-3% for male orgasmic disorder, 0%-5% for erectile disorder and 0%-3% for male hypoactive sexual desire disorder, 7%-10% for female orgasmic disorder and 4%-5% for premature ejaculation.

According to Lewis et al. (2004), the most common risk factor categories of sexual dysfunctions among men and women are the general health status of the individual, the presence of some medical conditions such as diabetes or cardiovascular disease, existence of psychiatric or psychological disorders and socio-demographic factors. Specific techniques, drug treatments, mechanical devices and couple therapy are some of the treatment methods which are used to treat sexual dysfunctions.

From now on, the relationship between depression and sexual dysfunctions will be discussed and perspectives on the issue of whether depression is the cause or outcome of sexual dysfunctions will be evaluated.

### *3.3. Depression and sexual dysfunctions*

The issue of whether depression is the cause or outcome of sexual dysfunctions is an important issue of the most debated issues, in which a lot of research has been done to determine the exact relationship between depression and sexual dysfunctions. Both the perspectives which conclude depression as the cause and the outcome of sexual dysfunctions are supported with evidence.

Baldwin (2001) states that depression is definitely associated with sexual dysfunctions and, indicates that in comparative studies, it has been shown that there are higher levels of sexual dysfunctions in clinical-depressed patients than non-depressed patients. However, Baldwin (2001) also claims that loss of sexual desire is also a typical symptom of depression and, because of this, there is an alternate relationship between depression and sexual dysfunctions.

According to Hartmann (2007), the relationship between depression and sexual dysfunctions are bidirectional and a high percentage of men and women suffering from mild, moderate, or severe forms of depression experience sexual dysfunction. From this point of view, it can be said that Hartmann (2007) indicates that depression is somewhat the cause of sexual dysfunctions.

Shabsigh et al. (1998) claims that men with erectile dysfunction have a higher incidence of depressive symptoms and depressive symptoms affect the level of libido and the success of the treatment of men's erectile dysfunction. In addition, Hayes, Dennerstein, Bennett and Fairley (2008) indicate that low arousal, which is one of the predominant etiological reasons for female sexual dysfunctions, is highly associated with depression. Also, according to Berman, Berman and Goldstein (1999), it has been stated that female sexual dysfunctions and especially female orgasmic disorder is highly associated with psychological disorders such as depression.

In contrast with the previously cited evidence, which regard depression as a cause of sexual dysfunctions, Michael and O'Keane (2000) state that sexual dysfunctions are well-known symptoms of depression and this issue needs to be more widely studied.

There is a remarkable and very critical issue about the relationship between sexual dysfunctions and depression, which certainly should be mentioned here. Drugs used in the treatment of depression, such as antidepressants and SSRIs, are found to cause sexual dysfunctions. For instance, Hirschfeld (1998) suggests that sexual dysfunctions are side effects of antidepressants and there is a probability of antidepressant-induced sexual dysfunctions. This is most likely due to post-synaptic stimulation of 5-HT<sub>2</sub> receptors and these receptors reduce sexual dysfunction and there is evidence in support of this hypothesis.

According to Werneke, Northey and Buhgra (2006), patients who take antidepressant medication needed to be routinely asked about their sexual function to identify early if there is a problem of antidepressant-induced sexual dysfunction, because many patients with depression suffer from this side effect of antidepressant drugs.

Overall, from all this cited evidence, it can be said that there is no exact way to say whether depression is the cause or outcome of depression. It can be said that there is a bi-dimensional

relationship between them and they are found to be highly associated with each other. It can be said that, regardless of whether depression is the cause or the outcome, whenever there is a case of a depression or a sexual dysfunction, they should be regarded and investigated because they are highly comorbid with each other.

#### 4. Conclusion and recommendations

In conclusion, it can be indicated that depression and sexual dysfunctions might be related with each other, regardless of being a cause or outcome. Based on the results of the study, the following recommendations are presented for further research and practice:

- Experimental research might be carried out in order to reveal the relationship between depression and sexual dysfunctions.
- Psychologists and mental health professionals should become more aware about the possible relationship between depression and sexual dysfunctions.
- Both depression and sexual dysfunctions have physical, social and emotional aspects and all of these aspects must be examined in-depth.

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