Obsessive-compulsive disorder and men's health. Part 2: Treatment and related sexual dysfunction

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Obsessive-compulsive disorder (OCD) commonly affects males and can manifest with a range of urological symptoms directly linked to the content of the OCD. In Part 1 of this article, the authors discussed the recognition and diagnosis of OCD. In Part 2 here, they consider its treatment and related sexual dysfunction.

Key points

- A form of cognitive behavioural therapy involving 'exposure and response prevention' and pharmacotherapy with selective serotonin reuptake inhibitors (SSRIs) are currently considered the first-line interventions for obsessive compulsive disorder (OCD)
- Augmentation of SSRIs with first- or second-generation antipsychotics, neurosurgical procedures and non-invasive neuromodulation techniques represent available therapeutic options for treatment-resistant OCD
- Clomipramine and all of the commonly prescribed SSRIs are relatively commonly associated with sexual side-effects
- Sexual dysfunction and/or reduced sexual satisfaction is likely to significantly diminish a person's quality of life by worsening self-esteem, provoking frustration, anxiety and depression, and importantly increasing tension with the sexual partner
- Clinicians should pay attention to sexual issues in patients presenting with OCD and take steps to support their management

Obsessive-compulsive disorder (OCD) is a common and disabling condition that can lead to urological consultation. The treatment strategies for OCD sometimes also have physical health repercussions, especially in the area of sexual dysfunction, which may also be affected by the illness itself. Urologists should therefore feel confident in understanding the clinical management of the disorder to support their own clinical practice. In this paper, we present an update on the standard treatments for OCD, including cognitive behaviour therapy (CBT) with exposure and response prevention and selective serotonin reuptake inhibitors (SSRIs). We also review the clinical management of sexual dysfunction associated with OCD and its treatment with SSRIs.

Part 1 of this article, published in the January/February 2023 issue of *Trends in Urology and Men's Health*, reviewed the common urological presentations of OCD as a guide for clinicians to aid recognition of the disorder and facilitate appropriate onwards referral and management.[1] However, as OCD is such a commmon disorder, it is also important for clinicians in general to understand the basics of OCD treatment, not only to provide support and guidance to their patients but also because some of these treatments may have physical health repercussions.

Standard treatment of OCD

As indicated by international evidence-based guidelines for OCD treatment, a form of cognitive behavioural therapy (CBT) involving 'exposure and response prevention' and pharmacotherapy with SSRIs is currently considered the first-line intervention for OCD.[2,3] However, up to 60% of treatment-seeking patients with OCD do not respond fully to these treatments and other or more intensive strategies are often required.[4]

CBT is considered the most effective evidence-based psychotherapy for OCD.[2] Exposure and response prevention (ERP) for OCD is a structured form of psychotherapy that involves exposing patients to stimuli to provoke obsessions and the accompanying anxiety, distress and urge to perform 'neutralising' compulsions ('exposure'), and instructing patients to resist the associated compulsions or avoidance behaviours generated by the exposure ('response prevention').[5] However, treatment with CBT has drawbacks, including lack of availability (*eg* few local physicians trained in OCD-specific approaches), intense time requirement (typically one or more hours per week for therapy sessions, plus daily tasks or 'homework' for at least 12 weeks) and poor patient motivation to engage in CBT.[6] Moreover, CBT is not yet shown to protect against relapse of OCD, which commonly occurs.

SSRIs are the first-line drug treatment for OCD, with documented efficacy in reducing OCD symptoms and depression and preventing relapse,

alongside reasonable treatment tolerability as demonstrated in multiple studies. According to clinical practice guidelines, the use of SSRIs at the maximum tolerated dosage (*ie* dosages at the top of the licensed range; higher than those usually used for depression and anxiety) is optimal for symptom relief and relapse prevention.[3] Before determining that a particular SSRI is not beneficial, at least 8–12 weeks of treatment are recommended.[2] It is advisable to continue the SSRI at maximally tolerated dosages for at least 12 months after treatment response is achieved; in fact, irrespective of the duration of treatment, discontinuing SSRIs or even reducing the dosages[7] is likely to be associated with a significant risk of relapse and it is for this reason that indefinite treatment with maximally dosed SSRI is indicated for many patients.[3] Clomipramine, a partially serotonin-selective tricyclic antidepressant, was the first medication demonstrated to be effective for OCD, and it is still used to treat OCD today. However, clomipramine produces anticholinergic side-effects, such as dry mouth, blurred vision, urinary retention and constipation, that are minimal or absent with SSRI treatment. Furthermore, clomipramine is associated with increased risk of cardiac arrhythmia and seizures at dosages greater than 200mg daily, and may be lethally toxic in overdose. Thus, clomipramine is most appropriate as a second-line treatment for patients who do not respond to SSRIs and who are considered to be at low risk of suicide.[2]

SSRI and clomipramine-related sexual dysfunction

It is important to take into consideration sexual functioning in patients undergoing treatment for OCD. The illness itself may directly impact sexual functioning, for reasons already described in Part 1.[1] In summary, individuals with sexual or contamination-related obsessions or compulsions may find engaging in sexual intercourse particularly challenging as they may be afraid of contact with bodily fluids such as seminal fluid, blood, etc. Obsessions related to aggression can also lead to avoidance of sexual activity, to prevent the imagined risk of loss of control and perpetration of a sexual assault. In addition, clomipramine and all the commonly prescribed SSRIs are relatively commonly associated with sexual side-effects.[8] Symptoms include impairments of penile erection, lubrication, orgasm, libido, retrograde ejaculation, sexual arousal or overall sexual satisfaction. As the dosages of SSRI or clomipramine required in the treatment of OCD are usually higher than those used for depression, this leads to a greater theoretical risk and severity of sexual side-effects.[9] However, while it has been reported that 40% of patients undergoing medication with an antidepressant experience any type of sexual side-effect, and that 25–73% of patients taking an SSRI may be affected,[10] the incidence of sexual side-effects occurring in patients treated specifically for OCD with these agents is not fully known.

Consequences of sexual dysfunction

Psychotropic-induced sexual dysfunction may have serious negative consequences such as non-adherence with or early discontinuation of pharmacotherapy. As discussed above, dosage reduction or discontinuation may be associated with relapse of the OCD, with potentially harmful effects (also see next paragraph). Moreover, sexual dysfunction and/or reduced sexual satisfaction is likely to significantly diminish a person's quality of life (QoL) by worsening self-esteem, provoking frustration, anxiety and depression, and importantly increasing tension with the sexual partner.[8]

Males troubled by sexual problems are more likely to report lower overall life satisfaction scores, mental health QoL scores, and vitality QoL scores. Sexual satisfaction, in contrast, is associated with significantly better overall life satisfaction and QoL.[11] Indeed, sexual issues, if not addressed correctly, can negatively affect a couple's relationship: not only the affected party, but also the partner may experience anger, sadness, anxiety or guilt. Recognising and facing the problem is sometimes essential to preserve the relationship between partners.[12] There may also be broader social consequences: the patient may fear the risk of engaging in an intimate relationship and therefore avoid or reduce his social contact.

Managing SSRI-related sexual dysfunction

Sexual dysfunction should be investigated in patients of all genders as it is significantly associated with lower overall life satisfaction and poorer QoL.[11] As a first step, taking an appropriate sexual history is needed for the basic evaluation of all patients presenting with sexual complaints. Specifically, the sexual history aims to identify, assess and interpret any sexual problems, possible biological and psychosocial contributing factors, and a patient's and/or couple's treatment goals.[13] In clinical practice, screeners can be integrated into routine health care visits to help identify patients experiencing sexual problems. Screeners can complement, but should in no case substitute for, a comprehensive sexual, medical and psychosocial history. Once identified, validated rating scales can be useful for exploring the severity and impact of sexual problems, such as drug-related side-effects, on patients' sexual life quality. The Psychotropic-Related Sexual Dysfunction Questionnaire (PRSexDQ-SALSEX) specifically evaluates different aspects of sexual dysfunction after the onset of any psychotropic treatment and the effect of these sexual changes on treatment tolerability.[14] In some cases, sexual dysfunction remits spontaneously over time.[15] As it may take several months for the sexual dysfunction to improve with watchful waiting, this may not be practical for many patients, and medication non-adherence is a potential concern.[16] Various approaches for managing SSRI-induced sexual dysfunction that have been tested in depressed patients can also be applied for people with OCD,[8] but it must be recognised that the supportive evidence is extremely limited. In Box 1, we present some of the commonly used strategies.

Reducing the dosage of antidepressant has been shown to improve sexual dysfunction in 75% of cases, with total recovery of function being almost guaranteed after a few days or weeks of complete withdrawal from the medication.[17] However, as previously discussed, it is important to be aware that reducing dosages of SSRIs may result in deterioration of OCD[7] and that full drug discontinuation

is frequently associated with symptomatic relapse,[18] which can in turn be harmful for QoL.[19] Moreover, the onset of relapse may be delayed for several weeks or months, by which time patients may have been discharged from clinical care, introducing additional risks. Therefore, this strategy should be approached with caution – patients should be advised to be vigilant for early signs of worsening of OCD symptoms and opportunities should be provided for timely access to clinical care, *eg* from a GP or psychiatrist, should relapse occur.

Briefly stopping or reducing the dosage of a short half-life antidepressant (*eg* 'drug holiday' for 1–3 days per week) is another commonly used approach. It was found to be reasonably safe and beneficial in one small study of 30 patients with paroxetine- or sertraline-related (but not fluoxetine-related, possibly owing to the extended half-life of this agent) sexual dysfunction.[20] However, this approach may be associated with withdrawal reactions and worsening or relapse of OCD, and may also encourage non-adherence.[18]

Switching SSRI may also be helpful, based largely on anecdotal evidence. However, there have been no randomised trials assessing the effects of switching SSRI on adverse sexual effects.[21] Alternatively, various psychopharmacological augmentation strategies may be helpful, based on limited data. One small open label study of patients receiving SSRIs for OCD found adjunctive treatment with cyproheptadine, primarily an antihistamine with additional anticholinergic, antiserotonergic and local anaesthetic properties, in doses of 4mg to 12mg before sexual intercourse, to be effective in improving sexual function.[22] Another small open label study of depressed patients with SSRI-induced sexual side-effects found that roughly half experienced resolution of sexual symptoms following adjunctive treatment with the antidepressant mirtazapine.[23] A randomised controlled trial of adjunctive bupropion in depressed patients taking an SSRI found the active drug improved libido and frequency of engaging in sexual activity compared with adjunctive placebo.[24] However, bupropion should probably not be routinely used in OCD because the drug has been shown to exacerbate OCD symptoms.[25]

Box 1. Strategies for managing SSRI-induced sexual dysfunction

1. Wait for spontaneous remission
2. Dose reduction
3. Drug holidays
4. Switch to a different SSRI
5. Psychopharmacological augmentation strategies
6. Phosphodiesterase (PDE) inhibitors
7. Psychosocial approaches such as CBT

Various clinical trials have reported a beneficial effect of phosphodiesterase inhibitors on SSRI-induced sexual dysfunction. Tadalafil in doses of 20mg taken on demand was found to be efficacious in a sample of depressed patients with SSRI-induced sexual dysfunction, producing an improvement in erectile function, orgasm and sexual satisfaction.[26] Sildenafil of 25–100mg was also reported to be efficacious in a sample of males with major depressive disorder in remission who experienced SSRI-induced sexual dysfunction, resulting in improved sexual function and satisfaction.[27] However, to our best knowledge, there are no published studies of these agents used in patients receiving treatment for OCD.

Finally, psychosocial approaches such as CBT may be effective in improving antidepressant-induced sexual dysfunction, based on a limited number of investigations, principally in female patients.[28]

Treatment-resistant OCD

When a patient fails to achieve adequate symptom relief on sequential trials of SSRI or clomipramine, or CBT, or drug-CBT combination, there are only a few evidence-based therapeutic options available. Augmentation of SSRIs with first- or second-generation antipsychotics (dopamine antagonists) is one effective approach that is commonly used.[29] However, these drugs can have significant side-effects, including weight gain and increased risk of diabetes. If there is no improvement in symptoms after 6–10 weeks of adjunctive treatment, the antipsychotic is usually stopped.[30]

Neurosurgical procedures targeting brain areas known to be implicated in the aetiology of OCD, such as anterior cingulotomy, capsulotomy and limbic leucotomy, are still practised rarely and are reserved for only the most severe, treatment-refractory cases. Deep brain stimulation, involving surgical implantation of electrodes and introduction of targeted electrical stimulation to specific brain regions, is another partially reversible surgical option for extremely severe, refractory OCD.[31] Contemporary non-surgical and non-invasive neuromodulation techniques, such as repetitive transcranial magnetic stimulation or transcranial direct current stimulation, have recently been investigated in the treatment of OCD. These newer techniques tend to be well tolerated, are not known to significantly adversely affect sexual function and show promise as clinical treatments, but the evidence of their efficacy in OCD is still limited and they remain experimental.[32]

Conclusions

Sexual dysfunction commonly presents as a concomitant of the OCD itself, or as an adverse effect of pharmacotherapy and can be challenging to manage, contributing to a range of serious negative outcomes including treatment non-adherence, relationship problems and impaired QoL. Clinicians should pay attention to sexual issues in patients presenting with OCD and take steps to support their management.

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Declaration of interests

Drs Conti, Pellegrini, Riaz, Mpavaenda and Sim have nothing to disclose related to the present work. Professor Fineberg declares that she has been a member of the WHO advisory group on obsessive compulsive disorders. In the past three years she has held research or networking grants from the UK NIHR, EU H2020, Orchard; she has accepted travel and/or hospitality expenses from the BAP, ECNP, RCPsych, CINP, International Forum of Mood and Anxiety Disorders, World Psychiatric Association; she has received payment

from Elsevier for editorial duties; she has accepted a paid speaking engagement in a webinar sponsored by the Global Mental Health Academy. Previously, she has accepted paid speaking engagements in various industry-supported symposia and has recruited patients for various industry-sponsored studies in the field of OCD treatment. She leads an NHS treatment service for OCD. She holds Board membership for various registered charities linked to OCD. She gives expert advice on psychopharmacology to the UK MHRA and NICE.

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