

School of Public Health

**Coping with Sexual Difficulties: The Lived Experience of Women Taking
Selective Serotonin Reuptake Inhibitor (SSRI) Medication**

Catherine O'Mullan

**This thesis is presented for the Degree of
Doctor of Public Health
of
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DECLARATION

To the best of my knowledge and belief this thesis contains no material previously published by any other person except where due acknowledgment has been made.

This thesis contains no material which has been accepted for the award of any other degree or diploma in any university.

Human Ethics The research presented and reported in this thesis was conducted in accordance with the National Health and Medical Research Council National Statement on Ethical Conduct in Human Research (2007) – updated March 2014. The proposed research study received human research ethics approval from the Curtin University Human Research Ethics Committee (EC00262), Approval Number HR 94/2012

Author:

Catherine Mary O'Mullan

Signature: 

Date: 13th May 2015

ABSTRACT

A growing body of evidence has highlighted the sexual side effects of selective serotonin reuptake inhibitor (SSRI) medication. Whilst most of the research has focused on the prevalence and treatment of sexual difficulties relating to SSRI medication, little is known about how individuals cope with the sexual side effects. This thesis explores ten women's experiences of coping with the sexual side effects of SSRI medication. Using Interpretative Phenomenological Analysis as the research approach, four broad themes emerged from the data including i) searching; ii) suffering in silence; iii) trying to resolve; and iv) accepting what is. The themes provide an insight into the different strategies used by women to cope with the sexual side effects and highlight the importance of contextualising these difficulties as part of an overall approach to improve treatment and management. The findings emphasise the need to recognise and address psychological, social and cultural factors, which may have an influence on how women cope with sexual side effects, and underline the need for a multidisciplinary approach that moves beyond biomedical interventions.

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DEDICATION

I would like to dedicate this doctoral thesis to my father, Hugh O'Mullan.

Thank you for encouraging my lifelong love of learning – you are the best teacher and father anyone could ever have. Your patience, wisdom and belief that 'I could do anything' have given me the confidence to undertake this amazing journey. Although my work has never really struck a chord with you, you have still provided me with unwavering support. It is with pride and affection that I dedicate this thesis to you.

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ABBREVIATIONS

ALSWH:	Australian Longitudinal Study on Women's Health
APA:	American Psychiatric Association
DALY:	Disability-adjusted Life Year
DAS:	Dyadic Adjustment Scale
DSM:	Diagnostic and Statistical Manual of Mental Disorders
FSD:	Female Sexual Dysfunction
GP:	General Practitioner
HSRC:	Human Sexual Response Cycle
ICD:	International Classification of Disease and Related Health Concerns
IPA:	Interpretative Phenomenological Analysis
MAOI:	Monoamine Oxidase Inhibitors
MBS:	Medicare Benefits Schedule
NVWG:	New View Working Group
OECD:	Organisations for Economic Co-operation and Development
PBS:	Pharmaceutical Benefits Scheme
SRI:	Serotonin Reuptake inhibitor
SSRI:	Selective Serotonin Reuptake Inhibitor
TCA:	Tricyclic Antidepressants
WHO:	World Health Organisation

GLOSSARY OF TERMS

Mental Health Problem: In this study, the term 'mental health problem' describes a wide spectrum of mental health and behavioural disorders that can vary in severity and duration. Mental health problems are characterised by some combination of abnormal thoughts, emotions, behaviour and relationships with others. Examples include depression, mood disorders and anxiety disorders.

Phenomenology: A qualitative research approach concerned with understanding the lived experience of individuals or groups of people.

Reflexivity: A process that challenges the researcher to explicitly examine how his or her research agenda and assumptions, personal beliefs, and emotions enter into their research.

Selective Serotonin Reuptake Inhibitors (SSRIs): SSRIs are a type of antidepressant used to treat depression and other anxiety disorders including panic disorder, obsessive-compulsive disorder and post-traumatic stress disorder. SSRIs available in Australia include citalopram (Cipramil), escitalopram (Lexapro), fluoxetine (Prozac), fluvoxamine (Luvox), paroxetine (Aropax) and sertraline (Zoloft).

Side Effect: A side effect is an effect, whether therapeutic or adverse, that is secondary to the one intended. In this study, the term predominantly describes the adverse effects of SSRI medication.

CHAPTER 1:

Introduction and Background

1.1 Introduction

Female sexual difficulties are commonly associated with antidepressant therapy and are most frequently reported by women using selective serotonin reuptake inhibitors (SSRIs). Sexual difficulties often present as loss of desire, arousal difficulties or anorgasmia and are a common cause of non-adherence to medication. As pleasurable sexual activity is an important component of intimate relationships, sexual side effects may also adversely affect social and emotional wellbeing. To date, there is a paucity of research on women's self-reported experiences of sexual difficulties, in particular the impact such difficulties have on their sexual selves and everyday life. To address this gap, this study used Interpretative Phenomenological Analysis (IPA) as the research approach to explore the lived experience of coping with sexual difficulties amongst women who had been taking SSRI medication for at least three months. This chapter provides a background to the study and outlines the researcher's position and interest in the topic. The aim, research question and objectives of the research are stated, followed by a discussion of the significance and limitations. The chapter concludes by providing an overview of the thesis organisation.

1.2 Background

From a public health perspective, mental health problems have been identified as leading contributors to the non-fatal burden of disease in Australia. According to O'Brien (2012), these problems have moved from the third to the first largest cause of disease burden in disability-adjusted life years (DALY) over the past decade. Whilst it is frequently asserted that mental health problems are increasing globally in advanced Western countries, critics have argued there is insufficient evidence to report an increase, citing difficulties with accurate measurement and the expanding boundaries of psychiatric disorder (Busfield, 2012; Richter & Berger, 2013).

Such claims could be correct; however, what cannot be disputed are the increasing levels of antidepressant use. In the last decade, Australia has seen a 58.2% increase in psychotropic prescribing, with antidepressants being the most commonly prescribed psychotropic drug (Stephenson, Karanges & McGregor, 2013). Indeed, a recent study revealed that Australia had the second highest rate of antidepressant use of the 34 Organisations for Economic Co-operation and Development (OECD) nations (Karanges, Stephenson & Mc Gregor, 2014). Furthermore, research conducted by the Australian Longitudinal Study on Women's Health (ALSWH) 2008 noted antidepressant medications account for 10% of the Pharmaceutical Benefits Scheme (PBS) budget each year, and that women aged 30–39 were the most common users of antidepressant medication in Australia (Hollingworth, Burgess, & Whiteford, 2010).

Mental health problems have increasingly been identified as a gendered problem in Australia and other Western countries, with a number of studies reporting higher prevalence rates in women (Hollingworth et al., 2010; Paige, Korda, Kemp, Rodgers & Banks, 2015; Zhang et al., 2010). Driven by what O'Brien (2012, p. 573) refers to as 'recovery oriented service provision', women with such problems in Australia and other liberal democracies are encouraged to be actively involved in their own care and recovery, and ensure choices do not inappropriately burden the health system. Indeed, the 2008 Australian National Mental Health Policy reiterated the focus and importance of recovery, and highlighted the value of tracking progress to achieve required outcomes, including a return to productivity (Commonwealth of Australia, 2009). Fullagar (2009) argued that current mental health policy in Australia is underpinned by a governmental imperative focusing on a biomedical approach to treatment aimed at alleviating symptoms and seeking to restore chemical imbalances in the brain. Such approaches, she pointed out, 'normalise' antidepressant use whilst maximising individual functioning and social productivity (Fullagar, 2009, p. 390). Furthermore, feminist researchers highlight how the expansion of biopower through pharmaceutical markets and recovery oriented mental health policy has led to increasing

rates of diagnosis and prescription of antidepressant medication for women (Godderis, 2010; Ussher, 2011).

Despite contextual factors such as gendered inequity, motherhood and other psychosocial issues being identified as contributors to higher levels of mental health problems in women, a biomedical, individual focused approach to recovery continues to dominate (Fullagar & O'Brien, 2013). Although the effectiveness of antidepressant use for depression remains controversial (Fournier, DeRubeis, Hollon, Dimidjian, Amsterdam, Shelton & Fawcett, 2010; Parker, 2009), antidepressants remain pivotal in treatment, despite concerns about the efficacy and/or tolerability of such drugs (Stephenson et al., 2013). Whilst there has been increased interest in, and investment into non-pharmacological approaches, for example, the introduction of the Medicare Benefits Schedule (MBS) to improve access to psychologists and counsellors, antidepressant use in Australia continues to rise (Stephenson et al., 2013).

Selective serotonin reuptake inhibitors (SSRIs) are the most commonly prescribed antidepressant in Australia and are routinely referred to as the newer antidepressants (Stephenson et al., 2013). SSRIs differ from older antidepressants such as monoamine oxidase inhibitors (MAOIs) and tricyclic antidepressants (TCAs) in their chemical structure and method of action; moreover, the side effects of this newer medication are more easily tolerated making these a first-line treatment for anxiety and depression disorders (Moret, Isaac & Briley, 2009). Whilst SSRIs have better tolerability, they are not devoid of side effects. Of note, sexual side effects have been frequently reported, with prevalence rates exceeding 50% being cited in a number of studies (Serretti & Chiesa, 2009; Williams, Baldwin, Hogue, Fehnel, Hollis & Edin, 2006; Williams, Edin, Hogue, Fehnel & Baldwin, 2010). Although it remains difficult to obtain accurate prevalence statistics given sexual difficulties may occur for a number of reasons, it is becoming evident that sexual side effects are more common than initially perceived.

Concerns about the impact of sexual side effects have prompted an emerging body of research; indeed, numerous studies have focused

specifically on treating and managing such difficulties in women in an attempt to improve quality of life and increase adherence to medication (Fooladi, Bell & Davis, 2012; Safarinejad, 2011). Strategies proposed to treat and manage these side effects include drug holidays, natural supplements, augmenting antidepressant treatment with other medications including bupropion and sildenafil, and switching antidepressants (Fooladi et al., 2012; Rizvi & Kennedy, 2013). According to a recent Cochrane review, augmenting antidepressant treatment with bupropion at high levels offered the most promising strategy for treating women; however, the authors called for more evidence to guide the specific treatment and management of sexual difficulties (Taylor, Rudkin, Bullemor-Day, Lubin, Chukwujekwu & Hawton, 2013).

A number of scholars have critiqued the biomedical approach to sexuality research (Farrell & Cacchioni, 2012; Moynihan, 2003; Tiefer, 2012); however, this approach has dominated much of the research into SSRI related sexual difficulties (Clayton, Croft & Handiwala, 2014; Taylor et al., 2013). One major criticism of this approach is that it fails to consider the social and cultural construction of sexual experience. To date, there is a dearth of research on women's self-reported experiences of female sexual difficulties, in particular the impact such difficulties have on their sexual selves and everyday life. As such, a growing body of feminist qualitative research within sexual health has begun to 'raise up women's diverse voices' (Tiefer, 1995, p. 201) and to focus on the lived experiences of women, recognising that such approaches capture experiences which could not be encapsulated within a biomedical model (Marriott & Thompson, 2008; Sutherland, 2012; Svedhem, Eckert & Wijma, 2013).

Without question, there is a need for further research to explore women's experiences of coping with the sexual side effects of SSRI medication and to provide insight into strategies that may be helpful to women. Whilst the findings from this study are important for women, the findings also hold particular relevance for clinicians, therapists and other health professionals who have contact with women experiencing the sexual side effects of SSRIs.

Additionally, the findings illuminate new directions for future research within this field.

1.3 Researcher's position

My interest in this field stems from my experiences of coping with the sexual side effects of SSRI medication and from my professional role as a sexuality educator. This study arose out of a growing realisation that little, if any, attention had been paid to the topic of how women cope with the sexual side effects of SSRI medication. My theoretical orientation stems from my experience of working in the sexuality field for more than ten years. As such, my understanding of sexual difficulties has been informed by the biopsychosocial approach to health and illness. This approach recognises that biological, psychological and social influences impact on how individuals cope with health related problems.

1.4 Research aim, question and objectives

The aim of this research was to improve understanding of the coping experiences of women who were experiencing SSRI-related sexual difficulties that were causing problems or distress to them and/or their partners.

This research aimed to address the following question:

“What are the lived experiences of coping with sexual difficulties amongst heterosexual women who take SSRI medication?”

The specific objectives of the study were to:

- Explore the lived experience of coping with sexual difficulties amongst heterosexual women who had been taking SSRI medication for at least three months.
- Characterise the types of strategies used to cope with the sexual difficulties arising from SSRI use in order to assist women who are experiencing such difficulties.

- Provide recommendations to inform the professional practice of clinicians, therapists and other relevant health professionals.

1.5 Ethics process

Approval for this study was gained from Curtin University Human Research Ethics Committee, approval code HR 94/2012 (Appendix A). Given the sensitive nature of the research topic, a number of processes were put into place with due regard for the women's welfare, confidentiality and anonymity. These processes included the provision of an information sheet which outlined what to expect from the study (Appendix C); a list of topics to be included in the interview schedule (Appendix E) and a copy of the informed consent form (Appendix D). The issue of consent was revisited at the start of each interview and women were encouraged to ask questions about the process. Confidentiality was assured throughout the study (as noted in the participant information sheet) and pseudonyms were used to de-identify each woman. Furthermore, extra time was allocated at the end of each interview to provide an opportunity to debrief with the researcher. Additionally, as the research involved sensitive issues, each woman was provided with a list of local support services, and a list of appropriate telephone helplines.

1.6 Significance of the study

The study was significant for a number of reasons. Firstly, it aimed to increase understanding of this complex, under-researched phenomenon and complement the existing body of quantitative research around sexual difficulties associated with SSRI use. This research sought to further the traditional biomedical discourse, by obtaining women's subjective accounts of their sexual difficulties, thereby creating new knowledge and understanding of how women cope with the sexual side effects of SSRIs. Secondly, by exploring the lived experience of women coping with sexual difficulties, the study aimed to increase understanding of the complex interaction among the various psychological, cultural and social factors that potentially influence coping strategies. Finally, for this study, women were purposefully recruited from the general population in an attempt to capture the phenomenon of

coping irrespective of whether women sought help for their problems. As previous qualitative studies have predominantly recruited women from clinical populations, the voices of women who have not sought help for sexual difficulties are notably absent from the research literature.

1.7 Limitations of the study

There are a number of limitations to this study, including the homogeneity and self-selected nature of the sample. The women in the study were purposefully homogenous to enable the exploration of the phenomenon of coping with SSRI-related sexual difficulties across a particular target group (heterosexual, in a relationship, under 45 years old); however, this resulted in an over representation of highly educated women. It is also probable the women who chose to participate in the study had reached a stage of adjustment, as they were willing to talk openly about their coping experiences; women who were struggling to cope may not be represented here. It is recognised that this study does not represent the experiences of all women who experience SSRI-related sexual difficulties; however, the purpose was not to generalise, but to provide a detailed exploration of experiences from an individual perspective.

As the aim of the study was to explore the lived experience of coping with sexual side effects rather than 'prove' sexual difficulties were attributable to SSRIs, a further limitation relates to accepting women's self-reports of sexual difficulties without supporting medical evidence. In this study, a medical diagnosis was not sought; each woman brought her own understanding and identification of what sexual difficulties meant to her. *How* women interpreted their sexual difficulties was more important than investigating whether SSRIs were the cause of their difficulties as women viewed their lived experiences through this particular lens.

1.8 Thesis organisation

This is a thesis by publication (series of published papers). It is organised into seven chapters as follows:

Chapter 1 provides an introduction and background to the study. This chapter includes the rationale for the study, the research question and objectives. Ethical considerations, the significance of the study and the limitations were also outlined in this chapter.

Chapter 2 presents an overview of the literature in two discrete sections. The first section defines the term sexual difficulty, discusses current classification schemes and provides an overview of how sexual difficulties impact on women. The second section provides an overview of SSRIs, including a history of the medication, its uses, and the side effects associated with this medication. Sexual side effects are explored in depth, followed by an overview of treatment and management approaches.

Chapter 3 outlines the methodological approach and methods used for this study. This chapter presents the research question, aims and objectives of the study, and provides insight into the research design, methodology and methods of data collection and analysis. The chapter concludes by discussing matters relating to reliability and validity, and addresses the issue of reflexivity.

Chapters 4–6 are post-print copies of the text from each published paper. Publisher copyright information and permissions are provided in Appendices F and G. The following is an outline of the list of published papers associated with this thesis:

O'Mullan, C, Doherty, M, Coates, R & Tilley, PJM. (2014). Women's experiences of coping with the sexual side effects of antidepressant medication. *Psychology and Health*, 29 (12), 1388–1406.
<http://dx.doi.org/10.1080/08870446.2014.940951>

This paper presents the overall findings from the study and reports on the four broad themes emerging from the study.

O'Mullan, C, Doherty, M, Coates, R & Tilley, PJM. (2014). Searching for answers and validation: Australian women's experiences of coping

with the adverse sexual effects of antidepressants. *Australian Journal of Primary Health*, <http://dx.doi.org/10.1071/PY13172>

This paper presents the findings from one specific theme 'Searching'. The paper discusses and contextualises the findings for general practitioners (GPs).

O'Mullan, C, Doherty, M, Coates, R & Tilley, PJM (2015). Accepting what is: an approach for managing the long-term sexual side effects of selective serotonin reuptake inhibitors (SSRIs) in women. *Sexual and Relationship Therapy*, <http://dx.doi.org/10.1080/14681994.2015.1032236>

This paper presents the findings from one specific theme 'Accepting what is'. The paper discusses and contextualises the findings for sex and relationship therapists and offers suggestions for working with women on long-term medication.

Chapter 7, the final chapter of this thesis, brings together the three papers by summarising the findings. This chapter also provides recommendations for practice and further research.

CHAPTER 2:

Women, Sexual Difficulties and Selective Serotonin Reuptake Inhibitors (SSRIs): A Review of the Literature

2.1 Introduction

This chapter provides a review of the literature to document the extent of existing information relating to heterosexual women, SSRIs and sexual difficulties. The first section provides an overview of sexual difficulties in women; it explores the literature pertaining to definitions and classifications, and discusses the prevalence and impact of sexual difficulties. This section also explores the research relating to how women cope with such difficulties. Currently, female sexual difficulties relating to desire, arousal, orgasm and pain are grouped under the term 'sexual dysfunction' in the most recent Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM V) (American Psychiatric Association, 2013) and the tenth version of International Classification of Diseases and Related Health Problems (ICD-10) (World Health Organisation, 1993). As 'sexual dysfunction' is a contested term that aligns with a medicalised view of sexual difficulties, in this study, the term 'sexual difficulty' will be used where appropriate, rather than 'sexual dysfunction'.

The second section of this chapter reviews the literature relating to SSRIs. A history and overview of SSRI use is discussed, followed by a brief review of the general side effects associated with this medication. Finally, the specific sexual side effects are explored in detail with a particular focus on treating and managing the sexual side effects in women.

2.2 Female sexual difficulties – An overview

2.2.1 Definition and classification

The biomedical model

The current medical classification of 'sexual dysfunction' was developed by the American Psychiatric Association (APA) for the Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1980, and revised with minor changes in 1987, 1994 and 2000 (APA, 1980,1987,1994, 2000). The most recent DSM (DSM V) was published in 2013 (APA, 2013). The DSM is one of two major classification systems used to define female sexual dysfunction (FSD), and until its most recent iteration, relied heavily on the Human Sexual Response Cycle (HSRC) model developed by Masters and Johnson (1966); as such, it aligns closely with medical model thinking. Likewise, the ICD-10 classification system developed by the World Health Organisation (1993) is modelled closely on the HSRC; however, the definition of sexual dysfunction includes organic causes and is therefore not specifically limited to psychiatric disorders. According to the HSRC model, the female sexual response cycle consists of four successive phases – excitement, plateau, orgasm and resolution. This hypothesis was subsequently modified by Kaplan (1977) and Lief (1977) who proposed what is now referred to as 'sexual desire' as an integral first phase of the sexual response. The resulting triphasic model conceptualised three relatively independent phases consisting of sexual desire, excitement and orgasm (Kaplan, 1979). However, recent evidence shows that many facets of women's sexual function are at variance with these two models; indeed, critics have argued against these linear and genitally focused models of sexual function, on the basis that they mirror the male sexual response (Basson, 2001; Tiefer, 2010).

It is not surprising that over the past two decades, these models have come under increased scrutiny. In response to concerns regarding the limitations of existing linear models, a number of alternative models have been put forward (Fisher, Aron, Mashek & Brown, 2002; Janssen, Everaerd, Spiering & Janssen, 2000; Perelman, 2009). According to Hayes (2011, p.130), whilst these models have endeavoured to unify factors that promote or inhibit

sexual response, they do not accurately 'define the stages of sexual response itself'. In 2001, however, Rosemary Basson proposed a circular model that redefined the phases of the female sexual response and their relationship to each other (2001). In contrast to the linear models, she argued that motivation for commencing sexual activity was complex and it could commence for a number of reasons other than desire. Indeed, she argued that a significant number of women did not report spontaneous desire; once sexual activities commenced, however, increasing arousal could lead to desire for a continuation of sexual activities. This 'responsive' sexual desire could then feed back to increase levels of arousal, thereby eliciting a circular response. Her model also recognised that phases of the sexual response might overlap in time; desire and arousal, for example, might happen in unison rather than one preceding the other. Whilst alternative models of the female sexual response have been proposed, both Hayes (2011) and Meana (2010) have highlighted the lack of consensus as to which approach best describes women's sexual responses. The most likely conclusion to date is that there is a diversity of responses.

It is now recognised that there have been substantial advances in knowledge and understanding of women's sexual responses since the penultimate ICD revision (WHO, 1993) and indeed, since previous editions of the DSM (APA, 1980, 1987, 1994, 2000). Whilst the sexual disorders and sexual health categories are currently being revised for the ICD-11 (WHO, 2015), the recent DSM V (APA, 2013) draws upon updated knowledge and supports more recent models of sexual response. This new edition recognises that women's sexual responses may not be analogous to men's, and therefore moves away from the former, linear model of diagnostic categories (APA, 2013). As such, the resulting diagnostic categories have been simplified and there are now three female sexual dysfunctions (sexual interest/arousal disorder, female orgasmic disorder, and genito-pelvic pain/penetration disorder) as opposed to the five listed previously. In order to make a diagnosis, it is important to note that the disorder must be deemed to have caused considerable distress. Although the DSM V is viewed as advancement in terms of establishing specific diagnostic criteria for the

different genders (Sungur & Gunduz, 2013), debate continues whether there is enough evidence to combine female hypoactive desire dysfunction and female arousal dysfunction into a single syndrome called sexual interest /arousal disorder. Clayton, DeRogatis, Rosen and Pyke (2012) and Sarin, Amsel and Binik (2013) have argued that the new criteria are counterproductive and exclude a large number of women with low desire and arousal.

Despite recent changes to the DSM V, the classification of women's sexual difficulties continues to be widely critiqued for privileging the biomedical and ignoring the interpersonal and contextual factors influencing sexuality and its difficulties (Farrell & Cacchioni, 2012; McHugh, 2006; Tiefer, 2012).

Notwithstanding the increased interest in female sexual difficulties and advances in sexual medicine, Hall and Graham (2012) have argued that the continued focus on the biological basis of such difficulties has little to offer women who have sexual difficulties. Furthermore, feminist scholars and social scientists have argued that female sexual difficulties remain entrenched in a male dominated, medically based and commercially centred view; thereby, discounting how the context of women's lives impact on their sexual self (Moynihan, 2003; Nicolson & Burr, 2003; Tiefer, 2012). In order to contest the biomedical model used in classification systems, a group of feminist scholars, therapists and researchers collaborated under the leadership of Leonore Tiefer to form a working group referred to here as the New View Working Group (NVWG). This group draws on human rights documents from the World Health Organisation and the World Association for Sexual Health to conduct research and produce commentary that critiques current classifications and advocates for women-centred definitions of sexual difficulties (Tiefer, Hall & Tavriss, 2002; Wood, Koch & Mansfield, 2006).

Moving beyond a biomedical model – A New View

Since its inception in 2000, the NVWG have published a number of research articles and have proposed the development of a new classification system for sexual concerns based on women's real life experiences (Tiefer et al., 2002, Wood et al., 2006). Of note, the NVWG suggested replacing the term

'sexual dysfunction' with 'sexual problem' and defined 'problem' as experiencing discontent or dissatisfaction with any aspect (emotional, physical or interpersonal) of sexual experience (Kashak & Tiefer, 2001, p.5). According to Tiefer (2001), this definition avoided categorising any one pattern of sexual experience as normal and acknowledged the findings that women are often more concerned about intimacy or relationship problems as opposed to lack of physical sensation. As such, the New View classification framework is women-centred and subjective in order to avoid the universalisation and biological reductionism of the classification systems such as the DSM (Tiefer, 2002; Tiefer et al., 2002). It moves away from the DSM's genital and mechanical blueprint of female sexual difficulties, and aims to closely resemble women's own concerns through the adoption of a biopsychosocial approach that locates women's sexual difficulties within a sociocultural and relational context (Tiefer et al., 2002).

The New View classification identifies four categories that are interrelated in women's lived experiences, namely: i) sociocultural, political or economic factors; ii) partner and relationship factors; iii) psychological factors, and finally iv) medical factors (Tiefer et al., 2002). Although designed for researchers, clinicians and sexuality educators to provide insight into factors that may affect women's sexuality, Nicolson and Burr (2003) pointed out that that the New View classification may be of interest to women themselves. Despite the publication of a number of commentaries detailing the usefulness of this framework for researchers and clinicians (Kaschak & Tiefer, 2001), the publications have been limited to single case studies and clinical impressions. Whilst the New View classification scheme has been tested in one study (Nicholls, 2008) and shows potential as a new framework for classifying female sexual difficulties, it is important to note that the sample was self-selected, focused only on women aged 18–35 years, and did not adequately represent women from different cultures and sexual minority groups. Further research is required for the New View classification to be considered as a viable framework; however, it does offer a starting point for researchers, clinicians and educators, and it also encourages women to define their own sexual difficulties.

2.2.2 Prevalence, impact and coping

Prevalence

Despite increasing scientific interest in 'Female Sexual Dysfunction' (FSD), the true prevalence remains a contentious issue and is difficult to estimate. The most often quoted study relating to prevalence has been by Laumann, Paik and Rosen (1999) who sampled 1749 women and reported that 43% experienced sexual dysfunction. Whilst a number of worldwide population based studies have reported a wide range of prevalence estimates (Bancroft, Lotus & Long, 2003; Christensen, Gronbaek, Osler, Pedersen, Graugaard & Frisch, 2011; Nazareth, Boynton & King, 2003), such studies are not without limitations and need to be interpreted with caution. Previous studies have been critiqued for producing widely inflated estimates by i) failing to use stringent definitions of FSD; ii) using different measures and timeframes for symptoms; iii) not including 'sexual distress' as a criterion (Graham, 2010; Hayes, Dennerstein, Bennett & Fairley, 2008; Mc Cabe & Goldhammer, 2013). What is indicated from the literature is that attempts to research the prevalence of sexual difficulties in women are highly problematic.

In a comprehensive review, Hayes, Bennett, Fairley and Dennerstein (2006) used data from previous prevalence studies to assess female sexual difficulty/dysfunction. Amongst women with any sexual difficulty, prevalence rates for sexual desire disorder ranged from 16% to 75% (mean 64%), 16% to 48% (mean 35%) for orgasm disorder, 12% to 64% (mean 31%) for arousal disorder, and from 7% to 58% for sexual pain (mean 26%). Whilst their review highlighted wide variance between prevalence estimates, one of the more noteworthy findings to emerge was that the prevalence of sexual difficulties decreased when sexual distress was included as a criterion. This is consistent with findings from more recent studies where a sexual distress component of FSD was included in the outcome measure (Hayes et al., 2008; Giraldi & Kristensen, 2010; Shifren, Monz, Russo, Segreti & Johannes, 2008).

According to current definitions, sexual difficulties must have a significant negative impact on the woman's psychological status and everyday life

(defined as sexual distress) in order to be characterized as FSD (APA, 2013). The distress criterion was first added to the DSM IV in 1994 with the statement, 'the disturbance causes marked distress or interpersonal difficulties' (APA, 1994, p.513). These criteria stipulated that if the sexual difficulty did not sufficiently concern the individual or directly contribute to relationship problems, it was not diagnosable as a sexual dysfunction (APA, 1994, p.513). Since its inclusion in the DSM, the distress criterion has remained controversial and has been increasingly disputed (Hendrickx, Gijs & Enzlin, 2013). Clinicians and scholars such as Meana (2010) believe it is important to maintain the criterion so that women who are satisfied with their level of sexual function are not pathologised. Others have argued against the inclusion of distress as it is not based on empirical evidence and may compromise scientific rigour (Althof, 2000; Waldinger & Schweitzer, 2006).

Despite the ongoing debate relating to inclusion or exclusion of the distress criterion, in the most recent ICD-11 revisions, and in the DSM V, personal distress remains a key factor in defining FSD (APA, 2013; WHO, 2015). Although further academic debates will undoubtedly advance the discourse relating to distress and FSD, on a practical level, the inclusion of distress remains an important way to distinguish between a sexual difficulty and a normal variation.

Impact of sexual difficulties

Since sexuality is implicit in psychological wellbeing, quality of life and interpersonal satisfaction (Bancroft, 2009), it is not surprising that sexual difficulties have the potential to impact on the psychological and personal wellbeing of women and their partners. A number of studies have linked psychological distress, low self-esteem, and relationship conflict to sexual difficulties among women (Bancroft et al., 2003; Bond, Weerakoon & Shuttleworth, 2012; Burri, Rahman & Spector, 2011; Svedhem, Eckert & Wijma, 2013); however, much of the research has been conducted within a positivist framework using empirical investigations to measure and examine psychological distress. Whilst such studies are important, the nuanced experiences of women are not adequately captured, thereby limiting the

ability to explore and understand sexual difficulties from an individual perspective. However, over the past decade, a small number of researchers have used qualitative approaches to explore the impact of biopsychosocial factors on women's sexual experiences (Lavie-Ajayi & Willig, 2005; Marriott & Thompson, 2008; Svedhem et al., 2013).

Whilst the psychological impact of female sexual difficulties has been captured in a number of ways, symptoms such as anxiety and depression are commonly used as measures (Brauer, ter Kuile & Laan, 2009; Gates & Galask, 2001). According to the literature, the findings are contradictory; whilst some studies report that women with sexual difficulties experience high levels of psychological distress including depression, anxiety and hostility (Brauer et al., 2009; Gates & Galask, 2001; Wylie, Hallam-Jones, & Harrington, 2004), other studies found no association (Payne, Binik, Pukall, Thaler, Amsel & Khalife, 2007; Reissing, Binik, Khalif, Cohen & Amsel, 2003). Bond et al. (2012) pointed out that this lack of agreement may be attributed to lack of conformity in sampling or methodology, or as a result of women experiencing distress without any psychological symptoms. They also noted that while psychological distress may result from sexual difficulties, it was likely that some women have psychological distress prior to the onset of these difficulties.

Findings from a qualitative study undertaken by Mitchell, King, Nazareth and Wellings (2011), provide further insight into why some women feel distressed by their sexual difficulties whilst others do not. According to their study, three factors, namely, the severity of the problem, the perceived causes of the problem, and the partnership context, are influential in determining successful adjustment and diminishing distress. Whilst these findings are not able to be generalised given the sample was purposively heterogeneous, earlier research also supported the contention that the partnership context is particularly important with respect to how women adjust to their sexual difficulties (Bancroft, et al., 2003; Hayes et al., 2008). These findings have highlighted the importance of acknowledging and addressing interpersonal as well as individual distress.

A number of studies have explored the interpersonal impact of sexual difficulties in women. In quantitative research, the Dyadic Adjustment Scale (DAS) is considered to be the gold standard in measuring relational distress (Spanier & Cole, 1976); this validated instrument evaluates a number of measures including satisfaction with the expression of sex and affection in a relationship, shared interests, values and the level of interpersonal tension. Interestingly, studies measuring relationship distress, within the context of female sexual difficulties, have shown how interpersonal factors such as levels of communication and intimacy play an important role in helping women to adjust to sexual difficulties (Pazmany, Bergeron, Oudenhove, Verhaeghe & Enzlin, 2013; Smith & Pukall, 2014; Stephenson & Meston, 2010). Moreover, in a study examining predictors of distress in a sample of 987 women, Bancroft et al. (2003) reported that women expressed greater concern about the potential impact of sexual difficulties on intimate relationships rather than the personal distress of the sexual difficulty.

The qualitative research clearly highlights women's concerns relating to the impact of sexual difficulties on intimate relationships (Marriot & Thompson, 2008; Hinchliff, Gott & Wylie, 2012; Svedhem et al., 2013). Though these studies are not generalisable, they do provide a detailed exploration of experiences from an individual woman's perspective. In Marriot and Thompson's (2008) study, which focused on the sexual and relationship consequences of eight women living with vulval pain, women felt distressed over their inability to participate in sex and consequently experienced shameful feelings about the pain. Furthermore, women felt the quality of their sex life had an overall impact on the quality of the relationship. In a recent study, Svedhem et al. (2013) explored eight women's experiences of living with vaginismus. The central theme of 'sense of failure' revealed how women's experiences were influenced by the prevailing discourse about sex. Similarly, Hinchliff et al.'s (2012) study of women's attempts to renegotiate sexual difficulties also highlighted the impact of living up to heterosexual constructed sexual norms; many women reported feeling frustrated and inadequate as a sexual partner.

Although the impact of sexual difficulties is well documented, women are generally reluctant to seek help for sexual difficulties (Shifren, Johannes, Monz, Russo, Bennet & Rosen, 2009; MacDowall et al., 2010). As such, it is necessary to explore how women, when faced with such difficulties, essentially cope with the situation.

Coping with sexual difficulties

Definitions as to what constitutes 'coping' vary; moreover, coping strategies have been classified in a number of different ways (Brandtstädter & Renner, 1990; Lazarus & Folkman, 1984; Zeidner & Endler, 1996). Typically, researchers view coping in two ways, as a trait or style (person-based approach, dispositional) or as a process (environment-based approach, situational) (Carpenter & Scott, 1992; Lazarus, 1993). The style approach treats coping behaviours and activities as relatively stable in the process of dealing with stress; personality characteristics determine coping activities (Aldwin, 2007; Carpenter, 1992). The process approach, however, emphasises coping as an effort to manage changing stress and contexts (Lazarus, 1993; Lazarus & Folkman, 1984). Indeed, Lazarus and Folkman define coping as 'constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person' (Lazarus and Folkman, 1984, p.141). This definition is particularly suited to exploring coping strategies associated with sexual difficulties given that coping seeks to manage rather than master a stressful situation.

Although a number of conceptual models have been proposed to guide research into ways of coping, the literature reported that strategies employed by women with sexual difficulties appeared to fit into the categories proposed by Lazarus and Folkman (1984), namely problem-focused and emotion-focused strategies; and by Zeidner & Endler (1996), specifically active-cognitive and active-behavioural strategies. According to Lazarus and Folkman (1984), problem-focused coping refers to strategies that individuals use to change their circumstances; this may include information seeking, solution generation, and taking direct action to change a stressful event.

Emotion-focused coping involves an individual's efforts to alter her/his own experience of negative emotion, seek support from others, and avoid stressful situations. Although Zeidner and Endler (1996) use different terminology, there is considerable overlap with the strategies put forward by Lazarus and Folkman (1984). According to Zeidner and Endler, active-cognitive coping strategies are defined as internal processes; these may include, for example, positive reassessment, finding inner strength, and acceptance. Active-behavioural coping strategies are defined as external behaviours and examples include professional help seeking and/or problem-solving.

To date, a small number of studies have investigated how women cope with sexual difficulties, though no studies could be located which investigated specifically how women cope with the sexual side effects of antidepressants. The focus of these studies relates to sexual difficulties arising from cancer, chronic illness or specific sexual health problems such as vulvodynia or sexual pain (Kilic, Unver, Bolu & Demirkaya, 2012; Marriot & Thompson, 2008; Sutherland, 2012; Tang, Lai & Chung, 2010). Such studies highlighted an important link between adaptive coping and better sexual outcomes. Furthermore, many findings underscored the importance of combining individual coping efforts with support at the relationship level. One study that specifically examined Lazarus and Folkman-type coping strategies on sexual outcomes for Chinese women with gynaecological cancer (Tang et al., 2010), found that spousal support had the most salient influence on sexual satisfaction. Findings from other studies also highlight the importance of supportive relationships and open and honest communication between partners as part of adaptive coping efforts to manage sexual difficulties (Mitchell et al., 2011; Rosen, Bergeron, Sadikaj, Glowacka, Delisle & Baxter, 2014, Tang et al., 2010).

Despite consensus that supportive relationships and effective communication between partners play a key role in helping women to cope with sexual difficulties, some women chose avoidant coping strategies, such as suffering in silence and shouldering the burden alone (Esmail, Munro & Gibson, 2007; Hinchliff et al., 2012; Tang et al., 2010). Esmail et al.'s study of women living

with Multiple Sclerosis revealed that women often went to great lengths to buffer their partners from the full impact of their problems; indeed, many women continued to have intercourse in spite of pain or fatigue, at times driven by guilt or fear of abandonment. Hinchliff et al. (2012) reported that women with sexual pain also used strategies to avoid intimate situations, not only to protect their partner but also to protect themselves from the consequences associated with actively rejecting their partner. A tendency to avoid sexual interaction and intimacy was also reported by Sutherland (2012), in a qualitative study exploring women's experiences of sexual pain.

A number of studies report that strategies employed by women involve adjusting one's definition of sexual activity and changing expectations about sex (active-cognitive coping). Reese, Keefe, Somers and Abernethy (2010, p.793) argued that a notion of sexuality which adopts more 'flexible sexual cognitions and behaviours', may help couples to cope with sexual difficulties. A number of studies focusing on sexual challenges in cancer survivors supported this notion of coping flexibly by redefining sexuality and renegotiating intimacy (Gilbert, Ussher & Perz, 2010; Street, Couper, Love, Bloch, Kissane & Street, 2010). Moreover, in a qualitative study undertaken by Mitchell et al. (2011), it was reported that a flexible definition of 'good-enough sex', as well as a flexible stance toward the importance of sex, has the potential to enhance the process of adjusting to sexual difficulties. In research undertaken by Kaler (2006) and Svedhem et al. (2013), some women actively challenged traditional discourses around heterosexual norms; by questioning idealistic expectations of sex, such women were able to reframe their sexual difficulties and move forward.

Finally, some women employed problem-focused strategies and attempted to resolve or minimise the impact of sexual difficulties. Whilst some women sought help from health professionals, most studies highlighted women's attempts to self-manage the difficulty (Hinchliff et al., 2012; Holt & Slade, 2003; Sutherland, 2012). This is consistent with other research reporting that the majority of women respond to sexual difficulties without seeking formal help (Moreira, Glasser, King, Duarte & Gingell, 2008; Shifren, Johannes, Monz, Russo, Bennett & Rosen, 2009). Although the sensitive nature of the

topic may deter women from sharing practical strategies in a research setting, a small number of studies have reported on behavioural self-management strategies adopted by women. These have included attempts to adjust sexual positioning, the use of sexual enhancement products such as lubricants, and being more open to sexual creativity within the relationship (Herbenick, Reece, Hollub, Satinsky & Dodge, 2008; Svedhem et al., 2013). Unfortunately, not all problem-focused strategies were adaptive. For some women, the disruptive and potentially detrimental impact of sexual difficulties led to engagement in compensatory or potentially addictive behaviours such as drug and alcohol use (Kilich et al., 2012, Sutherland, 2012).

2.2.3 Summary of female sexual difficulties

In order to help women with sexual difficulties, it is important for clinicians, therapists and other relevant health professionals to have a clear understanding of current evidence-based debates within this field. As this section has revealed, the classification of female sexual difficulties is strongly influenced by a biomedical model. The current classification scheme has been critiqued for adopting a medically-based and commercially-centred view of sexual difficulties; as such, it has been argued that interpersonal and contextual factors influencing sexuality and its difficulties have been largely ignored. As highlighted by the literature, women's experiences of managing sexual difficulties are strongly influenced by the prevailing discourse about sex. Accordingly, there have been calls for a new classification scheme based on a biopsychosocial model that enables women to define what constitutes a sexual difficulty, and locates women's sexual difficulties within an interpersonal and social context.

Whilst the prevalence of sexual difficulties remains a contested issue, what cannot be contested is the impact of sexual difficulties on psychological wellbeing, quality of life and interpersonal satisfaction. What is clear from the literature is women do not frequently seek help for sexual difficulties; indeed, they employ a variety of coping strategies in an attempt to self-manage their difficulties. Although there is a dearth of literature relating to how women cope with the sexual side effects of antidepressants, the literature does

reveal an important link between adaptive coping and improved sexual health outcomes.

The following section provides an overview of SSRIs; it provides a history of the medication, its uses, and the side effects associated with the most commonly prescribed SSRIs. Lastly, the sexual side effects in women are explored in depth, followed by an overview of treatment and management approaches.

2.3 SSRIs: An overview

The introduction of fluoxetine, an SSRI, in the late 1980s, revolutionised therapy within the field of mental health and led to a new classification of antidepressants. Since the release of fluoxetine (Prozac®) by Eli Lilly, a number of other SSRIs have been released including: Sertraline (Zoloft®), followed shortly by Paroxetine (Paxil®), Citalopram (Celexa®) and Escitalopram (Lexapro®) and most recently Fluvoxamine (Luvox®). Whilst there are differences among the most commonly used SSRIs, it is widely accepted that SSRIs exert their therapeutic effect in depression and anxiety by increasing levels of serotonin in the synapse (Stephenson, Karanges & McGregor, 2013). Whilst the precise mechanisms of action differ for each SSRI, it is assumed the medication works by blocking the reuptake of serotonin in the synapses of the brain, thereby increasing the synaptic concentration of serotonin levels in the brain (Stahl, 1998).

SSRIs rapidly became the first-line treatment for a range of mental health problems in Australia and around the world (Nurnberg, 2001). In addition to depressive disorders, SSRIs are also approved as first line treatments for generalised anxiety disorders, panic disorder, agoraphobia and post-traumatic stress disorder (Bandelow et al., 2012). Off-label uses have included premature ejaculation (Hatzimouratidis et al., 2010), irritable bowel syndrome (Rance, Lindner & Ford, 2014), chronic fatigue syndrome (Thomas & Smith, 2006) and migraine and tension type headaches (Moja, Cusi, Sterzi & Canepari, 2005). Early research, including a number of meta-analyses (Anderson & Tomenson, 1994; Steffens, Krishnan & Helms, 1997),

highlighted the improved safety, tolerability and efficacy of the SSRIs when compared with that of older antidepressants. Lieberman (2003), in his study of the history of antidepressants, viewed the introduction of SSRIs as a turning point in the treatment of anxiety and depression, making the treatment and management of anxiety and depression in primary care the norm, rather than the exception.

SSRIs remain the dominant category of antidepressant dispensed in Australia, their use doubling between 2000 and 2011 (Stephenson et al., 2013). According to Sansone and Sansone (2010), this level of unrivalled popularity potentially relates to a number of factors, including the broad clinical efficacy associated with this medication, and their relatively minor side effects. The dispensing data for the six most commonly used SSRIs, show sertraline as the most popular SSRI in Australia, arguably as a result of greater tolerability (Stephenson et al., 2013), followed by escitalopram, which has been increasing in popularity since its introduction in 2004. According to Hollingworth et al. (2010), women are the most common users of antidepressant medication in Australia. This is not surprising given that a number of studies report higher prevalence rates of anxiety and depression in Australian women (Hollingworth et al., 2010; Paige, Korda, Kemp, Rodgers & Banks, 2015, Zhang et al., 2010).

Despite the popularity of such medications, the extent to how well these newer antidepressants actually work remains a controversial topic in the field of mental health. In recent years, questions have been raised with respect to efficacy and/or tolerability of the newer antidepressants (Karanges & McGregor, 2011; Mackin & Thomas, 2011). With respect to efficacy, a series of meta-analyses have been published, concluding that newer antidepressants such as SSRIs were only effective for individuals diagnosed with severe depression (Kirsch, Deacon, Huedo-Medina, Scoboria, Moore & Johnson, 2008), and more recently, that antidepressants have relatively modest effects when compared with a placebo over the same period (Fournier et al., 2010). Such findings are not new; indeed, these findings confirm what has been previously reported (Khan, Leventhal, Khan & Brown, 2002; Thase et al., 2002). According to Thase, Larsen and Kennedy (2011),

recent findings have attracted considerable attention in the media and have raised questions about the usefulness of these medications. Questions are also being asked about tolerability; whilst SSRIs are generally well tolerated, they have not been devoid of side effects (Moret, Issac & Briley, 2009). As noted by Gartlehner et al. (2008), one in six individuals discontinued treatments in randomised controlled trials as a result of adverse effects.

2.3.1 Side effects of SSRIs

According to Cascade, Kalali and Kennedy (2009), debates around the side effects of antidepressants have existed for years and attempts to minimise side effects and increase adherence to medication have ensured that research into side effects has retained a prominent focus. Whilst measures of non-adherence are rarely reported in the anxiety and depression literature specifically (Taylor, Abramowitz & McKay, 2012), a number of studies have concluded that adherence is problematic, with nearly 50% of users discontinuing antidepressant therapy prematurely as consequence of medication side effects (Fawzi, Abdel-Mohsen, Hashem, Moussa, Coker & Wilson, 2012; Sansone & Sansone, 2010; van Geffen, Hermsen, Heerdink, Egberts, Verbeek-Heida & van Hulten, 2011). In the context of mental health, non-adherence to antidepressant medication places individuals at high risk of relapse; this is considered a significant public health concern, particularly as antidepressants are often taken for extended periods of time (Fooladi, Bell & Davis, 2012).

Commonly reported short-term side effects of SSRIs include nausea, vomiting, diarrhoea, dry mouth, headache and dizziness (Hatcher & Arroll, 2012). Similarly, frequently reported longer term side effects, such as weight gain and sexual difficulties have also been reported (Cascade et al., 2009; Seretti & Mandelli, 2010). The weight gain attributed to SSRI use has also led to concerns about increased diabetes risk with long-term use (Andersohn, Schade, Suissa & Garbe, 2009). While the list is not exhaustive, emerging research also suggests SSRIs increase the risk of upper gastrointestinal (GI) tract bleeding (De Abajo, Montero, Garcia Rodriguez & Madurga, 2006; Loke, Trivedi & Singh, 2008) and pose particular problems for the elderly, including

increased risk for falls and bone fractures (Coupland, Dhiman, Morriss, Arthur, Barton & Hippisley-Cox, 2011; Richards et al., 2007). Additionally, in the past five years, studies have questioned the safety of SSRI use during pregnancy, documenting adverse neonatal outcomes including low Apgar scores, respiratory and metabolic dysfunction, and mild central nervous system disorders (Jensen, Gron, Lidegaard, Pedersen, Andersen & Kessing, 2013; Tuccori et al., 2010).

Although the physical side effects of SSRIs have been widely documented, an emerging body of evidence indicates SSRIs may also contribute to adverse emotional effects. Whilst findings should be interpreted with caution as there are no large epidemiological studies on this topic, Marazziti et al. referred to a phenomenon in the scientific literature known as 'SSRI induced indifference' (2014, p.151). The initial link between emotional blunting and SSRI use was put forward by Opbroek et al. (2002); however, their findings did little to confirm this given that side effects could be attributed to the residual symptoms of depression. The relationship between emotional blunting and SSRIs has since been explored by a number of authors; indeed, it has been reported that SSRI use can contribute to apathy and reduced motivation (Goldsmith & Moncrieff, 2011; Price, Cole & Goodwin, 2009), inability to cry (Van der Veen, Jorritsma, Krijger & Vingerhoets, 2012) and an 'increased disconnection' between the users of SSRIs and their worlds (Teal 2009, p. 19). Given the connection between emotions and romantic relationships, there is also speculation the emotional blunting associated with SSRI use may impair relationship satisfaction through the dulling of emotions (Meyer, 2007) and impact on feelings of love and attachment towards the partner (Marazziti et al., 2014).

Sexual difficulties have also been reported as an established side effect of SSRIs. According to Safarinejad (2011), sexual difficulties remain an underestimated but important problem. An increasing number of studies have highlighted the adverse impact of SSRI-related sexual difficulties for both genders with respect to adherence to medication, relationships with intimate partners and quality of life (Clayton, Croft & Handiwala, 2014; Meyer, 2007; Seretti & Chiesa, 2009). Although sexual difficulties may not be a pressing

issue during the early phase of SSRI treatment, this can emerge as a substantial problem once individuals are stabilised on medication.

2.3.2 Sexual side effects of SSRIs

As sexual difficulties may occur for a number of reasons, it remains difficult to obtain accurate prevalence statistics of SSRI-related sexual difficulties (Clayton & Balon, 2009; Safarinejad, 2011). According to a recent Cochrane review (Taylor, Rudkin, Bullemore-Day, Lubin, Chukwujekwu & Hawton, 2013), prevalence studies in this field have exhibited a number of methodological problems, including the frequent absence of comparison groups or baseline assessments, and inconsistent definitions of sexual dysfunction between studies. Whilst studies have shown that other factors such as depression, sociocultural factors and physical comorbidities also contribute to sexual difficulties (Schweitzer, Maguire and Ng, 2009; Wernecke, Northey & Bhugra, 2006), the relationship between the intake of SSRIs and sexual side effects has been demonstrated convincingly (Graf, Walter, Metzger & Abler, 2014; Segraves, 2007). Furthermore, what is becoming evident is that sexual side effects are more common than initially perceived, with numerous studies reporting prevalence rates of over 50% (Chen, Yang, Lee, Yeh, Lu & Chen, 2008; Montejo et al., 2010; Williams et al., 2006).

SSRI-related sexual side effects in women are certainly not a recent phenomenon. Whilst initial research appeared to focus on sexual side effects in men or mixed gender populations (Hsu & Shen, 1995; Jacobsen, 1992; Montejo-Gonzalez et al., 1996), two early retrospective reviews focused specifically on sexual difficulties in women, revealing a higher rate than previously thought (Aldrich, Cook & Pedersen, 1996; Shen & Hsu, 1995). Shen and Hsu's (1995) study, which analysed the clinical records of 110 women, revealed that 35 women reported sexual difficulties including desire disorder and anorgasmia; similar findings were reported a year later by Aldrich et al. (1996). In 1997, Modell, Katholi, Modell & DePalma compared the sexual side effects of fluoxetine, paroxetine and sertraline. Whilst the results of their study concluded there were no differences amongst the three

SSRIs, it was noted that sexual side effects in women appeared to be the rule rather than the exception. Likewise, results from the first longitudinal study of sexual side effects and SSRIs reported that 57% of women experienced sexual difficulties; anorgasmia was reported as the most common sexual side effect (Zajecka, Mitchell & Fawcett, 1997). Although one small scale study (n=15) found that SSRIs improved sex drive and psychological arousal in women (Piazza, 1997), by the end of the 1990s, the relationship between SSRIs and sexual side effects in women was well established.

Whilst all of the SSRIs induce sexual side effects to some extent, studies suggest the prevalence and type of sexual difficulty depends on the particular medication. Findings from a meta-analysis related to antidepressant-emergent sexual difficulties revealed that out of seventeen antidepressant medications, the SSRIs, namely sertraline, citalopram, paroxetine, and fluoxetine, demonstrated some of the highest rates of sexual difficulties across both genders, with amounts of 80.3%, 78.59%, 71.48%, and 70.6% respectively (Serretti & Chiesa, 2009). In that study, escitalopram was found to be significantly associated with a lower risk of sexual difficulties in women compared to other SSRIs, a finding consistent with a later study undertaken by Sidi, Asmidar, Hod & Guan (2012). In contrast, a systematic review undertaken by Reichenpfader et al. (2014), observed that both escitalopram and paroxetine showed a statistically significantly higher risk of sexual difficulties than other newer antidepressants. However, that study noted that the comparative risk between SSRIs could not be adequately assessed.

As noted earlier, there is some evidence that certain types of SSRI are associated with specific sexual difficulties. In the analysis undertaken by Serretti and Chiesa (2009), desire disorders were commonly reported by women taking fluoxetine and paroxetine (74.39% and 72.89% respectively); arousal disorders were reported by women taking paroxetine and sertraline (83.96% and 82% respectively); and finally orgasmic difficulties were experienced more frequently by women taking paroxetine and sertraline (44.84% and 44.22% respectively). These findings are consistent with data reported by recent studies; indeed, fluoxetine has been associated with up

to 50% higher rates of desire disorder in women when compared to other SSRIs (Khazaie, Rezaie, Payam & Najafi, 2014; Sidi et al., 2012).

While the precise mechanism by which SSRIs cause sexual difficulties has not been determined, a seminal paper published by Gitlin (1994), suggested there may be a number of possible mechanisms. These included: i) non-specific neurologic effects that globally impair behaviour including sexual function; ii) specific effects on brain systems mediating sexual function; iii) specific effects on the sexual organs through altering neurotransmitter concentrations at specific sites; and finally iv) direct or indirect effects on hormone levels that adjust sexual function. According to Clayton (2003), it was probable that antidepressants impact several of these physiologic substrates of sexual function. While it is beyond the scope of this thesis to provide a detailed discussion of the neurobiology of antidepressant related sexual difficulties, the reader is referred to two papers for more information (Gitlin, 1994; Graf et al., 2014).

2.3.3 Treatment and management of sexual side effects

As women have higher levels of SSRI use (Hollingworth et al., 2010), a number of studies have focused specifically on treating and managing the female sexual difficulties associated with SSRIs (Fooladi et al., 2012; Safarinejad, 2011; Zhang et al., 2010). While such studies have explored a number of approaches including, but not limited to dose reduction, switching antidepressant and adjunctive therapy, according to a recent Cochrane review, the evidence to support these is somewhat limited (Taylor et al. 2013). Consequently, Taylor et al. have called for more evidence to guide the treatment and management of SSRI-related sexual difficulties in women. This section will review the current strategies proposed for managing female sexual difficulties associated with SSRI use including: i) improving the therapeutic alliance ii) waiting for spontaneous remission iii) drug holidays iv) dose reduction v) switching antidepressant and finally, vi) adjuvant therapy.

Improving the therapeutic alliance

Despite increasing attention on the importance of communicating with individuals and ensuring informed consent when prescribing SSRIs (Gopal, Cosgrove, Shuv-Ami, Wheeler, Yerganian & Bursztain, 2012; van Servellen, Heise & Ellis, 2011), research has shown that treatment emergent sexual difficulties are infrequently discussed in primary care settings. A number of prohibitive factors have been identified for this lack of communication including personal discomfort, lack of time or expertise and/or the belief that treatment options are limited (Goldstein, Lines, Pyke & Scheld, 2009; Quinn, Happell & Browne, 2011; Shifren et al., 2009). Furthermore, Quinn et al. (2011) revealed that fear of non-adherence to medication has led to the deliberate withholding of information about sexual side effects, despite findings revealing that such knowledge can actually improve adherence rates (Smith & Henderson, 2000). Given that women have been generally reluctant to seek help for sexual difficulties (MacDowall et al, 2010; Shifren, Johannes, Monz, Russo, Bennett & Rosen, 2009), it is not surprising that women who take antidepressants are unlikely to report such adverse effects (Kikuchi, Uchida, Suzuki, Watanabe & Kashima, 2011).

As part of an overall strategy to improve the management of female sexual difficulties, there have been calls to strengthen the therapeutic alliance between clinicians/health professionals and women (Kikuchi et al., 2011) to ensure women are actively involved in making informed decisions relating to medication that may affect sexual function (Quinn et al., 2011; van Servellen et al., 2011). According to Roesch and Weiner (2001), having an explanation for an illness or health condition, can have a positive impact on adjustment. Happell, Manias and Roper (2004), concurred and reported that individuals who were informed of adverse drug effects reported feeling better prepared and less likely to be alarmed when an untoward effect occurred.

Similarly, a number of qualitative studies involving women with mental health problems have also revealed that withholding information about adverse drug effects can increase distress and isolation, and potentially damage therapeutic relationships (Gray, White, Schulz & Abderhalden, 2010; Quinn

et al., 2011). Although these findings have not been validated and may not be representative of all women, it is suggested that open and honest communication between clinicians/health professionals and women, in addition to collaborative decision-making may provide an opportunity to improve the treatment and management of sexual difficulties.

Waiting for spontaneous remission

In many cases, treatment regimes may be short; hence, one management strategy is to endure the sexual side effects until treatment ends, or 'wait and see' if sexual side effects resolve themselves. Although one study reported complete remission of sexual difficulties in 30% of participants at the end of a six month period (Haberfellner & Rittmannsberger, 2004), the limited research to date suggests spontaneous remission of sexual side effects is uncommon. In an earlier descriptive, clinical study undertaken by Shen and Hsu (1995), only three of 33 cases (11%) of female sexual side effects remitted spontaneously within three months of beginning treatment. Montejo-González and colleagues (1996) reported similar results in a mixed gender study of 344 participants. Whilst the percentage breakdown for each gender is not reported, at the end of a six-month study, only 5.8% of participants experienced a complete remission of their sexual dysfunction, 12.8% displayed moderate improvement and 81.4% displayed no improvement at all. A later study by Montejo, Llorca, Izquierdo and Rico-Villademoros (2001), concurred, reporting that spontaneous remission occurs in less than 10% of participants after six months of treatment.

Drug holidays

Drug holidays have been recommended in the past as part of a management strategy for sexual side effects (Rothschild, 1995), but without much evidence to support their use. Drug holidays involve brief interruptions in drug treatment (i.e. discontinuation of the drug two to three days before anticipated sexual activity); however, this practice could potentially put the individual at risk for withdrawal symptoms as well as a relapse of their psychiatric condition (Balon & Segraves, 2008; Shelton, 2005). Whilst Rothschild's (1995) study found that the majority of the 30 participants on

SSRIs experienced 'much' or 'very much' improved functioning related to desire and orgasm for at least half of the drug holidays, significantly better results were found with paroxetine and sertraline. Rothschild hypothesised this was due to the shorter half-lives of these medications although the placebo effect could not be ruled out.

The potential for discontinuation symptoms to occur shortly after missing doses, especially for those SSRIs with shorter half-lives such as paroxetine and sertraline remains a complicating factor, especially given the potential for depressive symptoms to worsen (Baldwin & Foong, 2013; Balon & Segraves, 2008). As a drug holiday is a precursor to sexual activity, Higgins, Nash and Lynch (2010, p. 148) argued that the mechanisation of scheduling sexual activity may increase 'performance anxiety' thereby potentially compounding the situation. Furthermore, drug holidays also carry the risk of the individual experiencing medication related withdrawal symptoms and may prevent the person from engaging in sexual activity (Keltner, McAfee & Taylor, 2002). In addition to a deterioration of depressive symptoms, other authors have highlighted how drug holidays may complicate and potentially add to existing sexual difficulties.

Dose reduction

There is some evidence that antidepressant related sexual difficulties may be dose related, hence a reduction in daily dose is commonly adopted as a first line approach to management (Balon & Segraves, 2008). Over the past two decades, a number of studies have explored dose reduction across a range of commonly prescribed SSRIs (Barton et al., 2010; Benazzi & Mazzoli, 1994; Montejo-Gonzalez et al., 1996, Shen & Hsu, 1995; Sidi et al., 2012). In an early study exploring the clinical records of women on SSRIs (Shen & Hsu, 1995), seven out of nine participants who experienced a dose reduction, experienced remission of sexual side effects whilst retaining clinical benefit. Of these participants, four were treated with paroxetine, three with fluoxetine. In Montejo-González et al.'s 1996 investigation of 344 participants treated with either fluoxetine, sertraline, fluvoxamine or paroxetine, of the thirty participants who experienced dose reduction, 73% experienced 'some' or

'quite a lot' of improvement in sexual functioning when the dose was decreased to 50% (Montejo-Gonzalez et al., 1996). Furthermore, there was no statistically significant correlation between increased dosage and severity of sexual dysfunction. This led the authors of that study to suggest that, above certain threshold dosages, individuals develop sexual dysfunction regardless of any dose increases.

Other recent studies concur, with outcomes suggesting that antidepressant-associated sexual difficulties may indeed be dose-related. In a study involving 254 postmenopausal women treated with citalopram (Barton et al., 2010), sexual difficulties worsened in women who took 30 mg as opposed to 10 mg. Likewise, in a study of 112 females prescribed either escitalopram or fluoxetine, Sidi et al. (2012), reported that women on medium to higher doses of medication were statistically more likely to experience sexual difficulties. With respect to paroxetine dosage, two studies found that sexual difficulties were affected by dose (Ballenger, Wheadon, Steiner, Bushnell & Gergel, 1998; Rizvi & Kennedy, 2013). In Ballenger et al.'s (1998) study involving 278 participants, it was noted that female genital disorders (this term was not defined by the authors), increased when paroxetine dosage increased from 10 mg to 20 mg. In Rizvi and Kennedy's single case study, a reduction in paroxetine dose from 60 mg to 40 mg led to an improvement in sexual difficulties (particularly anorgasmia) in a 45-year-old woman. Whilst the literature suggests that reducing the dosage of particular SSRIs may be an option for some women, Baldwin and Foong (2013), recommended caution is applied to avoid the onset of withdrawal symptoms or worsening of depressive symptoms.

Switching antidepressant

An increasing number of studies have shown that switching antidepressants may give the potential benefits of continuing to manage the depressive illness while reducing the potential for sexual difficulties (Clayton, Croft & Handiwala, 2014; Reichepfader et al., 2014; Rudkin, Taylor & Hawton, 2004; Watanabe et al., 2011; Zajecka et al., 2002). In a systematic review of strategies for managing sexual difficulties, Rudkin et al. (2004) reported that

a switch from sertraline to nefazodone (SRI) was significantly less likely to result in re-emergence of the sexual dysfunction and was not associated with any worsening depression. Ferguson et al. (2001) and Zajecka et al. (2002) also suggested that nefazodone has minimal or no negative impact on sexual functioning.

In Zajecka et al.'s (2002) study involving 681 participants, nefazodone was combined with psychotherapy; all treatment groups showed increase in sexual functioning over a twelve-week period, which led the authors to conclude that combined treatment significantly improved sexual functioning compared to psychotherapy alone. Ferguson et al.'s (2001) single blinded study, which compared individuals who were taking nefazodone with those taking sertraline, also appeared promising; over an eight-week period, 76% of individuals on sertraline experienced sexual difficulties compared to 26% on nefazodone. Whilst other studies have reported improved sexual functioning with this nefazodone (Fieger, Kiev & Shrivastava, 1996; Rudkin et al., 2004), this drug is not widely recommended due to its high risk of liver damage (hepatotoxicity). Consequently, the sale of this medication has been discontinued in Australia (Moll & Brown, 2011).

According to a current review of antidepressant treatment and sexual difficulties undertaken by Clayton, Croft and Handiwala et al. (2014), aside from nefazodone, other promising antidepressants include mirtazapine and bupropion. To date, a few studies have reported that mirtazapine (a noradrenergic and specific serotonergic antidepressant) can increase sexual functioning; however, it should be noted that most studies have been small, open labelled trials or case reports (Gelenberg, Delgado & Nurnberg, 2000; Koutouvidis, Pratikakis & Fotiadou, 1999). In the study undertaken by Gelenberg et al., nineteen men and women were switched to mirtazapine because of sexual side effects experienced whilst taking an SSRI. The findings from their study revealed that participants taking mirtazapine over a six-week period experienced a statistically significant improvement in sexual functioning. Similar results were reported in an open label study involving five female participants (Koutouvidis et al., 1999). A number of studies have nevertheless suggested a cautious approach be adopted when prescribing

mirtazapine for women as the significant weight gain and other side effects associated with this medication have led to a premature discontinuation (Hirschfeld, 2003; Michelson, Kociban, Tamura & Morrison, 2002).

Bupropion, an antidepressant that has dopamine-enhancing properties has been found to have less impact on sexual functioning when compared to most other antidepressants (Clayton et al., 2002; Nieuwstraten & Dolovich, 2001; Reichenpfader et al., 2014). In a systematic review of the literature undertaken by Nieuwstraten and Dolovich (2001), they reported that bupropion caused significantly less sexual difficulties and improved satisfaction with sexual functioning compared to SSRIs. One year later, this finding was confirmed by Clayton et al. (2002), in a USA-based cross sectional study involving 4534 women and then later in a meta-analysis conducted by Gartlehner et al. (2011). More recently, a systematic review of 63 studies, involving more than 23,000 participants, also reported that taking bupropion resulted in a statistically significant lower risk of sexual difficulties when compared to other newer antidepressants (Reichenpfader et al., 2014). Whilst a recent Cochrane review investigating strategies for managing sexual difficulties (Taylor et al., 2013) found that the evidence to support most strategies was limited, the authors did comment that the addition of bupropion as an adjuvant therapy appeared to be the most promising strategy for women experiencing sexual side effects.

Adjuvant therapy

A number of adjuvant compounds have been proposed for managing and treating SSRI associated sexual difficulties in women. However, according to Baldwin, Palazoo and Masdrakis (2013), and Taylor et al. (2013), relatively few compounds have been subject to rigorous evaluation. In the Cochrane review undertaken by Taylor et al. (2013), 22 randomised control trials investigated the addition of medication to treat sexual difficulties; however, most trials involved single case studies. To date, a few trials indicate probable efficacy for testosterone (Amiaz et al., 2011), sildenafil (Nurnberg, Hensley, Heiman, Croft, Debattista & Paine, 2008) and tadalafil (Segraves et al., 2007). However, with respect to female sexual difficulties, bupropion

holds the most promise (Clayton, Warnock, Kornstein, Pinkerton, Sheldon-Keller & McGarvey, 2004; Safarinejad, 2011; Taylor, Rudkin & Hawton, 2005). Although various drugs with different compounds, for example, olanzapine, mirtazaine, yohimbine and Gingko Biloba have been evaluated, such studies have not demonstrated any statistically significant benefits (Kang, Lee Kim & Cho, 2002; Michelson et al., 2002; Wheatley, 2004).

As mentioned previously, the addition of bupropion as an adjuvant therapy appears to be the most promising strategy for women. According to Taylor et al (2013), there are now five trials with 579 participants comparing the effect of augmenting antidepressant treatment with bupropion or placebo (Clayton et al., 2004; Debattista, Solvason, Poirier, Kendrick & Loraas, 2005; Masand, Ashton, Gupta & Frank, 2001; Safarinejad, 2011). Of these, one study involving 46 women reported a significant increase in enhancement of sexual desire and frequency of sexual activity amongst women taking 150 mg of bupropion twice a day (Clayton et al., 2004). In a larger placebo-controlled study involving 218 women (Safarinejad, 2011), similar results were reported with the addition of 150 mg of bupropion twice a day; again, the most significant improvement related to an increase in sexual desire. Of note, whilst no serious adverse effects were observed in the studies undertaken by Clayton et al. (2004) or Safarinejad (2011), the authors did note that a higher number of women withdrew from the treatment group due to adverse effects such as headaches, insomnia and dry mouth. Whilst bupropion was reported to be a promising strategy for most women in these trials, not all women were able to tolerate the resulting side effects.

2.3.4 Summary of SSRIs

In summary, the literature review relating to the sexual side effects of SSRIs reports a number of notable findings. Firstly, although prevalence rates of sexual side effects are difficult to obtain, it appears the rates are underestimated and are more common than initially perceived. Secondly, it has been reported that SSRIs affect all aspects of the female sexual response cycle, though each aspect is affected to varying degrees. Whilst certain types of SSRIs seem to be associated with specific sexual difficulties,

the research suggests that paroxetine and fluoxetine are commonly associated with anorgasmia and/or desire disorders in women. Finally, the literature identifies six strategies to assist with the treatment and management of SSRI-related sexual side effects, these include including improving the therapeutic alliance, waiting for spontaneous remission, drug holidays, dose reduction, switching antidepressant and adjuvant therapy. Whilst the addition of bupropion as an adjuvant therapy shows promise for some women, the evidence to support other approaches is limited. There have been calls for more research to guide the treatment and management of SSRI-related sexual difficulties in women.

2.4 Chapter summary

As highlighted by the literature review, female sexual difficulties arising from the use of SSRIs are an important but underestimated problem. Whilst the actual prevalence of such difficulties remains a contested issue, what is clear from the literature is that the sexual side effects of SSRIs influence adherence to medication, and impact on psychological wellbeing and quality of life. To date, most of the research has been within a positivist framework and is understood through a biomedical lens. Although such studies are important, the nuanced experiences of women are not adequately captured, thereby, limiting the ability to explore and understand sexual difficulties from an individual perspective. In line with calls for more research into the treatment and management of SSRI-related sexual difficulties in women, there is a need to capture and explore women's experiences of coping with sexual difficulties using a qualitative approach in order to complement the emerging body of quantitative research within this field.

CHAPTER 3: Methodology and Methods

‘Sex research should raise up women’s diverse voices, not pre-impose an existing paradigm’ Tiefer (1995, p.194).

3.1 Introduction

Over the past decade, a number of scholars have challenged the biomedical approach to sexual difficulties and have highlighted the need for qualitative research to capture the unique lived experiences of women (Farrell & Cacchioni, 2012; Lavie-Ajayi & Willig, 2005; Tiefer, 2012). Indeed, Tiefer (1995, p. 194) called for sexuality research to ‘raise up women’s diverse voices’, to ensure real life experiences are captured. Smith, Flowers and Larkin (2009) argued that Interpretative Phenomenological Analysis (IPA) is particularly suited to exploring sexuality and sexual experiences; it can further existing understandings that have emerged from medical or pathological approaches and provide more authentic insight into how social and cultural contexts influence sexual behaviour.

This chapter provides a discussion of the methodological approach used for this study. It restates the research aim, question, and objectives of the study; it also provides insight into the research design, methodology, data collection methods and data analysis techniques. Following on, the chapter discusses Yardley’s (2008) four broad principles for assessing the quality of qualitative research, which include sensitivity to context, commitment and rigour, coherence and transparency, and impact and importance. The chapter concludes by addressing the issue of reflexivity.

3.2 Research aim, question and objectives

The aim of this research was to improve understanding of the coping experiences of women who were experiencing SSRI-related sexual

difficulties that were causing problems or distress to them and/or their partners. As such, the research question was stated as:

“What are the lived experiences of coping with sexual difficulties amongst heterosexual women who take SSRI medication?”

The specific objectives of the study were to:

- Explore the lived experience of coping with sexual difficulties amongst heterosexual women who had been taking SSRI medication for at least three months.
- Characterise the types of strategies used to cope with the sexual difficulties arising from SSRI use in order to assist women who are experiencing such difficulties.
- Provide recommendations to inform professional practice amongst clinicians, therapists and other relevant health professionals.

Ethical approval for this study was gained from Curtin University Human Research Ethics Committee, approval code HR 94/2012 (Appendix A).

3.3 Research design

Crotty (1998, p.5) referred to the research design as the ‘plan or proposal to conduct research’, which involves the intersection of philosophy, strategies of inquiry and specific methods. He suggested a framework for the research process consisting of four elements: epistemology, theoretical perspective, methodology and methods. Epistemology is the theory of knowledge; it defines what kind of knowledge is possible and legitimate. The theoretical perspective is the philosophical position that grounds the choice of methodology. The methodology refers to the strategy that links the selection of research methods to the desired outcomes. The methods are the techniques used to gather and analyse data related to the research question or hypothesis (Crotty, 1998). Crotty’s framework enables researchers to understand and conceptualise the philosophical and theoretical perspectives that underpin a research project, and to consider how the different elements

inform and influence each other throughout the research process. Using Crotty's (1998) framework, the four elements are outlined in the following sections to justify the choice of methodology and method used for this study.

3.3.1 Epistemology: Social constructionist position

This research assumed a social constructionist epistemological position. According to Freeman and Mathison (2009, p.1), a social constructionist position is grounded in a belief that there is 'no objective reality' and that beliefs and knowledge about the world are actively constructed and mediated by the social, historical, institutional, and economic environment. A social constructionist position also recognises that research participants are active in the co-construction of meaning and understanding. Although phenomenological approaches emphasise the richness and complexity of lived experience, Cosgrove (2000) argues that social constructionism offers a way to deconstruct the stories that are told by women and to generate meaningful information about their lived experience. Whilst IPA is concerned with detailed accounts of individual experience, Smith et al., (2009) emphasise that IPA also subscribes to social constructionism (through concerns about how context is implicated in an individual's lived experience), albeit to a lesser extent than discursive psychology or discourse analysis.

In this study, social constructionism provides a useful epistemological framework to explore women's experiences of sexual difficulties: it does not see women's stories as a straightforward way to obtain access to their 'inner experiences', rather it problematizes women's subjective accounts and understands that meaning is constructed (Cosgrove, 2000, p.257). As emphasised by Tiefer et al. (2002), it is important to locate women's sexual difficulties within a sociocultural context, hence this epistemology was compatible with the research aim of uncovering the lived experiences of women who were coping with the sexual side effects of SSRI medication. The philosophical focus was on the women's socially constructed reality, interpreting the experience from their words, their experience of the world, their interactions and the settings where the experience occurred.

3.3.2 Theoretical perspective: Interpretive

This research adopted an interpretive theoretical perspective. Crotty argued that an interpretive stance is closely linked to the epistemological position of constructivism, and looks for culturally derived and historically situated interpretations of the social life-world (Crotty, 1998). As this research explored women's experiences, and co-constructed the meaning of such experiences based on cultural, historical and social perspectives, an interpretive stance was most appropriate. Consistent with this approach, the researcher was central to the study and played a key role in helping participants make sense of their experiences. As such, it is important to acknowledge that researchers bring a lens through which they interpret the data.

In this study, the researcher had prior experience of coping with the sexual side effects of SSRIs and a professional background in the field of sexuality. Consequently, the researcher held a worldview that aligned closely with a biopsychosocial perspective of health and illness; that is, psychological and social factors must also be included along with the biological factors when attempting to understand health and illness experiences (Engel, 1981). Whilst the biopsychosocial model of health is contested and has several limitations (Tavakoli, 2009), it is still considered to be a useful framework to explore and understand the lived experience of health and illness.

Furthermore, the researcher held an established feminist worldview. Whilst there are many forms of feminist thought, the lens through which this research was conceptualised and analysed aligns closely with Crotty's position (1998); that is, a feminist worldview prioritises women's voices, and attempts to understand the context and lives of women by understanding power relations and how these impact on individual lived experience.

3.3.3 Methodology: Interpretative Phenomenological Analysis (IPA)

IPA has been gaining attention as a flexible and inductive phenomenological research approach, which allows the researcher to move beyond a biomedical model of disease and illness to explore self-reported experiences

and meanings individuals assign to those experiences (Brocki & Wearden, 2006; Smith et al., 2009). Therefore, IPA was congruent with the positioning of this research as social constructivist and interpretative, and offered an appropriate methodological approach to explore women's lived experiences of coping with the sexual side effects of SSRI medication. Whilst Dorothy Smith's (1990) 'feminist standpoint theory' was considered as a methodology to give voice to women and to situate their concerns within a social and cultural context, her approach highlighted the importance of collective experiences rather than individual experiences. As such, it has been critiqued for its focus on social groupings and for failing to 'allow agency space to individual women as subjects' (Walby, 2001; Yuval-Davis, 2013, p. 3).

Phenomenological research is derived from philosophy, and was developed as a philosophical method of inquiry by the German philosopher Edmund Husserl (Koch, 1995). Husserl rejected the view that empirical science held the key to understanding the world, instead stressing the importance of the 'life world' or lived experience and the quest for the essences of things (eidetic reduction). According to Finlay (2009, p. 18), whilst phenomenologists generally agree a return to embodied, experiential meanings is central to the approach, many research methodologies and approaches are labelled as phenomenological despite stemming from 'different philosophical values, theoretical preferences and methodological procedures'. For example, van Manen's (1990) lived experience human science inquiry approach and Smith's (1996) IPA approach are labelled as interpretative; van Manen, however, is particularly interested in the phenomenological investigation of everyday practice, whereas Smith's IPA is concerned with the microanalysis of individual experiences and nuances arising from such an experience.

IPA as a phenomenological approach was specifically developed by Jonathan Smith in the 1990s. In his seminal paper (Smith, 1996), he argued for an accessible research approach to capture the experiential and qualitative dimensions of health psychology. As a qualitative research approach, IPA is committed to the examination of how individuals make sense of major life experiences; since its inception, IPA has become of one

of the most commonly used qualitative methodologies in psychology (Smith, 2011). It draws on theoretical ideas from phenomenology and hermeneutics, and is idiographic in its commitment to analyse each individual's experience in detail (Smith et al., 2009). It is also theoretically underpinned by symbolic interactionism, and recognises that individuals construct meaning within their social and personal world (Biggerstaff & Thompson, 2008; Smith et al., 2009).

Being phenomenological, IPA is concerned with exploring lived experience and the meanings individuals attach to their experiences. IPA is strongly influenced by the phenomenological perspective of Heidegger which considers the person as 'embodied and embedded in the world, in a particular historical, social and cultural context' (Shinebourne, 2011, p. 18). According to Larkin, Watts and Clifton (2006) Heidegger's phenomenology is consistent with a contextualist position; hence, an understanding of the individual cannot emerge in isolation from the person's context. Heidegger also recognises that 'the meaning of phenomenological description as a method lies in its interpretation' (Heidegger, 1962, p. 37). As highlighted by Shinebourne (2011), Heidegger considers the interpretive process integral to revealing what is conscious and what remains hidden with regards to an individual's lived experience.

The second key influence upon IPA is hermeneutics. Hermeneutics is the theory of interpretation; as such, the analysis involves an interpretative endeavour between the researcher and the participant. According to Smith et al. (2009), the researcher is trying to make sense of the individual trying to make sense of her/his experience. This is referred to as a 'double hermeneutic'; that is, 'the individual's meaning-making is considered first order, while the researchers sense-making is second order' (Smith et al., 2009, p.36). As part of this process, the analysis proceeds in a circular fashion. This often requires the researcher to revisit earlier findings as new results emerge. Smith et al. (2009) refer to this cyclical process as the hermeneutic circle – to understand any given part, one must look at the whole; to understand the whole one must look at its parts.

The third key influence upon IPA is idiography. Within a traditional psychological context, this term is associated with the study of an individual: however, within IPA it refers to the detailed examination of an individual case (Smith et al., 2009). Idiography wants to know in detail what the experience is like for a specific person, and seeks to detail the particular experiences of single individuals. IPA also strives to understand particular people's experiences within their individual social and cultural context (Smith et al., 2009; Willig & Stainton- Rogers, 2008). Whilst it is beyond the scope of this chapter to provide a detailed account of each of the three areas, Larkin et al. (2006), Shinebourne (2011) and Smith et al. (2009) can be referred to for a number of papers and texts that illuminate and further explore the theoretical underpinnings.

3.3.4 Methods

Whilst methods such as diaries and focus groups have been used to collect data in IPA studies, semi-structured interviews tend to be the preferred approach (Brocki & Wearden, 2006; Reid, Flowers & Larkin, 2005; Smith et al., 2009). For this study, semi-structured interviews were chosen as they were most appropriate for in-depth and personal discussion.

Sampling

IPA samples tend to be homogenous, and whilst the research question will have a bearing on selection factors, novice researchers have been encouraged to find a sample which is as uniform as possible so that patterns of similarities and differences can be explored (Smith et al., 2009). In this study, a set of inclusion criteria were developed to ensure a reasonably homogenous group of women who could illuminate the lived experience of coping with SSRI related sexual side effects based on relationship status, sexual orientation, age and length of time on SSRI medication.

The inclusion criteria were as follows:

- Women under 45 years old who were currently in a heterosexual relationship, and who had been taking SSRI medication for longer than three months.

- Women who self-identified as experiencing sexual difficulties that were believed to be attributable to the SSRI medication.
- Women who were experiencing sexual difficulties that they perceived to cause problems or distress to themselves and/or their partners.

Women aged 45 years and under were selected as the appropriate age cut-off for this study as prevalence and treatment rates of affective and anxiety disorders decline rapidly after this age (Hollingworth, Burgess & Whiteford, 2010). As lesbian relationships operate on different principles with respect to power and affect, compared to their heterosexual counterparts (Richards, Naveen & Kim, 2015), it seemed inappropriate to merge lesbian and heterosexual women in this study. As such, only heterosexual women were included in the sample. The three-month timeframe for taking SSRIs as an inclusion criteria has been based on recommendations from other studies. As stated by Moret, Isaac and Briley (2009), this timeframe distinguished the sexual side effects of the medication from the residual depressive symptoms.

The term 'sexual difficulty' was not defined for this study; each woman brought her own understanding and identification of what sexual difficulty meant to her. Unlike previous studies that have investigated women's sexual experiences (Marriot & Thompson, 2008; Svedhem, Eckert & Wijma, 2013), participants for this study were not recruited through health professionals or clinics but directly through a mental health website (depressionnet.com), social media sites and snowball sampling (Liamputtong, 2013). Given that women are often reluctant to seek help for sexual difficulties (Moreira et al., 2008; Shifren et al., 2009), it was important to ensure the experiences of women who may not have sought help were captured.

Interested women were emailed a brief questionnaire (to capture demographic information and further details relating to type of medication), and a participant information sheet (Appendix C) to complete. Those who met the inclusion criteria (ten women) were invited to participate in the study. Each woman who participated signed a consent form before data collection commenced. Whilst no definitive criteria exist for sample size in IPA, a sample of ten women adequately captured patterns of similarity within the

group whilst recognising the particularities of individual lives. This sample size is in keeping with IPA's commitment to an idiographic approach, with eight or fewer being interviewed in previous studies reporting women's sexual experiences (Holt & Slade, 2003; Lavie-Ajayi & Willig, 2005; Marriott & Thompson, 2008; Svedhem et al., 2013). Since the results of this research are presented through three published papers, one in Chapter 4, 5, and 6, further details about participants are provided in Table 3.1 below (pseudonyms have been assigned to protect anonymity).

Table 3.1: Demographic information

Name	Age	Diagnosis and SSRI	Length of time on SSRI	Relationship status	Education level
Alison	29	Mild depression (Escitalopram)	6 months	De Facto	Bachelor Degree
Charlotte	45	Severe depression (Sertraline)	13 years	Married	Postgraduate Diploma
Helen	23	Moderate depression (Escitalopram)	11 months	Married	Grade 12 completion
Julie	44	Severe depression (Fluoxetine)	7 years	Married	Postgraduate Degree
Lisa	44	Severe depression (Sertraline)	15 years	De facto	Postgraduate Degree
Mandy	38	Moderate depression (Escitalopram)	2 years	Married	Grade 12 completion
Nadia	42	Moderate depression, panic disorder (Paroxetine)	12 years	Married	Postgraduate Degree
Phoebe	40	Mild depression, panic disorder (Paroxetine)	13 years	Married	Grade 12 completion
Sonia	30	Moderate depression (Sertraline)	10 months	Married	Bachelor Degree
Tahlia	26	Severe depression (Sertraline)	10 months	De facto	Bachelor Degree

Data Collection

As previously mentioned, ethical approval was obtained and then informed consent was acquired from each woman before data collection commenced.

Two interviews were carried out with each woman over an eight-week period. Each interview was audio recorded with consent. During the first interview, six questions and a set of prompts for each question were used as a guide during the interview. Before the formal interview questions were asked, the woman were encouraged to talk about their personal history and experience of depression. Women were also asked to rate the severity of their depression (mild, moderate or severe) (Appendix E). First interviews lasted between 1 hour and 1 hour 45 minutes in length. When using IPA, the interviewer interacts closely with the respondent to elicit meanings; hence, the interview schedule was used flexibly allowing the respondent to take the lead where appropriate. Questions focused on the women's personal experiences of coping with the sexual side effects of SSRI medication, and were open-ended to generate discussion. Example interview questions included the following, 'Can you tell me about your experiences of coping with the sexual side effects of your medication?' and 'What coping strategies do you feel are particularly helpful?' Throughout the interview, non-verbal and non-behavioural communication was noted in the researcher's field notes. The second or follow-up interviews with each woman were between 45 minutes and 1 hour 15 minutes. Whilst second interviews are not essential within IPA, a small number of studies have used a second interview to gain clarity and greater richness from the participants (Wagstaff & Williams, 2014). During this interview, the transcript from the first interview was reviewed with each woman and emergent themes were discussed to clarify any issues and ensure accurate interpretation. An interview schedule was not required for this interview. Additionally, women were given the opportunity to further elaborate on their lived experiences; this led to enriched data as women had time to reflect on their experiences after the first interview. Whilst most of the women agreed with the emergent themes, one of the women (Charlotte) did not agree with one particular theme 'Acceptance'. Whilst she felt able to tolerate the situation, she felt that she had not fully *accepted* the situation, but

was in the process of *trying to accept* it. Upon further probing, she highlighted how she was trying to accept the situation, however, she felt her husband's lack of acceptance hindered her attempts to move forward. As such, it was decided that the theme 'Attempting to Accept' was more appropriate for this particular participant. Identical to the first interview, after each second interview, field notes were made to highlight noteworthy issues; for example, non-verbal communication.

Data Analysis

The process of analysis for this study followed the guidelines for IPA put forward by Smith et al. (2009), and involved reading and re-reading the transcript, initial noting, developing emergent themes, searching for connection across emergent themes, moving to the next case and looking for patterns across cases.

Re-reading and noting phase – a key tenet of IPA involves an iterative and inductive cycle of analysis, which involves moving back and forward between individual parts and the whole transcript in an attempt to interpret the whole (Biggerstaff & Thompson, 2008; Larkin et al., 2006; Smith, 2007). Neither the whole text nor any individual part can be understood without reference to one another; this is an iterative process and is referred to by Heidegger (1971) as the 'hermeneutic circle' or a metaphor that guides the process of inquiry on several levels. The analysis began with reading each transcript several times for an overall sense of the data. Coding in IPA consists of initial noting in which the researcher writes their analytic observations about the data (Smith et al., 2009). Once the transcript had been read several times, reflections and comments (initial noting) were made in the left hand margin of the transcript, noting any striking issues such as contradictions or connecting comments.

Identifying emergent themes – this was a challenging process and involved focusing on discrete sections of the transcript; moving from individual passages of text to the whole transcript, this process was informed by the hermeneutic circle. Rather than naming themes directly from the data, as is suggested for thematic analysis, data were interpreted by asking questions about the nature of what was happening. Having analysed an entire transcript,

I looked for a number of particularly resonant passages and moved to a more detailed reading and analysis of that part. In one of the passages in Table 3.2, Julie talks about how her husband “really likes sex”, and how she fakes pleasure to meet her husband’s needs. By examining the language used, it became evident that her language shifted from talking about a strategy *she* specifically employed to cope with her husband’s sexual needs “I find *myself*...faking pleasure and all that to meet *my husband’s* needs” to a generalised coping strategy of “letting *them* have their way..... and *you’re* not getting anything out of it”. As can be seen from researcher’s notes in Table 3.2, the comments made by the researcher with respect to the language shifts, move beyond descriptive comments which highlighted key words and phrases, to more interpretative comments which analysed the transcript at a conceptual level and started to acknowledge social and cultural contexts. To illustrate this process in more detail, a section of the transcript is provided in Table 3.2

Table 3.2: Extract from an interview with Julie

Researcher’s Notes	Transcription of Interview	Emergent themes
<p><i>Feelings of inadequacy here...clear sense that she is not good enough?</i></p> <p><i>Tough on him (not her?)</i></p> <p><i>He would be happier with other women. She feels that men need sex to be happy (social scripts coming into play here – check this interpretation!)</i></p>	<p>Interviewer: Ok, so you talk about this (sexual difficulties) impacting on him, are you able to expand on this a bit more?</p> <p>Woman: Yeah....well (<i>pause</i>) look (<i>pause</i>)he really likes sex and wants it a lot so I think it’s tough on him. One of the thoughts I had (<i>whisper in quiet voice</i>) when I was going through one of these really bad periods and tried suicide, is that he would be happier with another women. Not that I’d ever tell him that (<i>laughing</i>). You know he’d have lots more sex (<i>both laughing</i>) and he’d just be happier. You know and he would have somebody who would enjoy it and want it as much as he does.</p> <p>Interviewer: Right, that’s really interesting...</p> <p>Woman: ...so now I find myself just engaging n sex, you know, faking pleasure and all that just to meet my husband’s physical needs (<i>I pause</i>)</p>	<p><i>Protecting partner</i></p> <p><i>Non communication</i></p> <p><i>Pretending all is OK</i></p> <p><i>Protecting partner</i></p>

<p><i>Faking pleasure to meet his needs. (What about her needs?)</i></p> <p><i>Having their way with you. Highlights her sexual needs and role as passive, his needs as central.</i></p> <p><i>Language shift from him to they – this is common to all men, ‘they can get their rocks off’ not just her husband. You’re getting nothing out of it - Convincing herself this is a social norm? (Every body fakes it don’t they? This is normal isn’t it?)</i></p>	<p>Interviewer: Yeah.</p> <p>Woman: ...and it can set up a bit of a thing of resentment, because, you know, just letting them have their way with you so that they can get their rocks off (<i>slight laughing</i>) and you’re getting nothing out of it (<i>pause</i>) do you know what I mean?</p>	<p><i>Protecting partner</i> <i>Faking pleasure</i></p> <p><i>Protecting self</i></p> <p><i>Pretending all is OK</i></p>
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Emerging themes such as ‘protecting partner’; ‘protecting self’ and ‘faking pleasure’ were noted during this stage. Upon completion of this stage, the second interview was undertaken with each woman, and the transcript from the first interview was reviewed. Emergent themes were discussed during this interview to clarify any issues and ensure accurate interpretation. The second interview provided enriched data as women had time to reflect on their experiences after the first interview. After each second interview, the re-reading and noting phase was repeated, and emergent themes were revisited.

Searching for connections across themes – during this stage, patterns and connections among emergent themes were noted in order to showcase important or interesting aspects of the woman’s experience. For example, one of the emergent themes from Julie’s transcript (Table 3.2) reflected her commitment to protecting her partner and not communicating her own feelings and sexual needs. At this stage, the emerging themes ‘protecting one’s self’ and ‘protecting partner’ were grouped together and labelled ‘Suffering in Silence’ as she later revealed how she struggled to confide in her partner or friends about the extent of the problem and its impact. A subsequent interpretative analysis highlighted the influence of social and

cultural context. Her coping strategies were influenced not only by a need to protect her husband, but a need to protect herself from i) the perceived threat of losing her husband if she did not actively engage in sexual activity and ii) social discrimination as a result of confiding in others about her use of SSRIs.

Moving to the next case and looking for patterns across cases – the next step involved moving to the next participant’s transcript to repeat the process. Once each transcript had been analysed individually, patterns among emergent themes were explored across all transcripts, and themes were clustered to develop a set of final super-ordinate (master) themes. Whilst Smith et al. (2009), do not define how to determine a theme, for samples larger than six, it is suggested that a super-ordinate theme should be present in at least a third of all participants. These guidelines were adhered to in this study. See Table 3.3 for final list of themes.

Table 3.3: Overview of super- ordinate and sub- ordinate themes.

Super- ordinate theme	Sub-ordinate themes
'Suffering in silence'	Avoiding sexual encounters Protecting one's partner Protecting one's self
'Trying to resolve'	Communicating with partner Altering medication Taking steps to enhance sexual pleasure
'Accepting what is'	Counterbalancing the positive and negatives of SSRI medication Embracing positives within the relationship Altering expectations about how sex 'should be'
'Searching'	Searching for answers Searching for validation of problem

3.4 Yardley's (2008) principles for assessing the quality of qualitative research

Although reliability and validity are important aspects of IPA research, the appropriateness of applying quantitative criteria to qualitative research has been questioned by a number of authors (Kvale, 1996; Roulston, 2010; Yardley, 2008). For this reason, Yardley (2008) developed a set of guidelines, based on four broad principles, which are particularly suited to assessing the quality of qualitative psychological research. These four principles were used as a guide throughout the research process and are detailed below.

Sensitivity to context

Yardley (2008) identified two important ways in which a qualitative study can show sensitivity to context; both were applied to this research. The first, 'consideration of relevant theoretical and empirical literature', (p. 247) involved a comprehensive literature review. The detailed literature review highlighted gaps in understanding and informed the development of the research question. The second, 'sensitivity to perspective and socio-cultural context of participants' involved ensuring the research design and implementation was sensitive to individual women's needs. In this research, consideration was given to the setting in which the interviews took place (women chose the most appropriate setting), and to the choice of researcher (women were interviewed by a female researcher who had experience of the phenomenon and in interviewing women about issues relating to sexuality). Open-ended questions were used in both interviews to ensure the research did not confine and direct women's responses, but was sensitive to and accepting of women's perspectives.

Commitment and rigour

Yardley (2008) identifies four key factors for consideration in this area: thorough data collection, depth/breadth of analysis, methodological competence/skill, and in-depth engagement with the topic. Consistent with these factors, a thorough explanation of research design, data collection and

analysis is provided throughout this chapter to provide a clear description of the processes undertaken. Smith et al. (2009), referred to rigour as the 'thoroughness of the study' (p. 181), and recommended researchers keep an audit trail to enhance rigour. An audit trail involves filing all data from the research project in such a way that someone could follow the chain of evidence that leads from the design of the study through to the research findings. Thus, this research project includes a file of material including the initial research proposal, revised research proposal, an interview schedule, audio recordings, field notes, reflective journal, annotated transcripts, tables of themes and the final papers that will be kept in a secure locked location for seven years after the thesis has been published.

Coherence and transparency

Yardley (2008, p. 248) defined coherence of a study as 'the extent to which it makes sense as a consistent whole'. She emphasised that a coherent piece of qualitative research must have a solid grounding in the methodology and methods used and the theoretical background needs to be outlined. A detailed rationale for this study is provided in the literature review and introduction; the theoretical background of IPA is discussed earlier in this chapter. According to Yardley (2008), the transparency of a qualitative study is concerned with how well a reader can understand what was done and why. In addition to the audit trail discussed earlier, peer review was also utilised and a supervisor with expertise in qualitative research simultaneously audited one of the transcripts. Furthermore, transcripts from first interviews were member-checked with each woman and emergent themes were discussed to ensure accurate interpretation and clarify any issues. This led to enriched data as women had time to reflect on their experiences after the first interview. This also provided the space to ensure themes were coherent and to reflect on how the researcher's assumptions and biases may have influenced the data. As reflexivity is considered an important aspect of an IPA study (Smith et al., 2009), the researcher's position is outlined in the introduction chapter, and a section on self-reflexivity has been included, to illustrate the researcher's values, interests and assumptions.

Impact and importance

According to Yardley (2008), there is no value in conducting research unless the findings have the potential to make a difference. The relevance and significance of this research are outlined in the introduction and the literature review. Suggestions have been made regarding how this research can inform women and professional practice in order to enhance the management of SSRI-related sexual difficulties in women. Three papers have been published to disseminate the findings.

3.5 Reflexivity

Within IPA, the researcher plays an active role in interpreting data. The importance of reflexivity (where the researcher reflects on how their experiences may influence the research) has been highlighted by Smith et al. (2009). As such, it is imperative that IPA researchers reflect on how their involvement affected the research process.

As a woman who had experienced the sexual side effects of SSRI medication; I was conducting the research from an insider or emic perspective. The impact and advantages of insider epistemology have been considered by a number of researchers (Cooper & Rogers, 2015; Dwyer & Buckle, 2009; Taylor, 2011), however there are also challenges to be considered. As an inside researcher, I was better placed to identify an appropriate research question, and I felt this membership role afforded increased access, acceptance and a common ground from which to begin my research. As I was researching a particularly sensitive subject, I felt the women were more open with me, and considered me to 'be one of them'; I strongly believe this allowed me to explore the topic in greater depth and breadth. Although this shared status was beneficial, my perceptions were sometimes clouded by my own personal experience, however, I ensured that steps were put into place to reduce any potential concerns associated with insider status.

At the start of each interview, I briefly touched upon my experiences of sexual difficulties whilst emphasising that the purpose of the study was to

explore participants' individual stories and unique experiences of coping. Women were given the opportunity to ask questions about my experiences at the end of each interview although no one did. Whilst I endeavoured to begin each interview with an open mind, I do acknowledge that non-verbal communication may have encouraged or discouraged certain responses and that a different researcher may have elicited a different response.

During the data collection process, I also utilised a reflexive journal to acknowledge my preconceptions and assumptions before and immediately after each interview. By attempting to set aside my preconceptions immediately before the interview, I felt able to listen attentively to the participant's story rather than being distracted by my own experiences. An example of a journal entry (written after an interview) is provided below:

I was actually quite shocked when (name) talked about not being interested in receiving any type of pleasure from sex. I found it hard to believe that a young woman (older women, maybe?) would only be having sex out of duty, or because she was scared her husband might leave her. Fortunately, I don't think my response came across as one of shock or of being judgmental – but it has made me more aware of my assumptions and the need to revisit these before and during the analysis stage.

Throughout the analysis stage, I continued to use reflexive journaling in order to highlight preconceptions and assumptions.

3.6 Chapter summary

This chapter reviewed the methodology used to guide this study. It explored IPA as a research approach and outlined the reasons for this choice. This was followed by an in depth discussion of methods employed throughout the study, data analysis and a section on reflexivity. In summary, IPA offers a structured approach to phenomenological research, and is particularly relevant for exploring women's sexual experiences and difficulties as it can further existing understandings that have emerged from biomedical approaches to research.

In the following three chapters, the research findings will be presented in the form of one published paper per chapter.

CHAPTER 4:
**Women's experiences of coping with the sexual
side effects of antidepressant medication**

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Chapter overview

This chapter is the author-accepted (post-print) version of the article published in the journal of *Psychology and Health*. Publisher copyright policies relating to this article are supplied in Appendix F. Co-author statements are provided in Appendix H.

This chapter presents the overall findings from the study and reports on the four broad themes, namely i) searching; ii) suffering in silence; iii) trying to resolve and; iv) accepting what is. The themes provide insight into the different strategies used by women to cope with the sexual side effects of SSRI medication and have practical implications for women on SSRIs and for clinicians, therapists and other relevant health professionals. The findings highlight the importance of contextualising these difficulties as part of an overall approach to improve the management and treatment of SSRI-related sexual side effects.

Abstract

A growing body of evidence has highlighted the sexual side effects of selective serotonin reuptake inhibitor (SSRI) medication. Whilst most of the research has focused on the prevalence and treatment of sexual difficulties, little is known about how individuals cope with the SSRI related sexual side effects. The objective of this study was to explore women's experiences of coping with the sexual side effects of SSRI medication and interpretative phenomenological analysis (IPA) was employed for an in-depth exploratory study of a sample of ten women. Four broad themes emerged which are discussed under the following headings: searching, suffering in silence, trying to resolve and accepting what is. The themes provide an insight into the different strategies used by women to cope with the sexual side effects of SSRI medication and highlight the importance of contextualising these difficulties as part of an overall approach to improve the management and treatment of SSRI related sexual side effects.

Key words: SSRI, sexual side effects, females, coping strategies, qualitative

Introduction

Depression is a leading contributor to the non-fatal burden of disease, and evidence suggests antidepressant drug use is increasing in developed countries (Saragoussi et al., 2012; Zhang et al., 2010). Although a variety of antidepressants are available, including tricyclics (TCAs), and monoamine oxidase inhibitors (MAOIs), selective serotonin reuptake inhibitors (SSRIs) are the most frequently prescribed antidepressant in Australia (Wong, Taylor, Ashby & Robinson, 2010). This paper focuses on the side effects of SSRIs including fluoxetine (Prozac), paroxetine (Aropax/Paxil), sertraline (Zoloft), citalopram (Celexa), escitalopram (Lexapro) and fluvoxamine (Luvox). SSRIs differ from older antidepressants in their chemical structure and method of action; the side effects of this newer medication are more tolerable making these a first line treatment for depression and anxiety (Moret, Issacc & Briley, 2009). Whilst SSRIs are generally well tolerated, they are not devoid of side effects. Several authors have reported on treatment emergent sexual side effects and state how these adverse side effects are a common cause for non-adherence to long-term treatment (Basson, Rees, Wang, Montejo & Incrocci, 2010; Serretti & Chiesa, 2009). Widespread use of SSRIs and concerns relating to adherence rates have prompted an emerging body of research into the sexual side effects (Basson et al., 2010; Grover et al., 2012) and have been the focus of a recent Cochrane review (Taylor et al., 2013).

As sexual difficulties may occur for a number of reasons, it remains difficult to obtain statistics relating to the prevalence of treatment emergent sexual difficulties resulting from this medication (Clayton & Balon, 2009; Safarinejad, 2011). What is becoming evident, however, is that sexual side effects are more common than initially perceived. Studies have reported treatment emergent sexual side effects of over 50% (Fisher & Thomson, 2006; Grover et al., 2012; Serretti & Chiesa, 2009). According to Basson et al. (2010), side effects were related to all aspects of sexual functioning but the main effects were loss of desire and delay of orgasm. As women are at increased risk of mental health problems, and have higher levels of SSRI use (Hollingworth, Burgess & Whiteford, 2010; Zhang et al., 2010), recent studies have focused

specifically on the treatment of SSRI related sexual difficulties in women in an attempt to improve quality of life and to increase adherence to medication (Demmyttenaere & Jaspers, 2008; Safarinejad, 2011). To date, treatment and management approaches have included a number of strategies including drug holidays, natural supplements, switching antidepressants and augmenting antidepressant treatment with other medications including bupropion and sildenafil (Nurnberg et al., 2008; Safarinejad, 2011). In the Cochrane review undertaken in 2013, 23 randomised studies focused on managing sexual difficulties associated with antidepressant use were reviewed (Taylor et al., 2013). Twenty-two of these studies investigated the addition of further medication to treat sexual difficulties and one study investigated switching to an alternative antidepressant. According to this report, augmenting antidepressant treatment with bupropion at high levels appeared to be the most promising strategy for treating women, however, the authors called for more evidence to guide the management and treatment of sexual difficulties (Taylor et al., 2013).

Numerous scholars have critiqued the biomedical approach to sexuality research (Farrell & Cacchioni, 2012; Moynihan, 2003; Tiefer, 2012), yet this approach has dominated most of the research into SSRI related sexual difficulties (Safarinejad, 2011; Taylor et al., 2013; Williams et al., 2010). One major criticism of this approach is that it fails to consider the social and cultural construction of sexual experience. Dworkin and O'Sullivan (2007, p.106), revealed how traditional sexual scripts in Western culture which offer men 'greater sexual freedom and rights of sexual determination' than women, can affect sexual experiences and interactions. Weiderman's (2005) article, relating to male and female sexual scripts in Western culture, highlighted how women have felt pressured to follow traditional sexual scripts, adjusting their behaviour to meet cultural and social norms. Another limitation of the biomedical approach, according to Bahrnick and Harris (2009, p.136), was that psychosocial aspects of antidepressant related sexual difficulties have been largely ignored; little is known about how the addition of sexual difficulties may potentially 'complicate and confuse the clinical picture, exacerbate client distress and destabilise intimate relationships.' From the literature review, it

became obvious that investigating women's subjective experiences of coping with SSRI related sexual difficulties was necessary. As such, the focus of this research was on the coping aspect of heterosexual women's experiences and the research question was, 'What are the lived experiences of coping with the sexual side effects of SSRI medication?' The findings from this research provide further insight into the types of strategies that may be relevant for women on antidepressant medication and for clinicians, therapists and other health professionals, in order to improve the success of and satisfaction with SSRI treatment.

In this study, the term 'sexual difficulty' was used. A definition was not provided as each participant brought her own understanding and identification of what sexual difficulty meant to her. Whilst female sexual difficulties relating to desire, arousal, orgasm and pain are currently grouped under the term 'sexual dysfunction' in the most recent Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5^R) (American Psychiatric Association, 2013), sexual dysfunction is a contested term which aligns with a medicalised view of sexual difficulties. This approach has been criticised for pathologising women and often disregarding the social and cultural contexts of sexuality (Farrell & Cacchioni, 2012; Tiefer, 2012).

Method

Methodology

The study used Interpretative Phenomenological Analysis (IPA) as a research approach. Three key areas of philosophy of knowledge namely, 'phenomenology, hermeneutics and idiography' have informed this approach (Smith, Flowers and Larkin, 2009). IPA has been used for over a decade to capture women's experiences of intimate topics relating to their sexual health (Holt & Slade, 2003; Lavie & Willig, 2005; Marriott & Thompson, 2008) and was therefore particularly suited to this study as it captured the unique voices and experiences of women and situated those experiences within a social and cultural context.

Sampling

The intention was to recruit a purposive sample – that is, using criteria relevant to the research question, rather than necessarily being representative of the population living with SSRI related sexual difficulties. Whilst recognising that it is difficult to ensure complete homogeneity, especially with respect to factors such as relationship dynamics, a degree of homogeneity was sought by recruiting potential participants through the application of inclusion criteria. This criteria included the following i) Australian females under 45 years old who were currently in a heterosexual relationship and who had been taking SSRIs for longer than 3 months; ii) females who self described as experiencing sexual difficulties that were believed to be attributable to SSRIs; iii) females who were experiencing sexual difficulties that were causing problems or distress to them and/or their partners. The authors selected 45 years as the appropriate cut off for this study as prevalence and treatment rates of affective and anxiety disorders decline rapidly after this age (Hollingworth, Burgess & Whiteford, 2010).

Participants for this study were recruited via a mental health website (depressionnet.com), social media sites and snowball techniques (Liamputtong, 2013). As reported by Moreira, Glasser, King, Duarte and Gingell (2008) and Shifren et al. (2009), women have often been reluctant to seek help for sexual problems, therefore, we did not recruit through health professionals or clinics. Whilst a number of participants had sought help for sexual problems in the past, I did not want to exclude women who had decided not to seek professional help. This allowed me to explore potential self- management strategies used by women who had not sought assistance. Interested women were emailed a brief questionnaire to capture demographic information and to ensure inclusion criteria were met. Those who met the inclusion criteria (ten women), were invited to participate in the study.

Whilst no definitive criteria exist for sample size in IPA, its commitment to an idiographic approach results in such studies generally being conducted with small sample sizes of ten or less (Smith et al., 2009). The authors perceived

that the sample of ten women adequately captured patterns of similarity within the group whilst recognising the particularities of individual lives.

Data collection

Prior to data collection, ethical approval was obtained from the relevant university human research ethics committee. Data were collected through two semi-structured interviews comprised of questions that related to heterosexual women's experiences of coping with the sexual side effects of SSRI medication. The interview schedule comprised of eight open-ended questions, which were informed by the literature review and professional experience of the first author. Informed consent was obtained from each woman prior to the first interview. First interviews were face-to-face and lasted between 1 hour and 1 hour 45 minutes in length. Follow up interviews were between 45 minutes and 1 hour 15 minutes. During this second interview, the lead researcher and each woman reviewed the transcript and discussed emergent themes arising from the first interview to ensure accurate interpretation of the participant's experience. In addition, women were given the opportunity to further elaborate on their lived experiences; this led to enriched data as women had been given an opportunity to reflect on their experiences after the first interview.

Data analysis

Data analysis followed guidelines put forward by Smith et al. (2009), and involved the following: reading and re reading the transcript, initial noting, developing emergent themes, searching for connection across emergent themes, moving to the next case and looking for patterns across cases. As this research was interpretive, the lead researcher's comments whilst analysing and noting emergent themes, moved beyond descriptive words and phrases to a deeper conceptual analysis to acknowledge social and cultural contexts. Upon completion of analysis from both interviews, a description of the themes was given to each woman to check the interpretation. Once data analysis was completed for all cases, the next stage involved analysing for recurrent themes across all ten cases; this resulted in four super-ordinate themes. Eleven corresponding sub-ordinate

themes were nested within these super-ordinate themes. The super and subordinate themes are discussed under Findings.

Reflexivity

Within IPA, the researcher plays an active role in interpreting data. Smith et al. (2009) highlighted the importance of reflexivity (where the researcher reflects on how their experiences may influence the research). As the lead researcher had experienced the sexual side effects of SSRI medication, the experience meant that the interviewer was conducting the research from an insider emic perspective. She briefly touched upon her experiences of sexual difficulties with each woman at the beginning of the first interview while emphasising that the purpose of the study was to explore their individual stories and unique experience of coping. Women were given the opportunity to ask questions about the researcher's experiences at the end of each interview.

During data collection, the researcher utilised a reflexive journal to acknowledge her preconceptions and assumptions before and immediately after each interview. By attempting to set aside her preconceptions immediately before the interview, the researcher felt she was able to listen attentively to the participant's story rather than being distracted by her own experiences. Smith et al. (2009) highlight the importance of attentive listening and engagement with the participant, and argue that such close attention during the interview process limits the influence of the researcher's preconceptions. During the data analysis phase, the researcher obtained the support of a colleague to read through the transcripts and subsequent analysis of two women to ensure the analysis reflected the women's stories adequately. As part of this process, a number of questions were posed with respect to assumptions that had been made, and potential areas of bias were discussed. By asking questions such as "How do you feel when women talk about having sex to meet the needs of their partner?" the researcher was able to reflect on how her personal beliefs and worldview impacted on data analysis. Consequently, throughout the data analysis phase, reflexive journaling enabled the researcher to continually reflect upon the data to

ensure it reflected the experiences of women rather than her own experience.

Findings

The following is an account of the lived experiences of women coping with the sexual side effects of SSRI medication. The four separate but overlapping super-ordinate themes and eleven sub-ordinate themes that emerged from the data analysis are supported with quotations from the women's accounts. At various stages throughout their journey, women adopted one or more of the coping strategies and the combination of approaches used by the women tended to vary over time. Pseudonyms were assigned to protect each woman's identity.

Searching

This theme describes the processes women engaged in as part of their coping mechanism when first experiencing what they identified as sexual difficulties associated with SSRI medication, and at times throughout their journey. The theme *searching*, included two sub-ordinate themes i) searching for answers and ii) searching for validation.

Searching for answers

A search for reasons behind the sexual side effects frequently underpinned the coping experience of most women in this study, with women commonly commenting on how GPs had neglected to inform them about the side effects when the medication was prescribed. Consequently, these women particularly struggled with sexual side effects at an early stage in their journey, and frequently questioned whether they had psychological problems and/or whether their experiences were normal.

I guess for me, finding that information [on the internet], that was a real turning point, I finally had my answer.if you go back to the leaflet in the medication it says that you may experience side effects but there's about 5 million side effects on there. Initially I thought they're just covering their back you know just in case, and I thought, well you know, reality is it's probably 1 in a million chance that you're going to have sexual sides effects, and then I started reading about it and I thought...

hang on a minute, the amount of women that are experiencing this is not one in a million, there are thousands of us. (Nadia, 42)

The women talked about the difficulties of sharing their problems due to the perceived public stigma of mental illness, and the sensitive and emotive nature of their problem. As women were unable to communicate with friends or trusted others, information about their side effects was predominantly sought from the internet. By searching on the internet, women discovered sexual side effects were frequent amongst users of SSRIs. For these women, having a legitimate reason for their sexual difficulties and finding they were not alone with their experiences proved a positive turning point:

Once I realised that the sensation wasn't there, I started to freak out, I did actually quite freak out about for a while and then I think I Googled about possible female side effects, and I didn't find much on it, but found something, there was something. I don't know if there was a forum or something, where I kind of read about women not being able to reach orgasm. At the time, yeah I'm thinking relief, just relief that at least I knew why it was happening, it wasn't just me, I wasn't some kind of freak. (Mandy, 38)

The primary motivation for searching for information stemmed from a desire to protect current relationships. Having answers about the sexual side effects had positive implications for both their relationship, as well as their identity as a sexual person:

When I did eventually find the articles on the net, I would show him and say "Look it's not just me, lots of women are going through this. It's not your fault, it's got nothing to do with you, it's got nothing to do with our relationship" to help him understand. Because I guess you worry, you think well you know, they might think that I'm frigid or I'm not interested in them anymore. I guess I don't want him having a complex. (Tahlia, 26)

The majority of women felt having more information at an earlier stage, would have assisted them in coping. Alison, who had received information from her general practitioner, talked about feeling prepared and her experiences highlighted the importance of knowing about the side effects in advance:

I remembered exactly what she had told me um, so (pause) I guess to an extent it did help because you know I sort of had that awareness up

front that this could be an issue.....when it actually came up as an issue I was kind of a bit more prepared for it. If she hadn't even said those couple of sentences to me I would be thinking "What the hell is wrong? What's going on? I don't understand this at all?" um, and be pretty confronted and scared by that I guess. (Alison, 29)

Searching for validation

For the women, having their sexual concerns validated played an important part in helping them to cope. They felt the difficulties were serious enough to consider seeking professional help but their experiences of not having concerns validated by GPs had an impact on how they understood and hence coped with difficulties initially. Charlotte mentioned about '*psyching herself*' to build the courage to raise the issue with her GP, her comment below typifies the dismissive comments and reactions experienced by the women in this study:

When I eventually went to the Drs, it's like "Oh you know, it's a typical women thing. You've got kids, life's stressful deal with it". Well I've been through a lot more stress in my life and it didn't do that to my libido! I asked him if there was a Viagra for women or something - he laughed and said he'll get back to me - that's 6 months ago and I'm still waiting. (Charlotte, 45)

Furthermore, women reported that GPs appeared unwilling to accept their sexual side effects as a legitimate problem. This led them to seek validation and support through online discussions forums. Nadia commented:

But deep down I've always been really angry about that [GPs dismissing sexual concerns] and thought, "No that's not quite right." So I guess validating that and finding that other women on there [internet] also are saying you know "I haven't got a good sex life and I want to do something about it" makes me feel better. (Nadia, 42)

Suffering in Silence

For the women in this study, the theme suffering in silence emerged as a coping strategy and captured the women's sense of not being able to communicate about their experiences. The sub-ordinate themes of avoiding sexual encounters, protecting one's partner and protecting one's self were often intertwined, but are discussed separately to enhance conceptual clarity.

Avoiding sexual encounters

The women coped with sexual side effects by avoiding sexual encounters either through passive or proactive avoidance strategies. Whilst most women viewed this strategy as temporary, and recognised they were not adequately addressing the problem, Mandy considered this to be an appropriate strategy for a short term problem:

Well my husband works away so I mean his last stint away was for four weeks and I really could not have been interested, it was the best time of my life (pause) because he wasn't home annoying me about sex. If I could keep avoiding it for 4 weeks, wow, before I know it, I'll be off the medication again! (Mandy, 37)

Other women talked about the importance of not wanting to reject openly their partner's advances; hence, a number of proactive avoidance strategies were used which enabled women to avoid sexual activity without actually saying 'No':

I'd go to bed half an hour before him so I'd be asleep when he came in, or half an hour after so that he'd be asleep. Just so I could avoid sex in any way. (Charlotte, 45)

One woman talked about avoiding all forms of intimate contact, fearing such encounters would automatically lead to sex:

Sometimes I just feel like a kiss and cuddle, especially at night, but then I think "Am I leading him on?" 'cos I know I don't want sex. It's hard, I still want to be intimate but I'm scared because I know it will lead to other stuff. (Sonia, 30)

Interestingly, the avoidance strategies put into place by the women, highlighted again, the separate but overlapping nature of sub-ordinate themes grouped under 'Suffering in Silence'. By adopting avoidance as a coping strategy, women succeeded in protecting their partners (from rejection) and protecting themselves (from an unwanted sexual experience).

Protecting one's partner

Having sex was perceived as being central to the women's relationships in this study. Believing their partner would be upset if there was a sexual problem, many women were compelled to protect their partners and viewed

the problem as their 'own problem' as opposed to a shared problem. More than half of the women, predominantly those who had been taking medication for less than one year, made a conscious decision to cope with sexual difficulties alone. Most women held the view that they were obliged to have sex with their partners thereby placing his sexual needs as more important than their own:

I didn't want to tell him, that when I was having sex with him I'd rather be sleeping. That would have just killed his ego. It would have been very detrimental to him. There was no way I could say that I'm just going through with this just for your benefit. (Helen, 23)

Women also talked about the need to reciprocate as part of a healthy relationship and to be sensitive to their partner's needs:

My husband is so wonderful and I feel so guilty that I don't have a libido for him. I do feel obligated though, he's so gentle and kind – sometimes after sex I just end up crying, but I manage to hide it - he's my husband, I love him, so I let him do it. (Charlotte, 45)

Faking orgasm was a common coping strategy to manage the potential relationship impact of the sexual side effects. Although many women talked about feeling guilty and even deceptive within their relationship, in contrast, one woman considered this to be an acceptable and effective strategy:

It works well for our situation, I mean, you can fake sexual pleasure, but you can't fake the weight gain can you? (Mandy, 38)

Reasons why women engaged in non-pleasurable sex were driven by a need to protect their partner and the relationship, but also to protect themselves from unwanted consequences.

Protecting one's self

Women revealed how they chose to be silent about their experiences as a self-defence strategy to protect themselves from potentially negative consequences. Two women described how they chose not to communicate with their partner for fear their partner's reaction would lead to unwanted consequences:

I suppose there's a small fear that he would say "Oh go off those antidepressants that's crap." You know, "You shouldn't have to deal with it, go off them." But the thing is, is that I'm getting so many good benefits, and I don't want to yet, but I am planning to eventually.
(Mandy, 38)

If I speak to him, how do I put this? He's a typical truck driver – you know, take a spoon of concrete and "Harden the Fuck Up". If they're (the medication) doing that to you, just come off them. Of course, I can't do that. (Charlotte, 45)

Women often emphasised the importance of sex within their relationship, and mentioned the need to hide their sexual difficulties for fear they would illuminate other problems within their relationship or their partners would look elsewhere for sex:

I think generally, that would be a fear of whether to communicate that issue [with my husband], 'cause if you bring it up, you know, are they going to go elsewhere type thing. Do you know what I mean? Have affairs and stuff like that? (Mandy, 38)

Suffering in silence, and the high levels of secrecy surrounding the use of SSRIs appeared to be fuelled by the perceived public stigma of mental health problems and fear of being discriminated against. Women talked about being able to protect themselves from the negative public image of mental health problems and the ramifications in terms of their daily interactions and experiences. In Phoebe's case, she applied corresponding stereotypes and prejudices to herself when explaining her reluctance to communicate with others:

It's not something you go "Hi, how're you? I'm on anti-depressants". You know people will turn and walk the other way and go "Well you're screwed or something" - that's what they think - like you're an axe murderer or something. (Phoebe, 40)

Trying to resolve

The theme trying to resolve included self-help strategies aimed at trying to fix or at least minimise sexual side effects of SSRIs. Sub-ordinate themes included altering medication, communicating with partner and taking steps to enhance sexual pleasure. All women, with exception of one, attempted to fix or at least try to resolve the problem and increase sexual pleasure; however,

the type of approach was strongly influenced by length of time on medication. Women who had been on the medication for longer than two years used a combination of three approaches.

Altering the medication

For women who had been on medication for more than two years, altering the medication was identified as one of the major strategies. Many women adopted a self-help approach to altering the medication, using a range of different strategies including, taking drug holidays (a brief period where the woman stops taking the SSRI to regain sexual feelings), reducing the dosage and quitting the medication in an attempt to restore sexual feelings. Julie said:

I've resigned to the fact that, it's almost like being on par to being a diabetic, I need the insulin to just keep functioning on a day to day basis and, um (pause) um, and yeah, it's also led me to play with the dosage as well and try and decrease it so I can get some sexual function back, um, yeah. (Julie, 44)

Nadia described how she stumbled across this strategy and highlighted how she successfully self-managed her dosage of medication to suit her particular situation:

I forgot to bring my pills with me, and I started to experience really strong sexual dreams, and I almost like had an orgasm, it woke me up and I thought "oh" I've got these sexy feelings back again that's really weird. So I guess I figured on my own that if I stopped taking the medication for a couple of days those sexy feelings would come back again. No one told me about this, but then again no one told me about the sexual affects either. So I kind of cottoned on to this idea that if I have a bit of a break then I'm more likely to have an orgasm or for sex to be more pleasurable. So I guess now what I do is I guess try to anticipate when we might be more likely to have sex and I just stop taking the medication a couple of days before. (Nadia, 42)

Other women disagreed with the idea of self-managing their medication, highlighting the importance of taking the medication correctly and citing the fear of a relapse as a major reason for not altering the medication. This was the case even if they believed this strategy could work for them:

I did hear that you could take a few days off on some of them[medication], I just wouldn't, couldn't even think about that, no way, I mean this sucks, but it does work and there's just no way I ever want to risk get back to where I was. It was not a good place. (Helen, 23)

Communicating with partner

In contrast to the theme suffering in silence, some women on medication for more than two years, communicated with their partner about the sexual difficulties they were experiencing to resolve their sexual problems after other coping strategies had been attempted. For these women, communication with their partner was identified as being a necessary component of a longer-term coping strategy:

It really does, um get in the way of your relationship and um, yeah it does. You do have to talk a lot about it and you do have to communicate with your partner about it. ...and get across to them that it's not them, it's you, it's these pills. It's yeah, it's not them, they're not less physically appealing or less effective in the bedroom, yeah. (Julie, 44)

Lisa, who described how she finally opened up and started to communicate about both her mental health problems and the associated side effects of the medication, echoed this point. In her case, communication was triggered by a major depressive episode:

So it wasn't until I hit the ground in December last year where I went off the medications and then I had a massive terrible episode, I nearly ended up in hospital and then obviously he saw me. Like he saw me, he saw the deal, we saw what I was like and I honestly thought he was going to dump me but he didn't. He was fantastic, and that's when after that I've been more open with him about it. It's only the past 3 months I've been this open about the medication, how it wipes out the sex feelings, the everything really, but it has been so much better since I've been open. (Lisa, 44)

Taking steps to enhance sexual pleasure

The women commonly reported their desire to experience sexual pleasure again; however, they recognised that sustained efforts were needed to make

this happen. Women sought to enhance pleasure by using sex toys, pornography, masturbation, changing sexual positions and trying herbal supplements. For some women, sexual difficulties were considered to be a shared problem rather than the woman's problem; hence, this was a strategy that involved open and honest communication and cooperation between both partners:

Um, I don't know, I think in our case or my case I've just become more aware of what does really work for me, the big points that work for me, so I suppose not being afraid to (pause) use sex toys, pornography or anything else that particularly works for me. Um, (pause) you know and because my partner is aware, he doesn't feel that it's um, his failure, it's just that this is what we have to do at the moment to make it work. So we do that. (Tahlia, 26)

For other women, the search for sexual satisfaction involved trying to resolve the issue on their own:

Um, well I guess this is a bit uncomfortable to talk about but, you know there are certain positions where I know I can reach orgasm much quicker and easier so I kind of move my body into that position, you know, and it does work sometimes. (Alison, 29)

I did search on the internet for potions and supplements and stuff – I even bought Horny Goatweed, that Gingko Biloba is meant to work for sexual problems too, but you have to take a lot of it I think. (Lisa, 44)

Accepting what is

A further theme, particularly amongst women who had been on medication for over two years, related to acceptance of their particular situation. This theme included three sub-ordinate themes i) counterbalancing the positive and negatives of SSRIs ii) embracing the positives in the relationship and iii) altering expectations about how sex 'should be'. Sub-ordinate themes two and three were more commonly used as a strategy by women in longer-term relationships. Acceptance did not imply that the women have given up hope. This is exemplified by a comment from Nadia:

I don't see this getting any better so I don't think there is going to be a magic solution, I really don't believe there is going to be a pink Viagra or a pill that we are going to be able to pop that makes everything better. I'd love to think there would be and that would give other women and

myself something to look forward to. I don't think that's gonna happen but every now and then I do jump onto Google in case there is something new on the market that might help. In terms of how I cope overall though, I guess I focus on the positives in my relationship and what's working well and what's good. (Nadia, 42)

Counterbalancing the positive and negatives of SSRI medication

Women in the study acknowledged the benefits from the medication, and although the sexual side effects were problematic, at least two women chose to focus on benefits:

Sex isn't as enjoyable as it was before I was on it [the SSRI] but I'm actually feeling better, like I'm feeling well so I kind of balanced it I guess you know with kind of going well yeah this side effect does really suck but look at what I'm gaining as well. (Alison, 29)

In terms of coping, I think um, just um, acceptance is the thing that works for me the most, yeah. The medication has worked wonders for me, after my attempted suicide, well.... I don't want to go there again you know so the sex stuff, well I kind of just deal with it. (Julie, 44)

Others highlighted how sex had been relegated as less important, while they focused on recovering from either anxiety or depression. There appeared to be a high level of acceptance that the medication would have positive and negative outcomes associated with it:

I guess you have to sort of accept that you aren't going to have great sex...well you have to accept that I think. I think there's no alternative, I think, you know well what are you gonna do? Stop the medication altogether? Well that's not the right thing to do is it, I mean that stuff works.... it keeps me sane do you know what I mean? So you have to, you have to just take the positives with the negatives don't you? (Phoebe, 40)

Embracing the positives in the relationship

As part of an ongoing coping strategy, women in longer-term relationships described how they had started to focus on positives within the relationship,

particularly the relational aspects of sexuality such as companionship and intimacy, rather than the physical act of sex. Mandy stated:

I'm lucky, I guess, I actually get a lot out of just cuddling and kissing and being affectionate and the big thing that we always hear about is you know when the man puts the garbage out, you know I love all that stuff (both laughing). You know he's been home the last week and he's been making breakfast every morning and I find that really just wonderful. And to me that's more than sex. (Mandy, 38)

Similarly, Phoebe noted:

At the end of the day, the sex you know, only goes for what minutes? But it's that other stuff, hugging, intimacy, talking, helping each other - there's all that sort of stuff happening which is still really important for both of us. (Phoebe, 40)

Altering expectations about how sex 'should be'

The women in this study discussed how they lowered their expectations about sex, and used positive self-talk to challenge social and cultural expectations of what sex should be like:

I guess I have a tendency to think back to how it was in my 20's and how amazing it was. And maybe that's not realistic, even when you're not on Aropax. I mean, how many of my 41 year old friends are having amazing sex, hanging from the chandeliers and multiple orgasms three times a week? Just not happening, I don't think, you really need to just accept that I guess. (Nadia, 42)

Sonia commented how her and her partner's expectations about sexual frequency were altered as a result of their current circumstances. She also used positive self-talk:

When I had brought up the topic to with him [about the infrequency of sex], he just said "Oh well this is how it is now with the kids and.." yeah, so I suppose we're kind of just accepting that this is how it is, and how it would be, even if I wasn't on medication. (Sonia, 30)

Discussion

Managing and treating the sexual side effects of SSRIs have presented a challenge to women, clinicians/ health professionals and researchers; to our knowledge, this is the first qualitative study to investigate how women cope

with such side effects. Four discrete but overlapping super-ordinate themes emerged during analysis i) searching, ii) suffering in silence, iii) trying to resolve and iv) accepting what is. Women's experiences of coping with sexual difficulties were similar to those reported by Mitchell, King, Nazareth & Wellings (2011), that both men and women manage sexual difficulties by using a number of coping strategies simultaneously but a combination that varied over time. The choice of coping strategy for women in this study was commonly influenced by the length of time on medication, the partnership context and external influences, particularly the socio-cultural context of their experiences. Consistent with findings from other studies into female sexual difficulties (Ayling & Ussher, 2008; Holt & Slade, 2003; Marriott & Thompson, 2008), difficulties experienced by women in this study carried personal and relational meanings which impacted on their self-identity and influenced the type of strategies employed to cope with side effects.

Whilst coping strategies have been classified in a number of different ways (Brandtstadter & Renner, 1990; Suls & Fletcher, 1985; Lazarus and Folkman, 1984), the strategies employed in this study, fit well with the two broad coping classes put forward by Lazarus and Folkman (1984), namely, problem and emotion-focused coping. Problem-focused coping involves efforts to alter the situation or circumstances; in this study, the efforts included the strategies of 'searching' (for information and validation) and 'trying to resolve' (the problem). Whilst problem-focused coping strategies are considered to be adaptive or associated with positive coping actions (Levahot, 2012), the debate about whether a strategy is adaptive or not is contested. Indeed, studies have argued that all strategies potentially have an adaptive purpose (Bergvik, Sorlie & Wynn, 2010; Mitchell et al., 2011). Emotion-focused coping, on the other hand, involves efforts to manage emotional rather than physical distress associated with the situation or circumstance, and tends to include both active (generally perceived to be adaptive) and avoidant strategies (considered to be maladaptive or detrimental) (Levahot, 2012). In this study, emotion-focused coping comprised the active strategy of 'accepting what is' and the avoidant strategy of 'suffering in silence'. Although avoidant approaches (faking orgasm, avoiding sexual encounters, not

communicating with partner) could typically be labelled as maladaptive, the findings revealed they did serve an adaptive purpose for those women who were on medication for two years or less.

Searching

The theme searching was identified as a key coping strategy in this study; women frequently reported that they searched for both information and validation to help make sense of their experience and to interpret their situations. This finding is consistent with other studies which have focused on living with an intimate problem which impacts upon female sexuality (Holt & Slade, 2003; Marriot & Thompson, 2008). Once women had an explanation and could attribute their difficulties to SSRI medication, they reported feeling relieved and more capable to adjust to the sexual side effects. This finding corroborates the ideas of Happell, Manias and Roper (2004), who highlighted how individuals with mental health problems want to know about side effects from their medication in order to be better prepared. It also supports later research by Bahrik and Harris (2009), and Quinn, Happell and Browne (2012) that called for individuals to be better informed about the sexual side effects of antidepressants given their pervasiveness and potential to impact upon treatment and quality of life. Indeed, Mitchell and Selmes (2007) suggested that increased knowledge about side effects of medication may improve adherence rates in individuals with mental health problems.

Suffering in Silence

The theme suffering in silence included three strategies and the idea that relationships were at risk, was central to those selected. The sub-ordinate themes of protecting one's partner and protecting one's self were identified by Hinchliff, Gott and Wylie (2012), who reported that women with sexual difficulties used strategies to avoid sexual encounters to protect their partner from the disappointment of being let down but also to protect themselves from the consequences associated with actively rejecting their partner. Social scripts privileging men's wants and needs in a sexual relationship also strongly impacted most of the strategies used by the women in this study, particularly with respect to suffering in silence when they reported faking

orgasm, avoiding sexual encounters and choosing not to communicate with their partners. Whilst individualistic and reductionist approaches to women's sexual difficulties have been critiqued (Cacchioni & Tiefer, 2012; Tiefer, 2012), the women in this study attributed their sexual difficulties to SSRI medication, and viewed the problem as their 'own problem' as opposed to a shared problem. This is not surprising given the current biomedical approach to female sexual problems, which emphasises the importance of individual factors and 'renders the complexity of factors affecting women's sexual lives less visible' (Nicholls, 2008, p. 516; Tiefer, 2012).

Our findings concur with studies that argue the socially constructed nature of women's sexuality, and highlight the dominance of the male sexual drive discourse in Western culture (Ayling & Ussher, 2008; Davison & Huntington, 2010). The findings further our understanding of how social and cultural factors, such as dominant discourses of sexuality can influence how women cope with sexual side effects of SSRIs. Additionally, reluctance to communicate with their partner and others also featured prominently, and the women talked about how the perception of public stigma relating to mental health problems and/or a sexual problem led them to suffer in silence. Prior studies have noted that individuals with a stigmatised condition have been more likely to self-manage information or, to at least assess the costs and benefits of disclosure to others, citing risk, embarrassment and impact on social identity as key factors (Davison & Huntington, 2010; Goffman, 1963; Holt & Slade, 2003).

Trying to Resolve

Women on long-term medication frequently attempted to resolve sexual difficulties. Women attempted to self-manage the problem and did not seek help or report it to a clinician, therapist or health professional because of previous inadequate help-seeking experiences, and embarrassment about the sensitive nature of sexual difficulties. This finding supported the work undertaken by Rosenberg, Bleiberg, Koscis and Gross (2003) which reported that 80% of women with mental health problems did not seek formal help for sexual side effects of medication. Despite the sexual side effects, women in

this study continued to take their medication. However, those women on longer-term medication altered the dosage or took a drug holiday in an attempt to restore sexual feelings, which are consistent with strategies reported through biomedical research aimed at managing sexual side effects (Clayton & Balon, 2009; Schweitzer, Maguire & Ng, 2009).

Although switching antidepressant medication has been highlighted by Baldwin (2004) and Clayton and Balon (2009) as a legitimate strategy to help manage antidepressant related sexual difficulties, surprisingly, none of the women in this study considered this to be a realistic strategy. Our findings revealed that women made a conscious decision to continue their prescribed medication highlighting the perceived benefits and fear of potential relapse, which supports the work by Clayton and Balon (2009) that reported individuals might be fearful of therapeutic failure with a new drug. Other subordinate themes aimed at trying to resolve the problem included communicating with their partner and taking steps to enhance sexual pleasure. Although prior studies have highlighted how increased communication with a partner has positively impacted how women cope with sexual difficulties (Hayes, 2008; Mitchell et al., 2011), it was somewhat surprising that the women on medication for less than 12 months in this study chose not to communicate with their partner. This was a deliberate strategy to protect both their partner and themselves.

Accepting What Is

For women on long-term medication, acceptance of their situation helped them to cope with the sexual side effects. Attempts to embrace the positives within their relationship, and to change expectations about sex, were commonly employed findings which support the study on coping with sexual side effects conducted by Mitchell et al. (2011). These two coping strategies fit with the 'Good Enough Sex Model' proposed by Metz and McCarthy (2007), which encourages positive and realistic expectations about the role and meaning of both intimacy and sexuality across the lifespan. Proponents of this model argued such a perspective can provide a positive and genuine foundation for relationship and sexual satisfaction (McCarthy & McDonald,

2009; Metz & McCarthy, 2007). Our findings also support calls by other researchers to consider a therapeutic approach to managing female sexual difficulties, an approach based on questioning and challenging rigid sexual scripts and normative heterosexual practices (Farrell & Cacchioni, 2012; McCormick, 2010; Mitchell et al., 2011). Consistent with findings from Sutherland's (2012) study into women's experiences of sexual pain and discomfort, the women in this study had not given up hope that their situation would eventually improve; indeed those who employed acceptance as a coping strategy also continued to search for information in the hope of finding a solution.

Implications and limitations

Implications

The findings from our study have practical implications for women on SSRIs and for clinicians, therapists and health professionals, and provide further insight into the types of strategies that could be promoted to women in order to improve the success of and satisfaction with SSRI treatment. Our findings call for open and proactive communication between clinicians/health professionals and women with respect to sexual side effects, and highlight the importance of having sexual concerns validated. An authentic commitment is needed to ensure that clinicians, therapists and health professionals have the necessary education and skills to work effectively with women to enhance the management of sexual difficulties; the authors suggest such issues are highlighted by relevant professional associations and included in professional development programs. It is also evident from this study that women's lack of knowledge relating to the sexual side effects of SSRIs impacted on their ability to cope. It is imperative, therefore, that information materials, which outline sexual side effects and common concerns, be developed and made available in a variety of formats.

Our findings also emphasise the need to recognise and address psychological, social and cultural factors, which may have an influence on how women cope with sexual side effects. Effective management of SSRI related sexual difficulties calls for a collaborative approach, which moves

beyond biomedical interventions relating to the treatment of sexual difficulties. A psychological intervention, which recognises the influence of social and cultural context on women's experiences, may be effective in helping individual women to work through the influence of context on their experience, explore multiple meanings they may have around sex and help develop a positive sense of themselves as women. Such an approach also needs to be complemented by couple therapy, which explores relationship dynamics and how best to work with them to achieve mutually satisfying outcomes within the relationship. Understanding the complex interaction among the various psychological, cultural and social factors is essential for helping women to effectively manage the sexual difficulties associated with SSRIs and to ultimately improve treatment outcomes.

Limitations

The limitations to this study include the relative homogeneity and self-selected nature of the sample. The women in the study were purposefully selected to ensure a degree of homogeneity and to enable us to explore the phenomenon of coping with SSRI related sexual difficulties across a particular target group (heterosexual, in a relationship, under 45 years old). Hence, the findings cannot be generalised to all women who experience SSRI related sexual difficulties. Indeed, the diverse age range of women in the study (23 to 45 years) further limits this study, as the potential differences in sexual experiences across the lifespan were not addressed. Furthermore, it is also probable the women who chose to participate in the study had reached a stage of adjustment, as they were willing to talk openly about their coping experiences. Women who were struggling to cope may not be represented here.

The researchers recognise that this study does not represent the experiences of all women who experience SSRI related sexual difficulties; however, the purpose was to provide a detailed exploration of experiences from individual perspectives.

Conclusion

This study has captured the shared elements and unique voices of women who are coping with the sexual side effects of SSRI medication and has situated their experiences within a social and cultural context. It has provided an insight into what coping strategies women use, factors influencing choice of coping strategy, and how women use different strategies to manage the sexual side effects of SSRIs. Furthermore, it has illuminated the importance of contextualising these difficulties as part of an overall approach to improve the management and treatment of these sexual side effects.

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CHAPTER 5:
Searching for Answers and Validation:
Australian Women's Experiences of Coping with
the Adverse Sexual Effects of Antidepressants

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Chapter overview

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As discussed in Chapter Four, the research identified four discrete but overlapping coping strategies namely i) *searching*; ii) *suffering in silence*; iii) *trying to resolve* and iv) *accepting what is*. This chapter explores and expands on one particular theme 'searching' and provides and details the findings related to women's experiences of searching for answers and validation relating to their concerns. Most women found that early interactions with GPs were inadequate, and therefore hindered their attempts to prepare for the sexual side effects and adopt strategies to move forward. As such, this chapter discusses and contextualises these particular findings for general practitioners (GPs).

Abstract

Sexual difficulties relating to selective serotonin reuptake inhibitor (SSRI) medication have an impact on quality of life and are a common cause for non-adherence to medication. Whilst most research has focused on the prevalence and treatment of sexual difficulties relating to SSRIs, little is known about how individuals cope with the adverse sexual effects. This qualitative study, using Interpretive Phenomenological Analysis (IPA), investigated the experiences of ten Australian women currently coping with the adverse sexual effects of this antidepressant by conducting semi-structured interviews. This paper presents one major theme from the study and reports the findings specifically related to women's self-reported experiences of interacting with general practitioners (GPs) in their search for answers and validation of their concerns. Findings from the study add to the current literature by providing an insight into how interactions with GPs affect women's abilities to cope with adverse sexual effects. Empathic discussions and shared decision making between GPs and women can provide the opportunity to improve the management of the adverse sexual effects of SSRIs and may lead to improved outcomes for women.

What is known about this topic?

Female sexual difficulties associated with selective serotonin reuptake inhibitors are well-documented but women's experiences of coping with such difficulties have not been explored.

What does this paper add?

This study provides insight into how interactions with GPs affect women's abilities to cope with the adverse sexual effects of selective serotonin reuptake inhibitors, creating an opportunity to improve the management of sexual difficulties.

Introduction

Antidepressant prescribing in Australia has increased substantially over the past decade. Despite controversy surrounding the influence of the pharmaceutical industry, adverse drug effects and questions about efficacy (Fournier et al., 2010; Spence, 2013), antidepressants have become the most commonly dispensed psychotropic medication in Australia (Stephenson, Karanges & McGregor, 2013). Selective serotonin reuptake inhibitors (SSRIs) are the most widely prescribed category of antidepressant, and according to Stephenson et al., their use doubled in Australia between 2000 and 2011. Whilst there have been calls to reconsider medication as a first line treatment for mental health problems (Carlat, 2010), an increasing reliance on medication and indeed, patient reluctance to discontinue medication for fear of relapse (Spence, 2013) have led to an increased focus on the management of adverse drug effects.

Although a number of adverse effects have been associated with SSRIs (Moret, Isaac & Briley, 2009), sexual difficulties remain an underestimated but important problem (Safarinejad, 2011). Concerns relating to quality of life and adherence to medication have prompted an emerging body of research into the sexual difficulties associated with this medication; such difficulties were the focus of a recent Cochrane review (Taylor et al., 2013). Given that women have higher levels of SSRI use (Hollingworth, Burgess & Whiteford, 2010), several studies have focused specifically on managing female sexual problems associated with the medication (Safarinejad, 2011; Zhang et al., 2010). Whilst such studies have identified a number of management and treatment strategies, the evidence to support these approaches is somewhat limited (Taylor et al., 2013).

Therefore, current attention has focused on strengthening the therapeutic alliance between GPs and the patient. Researchers have highlighted the importance of a patient-centred approach to the management of sexual difficulties, calling for GPs and mental health clinicians to inform patients about potential sexual problems (Kikuchi, Uchida, Suzuki, Watanabe & Kashima, 2011) and to encourage shared decision making with respect to the

management of such difficulties (Quinn, Happell & Browne, 2011; van Servellen, Heise & Eiliis, 2011). Whilst attention has been drawn to the importance of informed consent when prescribing medication and the adoption of a patient-centred model (Gopal et al., 2012; van Servellen et al., 2011), such approaches have not been widely adopted.

Indeed, research has shown that treatment emergent sexual problems are infrequently discussed by GP's and mental health clinicians; personal discomfort, lack of time or expertise, and the belief that treatment options are limited have been cited as prohibitive factors (Goldstein, Lines, Pyke & Scheld, 2009; Quinn et al., 2011; Shifren et al., 2009). In addition, Quinn et al. (2011) highlighted that fear of non-adherence has prompted the deliberate withholding of information about adverse sexual effects in spite of findings revealing such knowledge can actually improve adherence rates (Smith & Henderson, 2000). Furthermore, women have been reported as generally reluctant to seek help for sexual problems citing personal embarrassment, lack of time and perceptions that sexual problems are not taken seriously as reasons for this lack of disclosure (Macdowall et al., 2010; Shifren et al., 2009). Subsequently, it has been reported that women who are taking antidepressants have been unlikely to report such adverse effects (Kikuchi et al., 2011).

Although there is a growing body of research on the adverse sexual effects of SSRIs, there is a dearth of research on women's self-reported experiences of coping. The aim of our study was to complement existing research by using Interpretative Phenomenological Analysis (IPA) to explore the subjective experiences of coping with sexual difficulties amongst women who chose to continue on SSRIs despite adverse drug effects. Within the field of health psychology, IPA has been gaining attention as a flexible and inductive research approach which allows the researcher to move beyond a biomedical model of disease and illness to explore self-reported experiences and meanings that individuals assign to those experiences (Brocki & Weardon, 2006; Smith, Flowers & Larkin, 2009). To offer detailed, nuanced analyses of lived experience, IPA utilises an idiographic approach that focuses on the individual or specific situations either in a single case study or

through a small number of participants (Larkin, Watts & Clifton, 2006). Unlike other qualitative approaches such as grounded theory which use larger sample sizes and seek to generate theory (Pringle, Drummond, Mc Lafferty & Hendry, 2011), the individual case is central to the inquiry in IPA. The overall analysis remains faithful to the individual through illustrating the particular lived experience of participants who have recounted their experiences whilst also illustrating more generalised themes (Smith, Flowers & Larkin, 2009).

This paper presents one major theme from the study and reports the findings related to women's experiences of searching for answers and validation relating to their concerns. This paper adds to the current literature by bringing to light an increased understanding of how interactions with GPs influence women's abilities to cope with adverse sexual effects.

Methods

Australian women were recruited to this study through homogeneous sampling and selection was based on the following inclusion criteria: heterosexual, under 45 years, in a relationship and currently taking SSRIs for depression and/or anxiety disorders. Participants for this study were recruited via a mental health website (depressionnet.com), social media sites and snowballing techniques (Liamputtong, 2013). As reported by Shifren et al., (2009), women have often been reluctant to seek help for sexual problems hence we did not recruit through health professionals or clinics. Participant details are provided in Table 1 (pseudonyms have been used to protect anonymity).

Table 1: Demographic information

Name	Age	Diagnosis and SSRI	Length of time on SSRI	Relationship status	Education level
Alison	29	Mild depression (Escitalopram)	6 months	De Facto	Bachelor Degree
Charlotte	45	Severe depression (Sertraline)	13 years	Married	Postgraduate Diploma
Helen	23	Moderate depression (Escitalopram)	11 months	Married	Grade 12 completion
Julie	44	Severe depression (Fluoxetine)	7 years	Married	Postgraduate Degree
Lisa	44	Severe depression (Sertraline)	15 years	De facto	Postgraduate Degree
Mandy	38	Moderate depression (Escitalopram)	2 years	Married	Grade 12 completion
Nadia	42	Moderate depression, panic disorder (Paroxetine)	12 years	Married	Postgraduate Degree
Phoebe	40	Mild depression, panic disorder (Paroxetine)	13 years	Married	Grade 12 completion
Sonia	30	Moderate depression (Sertraline)	10 months	Married	Bachelor Degree
Tahlia	26	Severe depression (Sertraline)	10 months	De facto	Bachelor Degree

Ten women were included in this study; each woman had made a conscious decision to continue medication despite adverse sexual effects. This enabled us to focus on coping strategies and explore these strategies in detail. According to Smith et al. (2009, p. 51), given the complexity of most human phenomena, 'it is more problematic to meet IPA's commitments with a sample size which is too large than with one that is too small'. Whilst no definitive criteria exist for sample size in IPA, the authors felt a sample of ten women adequately captured patterns of similarity within the group whilst recognising the particularities of individual lives. Whilst it is acknowledged that the findings are not able to be generalised, the study provides important

information about women's lived experiences. It also lays the groundwork for future research.

Data were collected through two semi-structured interviews comprising of open-ended questions. The interview schedule was informed by the literature review and the professional experience of the first author. The data were analysed following IPA guidelines put forward by Smith et al. (2009), namely, reading and re-reading the transcripts separately for each woman or case, initial noting, developing emergent themes, and searching for connection across emergent themes. The themes that emerged from the first interview were discussed during the second interview to check the interpretation. The next stage involved looking for recurrent themes across the data from the ten women and this resulted in four super-ordinate themes.

Results

The four super-ordinate themes were: i) searching, ii) suffering in silence, iii) trying to resolve and iv) accepting what is. This paper expands on the first major theme, 'searching', as this theme was reported by all the women and has particular relevance for improving experiences in a primary care setting. The theme *searching*, included two sub-ordinate themes i) searching for answers and ii) searching for validation.

Searching for answers

With the exception of one woman, women were not informed about the adverse sexual effects of SSRIs when the medication was prescribed, leaving them feeling confused and 'searching for answers' about the cause of their sexual problems. As such, this lack of information left some women feeling angry:

At one stage, I went to the doctor and said, "You need to see my husband, he has bad anxiety and needs this medication". She said, "Oh the sexual side effects are really bad for men". Nothing about women though. I'd been on them for years and she had never spoken about those side effects. Looking back, I feel a bit ripped off, yeah, a bit peeved to be honest. (Mandy)

Despite feelings of anger, a few women reflected on their situation and perceived withholding of information about adverse sexual effects to be deliberate, believing GPs actively did this to protect their mental health.

Mandy added:

I wonder if doctors look at women and think if I tell them they might not take them. I mean doctors have to consider the children and if a woman comes in and says, 'I'm depressed', it's just easier to hand over the medication, do you know what I mean?

Interestingly, a few women said they were 'owed an explanation' (Helen) and emphasised how having information about untoward sexual effects would not have deterred them from taking medication. Helen continued:

I really hate the fact that no one told me about this [the sexual side effects]. I reckon I would have still taken the medication even if I had known what it would do. At some stage, I would have then decided if it was still worth it.

As the majority of women perceived they did not have a legitimate medical reason for their sexual problems, they spent time questioning whether the adverse effects were psychological or caused by factors such as weight gain or other aspects related to their current relationship. For some women, 'searching for answers' continued for several years as outlined by Nadia:

Once I found out that the Aropax was causing the lack of libido, and all the other sexual problems, I started to look for remedies to try and resolve the problem. Until then, I was just, you know, hiding...I guess. For quite a few years I was secretly hoping it would go away.

Women were often embarrassed about the sexual nature of their problem and felt uncomfortable communicating with others, which affected their ability to seek help. For Tahlia, the internet became a source of information:

I found out about the sexual side effects through my group [mental health support group]. This guy, in his 50s said something about "... the side effects they don't tell you about" and he mentioned sex problems and libido. That's when I jumped onto the net to find out more. All the information about Zoloft and the associated sex problems were on there - that was a turning point in my journey.

In contrast with most of the women's experiences, Alison, who had received information from her GP, talked about feeling prepared. Her experiences

highlighted the importance of knowing about the adverse sexual effects in advance:

I remembered exactly what she had told me um, so (pause) I guess to an extent it did help because you know I sort of had that awareness up front that this could be an issue....when it actually came up as an issue I was kind of a bit more prepared for it. If she hadn't said those couple of sentences to me I would be thinking "What the hell is wrong? What's going on? I don't understand this at all?" I'd be pretty confronted and scared by that I guess.

Searching for validation

Despite being embarrassed about their sexual problems, women described how they sought to address their problem by raising issues directly with their GP; however, their experiences of not having their concerns validated affected how they coped with their difficulties:

I went to the doctor in the end and said "My sexual desire is really low and they go "yeah, that happens" they kind of shrug their shoulders you know "You can have good mental health or good sex but you can't have both" kind of attitude. What they don't tell you is that this is one of the main things that can tear you apart. (Phoebe)

Tahlia, who received a positive reaction, revealed how this helped:

It really helped to have the doctor support the idea, that yes, this {sexual problem} could be a side effect. When I had raised it before, she was a bit non-committal about whether it was a side effect, I felt quite relieved to be honest when she agreed with me – I knew then that it wasn't in my head!

Some women commented that their concerns had not been validated because of their gender. These women found it hard to cope with the implication that sex was somehow less important for women. As Charlotte explained:

I felt as though I was the only woman in the Universe who was concerned about the sex problems. I really got the impression that I should just put up with it, you know, go away and just deal with it. I often wonder if a doctor would treat a man the same way?

Most women reported feeling concerned that GPs believed their problem was psychological; this lack of validation by GPs led these women to seek

validation elsewhere. As Lisa highlighted, 'it's the type of problem you keep to yourself', as such, women turned to online support groups, which helped reduce their sense of isolation:

I couldn't believe it when I found a support group on the net, there were literally hundreds of women on there talking about this stuff and feeling distressed about it- just reading their comments, I'm thumping the desk shouting "yes, this is me, this is my story". It was such a good feeling to know I was not alone..... (Sonia)

In contrast, Nadia experienced a positive outcome because her concerns were validated. She provided insight into a conversation that gave her perspective and helped her to cope with the long-term sexual problems she had been experiencing:

After a while, I had a long conversation with my GP and he really listened to me and helped me to get my head around it all. He said to me "So, how many friends at your age with kids, mortgage and busy lives are having amazing sex all the time? Maybe you are missing something that's not a reality anymore". That was a bit of a wake -up call to be honest.

Discussion

Women found that interactions with GPs when they were initially prescribed the SSRIs, set the scene for how they coped with adverse sexual effects. Most women described their experiences as inadequate, and in an attempt to reduce feelings of isolation, confusion and distress, they actively tried to make sense of their situation and spent prolonged amounts of time searching for an explanation. This hindered their attempts to prepare for adverse side effects and adopt strategies that would help them to move forward. Our findings support previous research, which found withholding information about adverse sexual effects had the potential to increase isolation and distress amongst patients and inadvertently damage the therapeutic relationship between clinician and patient (Bahrack & Harris, 2009; Higgins, Barker & Begley, 2006). Whilst the specific reasons for withholding information were not included in the aim of our study, recent literature has identified a number of personal, structural and organisational factors that

impede or facilitate a proactive discussion of sexual problems (Dyer & das Nair, 2013; Quinn et al., 2011).

According to Heider's (1958) attribution theory, people attempt to provide a causal explanation for unexpected events; hence, it is not surprising women sought a causal explanation for their side effects. Furthermore, Roesch and Weiner (2001) reported that having an explanation for an illness or health problem positively affects coping and psychological adjustment. Our study also supports this finding; women who had positive interactions with GPs, and who were informed about potential sexual problems, felt supported and better able to cope. Happell, Manias and Roper (2004) concurred and highlighted that patients with mental health problems want to know about the adverse drug effects from their medication in order to be better prepared. Indeed, several researchers have suggested that increased knowledge about the adverse effects of medication may improve patient outcomes in patients with mental health problems (Gray, White, Schuklz & Abderhladen, 2010; Quinn et al., 2011). Once the women in our study had an explanation for the adverse effects, they reported being relieved and able to move forward and adjust to these effects.

Women have reported that their experiences of not having concerns validated also impacted on how they understood and initially coped with their difficulties. In some cases, this lack of validation appeared to reinforce the 'double standard' sexual script that views females as sexually passive (McCormick, 2012, p.99). There are similarities between this study and other studies that reported how mental health clinicians, in particular, perceive iatrogenic sexual difficulties as a male problem (Phillips, 2009; Quinn et al., 2011). Indeed, our findings seem to be consistent with one particular study by Higgins et al. (2006), which reported that mental health clinicians perceived women to be less concerned about iatrogenic sexual difficulties and more willing to tolerate the adverse sexual effects. Our findings suggest that the inadvertent reinforcement of traditional sexual scripts had a negative impact on women's coping experiences and acted as a barrier to the therapeutic relationship. These findings further support the need for GPs to

take a proactive and empathic role in discussing sexual problems and to create a safe space for disclosure and validation of such problems.

Conclusion

The adverse sexual effects resulting from SSRI use impact quality of life and are a common cause for non-adherence to medication. Current efforts by GPs to address this issue are most likely inadequate and have an impact on how women cope with their medication. In this context, there needs to be a continual shift towards a patient-centred approach, which emphasises women's active participation in decisions about their health, and seeks to strengthen the therapeutic alliance. Empathic discussions with women and collaborative decision-making can provide an opportunity to improve the management of sexual difficulties associated with SSRI use.

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CHAPTER 6:
**Accepting what is: An approach for managing the
long-term sexual side effects of selective
serotonin reuptake inhibitors (SSRIs) in women.**

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Chapter overview

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As discussed in Chapter Four, the research identified four discrete but overlapping coping strategies namely i) *searching*; ii) *suffering in silence*; iii) *trying to resolve* and iv) *accepting what is*. This chapter explores and expands on one particular response “accepting what is”. For women on longer-term medication, although a number of different strategies were employed as part of the coping process, acceptance based strategies were perceived to be most effective. In recent years, there has been growing interest in acceptance-based strategies within the field of sex therapy; indeed, there is a recognition that approaches that encourage women to accept and work around their sexual difficulties, may be more effective whilst treatment options are limited. This chapter aims to increase understanding of how ‘accepting what is’ can be a step forward, particularly for women who have chosen to remain on long-term medication. As such, this chapter contextualises the findings for sex and relationship therapists

Abstract

Sexual difficulties may not be a pressing issue for women on antidepressants during the early phase of selective serotonin reuptake inhibitor (SSRI) treatment; however, this can emerge as a substantial problem once women are stabilised on medication. Little is known about how women cope with the adverse sexual effects of SSRIs. This qualitative study used Interpretative Phenomenological Analysis to explore the experiences of Australian women currently coping with the sexual side effects of this antidepressant.

Interviews were conducted with ten heterosexual women, aged 45 years and younger. Four major coping strategies were identified; “searching”, “suffering in silence”, “trying to resolve” and “accepting what is”. This paper explores one particular response “Accepting what is”, which includes a number of strategies commonly employed by women on long-term medication. Findings from the study have particular relevance for sex and relationship therapists and may assist women in managing sexual side effects that are perceived to be beyond their control. This paper adds to the current literature by increasing understanding of how ‘accepting what is’ can be a step forward, particularly for women who have chosen to remain on long-term medication. In theoretical terms, a deeper understanding of how women cope, could inform debate about the appropriate management of long-term sexual side effects in the absence of effective pharmacological interventions.

Key words: SSRI, sexual side effects, women, coping strategies, phenomenology, acceptance

Introduction

Sexual difficulties may not be a pressing issue for women during the early phase of antidepressant treatment; however, a number of authors have highlighted how this can emerge as a substantial problem once women are stabilised on medication (Nurnberg et al., 2008; Schweitzer, Maguire & Ng, 2009). Amongst women, sexual problems arising from the use of SSRIs typically include loss of desire, arousal difficulties, delayed orgasm or anorgasmia (Safarinejad, 2011; Zhang et al., 2010). According to Segraves and Balon (2014) and Moret, Isaac and Briley (2009), these side effects can impair a woman's sense of self-worth and negatively affect intimate relationships and quality of life. Consequently, it is not surprising that sexual side effects are frequently cited as a reason for non-adherence to medication (Kennedy & Rizvi, 2009). Although the growing research focuses on restoring physiological sexual functioning through a pharmacological approach (Clayton et al., 2014), the evidence to support biomedical approaches is somewhat limited (Taylor et al., 2013). As such, efforts to identify alternative ways of managing sexual side effects are critical, particularly for women who have chosen to remain on long-term medication.

According to Berry and Berry (2014), the shift towards pharmacological intervention is relatively recent, however, it threatens to undermine more holistic approaches. As the limitations of biomedical approaches to managing and treating women's sexual problems become evident, there have been calls for psychosocial approaches that allow assessment of all aspects of women's experiences (Farrell & Cachionni, 2012; Kaschak & Tiefer, 2014). Bahrack and Harris (2009) claim that the psychosocial aspects of antidepressant related sexual difficulties have been largely ignored; indeed, little is known about how sexual difficulties may complicate the clinical picture, increase personal distress or affect intimate relationships. Furthermore, there has been limited research into how women cope with the sexual side effects of antidepressants. Although previous research has focused on coping with the general side effects of antidepressants (including sexual difficulties), these studies were based on either physician's experiences (McElroy, Keck & Friedman, 1995) or they employed large-scale

internet surveys to elicit data, thereby limiting the ability to explore and understand the personal experiences of participants (Kikuchi et al., 2012). Whilst a number of recent studies have used in-depth interviews to explore the experiences of coping with sexual difficulties from the woman's perspective (Hinchliff, Gott & Wylie, 2012; Mitchell et al., 2011; Sutherland, 2012), qualitative research into SSRI-related coping experiences were notably absent from the literature.

The aim of our study was to complement existing biomedical research by using Interpretative Phenomenological Analysis (IPA) to explore the subjective experiences of coping with sexual difficulties amongst women who chose to continue on SSRIs despite adverse drug effects. Although coping strategies have been classified in a number of different ways (Brandtstater & Renner, 1990; Lazarus & Folkman, 1984; Suls & Fletcher, 1995), the coping strategies in our study aligned with the transactional model of coping put forward by Lazarus and Folkman (1984). This model has been used previously to explore how people respond to and cope with sexual difficulties (Tang, Lai and Chung, 2010). As part of this model, Lazarus and Folkman (1984) proposed two broad coping classes: problem-focused and emotion-focused coping. Problem-focused efforts involve altering the situation or circumstances, whereas emotion-focused efforts attempt to manage the emotional rather than physical distress associated with the situation or circumstance. Whilst problem-focused coping strategies are considered to be adaptive or associated with positive coping actions (Lehavot, 2012), Lazarus and Folkman (1984) argue that every form of coping can be adaptive under certain circumstances, or maladaptive under others.

Our findings highlighted a number of different problem and emotion-focused coping strategies (themes) including "searching", "suffering in silence", "trying to resolve" and "accepting what is", the overall findings have been reported elsewhere (O'Mullan et al., 2014). This paper focuses in detail on one aspect of the research findings; it translates this finding into meaningful information for sex and relationship therapists. It explores one theme, "accepting what is", an emotion-focused strategy employed by women on long-term medication who had reached a stage of acceptance as part of the coping

process. This theme was chosen for further analysis as it has particular relevance for therapists working with women on long-term medication (defined as consecutive use of SSRIs for more than 12 months), and offers insight and practical coping strategies that may be incorporated into therapeutic practice. This paper adds to the current literature by bringing to light an increased understanding of how “accepting what is” as a coping strategy may be a step forward, particularly for women who have chosen to remain on long-term medication. In theoretical terms, a deeper understanding of how women cope, could inform debate about the appropriate management of long-term sexual side effects in the absence of effective pharmacological interventions.

Method

Participants for our study were recruited through purposive sampling. An invitation flyer explaining the study was posted to a mental health website (depressionnet.com), and via social media sites. Two women were recruited through snowball sampling (Liamputtong, 2013). For inclusion in the study, all three of the following criteria had to be met. The inclusion criteria were as follows: i) women under 45 years old who were currently in a heterosexual relationship ii) women who self-identified as experiencing sexual difficulties believed to be attributable to the SSRIs, iii) women who were experiencing sexual difficulties they perceived to cause problems or distress to themselves and/or their partners. The authors selected 45 years as the appropriate cut off for this study as prevalence and treatment rates of affective and anxiety disorders decline rapidly after this age (Hollingworth, Burgess & Whiteford, 2010). A brief questionnaire and participant information sheet were emailed to interested women; upon receipt of the completed questionnaire, those who met the criteria and believed their sexual difficulties were attributable to SSRIs were included in the study. The term “sexual difficulty” was not defined for this study; each woman brought her own understanding and identification of what sexual difficulty meant to her.

The study used Interpretative Phenomenological Analysis (IPA) as a research approach (Smith, Flowers & Larkin, 2009). IPA is concerned with

an individual's perception of a phenomenon, it is informed by the theoretical perspective of symbolic interactionism and understands that meanings are negotiated within a social context (Willig, 2008). Other qualitative approaches were considered, however, this approach allows a rigorous exploration of individual health experiences and is therefore particularly suited to exploring intimate topics such as sexuality (Marriott & Thompson, 2008). Another valuable benefit of IPA is its capacity to investigate human experiences within a social and cultural context (Smith et al., 2009). In IPA, research questions are typically broad and open-ended, hence the research question for our study was, "What is the lived experience of coping with the sexual side effects of SSRI medication?"

Ten women participated in this study, their details are recorded in Table 1 below. Pseudonyms were allocated to protect the identity of each woman. The age of the women ranged from 23 to 45 years of age and the length of time on SSRI medication ranged from 6 months to 15 years. Whilst no definitive criteria exist for sample size in IPA, we found a sample of ten women adequately captured patterns of similarity within the group whilst recognising the particularities of individual lives.

Table 1: Demographic information

Name	Age	Diagnosis and SSRI	Length of time on SSRI	Relationship status	Education level
Alison	29	Mild depression (escitalopram)	6 months	De Facto	Bachelor Degree
Charlotte	45	Severe depression (sertraline)	13 years	Married	Postgraduate Diploma
Helen	23	Moderate depression (escitalopram)	11 months	Married	Grade 12 completion
Julie	44	Severe depression (fluoxetine)	7 years	Married	Postgraduate Degree
Lisa	44	Severe depression (sertraline)	15 years	De facto	Postgraduate Degree
Mandy	38	Moderate depression (escitalopram)	2 years	Married	Grade 12 completion
Nadia	42	Moderate depression, panic disorder (paroxetine)	12 years	Married	Postgraduate Degree
Phoebe	40	Mild depression, panic disorder (paroxetine)	13 years	Married	Grade 12 completion
Sonia	30	Moderate depression (sertraline)	10 months	Married	Bachelor Degree
Tahlia	26	Severe depression (sertraline)	10 months	De facto	Bachelor Degree

Data collection

Prior to data collection, ethical approval was obtained from the relevant university human research ethics committee. In total, two semi-structured interviews were undertaken with each woman, both of these interviews were conducted over an eight-week period. The interviews were conducted at the woman's home or at another location chosen by the woman. As IPA aims to enable participants to share their experience of the phenomenon under investigation, Smith et al. (2009) consider semi-structured interviews to be the most appropriate form of data collection. Questions focused on personal experiences of coping with the sexual side effects of SSRI medication, and

were open-ended to generate discussion. Eight questions and a set of prompts for each question were used as a guide during the first interview; interviews lasted between 1 hour and 1 hour 45 minutes in length, and were audio recorded. The follow-up interviews were between 45 minutes and 1 hour 15 minutes. During this interview, the transcript from the first interview was reviewed with each woman and emergent themes were discussed to clarify any issues and ensure accurate interpretation. Women also provided additional comments that had emerged since the first interview.

Data analysis

The interviews were transcribed verbatim and the analysis followed the guidelines for IPA put forward by Smith et al. (2009). The analysis involved a number of stages. The first stage involved a detailed and repeated reading of each transcript to elicit ideas and meaning expressed by each woman. The left margin of the transcript was used to make note of comments that were particularly significant, and salient quotes were underlined. Emergent themes associated with key phrases were noted in the right-hand margins. These themes were then checked with each woman at the start of the second interview. The next stage involved looking for recurrent themes across the data from the ten women; during this step, themes were rationalised and removed if they did not align closely with the research question or could not be linked to any other theme. This led to a smaller final set of four super-ordinate themes and eleven sub-ordinate themes.

Reflexivity

Researchers using IPA recognise their analysis is characterised by subjectivity; indeed their main task involves offering their interpretations of participants' accounts. Several authors have discussed the importance of reflexivity in IPA, given how the researcher's presuppositions have the potential to influence the interpretation of another's lived experience (Shaw, 2010; Smith et al., 2009). As the lead researcher had experienced the sexual side effects of SSRI medication, the experience meant she was conducting the research from an insider perspective. Whilst collecting data, the researcher was conscious of the need to use neutral and open-ended

questions such as “Can you tell me about your experiences of coping with the sexual side effects of your medication?”, to draw out each woman’s story. The researcher also acknowledged her preconceptions and assumptions through jotting down thoughts in a reflexive journal (cyclical bracketing) before and immediately after the interview, and by revisiting her responses to participants’ comments after transcribing the interviews. By attempting to set aside her preconceptions immediately before the interview, the researcher felt she was able to listen attentively to the participant’s story rather than being distracted by her own experiences.

Results

The four super-ordinate themes generated from our study included: i) searching, ii) suffering in silence, iii) trying to resolve and iv) accepting what is. It is important to note that women used a number of different strategies as part of the coping process; the overall findings from the study have been reported elsewhere (O’Mullan et al., 2014). The theme “searching” describes the process women engaged in when they first experienced sexual difficulties; a search for reasons behind the sexual side effects frequently underpinned the coping experience of most women. Having a legitimate reason for their problem and finding they were not alone with their experiences, often proved to be a positive turning point. “Suffering in silence” captured the women’s sense of not being able to communicate about their experiences. A number of women who had chosen to remain silent used avoidance strategies to prevent intimate contact; others felt obligated to engage in non- pleasurable sex driven by a need to protect their partner and the relationship. In most cases, this approach was recognised as a temporary strategy for a short- term problem. The theme “trying to resolve” included a range of self- help strategies aimed at trying to fix or at least minimise the sexual side effects. At various stages throughout their journey, all women, with the exception of one, had tried to resolve their difficulties using a combination of approaches. These included altering medication, taking herbal supplements and/or taking steps to enhance sexual pleasure through use of pornography, sex toys or masturbation.

This paper reports on one theme, “accepting what is”, a strategy commonly adopted by women on long-term medication who had reached a stage of acceptance as part of the coping process. This theme has particular relevance for sex therapists working with women on long-term medication, and offers insight and practical coping strategies that may be useful in therapeutic practice. As part of this overall theme, three specific coping strategies (sub-themes) were identified. These included: i) counterbalancing the positive and negatives of SSRIs, ii) embracing the positives in the relationship, and iii) altering expectations about how sex “should be”.

Counterbalancing the positives and negatives of SSRI medication

Women in the study who had been on medication for more than twelve months, came to accept the benefits of medication. For a number of women, the acceptance of their situation stemmed from unsuccessful attempts to quit medication, the alternative to medication often meant a return to a debilitating illness. As Julie explained:

I guess I've accepted the situation to some extent. I dug myself into a really big hole a couple of years ago, um, I don't ever want to get back to that point. The medication has saved me, it really has. I've accepted that this is how it is; the medication works, and after my suicide attempt I realised just how much this medication, this little pill, has saved me.

Similarly, Lisa, who had unsuccessfully attempted to quit medication in the past, also learnt to accept she needed the medication. She also recognised the importance of maintaining her mental health irrespective of the adverse impact on sexual satisfaction:

You've got to balance it, the good and the bad I mean. You know I had a prolapsed disc in my back recently for the second time, believe me this is nothing you know. The physical is nothing compared to depression, I would never, ever come off this medication again, it has saved me. OK, so I have a low libido and I can't orgasmyes it makes me angry, but I think no point dropping your bundle over it, it's not the be all and end all.

For other women, engaging in positive self-talk and maintaining a perception of control helped them to cope more effectively with the situation. For example, Nadia talked about her choice to remain on the medication for “the

foreseeable future” and explained how she used positive self-talk to remind herself to “focus on how this tablet has changed my life”. Charlotte talked about “reaping the benefits” from her medication and again, illustrated how her choice was very much a conscious one:

I do have a choice – I can come off the medication and have a good libido but be a manic lunatic or I can stay on them and have a crap sex life but a cool, calm and collected relationship. Sometimes you just have to accept what is, and now I need to accept that this medication is working for me.

Interestingly, although the women talked about “accepting what is”, acceptance did not imply the women have given up hope. This is exemplified by a comment from Nadia:

I don't see this getting any better so I don't think there is going to be a magic solution, I really don't believe there is going to be a pink Viagra or a pill that we are going to be able to pop that makes everything better. I would love to think there would be and that would give other women and myself something to look forward to. I don't think that's gonna happen but every now and then I do jump onto Google in case there is something new on the market that might help.

Embracing the positives in the relationship

As part of an ongoing coping strategy, women in longer-term relationships described how they had started to embrace the positives within the relationship, particularly the relational aspects of sexuality such as companionship and intimacy, rather than the physical act of sex. Mandy stated:

I'm lucky, I guess, I actually get a lot out of just cuddling and kissing and being affectionate and the big thing that we always hear about is you know when the man puts the garbage out, you know I love all that stuff. You know he's been home the last week and he's been making breakfast every morning and I find that really just wonderful. And to me that's more than sex.

A focus on non-genital intimacy and maintaining an emotional connection were commonly reported by women on long-term medication. As Phoebe explained, by focusing on the emotional rather than the physiological experience, the sexual difficulties she experienced became less important:

The intimacy's still good, we still talk a lot and cuddle, we're very close. I do like the physical closeness of sex though and the feeling afterwards of connecting with somebody. So I guess it's more about, um, yeah kind of recognising that the pleasure's not there, the physical pleasure's not there but the intimacy still can be, and I can still feel connected to someone, so for me, that's a real positive".

Similarly, although sex for Julie lacked "*the sexual release, the climax*", it occurred within a caring and supportive relationship and she still derived emotional satisfaction from her sexual life:

Nowadays, I focus on the intimacy and the closeness we have. When we have sex, I think it's a way to re-connect; otherwise, it's just so busy and stressful. We just love feeling close, falling asleep together. It's a real bonus when you ah, get the physical pleasure from it too, but that's not why I do it anymore.

Nadia focused on the positive attributes in her marriage and described the mutual respect and adoration within their relationship; she also highlighted the importance of a sympathetic partner. Despite her sexual difficulties, she described her marriage as "*wonderful*" and emphasised the relational aspects:

Yeah, the pleasure stuff is lacking but I'm fortunate that I do have a partner that understands, and when we do have sex we still have the intimacy, or even without the sex we still have the intimacy. I mean, we have different ways of being intimate, things that don't necessarily involve sex per se. So yeah, I guess we hold hands a lot and we like to cuddle and hug. We're so lucky, we do have a great marriage – we make each other laugh all the time and we really do adore each other.

In contrast to women in long-standing relationships, Lisa, who was in a de facto relationship for less than two years, was able to give perspective to her sexual problems by focusing on the exhilarating aspects of her new relationship:

In the past, it may have been a bigger deal – you know, the lack of orgasms and physical sensations but I'm grateful for what we have –it's more than just sex. I mean, I waited 42 years for this man - I just love looking at him, touching him, smelling him, breathing him in. I love him, he is my best friend. Even if you took the sex away, I would still love him and would still be attracted to him.

Altering expectations about how sex “should be”

The women in this study discussed how they altered their expectations about sex, and used positive self-talk to challenge perceived social and cultural expectations of what sex should be like. Nadia commented:

And something he {the GP} said really resonated, really helped me to question my expectations you know. He said ‘You know at the end of the day most people with kids and busy lives aren’t having brilliant sex lives’. It’s like, you know, I guess again it comes back to the culture that we live in, we watch Sex and the City and we read sex in the magazines and I guess we’re in a very sexualised culture where we feel as though everyone’s having great sex all of the time, and he reminded me I guess of the reality. ‘.... what you’re experiencing, you know, maybe not that much different to what everyone else is experiencing’ he said. I guess I have a tendency to think back to how it was in my 20’s and how amazing it was. And maybe that’s not realistic, even when you’re not on Aropax.

Other women chose to acknowledge the impact of life cycle factors such as having children or stressful jobs. Whilst the SSRIs did affect desire and contribute to a number of sexual difficulties, a number of women questioned whether their expectations about sex were unrealistically high. Nadia referred to the misconceptions around sex and regularly used positive self-talk to challenge her own expectations, “*How many of my 42 year old friends are having amazing sex, hanging from the chandeliers and multiple orgasms three times a week? Just not happening...*”. For Sonia, open and honest communication with her partner, and understanding, was a key factor in helping her to alter her expectations about sex and be more accepting of the situation:

When I had brought up the topic with him [about the infrequency of sex], he just said “Oh well this is how it is now with the kids and..” yeah, so I suppose we’re kind of just accepting that this is how it is, and how it would be, even if I wasn’t on medication.

In contrast, although Charlotte was able to alter her own expectations about how sex should be, her husband had different expectations. This lack of support and understanding was problematic for Charlotte and made it difficult for her to accept the situation:

I still do the romantic dinner thing, candlelight, massage, bath – I have a bath and a few drinks, get a little tipsy and yeah, it can sometimes feel really nice. Although I do try to recreate that sexy feeling, part of me realises that sex does change as you get older and when you have kids and lots of other things going on. I don't have a problem with that, but my husband still thinks we need to be doing it 2-3 times a night, 7 nights a week. That is the problem for me.

Discussion

Given the scarcity of evidence-based treatments for the sexual side effects of SSRIs, sexual difficulties arising from this medication require a careful and multifaceted management approach. To date, none of the previous research has investigated how women, particularly those on long-term medication, cope with the sexual side effects. In our study, women on long-term medication commonly employed acceptance-based strategies as part of their coping repertoire; these were perceived to be effective in helping women to cope with enduring sexual problems. Whilst further research is needed to ascertain the circumstances in which acceptance strategies be considered as a preferred coping strategy (Kohl, Rief & Glombieweski, 2012), our findings are consistent with other studies suggesting that acceptance can enhance the treatment and management of enduring health conditions and decrease psychological distress (Jensen et al., 2014; Kohl et al., 2014; Thompson, Arnkoff & Glass, 2011).

In recent years, there has been growing interest in acceptance-based strategies within the field of sex therapy. Mindfulness-based behavioural therapy, which encourages acknowledgement and acceptance of what is in any given moment, has been shown to reduce distress amongst women with sexual difficulties arising from childhood sexual abuse, gynaecological cancer and provoked vestibulodynia (Brotto, et al., 2008; Brotto et al., 2012; Brotto et al., 2014). Likewise, acceptance and commitment therapy (ACT) which seeks to change the function of psychological events and the individual's relationship to them, rather than the event itself (Hayes, Pistorello & Levin, 2012), is showing promise for the treatment of problematic pornography viewing and for reducing distress caused by self-stigma relating to sexual orientation (Twohig & Crosby, 2010; Yadavaia & Hayes, 2012). Extrapolated

to sex therapy, Meana (2012) argues acceptance is useful in the regulation of emotions and can assist clients who live with limitations that are beyond their control. For most of the women in our study, there was recognition they were unable to achieve previous levels of sexual functioning whilst remaining on medication; as such, their coping strategy fits well with Meana's suggestion that accepting certain realities is as important as embracing change where change is possible (Meana, 2012).

By choosing to employ acceptance -based coping strategies, women highlighted how they were able to turn the experience of a less- than- perfect sexual interaction into an experience that was emotionally, if not physically, satisfying. Attempts to embrace the positives within their relationship and to challenge idealistic expectations of sex are consistent with findings from other studies focusing on the management of sexual difficulties (Mitchell et al., 2011; Svedhem, Eckert & Wijma, 2013). Our findings also fit with the "Good Enough Sex Model", a framework proposed for male, female and couple sexuality (Metz & McCarthy, 2007). This model recognises there is a trade-off between "drama/intensity and integrated/relational congruence" and provides a perspective that can be used to build a positive and genuine foundation for relationship and sexual satisfaction (McCarthy & Farr 2012, p.229). Some women in our study were able to reconceptualise sex and target unhelpful thoughts by using positive self-talk to challenge the explicit and implicit messages "sexual scripts" (Simon & Gagnon, 1984), regarding appropriate sexual behaviour and how sexual experiences should unfold. Our findings further support the idea of incorporating sex script modification into therapeutic interventions, and echo calls by other researchers to work openly with cultural assumptions around sex, and to challenge unrealistic and potentially damaging sexual scripts (Barker, 2011; Mc Cormick, 2010; Mitchell et al., 2011).

Since healthy sexuality requires both partners to value and develop a mutually comfortable level of physical and emotional satisfaction (McCarthy & Wald, 2012), we can assume the partner's norms and values also affect her. Although women's accounts of their partner's reactions to coping with the sexual side effects were varied, it became apparent that most couples had

developed a sexual style that balanced each other's needs. In our study, open and honest communication with a partner, and support and understanding appeared to play a key role in helping women to alter their expectations about sex and be more accepting of the situation. Other studies also highlight the importance of a supportive and understanding partner (Sutherland, 2012; Svedhem, Eckert & Wijma, 2013), and the value of open communication about sexual matters (Coffelt & Hess, 2014). Their findings are of significance to therapists, as women could be encouraged to reflect on their sexual difficulties in the context of their relationship. Where appropriate, couple therapy aimed at enhancing sexual communication, exploring psychosexual concerns and expanding definitions of sex and intimacy, may offer a useful approach to help the couple discover new ways to cope with the sexual difficulties arising from SSRI use.

Whilst it is important to accept limitations beyond our control, it must be noted that acceptance-based strategies do not involve a passive resignation in the face of the problem, and are not an end in itself. Rather, the goal of such strategies is to increase the "flexibility of responding in the presence of previously repertoire-narrowing experiences" and to enhance the psychological freedom of the individual (Hayes et al., 2012, p.982). Our findings revealed that although women employed acceptance as a coping strategy, this certainly did not imply they had given up hope. Active coping behaviours such as acknowledging the limitations of treatment for their difficulties, yet choosing to focus on the positives of their particular situation were regularly employed. In line with self-determination theory (Deci & Ryan, 1985), women who perceived they had choices and a sense of control over the situation, reported being able to move forward. For therapists who work with women on long-term medication, although acceptance based strategies are not a panacea, an approach that encourages women to accept and work around their sexual difficulties, rather than a symptom reduction approach, may be more effective whilst treatment options are limited.

Limitations and advantages

The limitations to this study include the homogeneity and self-selected nature of the sample. The women in the study were purposefully homogenous to enable us to explore the phenomenon of coping with SSRI- related sexual difficulties across a particular target group (heterosexual, in a relationship, under 45 years old), however, this resulted in an over representation of highly educated women. It is also probable that the women who chose to participate in the study had reached a stage of adjustment, as they were willing to talk openly about their coping experiences; women who were struggling to cope may not be represented here. The researchers recognise this study does not represent the experiences of all women who experience SSRI- related sexual difficulties; however, the purpose was not to generalise but to provide a detailed exploration of experiences from individual perspectives. Future research would benefit from interviewing diverse groups of women about their experiences, including lesbian or bisexual women, women from varied educational or ethnic backgrounds and women over the age of 45 years.

Conclusion

Limitations aside, this study has provided an important contribution to a growing discussion on the management and treatment of sexual side effects relating to SSRI use. In the absence of current effective biomedical interventions for SSRI -related sexual difficulties, acceptance -based coping strategies may offer an effective approach for women who have chosen to remain on long-term medication. Whilst acceptance is not an end in itself, it has potential to be an important therapeutic addition for professionals to consider in a sex therapy context.

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CHAPTER 7:

Summary and Recommendations

7.1 Introduction

Treating and managing the sexual side effects of SSRIs have presented a challenge to women, clinicians/health professionals, therapists and researchers. Whilst most of the research has focused on the prevalence and treatment of SSRI-related sexual difficulties, there is a paucity of research exploring how women cope specifically with the SSRI-related sexual side effects. The aim of this research was to enhance understanding of the coping experiences of women who were experiencing SSRI-related sexual difficulties that were causing problems or distress to them and/or their partners. IPA was employed as the research approach; this qualitative approach enabled women's voices and unique experiences of sexual difficulties to be captured, and ensured their sexual concerns were acknowledged and validated.

This research aimed to address the following question:

“What are the lived experiences of coping with sexual difficulties amongst heterosexual women who take SSRI medication?”

The specific objectives of the study were to:

- Explore the lived experience of coping with sexual difficulties amongst heterosexual women who had been taking SSRI medication for at least three months.
- Characterise the types of strategies used to cope with the sexual difficulties arising from SSRI use in order to assist women who are experiencing such difficulties.
- Provide recommendations to inform professional practice amongst clinicians, therapists and other relevant health professionals.

This chapter provides a brief summary of the findings in relation to the first two objectives, and outlines recommendations for practice and for further research to address the third objective.

7.2 Summary of research

This research explored the experiences of ten women who were coping with the sexual side effects of SSRI medication. By using Interpretative Phenomenological Analysis as the research approach, this study captured the unique voices of women and shared elements among them, and situated their experiences of coping within a social and cultural context. This investigation identified four discrete but overlapping themes: *searching*; *suffering in silence*; *trying to resolve* and *accepting what is*. These themes illuminate the importance of contextualising difficulties as part of an overall approach to improve both the treatment and management of these sexual side effects. They also provide an insight into the factors influencing the choice of coping strategy.

In relation to the second objective, the coping strategies employed by women in this study can be characterised by using the two broad coping classes put forward by Lazarus and Folkman (1984), namely problem- and emotion-focused coping. Problem-focused coping involved efforts to alter the situation or circumstances; in this study, the efforts included the strategies of 'searching' (for answers and validation) and 'trying to resolve' the problem. 'Searching' was identified as a key coping strategy in this study by women on both short and long-term medication, particularly during the early stages of the journey. Women frequently reported that they searched for both information and validation to help interpret their situations and to make sense of their experiences. Early interactions with GPs set the scene for how women coped; most women described their experiences as inadequate and this hindered their attempts to move forward. With the exception of one woman, women were not informed about the potential sexual side effects of SSRIs and spent prolonged amounts of time searching for answers to their problem. Consistent with previous research (Bahrack & Harris, 2009, Higgins et al., 2006), the withholding of information about sexual side effects led to

feelings of isolation, distress and confusion. Similarly, when women attempted to raise the issue of sexual side effects, their experiences of not having concerns validated by GPs led some women to cope alone or to seek support elsewhere.

For women on longer- term medication (defined as consecutive use of SSRIs for more than 12 months), problem- focused coping involved attempts to resolve sexual difficulties. Consistent with Kikuchi et al.'s (2011) study, most of these women attempted to self-manage their difficulties, in part due to the sensitive nature of their problem, but also because of previous inadequate help seeking experiences. At various stages throughout their journey, all women on longer-term medication, with the exception of one, had tried to resolve their difficulties using a combination of approaches aimed at minimising sexual side effects and enhancing sexual pleasure. Although switching medication has been identified in a number of studies as a legitimate strategy to manage SSRI-related sexual difficulties (Baldwin, 2004; Clayton & Balon, 2009), in this study, women made a conscious effort to continue medication, whilst taking steps to enhance sexual pleasure through the use of herbal supplements, pornography, sex toys or masturbation. Furthermore, in an attempt to minimise the sexual side effects, a few women on long-term medication self-managed their medication by either reducing the dosage or using drug holidays; such strategies are consistent with recommendations arising from biomedical research (Clayton & Balon, 2009; Schweitzer et al., 2009).

Emotion-focused coping involves efforts to manage the emotional rather than physical distress associated with the situation or circumstance; in this study, the efforts included the strategies of 'accepting what is' and the avoidant strategy of 'suffering in silence'. For women on longer-term medication, although a number of different strategies were employed as part of the coping process (including *searching* at the start of the coping journey, and *trying to resolve* during the later stages), acceptance based strategies were perceived to be most effective. For most of these women, they recognised they were unable to achieve previous levels of sexual functioning whilst remaining on SSRIs; as such, their coping strategy aligned with Meana's

suggestion that accepting certain realities is as important as embracing change where change is possible (Meana, 2012). It is important to note that although women on longer-term medication in this study employed acceptance as a coping strategy, this certainly did not imply they had given up hope. Instead, women consciously employed active coping behaviours such as acknowledging the limitations of treatment for their difficulties, and they chose to focus on the positives of their particular situation. Whilst acceptance is not an end in itself, these findings are consistent with other studies (Jensen et al., 2014; Kohl et al., 2014) suggesting acceptance-based strategies can enhance the treatment and management of enduring health conditions and decrease psychological distress.

The emotion-focused strategy 'suffering in silence', captured the women's sense of not being able to communicate about their experiences. This strategy was commonly employed by women on short term medication and the avoidant approaches typically included faking orgasm, avoiding sexual encounters and not communicating with a partner. Central to these approaches was the idea that relationships were at risk; hence, women perceived the need to protect their partner from disappointment, but also to protect themselves from the potential consequences of rejecting their partner. These findings are consistent with those reported by Hinchliff et al. (2012), and highlight the socially constructed nature of women's sexuality and indeed, the supremacy of the male sexual drive discourse (Ayling & Ussher, 2008). Whilst 'suffering in silence' could be labelled as maladaptive (Levahot, 2012), the findings revealed it did serve an adaptive purpose for those women who were on medication for less than two years.

Overall, the findings from this study were similar to those reported by Mitchell, King, Nazareth and Wellings (2011), that women generally manage sexual difficulties by using a number of coping strategies simultaneously but a combination that varied over time. For women coping specifically with the sexual side effects of SSRIs, the choice of coping strategy was commonly influenced by the length of time on medication, the partnership context and external influences, particularly the sociocultural context of their experiences. Consistent with findings from other qualitative studies (Ayling & Ussher,

2008; Holt & Slade, 2003; Marriot & Thompson, 2008) sexual difficulties also carried personal and relational meanings for the women; this had an impact on self-identity and influenced the type of coping strategy. Whilst the findings from this study highlighted the need for a patient-centred approach to the management of sexual difficulties, there is also a need to move beyond a biomedical approach, and recognise and address the psychological, social and cultural factors, which may influence how women cope.

7.3 Recommendations for practice

In addressing the third objective, the findings from this study have practical implications for women on SSRIs, clinicians, therapists and other relevant health professionals. For women, the findings may assist with the identification of strategies which could be used to help manage the sexual side effects of SSRIs. The findings may also provide women with a better understanding of the various factors such as psychological, social and cultural that impact their ability to cope. Additionally, by raising awareness of this important issue, this study can help to validate women's experiences, promote the realisation that they are not alone and provide reassurance. For clinicians, therapists and other relevant health professionals, a number of recommendations can be made in light of the findings from this study:

- Most women were not informed about the potential sexual side effects of SSRIs; hence, this hindered their attempts to move forward. As highlighted by several researchers, a number of prohibitive factors have been identified for this lack of communication about side effects including personal discomfort, lack of time or expertise and/or the belief that treatment options are limited (Goldstein, Lines, Pyke & Scheld, 2009; Quinn, Happell & Browne, 2011; Shifren et al., 2009). As a number of qualitative studies involving women with mental health problems have revealed, withholding information about adverse drug effects can increase distress and isolation, and potentially damage therapeutic relationships (Gray, White, Schulz & Abderhalden, 2010; Quinn et al., 2011). As such, it is proposed that sexual side effects are

discussed openly with women during the initial consultation and/or when the medication is prescribed.

- Women reported that their experiences of not having their concerns validated by GPs also impacted on how they understood and initially coped with their difficulties. In some cases, this lack of validation appeared to reinforce the 'double standard' sexual script that views females as sexually passive (McCormick, 2012, p.99). As noted by other studies, mental health clinicians, in particular, appear to perceive iatrogenic sexual difficulties as a male problem (Phillips, 2009; Quinn et al., 2011); as such, it has been assumed that women are less concerned about iatrogenic sexual difficulties and more willing to tolerate the adverse sexual effects (Higgins et al., 2006). This study's findings support the need for clinicians, therapists and other health professionals to take a proactive and empathic role when discussing sexual difficulties and to create a safe space for disclosure and validation of such problems.
- A number of scholars have highlighted the limitations of biomedical approaches and have called for biopsychosocial approaches that allow the assessment of all aspects of women's experiences (Farrell & Cacionni, 2012; Kaschak & Tiefer, 2014). Effective management of SSRI-related sexual difficulties calls for a collaborative approach, which moves beyond biomedical interventions relating to the treatment of sexual difficulties. Therapeutic interventions, which recognise the influence of social and cultural context on women's experiences, can be effective in helping women work through the influence of context on their experience. Furthermore, such interventions provide an opportunity for women to explore multiple meanings they may have around sex and help develop a positive sense of themselves.
- Since healthy sexuality requires both partners to value and develop a mutual level of physical and emotional satisfaction (McCarthy & Wald, 2012), couple therapy, which explores relationship dynamics and strategies aimed at achieving mutually satisfying outcomes within the

relationship, can also be a useful complementary approach. Couple therapy aimed at enhancing sexual communication and expanding definitions of sex and intimacy, can therefore offer a useful approach to help the couple discover new ways to cope with sexual difficulties arising from the use of SSRIs.

- Finally, for clinicians, therapists and health professionals who work with women on long-term medication, acceptance-based strategies that encourage women and their partners to accept and work with their sexual difficulties can be an effective approach whilst treatment options are currently limited. Meana (2012), argues acceptance is useful in the regulation of emotions and can assist clients who live with limitations that are beyond their control. There was recognition by many women in this study that they were unable to achieve previous levels of sexual functioning whilst remaining on medication; as such, Meana's suggestion that accepting certain realities is as important as embracing change where change is possible is particularly relevant. Although acceptance based strategies are not a panacea, and require further research as a coping strategy (Kohl, Rief & Glombieweski, 2012), in the absence of effective biomedical interventions for SSRI-related sexual difficulties, this approach has the potential to be an important therapeutic addition.

7.4 Recommendations for further research

In light of the findings obtained in this study, recommendations for further research include the following:

- This study could be replicated with women of other ethnic, cultural and educational backgrounds. As noted in other studies (Ayling & Ussher, 2008; Hinchliff, Gott & Wylie, 2012) this may offer additional insight into social and cultural elements of the coping experience.
- As lesbian relationships operate on different principles with respect to power and affect, compared to their heterosexual counterparts (Richards, Naveen & Kim, 2015), a replicate of this study could be

undertaken with lesbian women to explore whether coping strategies differ from those of their heterosexual counterparts.

- It would be useful to gather data from the partners of women who are coping with the sexual side effects of SSRI medication. As suggested by Ayling and Ussher (2008), exploring the lived experience of coping from the perspective of the partner(s), may help researchers and practitioners to better understand the impact of sexual difficulties on relationship dynamics.
- It is important to build a positive and genuine foundation to improve sexual satisfaction within a relationship (McCarthy & Farr, 2012); involving the partner in research may assist with this goal. A dyadic approach that focuses on the couple as the unit of investigation, and how they cope, may provide insight into joint coping efforts that may benefit the individuals and the relationship.

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Every reasonable effort has been made to acknowledge the owners of copyright material. I would be pleased to hear from any copyright owner who has been omitted or incorrectly acknowledged.

Appendix A: Ethics approval



Memorandum	
To	Associate Professor Maryanne Doherty, School of Public Health
From	Professor Stephan Millett, Chair, Human Research Ethics Committee
Subject	Protocol Approval HR 94/2012
Date	19 September 2012
Copy	Ms Catherine O'Mullan School of Public Health Associate Professor Rosemary Coates School of Public Health Mr Matt Tilley School of Public Health

Office of Research and Development
Human Research Ethics Committee
TELEPHONE 9266 2784
FACSIMILE 9266 3793
EMAIL hrec@curtin.edu.au

Thank you for providing the additional information for the project titled "*Coping with sexual difficulties: the lived experience of women taking Selective Serotonin Reuptake Inhibitor (SSRI) medication*". The information you have provided has satisfactorily addressed the queries raised by the Committee. Your application is now **approved**.

- You have ethics clearance to undertake the research as stated in your proposal.
- The approval number for your project is **HR 94/2012**. Please quote this number in any future correspondence.
- Approval of this project is for a period of twelve months **18-09-2012** to **18-09-2013**. To renew this approval a completed Form B (attached) must be submitted before the expiry date **18-09-2013**.
- Your project has the following special conditions: NIL

Applicants should note the following:

It is the policy of the HREC to conduct random audits on a percentage of approved projects. These audits may be conducted at any time after the project starts. In cases where the HREC considers that there may be a risk of adverse events, or where participants may be especially vulnerable, the HREC may request the chief investigator to provide an outcomes report, including information on follow-up of participants.

The attached **FORM B** should be completed and returned to the Secretary, HREC, C/- Office of Research & Development:

When the project has finished, or

- If at any time during the twelve months changes/amendments occur, or
- If a serious or unexpected adverse event occurs, or
- 14 days prior to the expiry date if renewal is required.
- An application for renewal may be made with a Form B three years running, after which a new application form (Form A), providing comprehensive details, must be submitted.

Yours sincerely,

Professor Stephan Millett
Chair Human Research Ethics Committee

Appendix B: Recruitment Flyer

Are you a female aged 18 - 45 years?

If you are currently taking antidepressant medication (examples include Prozac, Aropax, Zoloft) and you are experiencing sexual problems or difficulties.....

...here is an opportunity for you to take part in research that explores how women live and cope with these sexual problems.

Antidepressant medication can cause sexual side effects and these side effects may sometimes cause women to discontinue with their medication. Research has focused on the treating and managing these difficulties, however, little is known about how women cope with and manage the sexual difficulties that are often associated with this medication.

If you are eligible for this study, you will be asked to reflect upon your experiences of coping with the sexual difficulties or problems that are associated with this medication. The study is composed of several interviews with a researcher from Curtin University.

Confidentiality is guaranteed.

If you are willing to dedicate some time and feel able to share your experiences, please contact Cathy O'Mullan (07 4150 7153) or send an email to c.omullan@cqu.edu.au for more information



Appendix C:

Information Sheet for Participants

My name is Cathy O'Mullan and I am currently undertaking this research for my Doctor of Public Health Degree at Curtin University through the School of Public Health. **This study has been approved by the Curtin University Human Research Ethics Committee (Approval Number HR 94/2012).**

Topic. Coping with Sexual Difficulties: The Lived Experience of Women Taking Selective Serotonin Reuptake Inhibitor (SSRI) medication.

Introduction. Antidepressants have been shown to cause sexual problems and these problems can cause people to stop taking their medication. We have information on how to treat and manage these problems, but we don't know very much about how people cope with these problems or how these problems affect their daily lives. This study will explore how women on antidepressant medication cope with and manage their sexual difficulties or problems. It is hoped that the findings from this study will help us to understand how sexual problems impact on health and wellbeing, and help us to improve the support given to women.

Who is being invited to take part? I will be interviewing Australian women between 18 - 45 years of age who are currently taking antidepressants, are in a heterosexual relationship and who are experiencing sexual problems. The women will need to have been taking the medication for at least 3 months.

What is involved? If you are eligible for this study, you will be interviewed for approximately 45- 60 minutes. It is highly likely that each woman will be interviewed a few times (no more than 3 times) to consider further issues raised and for me to collate all of the information needed to acquire a greater understanding of this topic.

Participation is voluntary. Your participation is voluntary and you have the right to withdraw at any time without consequence. I greatly appreciate your consideration to be involved in this research and hope you decide to take part.

Privacy will be protected. I will be recording and transcribing all of the interviews to make sure that I capture everything we talk about. Only my supervisors and I will have access to this confidential information and it will be stored in a password protected file. The transcripts will be coded and you will not be able to be identified at any stage. Transcripts will be stored at CQUniversity (Bundaberg campus), and permanently destroyed after 7 years.

Further Contact Details

Cathy O'Mullan Ph 07 4150 7153 or c.omullan@cqu.edu.au

Supervisor contact: Assoc. Professor Maryanne Doherty. Ph 08 9266 3707 or M.Doherty@curtin.edu.au

You are welcome to contact me or my supervisor at any time should you choose to do so.

Appendix D: Informed Consent Form

Title of Research: Coping with Sexual Difficulties: The Lived Experience of Women Taking Selective Serotonin Reuptake Inhibitor (SSRI) medication.

Researcher: Cathy O'Mullan

I _____ have read and understood all of the information related to this research. I acknowledge the identity of the researcher, the issues being explored and the reasons for undertaking this research.

Furthermore, I understand that I will be interviewed and be asked to share my personal experiences and understanding of the issues being researched. Additionally, I understand that there will be a minimum of 2 and a maximum of 3 interviews and that each interview will be approximately 45 -60 minutes in length.

I am aware that this research has been approved by Curtin University of Technology Human Research Ethics Committee (Approval number HR94 /2012), and that my participation is voluntary. I also understand that I may withdraw from this study at any time without consequence.

I accept that all communication in my interview will be voice recorded, transcribed and kept on a protected software file for 7 years. After such time, the file will be permanently destroyed. I also acknowledge that any data that could identify me will be removed from the final report or any publications or presentations pertaining to the research.

I also acknowledge that my confidentiality will be maintained at all times.

I understand that I may contact either the researcher or the supervisor should I choose to do so.

Cathy O'Mullan
c.omullan@cqu.edu.au
(07) 4150 7153

Associate Professor Maryanne Doherty
M.Doherty@curtin.edu.au
(08) 9266 3707.

Therefore, I consent to participation in this research.

Name: (please print) _____

Signature: _____

Date: _____

Researcher: _____

Signature: _____

Date: _____

Please contact Curtin University (08 9266 9223) if you have any concerns about this project and quote project number HR94/2012

Appendix E:

Interview schedule

Profile Questions

Age:

Relationship Status (eg married, co habiting):

Length of current relationship:

Name of SSRI:

Length of time on medication:

How would you rate your depression? (Mild / Moderate/ Severe)

Highest level of education:

General Guiding Questions

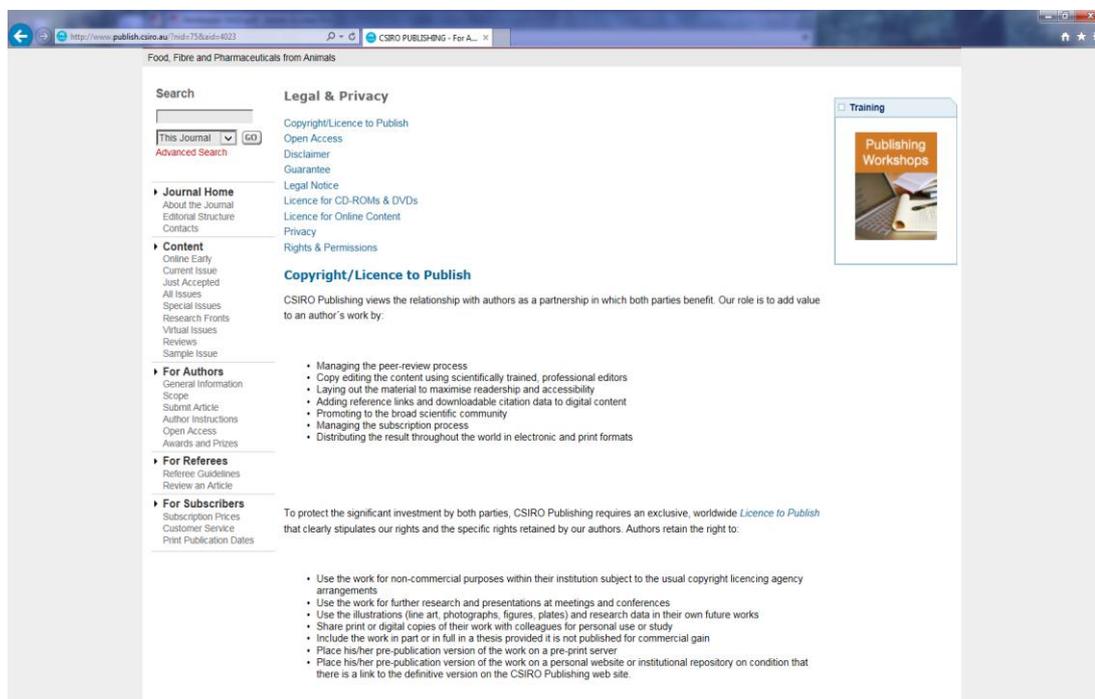
- Can you tell me about the sexual difficulties (side effects) you are experiencing?
- Can you tell me if there are any specific sexual difficulties that cause more problems or distress than others?
- How have these sexual difficulties impacted upon your life?
- Can you describe to me the strategies you have put in place to cope with the sexual difficulties that have been experienced?
- What has been the most difficult part of your *overall experience* of coping with sexual difficulties whilst taking this medication?
- Is there anything else that you think is important to share?

Appendix F:

Copyright/Licence to Publish Agreement (CSIRO – Australian Journal of Primary Health)

For further details of this agreement:

<http://www.publish.csiro.au/?nid=75&aid=4023>



The screenshot displays the CSIRO Publishing website interface. The browser address bar shows the URL <http://www.publish.csiro.au/?nid=75&aid=4023>. The page title is "Food, Fibre and Pharmaceuticals from Animals". The main content area is titled "Legal & Privacy" and includes a "Copyright/Licence to Publish" section. This section states: "CSIRO Publishing views the relationship with authors as a partnership in which both parties benefit. Our role is to add value to an author's work by:" followed by a list of services: Managing the peer-review process, Copy editing the content using scientifically trained, professional editors, Laying out the material to maximise readership and accessibility, Adding reference links and downloadable citation data to digital content, Promoting to the broad scientific community, Managing the subscription process, and Distributing the result throughout the world in electronic and print formats. Below this, it notes: "To protect the significant investment by both parties, CSIRO Publishing requires an exclusive, worldwide Licence to Publish that clearly stipulates our rights and the specific rights retained by our authors. Authors retain the right to:" followed by a list of author rights: Use the work for non-commercial purposes within their institution subject to the usual copyright licencing agency arrangements, Use the work for further research and presentations at meetings and conferences, Use the illustrations (line art, photographs, figures, plates) and research data in their own future works, Share print or digital copies of their work with colleagues for personal use or study, Include the work in part or in full in a thesis provided it is not published for commercial gain, Place his/her pre-publication version of the work on a pre-print server, and Place his/her pre-publication version of the work on a personal website or institutional repository on condition that there is a link to the definitive version on the CSIRO Publishing web site. The left sidebar contains navigation menus for "Search", "Journal Home", "Content", "For Authors", "For Referees", and "For Subscribers". A "Training" box on the right features a "Publishing Workshops" graphic.

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From: Helen.Pavlatos@csiro.au [mailto:Helen.Pavlatos@csiro.au]

Sent: Friday, 23 May 2014 10:34 AM

To: Catherine O'Mullan

Subject: Australian Journal of Primary Health: online early PDF reprint (PY13172)

Dear Cathy

Congratulations! Your paper has now been published Online Early in *Australian Journal of Primary Health*.

Online Early is a service being offered to our authors whereby your paper is published online in advance of being allocated to an issue.

At this stage the paper does not have final page numbers, volume or issue information. These will be added when the paper is included in an issue. However, the Online Early paper is considered the 'version of record' and has a DOI which can be used to cite the paper. *For convenience, the PDF version of the paper is given temporary pagination which is unrelated to the final pagination in the issue.* You can view the your paper online from the journal website www.publish.csiro.au/journals/py

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Yours sincerely

Helen Pavlatos

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E helen.pavlatos@csiro.au **T** +61 3 9662 7613 **F** +61 3 9662 7611

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Appendix G: Copyright/Licence to Publish Agreement (Taylor & Francis – Psychology & Health, Sex & Relationship Therapy Journal)

For further details of this agreement:

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Correspondence)**

From: Academic Journals CSMT Production [csmt-production@tandf.co.uk]
Sent: Wednesday, 29 April 2015 4:43 PM
To: Catherine O'Mullan
Subject: Re: Copyright question for Manuscripts (Taylor and Francis)

Dear Cathy,

Apologies for not getting back to you on this earlier.

Unfortunately, it is prohibited to use the published paper as part the doctoral thesis but you can use the Author Accepted Manuscript (AAM). The AAM is defined as the manuscript in its accepted, post-peer review form, but not the final published article.

Do let me know if you have any questions.

Best wishes,

Sudeshna

Sudeshna Nandy

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Appendix H: Statements of Contributions (Co-authors)

To whom it may concern,

I, Associate Professor Maryanne Doherty, contributed as Primary Supervisor of this Dr of Public Health thesis. I had an ongoing close involvement with the research including contributing to the project proposal, discussing the structure of papers, the reading of drafts and making suggestions for improvements to the papers entitled:

1) O'Mullan, C., Doherty, M., Coates, R., & Tilley, P. M. (2014). Women's experiences of coping with the sexual side effects of antidepressant medication. *Psychology & health*, 29(12), 1388-1406.

2) O'Mullan, C., Doherty, M., Coates, R., & Tilley, P. M. (2014). Searching for answers and validation: Australian women's experiences of coping with the adverse sexual effects of antidepressants. *Australian Journal of Primary Health* (ahead of print).

3) O'Mullan, C., Doherty, M., Coates, R., & Tilley, P. M. (2015). 'Accepting what is': an approach for managing the long-term sexual side effects of selective serotonin reuptake inhibitors (SSRIs) in women. *Sexual and Relationship Therapy*, (ahead of print), 1-13.

with Catherine O'Mullan.

Signed: _____



Associate Professor Maryanne Doherty (Primary Supervisor/co-author)

Signed: _____



Catherine O'Mullan

Statements of Contributions (Co-authors)

To whom it may concern,

I, Professor Rosemary Coates contributed as Co-supervisor of this Dr of Public Health thesis. I had an ongoing involvement with the research including contributing to the project proposal, the reading of drafts and making suggestions for improvements to the papers entitled:

1) O'Mullan, C., Doherty, M., Coates, R., & Tilley, P. M. (2014). Women's experiences of coping with the sexual side effects of antidepressant medication. *Psychology & health*, 29(12), 1388-1406.

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with Catherine O'Mullan.

Signed: 

Professor Rosemary Coates (Co –supervisor/co-author)

Signed: 

Catherine O'Mullan



Statements of Contributions (Co-authors)

To whom it may concern,

I, Mr P.J. Matt Tilley contributed as Co-supervisor of this Dr of Public Health thesis. I had an ongoing involvement with the research including contributing to the project proposal, the reading of drafts and making suggestions for improvements to the papers entitled:

1) O'Mullan, C., Doherty, M., Coates, R., & Tilley, P.J.M. (2014). Women's experiences of coping with the sexual side effects of antidepressant medication. *Psychology & health*, 29(12), 1388-1406.

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with Catherine O'Mullan.

Signed: 

P.J. Matt Tilley (Co-supervisor/co-author)

Signed: 

Catherine O'Mullan