THE UNIVERSITY OF SOUTHAMPTON

Antidepressant drugs and sexual dysfunction

Two volumes

Volume 2

Appendices and References

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LIST OF CONTENTS

VOLUME TWO

Appendix 1.1 Examples of ICD-10 defined sexual dysfunction

F52 Sexual dysfunction, not caused by organic disorder or disease

G1. The subject is unable to participate in a sexual relationship as he or she would wish.

G2. The dysfunction occurs frefquently, but may be absent on some occasions.

G3. The dysfunction has been present for at least six months.

G4. The dysfunction is not entirely attributable to any of the other mental and behavioural disorders in ICD-10, physical disorders or drug treatment.

F52.0 Lack or loss of sexual desire

A. The general criteria for sexual dysfunction (F52) must be met.

B. There is a lack or loss of sexual desire, manifest by diminution of seeking out sexual cues, or thinking about sex with associated feelings of desire or appetite, or of sexual fantasies.

C. There is a lack of interest initiating sexual activity either with a partner or as solitary masturbation, resulting in a frequency of activity clearly lower than expected, taking into account age and context, or in a frequency very clearly reduced from much higher levels.

F52.2 Failure of genital response

A. The general criteria for sexual dysfunction (F52) must be met.

In addition, for men:

B. Erection sufficient for intercourse fails to occur when intercourse is attempted. The dysfunction takes one of the following forms:

(1) full erection occurs during the early stages of lovemaking but disappears or declines when intercourse is attempted (before ejaculation if it occurs);

(2) erection does occur, but only at times when intercourse is not being considered;

(3) partial erection, insufficient for intercourse, occurs, but not full erection;

(4) no penile tumescence occurs at all.

In addition for women:

B. There is failure of genital response, experienced as failure of vaginal lubrication, together with inadequate tumescence of the labia. The dysfunction takes one of the following forms:

(1) general: lubrication fails in all relevant circumstances;

(2) lubrication may occur initially but fails to persist for long enough to allow comfortable penile entry;

(3) situational: lubrication occurs only in some situations (e.g. with one partner but not another, or during masturbation, or when sex is not contemplated).

Appendix 1.2

Examples of DSM-IV defined sexual dysfunction

302.71 Hypoactive sexual desire disorder

- Persistent or recurrent deficient or absent sexual fantasies and desire for sexual activity
- Disturbance causes marked distress or interpersonal difficulty
- Not better accounted for by another Axis I disorder and not due exclusively to direct physiological effects of a substance or general medical condition

302.72 Male erectile disorder

- Persistent or recurrent inability to attain, or to maintain until completion of sexual activity, an adequate erection
- Disturbance causes marked distress or interpersonal difficulty
- Not better accounted for by another Axis I disorder and not due exclusively to direct physiological effects of a substance or general medical condition

302.73 Female orgasmic disorder

- Persistent or recurrent delay in, or absence of, orgasm following a normal sexual excitement phase
- Disturbance causes marked distress or interpersonal difficulty
- Not better accounted for by another Axis I disorder and not due exclusively to direct physiological effects of a substance or general medical condition

Substance-induced sexual dysfunction

- Clinically significant sexual dysfunction that results in marked distress or interpersonal difficulty predominates the clinical picture
- Evidence from the history, physical examination or laboratory findings that the sexual dysfunction is fully explained by substance use as manifested by either (1) or (2)
    1. Symptoms developed during or within a month of intoxication
    2. Medication use is aetiologically related to the disturbance
- Disturbance is not better accounted for by a sexual dysfunction that is not substance induced

Appendix 2.1

HAMILTON RATING SCALE FOR DEPRESSION (HAM-D)

CIRCLE THE NUMERIC CODE which best describes the patient

1. DEPRESSED MOOD: (Sadness, hopeless, helpless, worthless)

   0 Absent
   1 These feeling states indicated only on questioning
   2 These feeling states spontaneously reported verbally
   3 Communicates feeling states non-verbally – i.e. through facial expression, posture, voice, and tendency to weep
   4 Patient reports VIRTUALLY ONLY these feeling states in his spontaneous verbal and non-verbal communication

2. FEELINGS OF GUILT

   0 Absent
   1 Self-reproach, feels he has let people down
   2 Ideas of guilt or rumination over past errors or sinful deeds
   3 Present illness is a punishment. Delusions of guilt
   4 Hears accusatory or denunciatory voices and/or experiences threatening visual hallucinations

3. SUICIDE

   0 Absent
   1 Feels life is not worth living
   2 Wishes he were dead or any thoughts of possible death to self
   3 Suicide ideas or gestures
   4 Attempts suicide (any serious attempt rates 4)

4. INSOMNIA EARLY

   0 No difficulty falling asleep
   1 Complains of occasional difficulty falling asleep, i.e. more that ½ hour
   2 Complains of nightly difficulty falling asleep

5. INSOMNIA MIDDLE

   0 No difficulty
   1 Patients complains of being restless and disturbed during the night
   2 Waking during the night – any getting out of bed rates 2 (except for purposes of voiding)

6. INSOMNIA LATE

0 No difficulty
1 Waking in early hours of the morning but goes back to sleep
2 Unable to fall asleep again if get out of bed

7. WORK AND ACTIVITIES

0 No difficulty
1 Thoughts and feeling of incapacity, fatigue, or weakness related to activities, work, or hobbies
2 Loss of interest in activity, hobbies or work – either directly reported by patient, or indirect in listlessness., indecision and vacillation (feels he has to push self to work or join activities)
3 Decrease in actual time spent in activities or decrease in productivity. In hospital, rate 3 if patients does not spend at least three hours a day in activities (hospital job or hobbies) exclusive of ward chores
4 Stopped working because of present illness. In hospital, rate 4 if patient engages in no activities except ward chores; or if patient fails to perform ward chores unassisted

8. RETARDATION: Slowness of thought and speech; impaired ability to concentrate; decreased motor activity

0 Normal speech and thought
1 Slight retardation at interview
2 Obvious retardation at interview
3 Interview difficult
4 Complete stupor

9. AGITATION

0 None
1 Fidgetiness
2 "Playing with" hands, hair, etc
3 Moving about, can't sit still
4 Hand-wringing, nail-biting, hair-pulling, biting of lips

10. ANXIETY/PSYCHIC

0 No difficulty
1 Subjective tension and irritability
2 Worrying about minor matters
3 Apprehensive attitude apparent in face or speech
4 Fears expressed without questioning

11. ANXIETY (SOMATIC): Physiological concomitants of anxiety, such as: gastrointestinal – dry mouth, wind, indigestion, diarrhoea, cramps, belching; cardiovascular – palpitations, headaches; respiratory – hyperventilation, sighing; urinary frequency; sweating.

    0 Absent
    1 Mild
    2 Moderate
    3 Severe
    4 Incapacitating

12. SOMATIC SYMPTOMS/GASTRO-INTESTINAL

    0 None
    1 Loss of appetite but eating without staff encouragement. Heavy feelings in abdomen
    2 Difficulty eating without staff urging. Requests or requires laxatives or medication for bowels or medication for gastro-intestinal symptoms

13. SOMATIC SYMPTOMS/GENERAL

    0 None
    1 Heaviness in limbs, back or head. Backaches, headaches, muscle aches. Loss of energy and fatigability
    2 Any clear-cut symptom rates 2

14. GENITAL SYMPTOMS: Loss of libido, menstrual disturbances

    0 Absent
    1 Mild
    2 Severe

15. HYPRCHONDRIASIS

    0 Not present
    1 Self-absorption (bodily)
    2 Preoccupation with health
    3 Frequent complaints, requests for help, etc.
    4 Hypochondrial delusions

16. LOSS OF WEIGHT

    0 No weight loss, or weight loss NOT caused by present illness
    1 Weight loss probably caused by present illness
    2 Definite weight loss caused by present illness

17. INSIGHT

0 Acknowledges being depressed and ill
1 Acknowledges illness but attributes cause to bad food, climate, overwork, virus, need for rest, etc
2 Denies being ill at all

18. DIURNAL VARIATION

A Note whether symptoms are worse in morning or evening. If NO diurnal variation, mark none

0 No variation
1 Worse in A.M.
2 Worse in P.M.

B When present, mark the severity of the variation. Mark "None" if NO variation

0 None
1 Mild
2 Severe

19. DEPERSONALIZATION AND DEREALIZATION: Such as: Feeling of unreality; nihilistic ideas

0 Absent
1 Mild
2 Moderate
3 Severe
4 Incapacitating

20. PARANOID SYMPTOMS

0 None
1 Suspicious
2 Ideas of reference
3 Delusions of reference and persecution

21. OBSESSIONAL AND COMPULSIVE SYMPTOMS

0 Absent
1 Mild
2 Severe

Appendix 2.2

Clinical Global Impression Scales

Clinical Global Impression of Severity of Illness

Considering your total clinical experience with this particular population, how ill is this patient at this time?

- ○ 1. Normal, not at all ill
- ○ 2. Borderline ill
- ○ 3. Mildly ill
- ○ 4. Moderately ill
- ○ 5. Markedly ill
- ○ 6. Severely ill
- ○ 7. Among the most extremely ill patients

Clinical Global Impression of Improvement

Compared to the patient's condition at baseline, how much has the patient changed?

Rate total improvement whether or not, in your judgement, it is due entirely to drug treatment.

- ○ 1. Very much improved
- ○ 2. Much improved
- ○ 3. Minimally improved
- ○ 4. No change
- ○ 5. Minimally worse
- ○ 6. Much worse
- ○ 7. Very much worse

The following published papers were included in the bound thesis. These have not been digitised due to copyright restrictions, but the links are provided.

M.I.N.I – Mini International Neuropsychiatric Interview – English version 5.0.0 DSM-IV

https://eprovide.mapi-trust.org/instruments/mini-international-neuropsychiatric-interview [Accessed 14th January 2026]

Appendix 3.2

SEXUAL FUNCTION AND ENJOYMENT QUESTIONNAIRE FOR MEN

Please tick one answer for each question

Has your desire for sex changed?	**Please tick**
Reduced a lot	
Reduced a little	
Stayed the same	
Increased a little	
Increased a lot	
How easy is it to achieve your normal erection?	
A lot less	
A little less	
Same as usual	
A little more	
A lot more	
Has your ability to maintain an erection changed?	
Much worse than usual	
A little worse than usual	
Same as usual	
A little more than usual	
Much more than usual	
Has your ability to ejaculate ('come') changed?	
Much less easy than usual	
A little less easy than usual	
Same as usual	
A little more easier than usual	
Much more easier than usual	
Can you enjoy sex?	
Much less than usual	
A little less than usual	
Same as usual	
A little more than usual	
Much more than usual	

Appendix 3.3

SEXUAL FUNCTION AND ENJOYMENT QUESTIONNAIRE FOR WOMEN

Please tick one answer for each question

Has your desire for sex changed?	**Please tick**
Reduced a lot	
Reduced a little	
Stayed the same	
Increased a little	
Increased a lot	
Do you become as aroused as you used to?	
A lot less	
A little less	
Same as usual	
A little more	
A lot more	
Has your ability to achieve orgasm changed?	
Much worse than usual	
A little worse than usual	
Same as usual	
A little more easy than usual	
Much more easy than usual	
Are you satisfied with the intensity of your orgasm?	
Much less than usual	
A little less than usual	
Same as usual	
A little more than usual	
Much more than usual	
Can you enjoy sex?	
Much less than usual	
A little less than usual	
Same as usual	
A little more than usual	
Much more than usual	

APPENDIX 3.4

CLINICAL VIGNETTE FOR EACH PATIENT

Patient P001

A 41-year old single man, with a probable family history (mother) of schizophrenia. He was abused sexually and physically at boarding school. He developed pronounced fatigue at the age of 35 years, and became progressively more disabled over the next six years, with a self-diagnosis of myalgic encephalomyelitis. He developed depressive symptoms and was referred to another consultant, leading to the diagnosis of chronic fatigue syndrome and secondary depression, but treatment with clomipramine proved unhelpful. He became disenchanted with his medical care and was referred for a second opinion. The diagnosis was chronic fatigue syndrome. His treatment at interview was moclobemide 150 mg b.d. Interview with the MINI generated DSM-IV diagnoses of current major depressive episode, current bipolar disorder, current panic disorder with agoraphobia, current obsessive-compulsive disorder, lifetime mood disorder with psychotic features and current post-traumatic stress disorder. He had no sexual partner, and described increased sexual desire, considerable difficulty in achieving erection, considerable difficulty in ejaculation, and slight reduction in ability to enjoy sex.

Patient P002

A 51-year old divorced woman and mother of two adult sons, with long-standing mental and physical health problems. She experienced her first depressive episode when aged 20 years, the second twenty years later. She had six further episodes between 1990 and 1996, despite prescription of antidepressant drugs and considerable support from a community mental health nurse, each episode resulting in hospital admission. The psychiatric diagnosis was recurrent depressive disorder. Her current physical health problems included breathlessness due to chronic obstructive pulmonary disease, abdominal pain of unknown cause, and stress incontinence. Previous surgical procedures included appendectomy, cholecystectomy, hysterectomy and vesical colposuspension. Her GP was prescribing venlafaxine 225 mg/day; diazepam 2 mg b.d.; nitrazepam 5 mg nocte; chlorpromazine 200 mg nocte; procyclidine 5 mg t.d.s.; sodium valproate 600 mg b.d.; prednisolone 40 mg per day; theophylline 100 mg per day; ranitidine 300 mg per day; 'Co-dydramol' two tablets q.d.s p.r.n; and flavoxate hydrochloride 200 mg t.d.s. Her breathlessness was partly controlled with beclomethasone dipropionate inhaler 500 mcg b.d.; salbutamol inhaler 100-200 mcg q.d.s; ipatropium bromide nebuliser solution 500 mcg q.d.s; and eformoterol fumarate 24 mcg b.d. Interview with the MINI generated DSM-IV diagnoses of current major depressive episode, current agoraphobia without history of panic disorder, current social phobia, and current post traumatic stress disorder. She had been sexually assaulted repeatedly by her husband prior to their divorce, had no current sexual partner and described long-standing loss of sexual desire, impairment in arousal, and had not experienced orgasm for many years.

Patient P003

A 62-year old married man and father of an adult daughter, with a family history (mother) of bipolar affective disorder and suicide. He experienced his first depressive episode when aged 34 years, then developed a cycling affective illness with recurrent depressive and probable hypomanic episodes; three depressive episodes resulted in hospital admission. This cycling pattern lasted over 10 years, before he started prophylactic treatment with lithium. He remained well for ten years, but experienced mild depressive symptoms in five of the previous six winters, before his assessment. He underwent cholecystectomy in 1975. The psychiatric diagnosis was probable bipolar affective disorder, currently euthymic. He described nocturia and breathlessness in the summer, but reported no other physical health problems. He was being prescribed lithium carbonate 900 mg nocte and venlafaxine 75 m.g. b.d. His wife had recently experienced a depressive episode associated with reactivation of dormant pulmonary tuberculosis, acquired during wartime internment. Interview with the MINI generated no current DSM-IV diagnosis. He and his wife were sexually active, but he described reduction in sexual interest, difficulty in achieving and maintaining erection, and reduced ability to enjoy sexual activity.

Patient P004

A 55-year old married woman with five adult children (one adopted) and a family history (sister, daughter) of recurrent depressive disorder. She experienced her first depressive episode after the birth of one of her children; the second episode fifteen years later after the death of her mother and father; and multiple episodes between 1980 and 1996, despite prescription of antidepressant drugs. The psychiatric diagnosis was recurrent depressive disorder. She had undergone appendectomy in 1974, and hysterectomy in 1982. Her current physical health problems included abdominal pain and changeable bowel habit (attributed to 'irritable bowel syndrome'), joint pain and stiffness, stress incontinence, vulval itching and long-standing insomnia. Her GP was prescribing paroxetine 30 mg mane; nitrazepam 5 mg nocte; cimetidine 400 mg b.d. and 'Oestroderm' patches every third day. Interview with the MINI generated no current DSM-IV diagnosis. She reported that she and her husband engaged in sexual activity very infrequently, and described reductions in sexual desire and arousal.

Patient P005

A 46-year old married man with two adult children. He experienced emotional and physical abuse during childhood, and was recognised as dyslexic in his teenage years. He experienced a manic episode when aged 37 years, a subsequent depressive episode requiring treatment with electroconvulsive therapy. Prophylactic treatment with lithium was started one year after the onset of his affective illness, but lithium was stopped within two years. He then experienced infrequent brief depressive or hypomanic episodes over the next seven years, associated with irregular compliance with prescribed psychotropic drugs. The psychiatric diagnosis was bipolar affective disorder, currently depressed. There was no history of physical health problems. He was prescribed venlafaxine 75 mg b.d. and lamotrigine 100 mg per day. Interview with the MINI generated DSM-IV

diagnoses of current major depressive episode, past bipolar disorder, current agoraphobia without history of panic disorder, and current social phobia. Although he and his wife engaged in regular sexual activity, he described reduction in sexual desire, difficulty in achieving and maintaining erection, some difficulty in ejaculation, and reduced ability to enjoy sexual relations.

Patient P006

A 35-year old married woman with two children, and a family history (mother) of schizoaffective disorder. When aged 26 years, she developed a puerperal psychotic illness in the first week after delivery of her first child, was admitted to hospital under the Mental Health Act and treated for three weeks with amitriptyline and thioridazine. She was readmitted in a perplexed state three days later, and responded to electroconvulsive therapy (six applications). Despite starting lithium prophylaxis in the late stages of her second pregnancy, she developed a puerperal psychotic illness two weeks after delivery; she was admitted to hospital and treated with sulpiride, lithium and electroconvulsive therapy (three applications). Three months after stopping lithium, she developed a psychotic depressive illness with akinetic mutism. She was admitted to hospital, detained under the Mental Health Act, and required treatment with electroconvulsive therapy (five applications), before being discharged on lithium, paroxetine and an oral contraceptive pill. The psychiatric diagnosis was recurrent affective disorder with psychotic features (probably bipolar disorder). When interviewed her treatment was lithium carbonate 1200 mg nocte; fluoxetine 20 mg and 40 mg, on alternate days; and 'Microgynon'. Interview with the MINI generated DSM-IV diagnoses of past bipolar disorder, lifetime panic disorder, and lifetime mood disorder with psychotic features. She and her husband had sexual relations, but she described significant reductions in sexual desire and arousal, difficulty in achieving and dissatisfaction with orgasm, and significant reduction in her ability to enjoy sex.

Patient P007

A 34-year old divorced man, troubled by severe anxiety symptoms since late adolescence. He experienced his first panic attack when aged 17 years, and became increasingly agoraphobic throughout adult life. Previous drug treatment with clomipramine and phenelzine was unhelpful, and exposure therapy was also ineffective. The psychiatric diagnosis was panic disorder with agoraphobia. He reported no previous or current physical health problems. Treatment with paroxetine for 12 months (current dose 60 mg per day) had been associated with a significant reduction in agoraphobic avoidance and the frequency of panic attacks, despite the recent death of his mother. He started attending an anxiety management group led by a community mental health nurse two months prior to the interview. The MINI generated DSM-IV diagnoses of current panic disorder with agoraphobia, and current social phobia. He had no sexual partner, but described difficulty in achieving erection, and consistent delay in ejaculation.

Patient P008

A 32-year old single man, with a family history (father) of depression. He developed obsessional ruminations, compulsive rituals and excessive hoarding when aged 19 years, and depressive

symptoms two years later. He was referred to mental health services when aged 32 years, but did not respond to outpatient treatment with antiobsessional antidepressant drugs (clomipramine, fluoxetine) either alone or in combination with behaviour therapy, and two months of inpatient treatment was unhelpful. He was referred for a second opinion after deriving no benefit from augmentation of fluoxetine with risperidone. The psychiatric diagnosis was obsessive-compulsive disorder. His current treatment was fluoxetine 20 mg b.d. Interview with the MINI generated DSM-IV diagnoses of current obsessive-compulsive disorder and current generalised anxiety disorder. He had no sexual partner, and described no disturbance in his sexual function.

Patient P009

A 48-year old woman, separated but not divorced from her husband, with two teenage sons. There is a family history of depression (mother, sister) and eating disorder (another sister, niece). She attempted suicide three times in her teenage years, and was raped when aged 25 years. Her first (current) depressive episode started when aged 46 years, was associated with alcohol abuse and repeated deliberate self-harm, and resulted in admission and readmission, and treatment with electroconvulsive therapy. There was no significant medical history. The psychiatric diagnosis was depressive episode. She was prescribed venlafaxine 75 mg mane, 37.5 mg in the evening; lithium carbonate 800 mg nocte; and was drinking approximately 14 units of alcohol per week. Interview with the MINI generated DSM-IV diagnoses of current major depressive episode, current social phobia, current specific phobia, current obsessive-compulsive disorder, and current alcohol dependence. She stated that she had not experienced a sexual relationship for 18 years, although the medical notes indicate she was the sexual partner of a married man. She described herself as more able to enjoy sex than usual, but also described consistent difficulty in achieving and reaching orgasm, and dissatisfaction in achieving with the intensity of orgasm.

Patient P010

A 46-year old man, with a family history of depression and persecutory delusions (mother). He became troubled by panic attacks, anticipatory anxiety, depressive symptoms, obsessional ruminations and compulsive rituals at the age of 43 years. The psychiatric diagnosis was probable panic disorder with agoraphobia and secondary depression, although he had some ideas of reference. These symptoms had not resolved with a range of drug treatments including fluoxetine, imipramine (with subsequent lithium augmentation), clomipramine, and concomitant antipsychotic treatment (sulpiride) or anxiolytic medication (diazepam). He developed bilateral sensorineuronal deafness when aged 3 years, and experienced intestinal obstruction when aged 5 years. At the time of interview, he was being prescribed clomipramine 250 mg nocte and diazepam 2 mg b.d. Interview with the MINI generated DSM-IV diagnoses of current major depressive episode, past bipolar disorder, current panic disorder with agoraphobia, current social phobia, current obsessive-compulsive disorder, and current mood disorder with psychotic features. He had regular sexual relations with a long-standing (25 years) homosexual partner, but described reduction in sexual

desire, difficulty in achieving and maintaining erection, difficulty in ejaculation and reduced ability to enjoy sex.

Patient P011

A 40-year old married woman and mother of three adolescent children, with a family history of depression (mother) and alcohol dependence (father). She was sexually abused repeatedly by a family member in her early teenage years, and had intermittent depressive symptoms at that time. Her first and second depressive episodes occurred after late miscarriages of pregnancy; a third followed a brief separation from her alcohol dependent husband. Eighteen months prior to referral she had sustained minor injuries in a traffic accident, and developed depressive symptoms, panic attacks and agoraphobic avoidance. The psychiatric diagnosis was recurrent depressive disorder, and panic disorder with agoraphobia. She had undergone appendectomy, caesarean section in her third pregnancy, and hysterectomy when aged 38 years: her current physical health problems were limited to epigastric discomfort arising from a hiatus hernia. She was prescribed nefazodone 200 mg t.d.s; cisapride 10 mg t.d.s.; and omeprazole 10 mg mane. Interview with the MINI generated the DSM-IV diagnoses of current major depressive episode; and current panic disorder with agoraphobia. She and her husband had regular sexual relations, but she described reduction in sexual desire and arousal, difficulty in achieving orgasm, dissatisfaction with orgasm and reduced ability to enjoy sex.

Patient P012

A 40-year old single woman, with one son (adopted away when aged three years). There is a family history (brother) of learning disability, and the patient was recognised as having borderline learning disability by the age of 17 years. She was abused physically by her father during childhood, and had several sexual relationships with physically abusive older men in early adult life. She experienced multiple depressive and manic episodes, some requiring hospital admission and treatment with electroconvulsive therapy. Her last period of inpatient care was when aged 34 years, when she started lithium prophylaxis. The psychiatric diagnosis was bipolar affective disorder. Her treatment was lithium carbonate 1200 mg nocte; lofepramine 280 mg nocte; and sulpiride 400 mg nocte. Interview with the MINI generated DSM-IV diagnoses of past bipolar disorder, lifetime mood disorder with psychotic feature, lifetime panic disorder and current post-traumatic stress disorder. She and her aged boyfriend had infrequent sexual relations: she described some reduction in sexual arousal.

Patient P013

A 37-year old single man, with a family history of schizophrenia (brother) and recurrent depression (sister). He developed severe disabling obsessional ruminations at the age of 16 years, but was not referred for 10 years. The psychiatric diagnosis was obsessive-compulsive disorder. He did not respond to drug treatment with clomipramine, clomipramine augmented with sulpiride, tranylcypromine, or clomipramine with lithium augmentation. Behaviour therapy and individual psychotherapy proved unhelpful, and he underwent stereotactic sub-caudate tractomy when aged

28 years, with no lasting benefit. Subsequent anti-androgen treatment and high-dose clomipramine treatment were both unsuccessful. He was referred back when aged 36 years, but did not respond to fluoxetine, or fluoxetine combined with buspirone. His treatment was fluoxetine 20 mg t.d.s. and buspirone 5 mg b.d. Interview with the MINI generated DSM-IV diagnoses of current major depressive episode, and current obsessive-compulsive disorder. He had no sexual partner, and described considerable difficulty in ejaculation since starting fluoxetine treatment.

Patient P014

A 37-year married woman with six children. She developed anxiety and depressive symptoms two months after delivery of her youngest child; three months later she became troubled by panic attacks and agoraphobic avoidance. She was recognised as having thyrotoxicosis, and was treated with propranolol and carbimazole: her depressive symptoms persisted and she was referred. The psychiatric diagnosis rested between depressive illness and panic disorder. She was unable to tolerate treatment with amitriptyline, imipramine or lofepramine, but improved with nefazodone. Her treatment was nefazodone 200 mg t.d.s. Interview with the MINI generated DSM-IV diagnoses of current major depressive episode, current panic disorder with agoraphobia, current social phobia, and current specific phobia (airplanes). She and her husband had infrequent sexual relations: she described reduction in sexual interest and arousal, some difficulty in achieving and dissatisfaction with orgasm, and some reduction in ability to enjoy sex.

Patient P015

A 29-year old divorced woman, with a family history of panic attacks and agoraphobia (mother). She was held at gunpoint whilst at work when aged 24 years, and developed depressive symptoms, panic attacks, agoraphobic avoidance, hypervigilance, marked insomnia and 'flashbacks' approximately 12 months later. These symptoms responded partially to cognitive therapy, but she had been unable to tolerate imipramine, diazepam, and various hypnotics. The psychiatric diagnosis was post-traumatic stress disorder and depression. She developed severe psoriasis when aged 21 years, her skin eruption being poorly controlled even with methotrexate. She was prescribed trazodone 150 mg nocte; and methotrexate 10 mg weekly. Interview with the MINI generated DSM-IV diagnoses of current major depressive episode, previous panic disorder, current agoraphobia, current social phobia and current post-traumatic stress disorder. She had a sexual partner, but described reduction in sexual desire and arousal, difficulty in achieving orgasm, dissatisfaction with orgasm and reduced ability to enjoy sex.

Patient P016

A 24-year old single woman. She was subject to repeated penetrative sexual abuse between the age of five and ten years, and was investigated for abdominal and pelvic pain during childhood and adolescence. She underwent counselling, focusing on her earlier experiences, when aged 21 years, but developed depressive symptoms in April 1995, followed four months later by obsessional ruminations and compulsive rituals relating to the position of furniture in her bedroom and car on the

road. Earlier treatment with clomipramine, fluoxetine and lofepramine had been ineffective, but after hospital admission she made a partial response to venlafaxine. The psychiatric diagnosis was depressive illness with mood-congruent psychotic phenomena. She had undergone appendectomy, and cone biopsy for presumed cervical carcinoma-in-situ. Her current treatment was venlafaxine 150 mg b.d.; thioridazine 40 mg b.d., 60 mg nocte; and temazepam 20 mg nocte. Interview with the MINI generated DSM-IV diagnoses of current major depressive episode with psychotic features, current bipolar disorder, current panic disorder with agoraphobia, current social phobia, and current obsessive-compulsive disorder. She and her boyfriend had regular sexual relations, but she described reductions in sexual desire and arousal, impaired ability to achieve orgasm, dissatisfaction with orgasm and reduced ability to enjoy sex. She was being stalked by a previous sexual partner.

Patient P017

A 35-year old married woman, the mother of two boys. She gave an approximately twenty-year history of severe anxiety symptoms and panic attacks in anticipation of and during social situations, and developed a secondary phobic avoidance of family and other gatherings. The psychiatric diagnosis was social phobia. She experienced migraine-like headaches in adolescence and early adult life; developed a Bell's palsy in her mid-twenties, and underwent ovarian cystectomy and hysterectomy in 1995, having been troubled by menorrhagia and intermenstrual bleeding. She was being prescribed paroxetine 20 mg mane. Interview with the MINI generated DSM-IV diagnoses of current social phobia, current agoraphobia, and current obsessive-compulsive disorder. She usually enjoyed frequent sexual relations with her husband, but had reported anorgasmia during treatment with paroxetine: her husband had recently been admitted to hospital with severe ulcerative colitis, necessitating colectomy. She described some reduction in sexual desire and arousal, significant difficulty in achieving orgasm and dissatisfaction with orgasm, and some reduction in ability to enjoy sex.

Patient P018

A 34-year old man and father of three children, with a family history of depression (mother). He suffered emotional abuse during childhood, and had experienced severe anxiety symptoms and panic attacks in anticipation of and during social events since early adolescence. He developed depressive symptoms twelve months previously, associated with harmful and dependent use of alcohol, and responded to fluoxetine prescribed by his GP. He experienced a relapse of symptoms within two months, and did not respond to amitriptyline. The psychiatric diagnosis was social phobia with secondary depression. A superficial malignant melanoma was removed by wide excision two years previously. Minor abnormalities in routine liver function tests led to further investigations and the subsequent diagnosis of Gilbert's syndrome. His anxiety and depressive symptoms responded partly to treatment with paroxetine 20 mg mane. Interview with the MINI generated DSM-IV diagnoses of current major depressive episode, current agoraphobia, current social phobia and previous alcohol dependence. He reported long-standing (approximately 10 years) reduction in

sexual desire, but reported no change in his sexual function with the onset of his depressive symptoms. He separated from his wife eight months later.

Patient P019

A 33-year old single man. He first developed severe anxiety and depressive symptoms when aged 21 years, but responded promptly to treatment with fluoxetine 20 mg mane. He continued with fluoxetine for 18 months, but stopped treatment after developing urinary symptoms. These symptoms then worsened, culminating in acute retention necessitating suprapubic catheterisation. The anxiety and depressive symptoms returned within five months of stopping fluoxetine, but responded to treatment with paroxetine 30 mg mane, thioridazine 10 mg t.d.s, zopiclone 7.5 mg nocte, and a brief course of cognitive-behaviour therapy. The psychiatric diagnosis was recurrent depressive disorder. His treatment at interview was paroxetine 30 mg mane. Interview with the MINI generated the DSM-IV diagnosis of current generalised anxiety disorder. He reported reduction in sexual desire and arousal prior to the onset of his second depressive episode; and described increased sexual desire and greater ability to maintain erection, but significant difficulty in ejaculation and some reduction in sexual enjoyment since starting paroxetine treatment.

Patient P020

A 26-year old man, the father of three young children, with a family history of depression and suicide (mother). He became troubled by anxiety symptoms when aged eight years, after the death of his mother and whilst being bullied at school; his symptoms worsened throughout adolescence, with the development of panic attacks in social situations, and secondary phobic avoidance. He did not respond to treatment with beta-blockers by his general practitioner. The psychiatric diagnosis was social phobia. Interview with the MINI generated DSM-IV diagnoses of current agoraphobia without a history of panic disorder, current social phobia and current specific phobia (heights). He responded to treatment with paroxetine 20 mg mane. He and his partner enjoyed regular sexual activity, but he reported delayed ejaculation since starting paroxetine treatment, and described some reduction in sexual desire and difficulty in ejaculation.

Patient P021

A 35-year old married woman, with a family history (maternal grandmother, paternal aunt) of depression, who was sexually abused repeatedly by a family member during childhood. She became troubled by hay fever in childhood. Having developed depressive symptoms when aged 30 years, she was prescribed various antidepressants by her general practitioner, and participated in two courses of group psychotherapy. The psychiatric diagnosis was dysthymia. Her treatment was paroxetine 20 mg mane and thioridazine 25 mg nocte. Interview with the MINI generated DSM-IV diagnoses of current major depressive episode, past bipolar disorder, current panic disorder with agoraphobia, current specific phobia (horses, water, heights) and current post-traumatic stress disorder. She and her husband had sex infrequently: she described a slight increase in sexual

desire, a slight reduction in sexual arousal, significant difficulty in achieving orgasm and dissatisfaction with orgasm, and slight reduction in her ability to enjoy sex.

Patient P022

A 38-year old single man, with a family history of alcoholism (father) and agoraphobia (sister). When aged 31 years, he developed panic attacks in public places and agoraphobic avoidance. He became troubled by depressive symptoms three years later; his general practitioner prescribed amitriptyline 25 mg nocte, then clomipramine 100 mg nocte, with little effect. He was referred when aged 36 years, but did not attend follow-up appointments. The psychiatric diagnosis was panic disorder with secondary depression. After another referral he was treated with imipramine 200 mg per day and exposure therapy, without benefit. His anxiety symptoms, panic attacks and agoraphobia responded partly to subsequent treatment with paroxetine 60 mg mane, his treatment at interview. Assessment with the MINI generated the DSM-IV diagnosis of current panic disorder with agoraphobia. His girlfriend and he engaged in regular sexual activity, and he described some difficulty with ejaculation, but greater ability to enjoy sex.

Patient P023

A 38-year old woman, with four children, and a family history (sister) of anorexia nervosa. When aged 15 years, she experienced an episode of shaking which was presumed to be of psychological origin. She developed depressive symptoms when aged 35 years, and remained consistently and severely depressed for the next three years, with intermittent auditory hallucinations, despite treatment with a range of antidepressants, augmentation strategies, concomitant antipsychotic drugs, and electroconvulsive therapy. She made a number of suicide attempts over the three years. The psychiatric diagnosis was severe depressive episode with mood-congruent psychotic features. Her medical history was limited to long-standing mild asthma, sciatica when aged 35 years and a Bartholin's haematoma. Her treatment was clomipramine 200 mg nocte; lithium carbonate 600 mg nocte; liothyronine 100 mcg mane; l-tryptophan 1 g t.d.s.; flupenthixol decanoate 30 mg IM every two weeks; and procyclidine 10 mg per day. Interview with the MINI generated the DSM-IV diagnosis of current major depressive episode. Although she and her husband had regular sexual relations, she described considerable reductions in sexual desire and arousal and in ability to enjoy sex, and considerable difficulty in achieving orgasm.

Patient P024

A 31-year old single man. When aged 28 years he took 'Ecstasy' and LSD and experienced severe anxiety symptoms; over the next twelve months he developed panic attacks, anticipatory anxiety, agoraphobia and some depressive symptoms. After unsuccessful treatment with propranolol he improved with combination treatment with diazepam and clomipramine, prescribed by his general practitioner, but was referred to mental health services for a specialist opinion. The psychiatric diagnosis was panic disorder with secondary depression. He made a further response to treatment with fluoxetine, taking 20 mg then 40 mg on alternate days, this being his current treatment.

Interview with the MINI generated DSM-IV diagnoses of current panic disorder with agoraphobia and current drug dependence (cannabis). He and his partner had regular sexual relations; he did not report or describe any problems with sexual function or satisfaction.

Patient P025

A 70-year old married man. He developed depressive symptoms when aged 47 years, after an accident at work in which a colleague lost an arm: two years later he started experiencing panic attacks. He became dependent upon alcohol during the next fifteen years. He had been admitted to psychiatric hospital on at least two occasions before the age of 64 years (previous notes missing). His anxiety and depressive symptoms and panic attacks responded to treatment with paroxetine 40 mg mane. He was referred again three years later, with a recurrence of anxiety and depression, and excessive alcohol consumption, and made a partial response to lithium augmentation of paroxetine. His compliance with antidepressant treatment improved when paroxetine was later changed to sertraline. The psychiatric diagnosis was recurrent depressive disorder. He was troubled by severe back pain arising from osteoporosis, but derived only partial benefit from analgesics and a TENS machine. His treatment was sertraline 100 mg mane; lithium carbonate 600 mg nocte; and paracetamol prn, eight tablets maximum per day. Interview with the MINI generated DSM-IV diagnoses of current major depressive episode and lifetime panic disorder. He and his wife had not engaged in sexual relations for 22 years. He chose not to complete the questionnaire.

Patient P026

A 42-year old single man, with a teenage daughter and a family history of alcohol dependence (mother) and suicide (cousin). He started to worry excessively when aged 10 years; his general practitioner started antidepressant treatment when he was aged 15 years, and referred him to psychiatric services two years later. He had three previous periods of outpatient care (1972-77; 1983-84; 1992-94) and was referred when aged 41 years. The psychiatric diagnosis was recurrent depressive disorder, with a pre-morbid anxiety-prone personality. Previous treatment with paroxetine and citalopram resulted in distressing penile anaesthesia, erectile and ejaculatory difficulties; nefazodone and mirtazapine were ineffective. He reported long-standing back pain, and was abusing analgesics. His treatment was sertraline 100 mg mane; temazepam 30 mg nocte; diclofenac sodium 75 mg b.d; and dihydrocodeine four tablets per day. Interview with the MINI generated DSM-IV diagnoses of current major depressive episode, current panic disorder with agoraphobia, current obsessive-compulsive disorder, current alcohol dependence, current drug dependence, current mood disorder with psychotic features, and current post-traumatic stress disorder. He had no sexual partner, and described a reduction in sexual desire, difficulty in achieving and maintaining erection, significant delay in ejaculation and significant reduction in ability to enjoy sex.

Patient P027

A 19-year old single man. He developed agoraphobia at the age of 15 years, linked to a fear that others would comment adversely on his acne: the agoraphobia resolved after 18 months. He became troubled by severe anxiety symptoms and panic attacks, followed by depressive symptoms, when aged 18 years. Treatment with fluoxetine 40 mg mane and diazepam (reducing from 10 mg to 7.5 mg per day) had been effective in improving his symptoms. The psychiatric diagnosis rested between depressive illness with associated marked anxiety, or panic disorder with secondary depression. Interview with the MINI generated the DSM-IV diagnosis of current panic disorder without agoraphobia. He reported some reduction in sexual activity with his girlfriend since the onset of his mental health problems, and described reduction in sexual desire, difficulty in achieving and maintaining erection, significant delay in ejaculation, and reduced ability to enjoy sex.

Patient P028

A 50-year old married man, with four children and a family history (mother) of agoraphobia and probable depression. He received inpatient treatment for a probable depressive episode when aged 17 years. His consumption of alcohol was excessive for many years before referral to the psychiatric services at the age of 47 years. He had not responded to treatment with sertraline 50 mg mane or fluoxetine 40 mg mane, prescribed by his general practitioner; increasing fluoxetine to 40 mg mane proved unhelpful. Worsening depression led to inpatient treatment for three months, with lofepramine, thioridazine, lithium and electroconvulsive therapy (13 applications). He complained of reduced sexual desire and difficulty in achieving erection, but switching from lofepramine to nefazodone was unsuccessful. The psychiatric diagnosis was recurrent depressive disorder. He was abstinent from alcohol. He sustained a fractured right elbow in early adult life, and gave a history suggestive of migraine. His treatment was lofepramine 350 mg nocte and lithium carbonate 1600 mg nocte. Interview with the MINI generated DSM-IV diagnoses of lifetime panic disorder, current agoraphobia, and current social phobia. His wife and he had regular sexual intercourse, but he described reduction in sexual desire, significant difficulty in achieving and maintaining erection, and significant reduction in ability to enjoy sex.

Patient P029

A 50-year old married woman, with two adult sons. She developed depressive symptoms and compulsive rituals when aged 25 years, a few months after the birth of her second child. When aged 48 years, she developed depressive and anxiety symptoms, panic attacks and agoraphobic avoidance, together with the delusional experience of thought broadcast and auditory pseudohallucinations, telling her to refrain from eating to avoid becoming fat. The psychiatric diagnosis was probable recurrent depressive disorder, with mood-congruent and incongruent psychotic features. She developed thyrotoxicosis in early adult life, requiring thyroid surgery and subsequent thyroid replacement therapy. She did not respond to outpatient treatment with paroxetine 20 mg mane and thioridazine 75 mg nocte. Subsequent hospital admission and treatment with electroconvulsive therapy (21 applications) was initially successful, although she

relapsed shortly after discharge. She responded to imipramine 200 mg nocte; chlorpromazine 50 mg b.d.; procyclidine 5 mg b.d.; and thyroxine 150 mcg mane, her treatment at interview. The MINI generated DSM-IV diagnoses of current dysthymia, current panic disorder with agoraphobia, current social phobia, lifetime psychotic syndrome, and current anorexia nervosa. She and her husband engaged in sexual activity infrequently: she described considerable reductions in all areas of the sexual response.

Patient P030

A 41-year old divorced woman with two adult children, and a family history (mother, sister) of depression and suicidal behaviour. When aged 16 years she had a miscarriage of an undeclared pregnancy and attempted suicide. Her general practitioner had prescribed antidepressants intermittently, over many years. She was referred when aged 40 years, following her divorce, having not responded to treatment with paroxetine 20 mg. The psychiatric diagnosis was depression associated with adverse life events. Increase in dose was unhelpful, but switching to fluoxetine appeared partly successful. At interview her treatment was fluoxetine 20 mg mane. She had a history of possible endometriosis. Interview with the MINI generated DSM-IV diagnoses of current major depressive episode, current panic disorder without agoraphobia, and current social phobia. She had a sexual partner, reported a loss of sexual interest and deep dyspareunia, and described some reductions in sexual arousal, ability to achieve orgasm, and ability to enjoy sex.

Patient P031

A 29-year old single woman, with a family history (mother) of depression. She developed panic attacks and severe agoraphobia at the age of 17 years. She did not respond to clomipramine 125 mg per day prescribed by her general practitioner, and was referred at the age of 24 years. The psychiatric diagnosis was panic disorder with agoraphobia and secondary depression. Subsequent treatment with guided exposure and paroxetine 40 mg per day proved ineffective. She made some response to higher doses (200 mg per day) of clomipramine, but continued to show some agoraphobic avoidance. She had a bilateral breast reduction a few weeks before her assessment. Interview with the MINI generated DSM-IV diagnoses of current panic disorder with agoraphobia, and specific phobia. She and her boyfriend had regular sexual relations: she described occasional difficulty in achieving orgasm.

Patient P032

A 34-year old man with three young children, and a family history of schizophrenia (maternal aunt, brother) and anxiety (brother). He developed panic attacks at the age of 24 years; these did not respond to treatment with fluoxetine or lofepramine, prescribed by his general practitioner. Ten years after the onset of anxiety symptoms, he developed interpersonal sensitivity with visual illusions, and was referred. He reported excessive consumption of alcohol (16 units per day) until the month before assessment. The main psychiatric diagnosis rested between panic disorder and 'pseudoneurotic' schizophrenia. He did not respond to flupenthixol 1 mg b.d., but made a partial

response to treatment with paroxetine. He was being investigated for palpitations (possible intermittent atrial fibrillation) and being treated with cardiac drugs. His treatment was paroxetine 40 mg mane and flecanide 50 mg b.d. Interview with the MINI generated DSM-IV diagnoses of lifetime panic disorder with agoraphobia, and current alcohol dependence. He reported some impairment of sexual function since starting paroxetine, and described reduction in sexual desire, considerable difficulty in achieving erection, some difficulty in maintaining erection and in ejaculation, and some reduction in ability to enjoy sex.

Patient P033

A 37-year old woman. Her treatment at interview was fluoxetine 20 mg mane. Her medical history was limited to Caesarean section. Interview with the MINI generated DSM-IV diagnoses of current panic disorder with agoraphobia, current obsessive-compulsive disorder. She reported an improvement in her sexual function with fluoxetine treatment, and described slight increase in sexual desire, and slightly greater ease in arousal.

Patient P034

A 62-year old widowed woman, with four children. She underwent hysterectomy for menorrhagia, when aged 41 years. Her husband died when she was aged 47 years: four years later she developed depressive symptoms and was treated with antidepressants and group psychotherapy. Twelve months after an armed robbery in her home she developed anxiety and depressive symptoms, together with hypervigilance and 'flashbacks'. She did not respond to sertraline treatment prescribed by her general practitioner and was referred when aged 59 years. The psychiatric diagnosis was recurrent depressive disorder. She did not respond to lofepramine 140 mg nocte, but responded to fluvoxamine 100 mg b.d. Her depressive symptoms returned within nine months; she was admitted to hospital and responded to treatment with trazodone 250 mg nocte and thioridazine 25 mg b.d. She had a further depressive episode nine months later, but responded to venlafaxine treatment. She sustained a fractured femur necessitating hip replacement two months before her assessment. Her treatment at interview was venlafaxine 225 mg per day; ibuprofen 400 mg t.d.s. Interview with the MINI generated DSM-IV diagnoses of current panic disorder without agoraphobia, current social phobia, and current post-traumatic stress disorder. She and her boyfriend had regular sexual relations: she described considerable reductions in sexual desire and arousal, considerable difficulty in achieving and dissatisfaction with orgasm, and considerable reduction in ability to enjoy sex whilst depressed, but described no sexual problems once her depression had resolved.

Patient P035

A 44-year old married man with two children. He developed anxiety and depressive symptoms and panic attacks at the age 41 years. He responded to dothiepin prescribed by his general practitioner, but relapsed two years later, and did not respond to paroxetine 40 mg and trifluoperazine 2 mg b.d., and was referred. At assessment he described incapacitating anxiety symptoms, agoraphobia,

frequent panic attacks in feared situations, moderate intensity depressive symptoms, and compulsive rituals. The provisional psychiatric diagnosis was panic disorder or generalised anxiety disorder, with secondary depression. He sustained a head injury when aged 12 years, fracturing his skull and needing facial reconstruction. Interview with the MINI generated DSM-IV diagnoses of current depressive episode, current panic disorder with agoraphobia, and current social phobia. He reported a reduction in sexual drive since vasectomy at the age of 37 years, and described considerable reduction in sexual desire, some reduction in ability to achieve and maintain erection, and some reduction in ability to enjoy sex.

Patient P036

A 56-year old divorced father of one adult son. He developed anxiety and depressive symptoms in early adult life, taking benzodiazepines intermittently. He was referred to psychiatric services when aged 38 years: no psychiatric diagnosis was recorded, but he started tranylcypromine and continued it for most of the next twenty years. He was subsequently described as having an obsessional personality disorder. There was no further sustained improvement with three months of day hospital treatment, or with other antidepressant drugs (fluoxetine, sertraline, nefazodone). He suffered an anterior myocardial infarction when aged 55 years. His treatment at interview was tranylcypromine 40 mg per day; diazepam 2 mg q.d.s; aspirin 75 mg mane; omeprazole 20 mg mane; and ramipril 2.5 mg mane. Interview with the MINI generated DSM-IV diagnoses of current dysthymia, current social phobia and current post-traumatic stress disorder. He had no sexual partner, and described no impairment of his sexual function.

Patient P037

A 51-year old married man with four adult children, and a family history (mother) of relapsing severe mental illness. He developed depressive symptoms when aged 34 years and was treated by his general practitioner. Seven years later he became depressed again, and responded to amitriptyline treatment. Depressive symptoms returned when aged 50 years, did not respond to treatment with lofepramine, fluoxetine or dothiepin prescribed by his general practitioner, and he was referred to psychiatric services. The psychiatric diagnosis was recurrent depressive disorder. There was no improvement during a double-blind study of paroxetine versus a melatonin analogue, but he responded to subsequent treatment with amitriptyline 150 mg nocte. He underwent vasectomy when aged 31 years, and transurethral removal of renal calculi six weeks before assessment. His treatment was amitriptyline 50 mg nocte. Interview with the MINI three months previously generated DSM-IV diagnoses of current major depressive episode, current panic disorder without agoraphobia, and current generalised anxiety disorder. He and his wife had regular sexual relations, but he described difficulty in achieving and maintaining erection, and consistent premature ejaculation.

Patient P038

A 37-year old married man with four young children. When aged 17 years he developed anxiety and depressive symptoms and obsessional ruminations, which resolved after brief hospital admission

and treatment with dothiepin and chlorpromazine. Anxiety and depressive symptoms and obsessional thoughts returned three years later, and persisted for four years despite treatment with amitriptyline, imipramine, clomipramine, dothiepin, diazepam, lorazepam, and trifluoperazine: he was not considered suitable for behaviour therapy. He attempted suicide when aged 26 years. He was referred when aged 35 years, with a return of incapacitating anxiety, depressive symptoms and obsessional ruminations, which had not responded to sertraline treatment. The psychiatric diagnosis was recurrent depressive disorder with marked obsessional features. After unsuccessful treatment with lofepramine, fluoxetine, (both with concomitant thioridazine), he responded to clomipramine with lithium augmentation. He underwent vasectomy two months prior to interview. His treatment at assessment was clomipramine 150 mg nocte. Interview with the MINI generated no current DSM-IV diagnosis. He described some reduction in sexual desire, but his wife and he enjoyed regular sexual activity.

Patient P039

A 43-year married woman with a teenage son, and a family history of depression (aunt, niece) and suicide (grandfather). She developed a specific phobia of spiders when aged 25 years, and responded to behaviour therapy. Six years later, she developed anxiety and depressive symptoms and responded to mianserin treatment followed by prolonged individual psychotherapy. She experienced a second depressive episode when aged 38 years, and responded to lofepramine and assertiveness training. She was referred when aged 41 years, as attempts by her general practitioner to stop antidepressants had resulted in early relapse of symptoms. The psychiatric diagnosis was recurrent depressive disorder. She responded to but was unable to tolerate either nefazodone or paroxetine: she had a satisfactory response to trazodone. Her treatment was trazodone 250 mg nocte. Interview with the MINI generated DSM-IV diagnoses of current agoraphobia without a history of panic disorder and current generalised anxiety disorder. Her husband and she had regular sexual relations, but she described considerable reduction in sexual desire and arousal, considerable dissatisfaction with the intensity of orgasm, and reduced ability to enjoy sex.

Patient P040

A 30-year old married man with two young children, and a family history (grandfather) of relapsing mental illness. When aged 25 years, he sustained a head injury necessitating admission to the regional neurosurgical centre. Two years later, he started to experience irregular brief periods of irritability and hostility, 'confusion' and intense self-preoccupation, together with low mood and avoidance of social interactions, and was referred. The psychiatric diagnosis was probable organic brain disease with cerebral dysrhthymia. Two electroencephalograms revealed evidence of abnormal electrical activity in the left temporal area, leading to the provisional diagnosis of complex partial seizures with a left temporal focus. Subsequent treatment with carbamazepine and sertraline resulted in a significant reduction in frequency of episodes of disorganised behaviour and intensity of depressive symptoms. His treatment was carbamazepine 400 mg b.d. and sertraline 50 mg b.d.

Interview with the MINI generated DSM-IV diagnoses of current major depressive episode, past bipolar disorder, current panic disorder with agoraphobia, current social phobia, current obsessive-compulsive disorder, and current mood disorder with psychotic features. He and his wife had regular sexual relations, but he reported a loss of sexual interest after the onset of depression, and described a considerable reduction in sexual desire, considerable difficulty in achieving and maintaining erection, some difficulty and delay in ejaculation, and some reduction in ability to enjoy sex.

Patient P041

A 42-year old single woman, with a family history of schizophrenia (uncle) and depression (grandmother, mother, father, brother). She was sexually abused repeatedly when aged 9 years. She experienced her first depressive episode when 25 years, and her second two years later. She had a recurrence of depressive symptoms when aged 38 years, and had not responded to treatment with a range of antidepressants (paroxetine, fluoxetine, sertraline, clomipramine, phenelzine, tranylcypromine isocarboxazid), electroconvulsive therapy or cognitive therapy by the time of her referral. The psychiatric diagnosis was recurrent depressive disorder. She had mild hypertension and acne, and was found to be hypothyroid. Subsequent treatment with nefazodone was also ineffective, but she improved with venlafaxine, augmented with lithium. Her treatment was venlafaxine 487.5 mg mane, lithium carbonate 800 mg nocte, thyroxine 50 mcg mane, bendrofluazide 5 mg mane and oxytetracycline 500 mg b.d. Interview with the MINI generated DSM-IV diagnoses of current major depressive episode, current panic disorder without agoraphobia, current social phobia, and current post-traumatic stress disorder. She had not experienced any consenting intimate relationship, and completion of the sexual function questionnaires was not possible.

Patient P042

A 22-year old single man with a family history of depression (mother) and alcohol abuse (father). Troubled by social anxiety symptoms since late childhood, he developed depressive symptoms at the age of 17 years, shortly after his parents separated. He was unable to tolerate amitriptyline treatment, did not respond to fluoxetine, and was referred by his general practitioner. The psychiatric diagnosis was major depressive episode and social phobia, with recent-onset alcohol abuse. After treatment with venlafaxine and lofepramine was ineffective, he consented to participate in a placebo-controlled study of paroxetine in the treatment of social phobia. His anxiety symptoms improved during the study, but later he developed insomnia and was started on amitriptyline. His treatment at assessment was amitriptyline 75 mg nocte. Interview with the MINI generated DSM-IV diagnoses of agoraphobia without a history of panic disorder, current social phobia, and current obsessive-compulsive disorder. He described no problems in sexual function.

Patient P043

A 52-year old married man with two children. He developed tinnitis and dizziness at the age of 42 years and was diagnosed with Meniere's disease. He underwent a variety of ENT procedures over the next ten years, including left saccus decompression and labyrinthine vestibular nerve section. At the age of 44 years he developed depressive symptoms; these did not respond to lofepramine or amitriptyline prescribed by his general practitioner, and he was referred. Subsequent treatment with fluoxetine produced no lasting benefit, but he made some response to combination treatment with trazodone. The psychiatric diagnosis was depressive episode. His treatment was fluoxetine 40 mg mane and trazodone 150 mg nocte. Interview with the MINI generated the DSM-IV diagnosis of current major depressive episode. He reported a loss of sexual interest since the onset of depression, and he and his wife had infrequent sexual relations: he described considerable reduction in sexual desire, some difficulty in achieving erection, and some reduction in ability to enjoy sex.

Patient P044

A 39-year old married woman with two adolescent sons. She had a termination of pregnancy and attempted suicide when aged 15 years, in the year after her mother died. At the age of 34 years, she developed anxiety and depressive symptoms, panic attacks and agoraphobic avoidance, following the vandalism of her workplace. She was referred by her general practitioner three years later. The psychiatric diagnosis was panic disorder. She did not tolerate treatment with fluvoxamine, and exposure therapy proved ineffective. Subsequent treatment with citalopram reduced the frequency of panic attacks and the intensity of agoraphobia and anticipatory anxiety. Her treatment at assessment was citalopram 20 mg mane and quinine 200 mg nocte. Interview with the MINI generated DSM-IV diagnoses of lifetime panic disorder, current agoraphobia, and current social phobia. She reported a loss of sexual interest prior to starting citalopram, but described no change in her sexual function with citalopram treatment.

Patient P045

A 50-year old divorced woman with twin daughters, and a family history (mother) of probable depression. She developed anxiety and depressive symptoms and agoraphobia when aged 45 years and was referred to mental health services. She responded to paroxetine treatment, but had a recurrence four years later. She did not respond to trazodone treatment, and was referred for a second opinion. Her medical history was limited to an operation for varicose veins. The psychiatric diagnosis was recurrent depressive disorder; she improved with an increase in dosage of trazodone. Her current treatment was trazodone 100 mg b.d. and thioridazine 25 mg p.r.n. t.d.s. Interview with the MINI generated DSM-IV diagnoses of current major depressive episode, current panic disorder with agoraphobia, and current obsessive-compulsive disorder. She had no sexual partner, and did not wish to complete the questionnaire relating to sexual function.

Patient P046

A 25-year old married woman with one son, and a family history (father) of alcohol dependence. She first developed depressive symptoms whilst pregnant. Six months after delivery her depression worsened and she was treated with paroxetine and flupenthixol by her general practitioner. Two months later she was referred, having become agitated and suicidal. The diagnosis was depressive episode. She was admitted to hospital, and responded to treatment with lofepramine and flupenthixol. Her medical history included childhood endomyocardial fibroelastosis, recurrent patellar dislocation, and salpingo-oophorectomy for a torted ovarian cyst when aged 22 years. Her treatment at assessment was lofepramine 140 mg nocte and amoxycillin 250 mg t.d.s. Interview with the MINI generated DSM-IV diagnoses of current major depressive episode, past bipolar disorder, current panic disorder with agoraphobia, and current alcohol dependence. Although she and her husband had frequent sexual relations, she reported a loss of sexual interest, and described considerable reduction in sexual desire and arousal, some difficulty in achieving orgasm and considerable reduction in ability to enjoy sex. She was later found to have been four weeks pregnant at the time of her assessment.

Patient P047

A 36-year old single woman, with a family history of depression (mother) and alcohol abuse (sister). She was abused sexually when aged five years. When aged 28 years she developed depressive symptoms and panic attacks, associated with derealisation-depersonalisation phenomena. She did not respond to treatment with lofepramine, dothiepin, trazodone or fluoxetine, prescribed by her general practitioner, and was referred. There was no history of physical illness, although she was undergoing investigations for headache and peripheral sensory loss (all proved unremarkable). The psychiatric diagnosis was probable depressive episode. Her treatment at interview was fluoxetine 40 mg mane; coproxamol two tablets p.r.n; and prochlorperazine two tablets p.r.n. Interview with the MINI generated DSM-IV diagnoses of current depressive episode, and current panic disorder without agoraphobia. She and her female partner had infrequent sexual relations. She reported a loss of sexual desire associated with onset of her depressive symptoms, and described considerable reduction in sexual desire and ease of arousal, slight difficulty in achieving orgasm, considerable dissatisfaction with orgasm and slight reduction in ability to enjoy sex.

Patient P048

A 22-year old single woman. She developed anxiety and depressive symptoms and panic attacks when aged 19 years. She did not respond to treatment with beta-blockers, sertraline, or diazepam prescribed by her general practitioner and was referred. The psychiatric diagnosis was depressive illness. She defaulted on follow-up appointments and was referred two years later. The diagnosis rested between dysthymic disorder and agoraphobia with panic disorder. There was no history of physical ill health. She responded to treatment with paroxetine 20 mg mane, her treatment at assessment. Interview with the MINI generated DSM-IV diagnoses of current dysthymia and current panic disorder with agoraphobia. She and her boyfriend had infrequent sexual relations and had

recently separated; she described some reduction in sexual arousal, some dissatisfaction with intensity of orgasm and considerable reduction in ability to enjoy sex.

Patient P049

A 51-year old single man. He developed phobic avoidance of social situations in his teenage years. When aged 32 years, he developed depressive symptoms and attempted suicide, leading to his attendance at group psychotherapy sessions. He attempted suicide again ten years later, and was admitted to hospital. In the following six years, he showed no lasting improvement with a range of antidepressants (tranylcypromine, fluoxetine, clomipramine), assertiveness training, or cognitive-analytic therapy. He was referred again when aged 50 years. The psychiatric diagnosis was recurrent depressive disorder and alcohol abuse. Treatment with lofepramine and paroxetine was ineffective, but he improved with paroxetine and flupenthixol in combination treatment. His medical history included chronic back pain, bilateral cataracts and psoriasis. His treatment was paroxetine 20 mg b.d. and diclofenac sodium 25 mg q.d.s. Interview with the MINI generated DSM-IV diagnoses of current depressive episode, past bipolar disorder, current alcohol dependence, and lifetime mood disorder with psychotic features. He had no sexual partner, reported long-standing (10 years) reduction in sexual interest, and described some reduction in sexual desire, some difficulty in achieving erection, and some reduction in ability to enjoy sex.

Patient P050

A 38-year old widow with three adult children. She developed a pattern of recurrent brief depressive episodes and repeated deliberate self-harm, often associated with adverse life events or minor social or interpersonal difficulties, by the age of 22 years. Over the next fourteen years, she derived no lasting benefit from a series of antidepressant drugs combined with considerable support from community mental health nurses. She experienced a depressive episode with psychotic features when aged 36 years, and responded to paroxetine treatment. She developed a recurrence of symptoms within 12 months. The psychiatric diagnosis rested between recurrent depressive disorder and emotionally unstable character disorder. Her current treatment was paroxetine 40 mg mane; lithium carbonate 800 mg nocte; zopiclone 7.5 mg nocte; and chlorpromazine 50 mg nocte. Interview with the MINI generated DSM-IV diagnoses of current major depressive episode, current bipolar disorder, current panic disorder with agoraphobia, current social phobia, current specific phobia (spiders), and lifetime mood disorder with psychotic features. She had no sexual partner, and described considerable reduction in sexual desire and arousal, considerable difficulty in achieving and dissatisfaction with orgasm, and considerable reduction in ability to enjoy sex.

Patient P051

A 19-year old single woman, with a family history of depression (mother, grandmother) and dyslexia (brother). When aged 7 years she was recognised as having dyslexia. She sustained a head injury and fractured humerus in a road accident when aged 14 years. When physically unwell (lobar pneumonia) nine months later, she developed anxiety symptoms, hypervigilance and flashbacks to

the accident. In the ensuing months she became troubled by depressive symptoms and was referred to an adolescent psychiatrist, and then to local adult services. The psychiatric diagnosis was post-traumatic stress disorder with secondary depression. Her symptoms improved with sertraline and brief cognitive behavioural therapy. Her treatment at assessment was sertraline 100 mg mane and oxytetracycline (for acne). Interview with the MINI generated DSM-IV diagnoses of current major depressive episode and current social phobia. She had no sexual partner, and described no problems in her sexual response.

Patient P052

A 48-year old man with four adult children, and a family history (mother, father) of alcohol dependence. He was sexually abused repeatedly by a first degree relative when aged 7 years, and ran away from the family home on many occasions. He was referred when aged 27 years, was diagnosed as having neurotic depression, and referred for individual psychotherapy. He started to abuse alcohol regularly within the next four years. He was treated with phenelzine and community nurse support with some success, but regularly defaulted on attending appointments. He was referred at the age of 48 years, having developed depressive symptoms after finding the body of his brother. The psychiatric diagnosis was recurrent depressive disorder and co-morbid alcohol dependence. Treatment with paroxetine was ineffective, but his anxiety symptoms improved with nefazodone. His treatment was nefazodone 200 mg b.d. Interview with the MINI generated DSM-IV diagnoses of current bipolar disorder, and current alcohol dependence. He and his wife had regular sexual relations; he described some increase in ability to achieve erection, but some difficulty in maintaining erection, and frequent delays in ejaculation.

Patient P053

A 30-year old married woman. She was sexually abused in childhood. She developed depressive symptoms, obsessional ruminations and auditory pseudohallucinations at the age of 19 years, and was referred to mental health services. Over the next 11 years, she did not respond to treatment with a series of antidepressant or antipsychotic drugs, combined with considerable support from community mental health nursing services. The psychiatric diagnosis was schizoaffective psychosis. Her medical history included mild hypertension and gastrointestinal symptoms of unknown cause. Her treatment at interview was venlafaxine 75 mg t.d.s.; olanzapine 15 mg nocte; orphenadrine 50 mg nocte; thyroxine 50 mcg mane; and bendrofluazide 2.5 mg mane. Interview with the MINI generated DSM-IV diagnoses of current bipolar disorder, current panic disorder with agoraphobia, current specific phobia (spiders), current obsessive-compulsive disorder, current psychotic syndrome and current post-traumatic stress disorder. Her alcohol-dependent husband and she had infrequent sexual relations. She reported long-standing (12 years) loss of sexual interest, and described considerable reduction in sexual desire, considerable difficulty in arousal, considerable difficulty in achieving and dissatisfaction with orgasm, and considerable reduction in ability to enjoy sex.

Patient P054

A 44-year old divorced woman, with a family history of depression (niece) and alcohol dependence (father). She became troubled by severe anxiety symptoms in social situations in her early adult years, and began to abuse alcohol for its anxiolytic properties. She developed depressive symptoms and alcohol dependence by the age of 24 years, underwent detoxification when 38 years, but had a second depressive episode three years later. She did not respond to treatment with amitriptyline, clomipramine, trimipramine, fluoxetine, sertraline or trazodone, and was referred. She had recently been found to have maturity-onset diabetes mellitus, managed by diet. The psychiatric diagnosis was social phobia and recurrent depressive disorder. She derived little benefit from paroxetine treatment or individual cognitive behavioural therapy. Her treatment was paroxetine 20 mg mane and 'Ovranette'. She was abstinent from alcohol. Interview with the MINI generated DSM-IV diagnoses of current major depressive episode, current panic disorder with agoraphobia, current social phobia and lifetime mood disorder with psychotic features. She reported loss in sexual interest for six years, which did not vary with antidepressant treatment. She and her partner did not engage in sexual activity, and she described no recent changes in her sexual response.

Patient P055

A 35-year old divorced woman with three teenage children, and a family history of depression (mother) and alcohol dependence (brother). She started to experience recurrent brief (less than two weeks) depressive symptoms when aged 25 years, had six extended depressive episodes (each approximately three months) over the next 11 years, and underwent outpatient treatment with phenelzine and electroconvulsive therapy. She was referred when aged 33 years, three months after separation from her husband, and described depressive symptoms and mood-congruent auditory hallucinations. Her medical history included menorrhagia, treated with hysterectomy when aged 31 years. The psychiatric diagnosis was recurrent depressive disorder, the current episode being severe and associated with psychotic symptoms. She did not respond to lofepramine treatment, but improved with electroconvulsive therapy (10 applications) followed by treatment with paroxetine, sulpiride and lithium augmentation. Her antidepressant was changed from paroxetine to fluoxetine by her general practitioner. An MRI scan revealed a cystic midline lesion (probably a colloid cyst) with no associated hydrocephalus. Her treatment at assessment was fluoxetine 40 mg mane and temazepam 20 mg nocte. Interview with the MINI generated DSM-IV diagnoses of current major depressive episode, current panic disorder with agoraphobia, and current social phobia. She had no sexual partner, reported long-standing reduction in sexual interest, and described considerable reduction in sexual desire and arousal, considerable difficulty in achieving and dissatisfaction with orgasm, and considerable reduction in ability to enjoy sex.

Patient P056

A 41-year old married woman with four teenage children. She was sexually abused by her foster father during her teenage years, developed anorexia and made several suicide attempts. She became troubled by recurrent abdominal and pelvic pain and underwent appendectomy,

laparoscopy and ovarian cystectomy. She developed depressive symptoms when aged 40 years, did not respond to amitriptyline, fluoxetine, lofepramine or paroxetine prescribed by her general practitioner and was admitted to hospital. The psychiatric diagnosis was recurrent depressive disorder and anorexia nervosa. She improved with electroconvulsive therapy, imipramine and lithium augmentation, but relapsed within six months, and was referred by another consultant for a second opinion. Electro-convulsive therapy (12 applications) was followed by combination antidepressant-antipsychotic therapy, with lithium augmentation. She responded, but relapsed within two months. Her treatment was trimipramine 250 mg nocte, trifluoperazine 4 mg mane, lithium carbonate 400 mg b.d. and liothyronine 400 mcg mane. Interview with the MINI generated DSM-IV diagnoses of current major depressive episode, current panic disorder without agoraphobia, and current social phobia. She and her husband had infrequent sexual relations; she described considerable reduction in sexual desire and arousal, some difficulty in achieving, and dissatisfaction with orgasm, and some reduction in ability to enjoy sex.

Patient P057

A 56-year old married woman with three adult children. She experienced recurrent depressive episodes in early adult life (26, 29 and 32 years) and was treated with benzodiazepines by her general practitioner. She was referred when aged 54 years whilst experiencing her fourth depressive episode. The psychiatric diagnosis was recurrent depressive disorder with agoraphobia. Her medical history included laminectomy, termination of pregnancy and hysterectomy with bilateral oophorectomy. Treatment with fluvoxamine 100 mg b.d. reduced her depressive symptoms, but her agoraphobia worsened and she was changed to nefazodone. Her treatment at assessment was nefazodone 200 mg b.d. and hormone replacement therapy. Interview with the MINI generated DSM-IV diagnoses of current major depressive episode, current panic disorder with agoraphobia, current social phobia, and current obsessive-compulsive disorder. She and her husband had infrequent sexual relations; she described considerable reduction in sexual desire and arousal, considerable difficulty in achieving and dissatisfaction with orgasm, and considerable reduction in ability to enjoy sex.

Patient P058

A 35-year old married woman, with a family history (father) of alcohol dependence. During childhood she was physically abused repeatedly at home, and bullied at school. She attempted suicide when aged 22 years. Six years later she attempted suicide again, developed panic attacks, and underwent individual psychotherapy. She was referred when aged 35 years, having developed mild depressive symptoms, which had not responded to flupenthixol 1 mg mane or amitriptyline 80 mg nocte, prescribed by her general practitioner (her treatment at assessment). The psychiatric diagnosis was panic disorder and secondary depression. Interview with the MINI generated the DSM-IV diagnosis of current panic disorder without agoraphobia. Although she and her husband had regular sexual relations, she described considerable reduction in sexual desire and arousal, some difficulty in achieving orgasm, and some reduction in ability to enjoy sex.

Patient P059

A 30-year old single woman. She developed depressive symptoms, and obsessional ruminations and compulsive rituals relating to body shape and symmetry, when aged 16 years, and these persisted over the next 15 years, waxing and waning in severity. She was admitted to hospital when aged 18 years, the initial diagnosis being adolescent turmoil, being revised to obsessive-compulsive disorder in the subsequent year. Her symptoms improved during treatment with antiobsessional antidepressant drugs (fluvoxamine, clomipramine, fluoxetine, paroxetine) and prolonged behavioural therapy, but relapses occurred despite compliance with treatment. She underwent bilateral mammoplasty when aged 19 years. She was referred for a second opinion when aged 30 years, with a relapse of depressive symptoms. The psychiatric diagnosis was obsessive compulsive disorder with secondary depression. Treatment with dothiepin 250 mg nocte reduced the depressive but not the obsessional symptoms. Interview with the MINI generated DSM-IV diagnoses of current major depressive episode, current panic disorder without agoraphobia, current social phobia and current obsessive-compulsive disorder. She had no sexual partner, reported a reduction in sexual interest since becoming depressed, and described considerable reduction in sexual arousal, considerable difficulty in achieving and dissatisfaction with orgasm, and considerable reduction in ability to enjoy sex.

Patient P060

A 31-year old single man. His treatment at interview was fluoxetine 20 mg mane and 'Migraleve' p.r.n. Interview with the MINI generated DSM-IV diagnoses of current major depressive episode, current agoraphobia without history of panic disorder, current specific phobia (flying), and current alcohol dependence. He and his partner had regular sexual relations. He reported some reported difficulty with ejaculation after starting fluoxetine treatment, but described considerably increased sexual desire.

Patient P061

A 50-year old married man with one daughter. He was referred at the age of 49 years, one month before his daughter's wedding. For over thirty years, he had been troubled by anxiety symptoms in social, work and leisure situations. His medical history was limited to long-standing 'irritable bowel syndrome', and cellulitis when aged 45 years. The psychiatric diagnosis was social phobia. He participated in a double-blind placebo-controlled study of paroxetine in the treatment of social anxiety disorder, and improved over the subsequent eight weeks, being able to give a speech at the wedding reception and take on new responsibilities at work. He started open-label treatment with paroxetine 20 mg mane at the end of the study, five weeks before his assessment. Interview with the MINI generated the DSM-IV diagnosis of current social phobia. He and his wife had regular sexual relations: he described no problems in his sexual response.

Patient P062

A 38-year old single man. He developed depressive symptoms at the age of 31 years and responded to treatment with dothiepin prescribed by his general practitioner. His second depressive episode when aged 36 years was associated with mood-congruent psychotic symptoms, and resulted in hospital admission. He responded to treatment with isocarboxazid and chlorpromazine. He was referred when aged 37 years, having relapsed whilst undergoing individual cognitive behavioural therapy. The psychiatric diagnosis was recurrent depressive disorder and co-morbid alcohol abuse. His depressive symptoms responded initially to paroxetine, but he relapsed and then responded to combination treatment with paroxetine and flupenthixol. He continued to drink excessively intermittently. His treatment was paroxetine 40 mg mane. Interview with the MINI generated DSM-IV diagnoses of current dysthymia, previous bipolar disorder, current panic disorder with agoraphobia, current alcohol dependence, and lifetime mood disorder with psychotic features. He had no sexual partner, reported delayed ejaculation after starting paroxetine treatment, and described considerable difficulty in achieving and maintaining erection, and considerable difficulty in ejaculation, but some increase in ability to enjoy sex.

Patient P063

A 37-year old married woman with two children, and family history (mother) of bipolar disorder and suicide. She first developed depressive symptoms when aged 24 years, was admitted to hospital and treated with antidepressants, electroconvulsive therapy and psychotherapy. She had a recurrent depressive episode when aged 31 years, after the birth of her second child. She did not respond to lofepramine but did to combination treatment with fluoxetine and thioridazine. She developed anorgasmia, and had a further depressive episode (despite undergoing individual cognitive behaviour therapy) when aged 36 years, having changed from fluoxetine to nefazodone. She was admitted to hospital, responded to fluoxetine, but relapsed following a miscarriage of pregnancy. At assessment her treatment was fluoxetine 60 mg mane. Interview with the MINI generated DSM-IV diagnoses of current major depressive episode, past bipolar disorder, current panic disorder with agoraphobia, current social phobia, and current obsessive compulsive disorder. She reported a loss of sexual interest with depression and anorgasmia with fluoxetine, and described considerable reduction in sexual desire and arousal, considerable difficulty in achieving and dissatisfaction with orgasm, and considerable reduction in ability to enjoy sex.

Patient P064

A 21-year old single woman, with a family history (sister) of agoraphobia. She was bullied at school and developed anxiety symptoms and panic attacks in anticipation of and during of social situations in her teenage years. When aged 20 years she developed depressive symptoms and thoughts of self-harm, and was treated by her general practitioner with paroxetine, but did not respond and was referred. Combination treatment with paroxetine and thioridazine, and treatment with lofepramine, were both unhelpful. She subsequently responded to venlafaxine treatment but stopped it having cut

her forearm, and reverted to paroxetine. The psychiatric diagnosis was social phobia with secondary depression. Her current treatment was paroxetine 30 mg mane. Interview with the MINI generated DSM-IV diagnoses of current bipolar disorder, current panic disorder with agoraphobia, current social phobia, and current specific phobia (spiders, storms). She and her boyfriend had infrequent sexual relations. She reported improved libido as her depressive symptoms lifted, and described considerably increased sexual desire and slight increase in ease in becoming aroused, but slight difficulty in achieving orgasm, slight dissatisfaction with orgasm, and slight reduction in ability to enjoy sex.

Patient P065

A 49-year old divorced man with one adult daughter, and a family history (mother, uncle) of depression. He consumed alcohol excessively from the age of 22 years, and was dependent within two years. When aged 32 years, he developed depressive symptoms associated with marital breakdown, was treated with mianserin, and attempted suicide. He had a recurrent depressive episode with mood-congruent psychotic symptoms three years later, was admitted to hospital and treated with amitriptyline and flupenthixol. He became abstinent from alcohol at the age of 43 years, suffered a myocardial infarction in the following year and developed depressive symptoms that did not improve with paroxetine or sertraline combined with flupenthixol. He was referred by another consultant when aged 49 years. The psychiatric diagnosis was recurrent depressive disorder. His treatment at assessment was fluoxetine 40 mg mane; flupenthixol 1 mg mane; trazodone 50 mg nocte; and aspirin 150 mg mane. Interview with the MINI generated DSM-IV diagnoses of current major depressive episode, current panic disorder with agoraphobia, lifetime mood disorder with psychotic features and lifetime antisocial disorder. He and his girlfriend had infrequent sexual relations; he reported a loss of libido since the relapse of depression, and described some reduction in sexual desire and difficulty in achieving erection, considerable difficulty in maintaining erection, some difficulty in ejaculation and considerable reduction in ability to enjoy sex.

Patient P066

A 23-year old single man with a family history (sister) of obsessive-compulsive disorder. He developed obsessional ruminations and compulsive rituals in early adolescence and depressive symptoms when aged 16 years. He had a recurrence of depressive and obsessive-compulsive symptoms, with depersonalisation and derealisation, when aged 22 years, was referred to psychiatric services, but did not respond to fluoxetine or cognitive behaviour therapy. Subsequent combination treatment with sertraline and trifluoperazine reduced the depressive and obsessive-compulsive symptoms, but not the depersonalisation-derealisation symptoms, and he was referred for a second opinion. It was not possible to record a definitive diagnosis. His treatment was sertraline 200 mg mane; trifluoperazine 2 mg mane; and amitriptyline 25 mg nocte. Interview with the MINI generated DSM-IV diagnoses of current major depressive episode, current agoraphobia with history of panic disorder, and current social phobia. He had no sexual partner, reported a loss of sex drive when depressed, which improved with antidepressant treatment, and described a slight

increase in sexual desire, considerable difficulty in achieving erection, slight difficulty in maintaining erection and in ejaculation, and some reduction in ability to enjoy sex.

Patient P067

A 49-year old divorced man with one daughter, and a family history of anxiety (mother), schizophrenia (half-sister) and alcohol abuse (another half-sister). He developed anxiety and depressive symptoms at the age of 44 years, associated with marital breakdown and business difficulties. He did not respond to lofepramine treatment prescribed by his general practitioner, and was referred to mental health services. Treatment with paroxetine, cognitive-behavioural therapy, rational emotive therapy and a further course of lofepramine proved ineffective and he was referred for a second opinion. His medical history included herniorraphy and asthma treated with salbutamol inhalers. The psychiatric diagnosis rested between depressive episode and dysthymic disorder. His treatment at interview was lofepramine 210 mg nocte. Interview with the MINI generated DSM-IV diagnoses of current major depressive episode and current panic disorder with agoraphobia. He had no sexual partner, reported erectile failure since starting lofepramine treatment, and described considerable reduction in sexual desire, considerable difficulty in achieving and maintaining erection and considerable reduction in ability to enjoy sex.

Patient P068

A 47-year old man with three adult children. He developed a pattern of recreational multiple substance abuse at the age of 22 years. He stopped abusing drugs other than cannabis eight years later. At the age of 36 years he developed mild depressive symptoms, but did not seek treatment nine years. He was referred following unsuccessful paroxetine treatment, prescribed by his general practitioner. he psychiatric diagnosis was dysthymic disorder. He made some improvement with venlafaxine and cognitive-behaviour therapy. His treatment at interview was venlafaxine 300 mg mane. Interview with the MINI generated DSM-IV diagnoses of current major depressive episode and current agoraphobia without history of panic disorder. He and his partner had infrequent sexual relations. He reported reduced sexual interest for six months, and described considerable reduction in sexual desire, some difficulty in achieving erection, considerable difficulty in maintaining erection and in ejaculation, and considerable reduction in ability to enjoy sex.

Patient P069

A 55-year old married man with two adult children. He developed agoraphobia and depressive symptoms when aged 33 years and was treated with a monoamine oxidase inhibitor antidepressant. He remained depressed and anxious for most of the next 25 years. He attempted suicide twice when aged 54 years, and was referred by his general practitioner. He did not respond to a range of antidepressants or electroconvulsive therapy. He had cardiomyopathy of unknown cause, associated hypotension, and sleep apnoea. The psychiatric diagnosis rested between dysthymia and a depressive syndrome of organic origin. His treatment was imipramine 225 mg per day; haloperidol 3 mg per day; orphenadrine 50 mg q.d.s.; and nitrazepam 10 mg nocte. Interview with

the MINI generated DSM-IV diagnoses of current major depressive episode, current bipolar disorder, current agoraphobia, and current generalised anxiety disorder. He and his wife had infrequent sexual relations; he described considerable reduction in all components of the sexual response.

Patient P070

A 33-year old separated man with two young children. He developed anxiety and depressive symptoms, together with flashbacks and over-arousal, shortly after a road accident when aged 27 years. He did not respond to amitriptyline, fluoxetine, imipramine, trazodone, trimipramine or flupenthixol treatment, hospital admission or cognitive therapy, and was referred at the age of 31 years. The psychiatric diagnosis was post-traumatic stress disorder with secondary depression. His medical history was limited to cervical pain and restriction of movement. He improved with venlafaxine treatment, but relapsed after he was assaulted, with the development of obsessional ruminations and persecutory thoughts, in addition to depression. His current treatment was venlafaxine 150 mg b.d. Interview with the MINI generated DSM-IV diagnoses of current major depressive episode, current panic disorder with agoraphobia, current social phobia, current obsessive-compulsive disorder, lifetime mood disorder with psychotic features and current post-traumatic stress disorder. He had no sexual partner, and described considerable difficulty in achieving erection.

Patient P071

A 46-year old married man with two adult children. He sustained head and leg injuries and right lower motor neurone facial palsy in an industrial accident when aged 42 years and was admitted to the regional neurosurgical centre. He lost the sense of smell after the accident, developed low mood, reduced libido and apathy, and was referred when aged 44 years. The psychiatric diagnosis was depressive syndrome secondary to frontal lobe damage. Neuropsychological tests revealed evidence of left-sided frontal dysfunction and more widespread mild impairment of memory. He did not respond to fluoxetine 60 mg mane, his treatment at assessment. Interview with the MINI generated DSM-IV diagnoses of current major depressive episode, lifetime panic disorder, and current post-traumatic stress disorder. He and his wife no longer had sexual relations; he described considerable impairment in all aspects of the sexual response.

Patient P072

A 57-year old married woman with two adult sons, and a family history (mother, sister) of depression and suicide (sister). She experienced four depressive episodes in early adult life (aged 21, 22, 26, and 27 years). From the age of 47 years, she again experienced frequently recurring depressive episodes, with possible brief hypomanic episodes. Treatment with tricyclic antidepressants, selective serotonin reuptake inhibitors, monoamine oxidase inhibitors, lithium and group psychotherapy was ineffective in reducing the frequency of affective disturbance. She underwent hysterectomy when aged 50 years, and developed hypothyroidism three years later, whilst taking lithium. She was

referred for a second opinion when aged 57 years, having derived no benefit from carbamazepine treatment. The psychiatric diagnosis rested between recurrent depressive disorder and bipolar II affective disorder. Her current treatment was dothiepin 75 mg nocte and thyroxine 100 mcg mane. Interview with the MINI generated DSM-IV diagnoses of current major depressive episode, and current agoraphobia without history of panic disorder. She and her husband had infrequent sexual relations; she reported reduced sexual desire and anorgasmia, and described considerable impairment in all aspects of the sexual response.

Patient P073

A 36-year old married woman with two teenage sons, and a family history (mother) of panic attacks. She was raped at the age of 17 years, and developed anorexia and bulimia two years later; this resolved after 12 months, without treatment. She developed anxiety and depressive symptoms, obsessional ruminations, and panic attacks when aged 35 years. She did not respond to propranolol prescribed by her general practitioner, was referred and admitted to hospital for eight weeks. The psychiatric diagnosis was panic disorder with secondary depression. She made a partial response to clomipramine, then paroxetine, but experienced anorgasmia with both. Her treatment at assessment was paroxetine 30 mg mane. Interview with the MINI generated DSM-IV diagnoses of current major depressive episode, current panic disorder without agoraphobia, current social phobia, current specific phobia, and current obsessive-compulsive disorder. She and her husband had regular sexual relations; she reported a loss of sexual interest since becoming depressed, and described considerable impairments in all aspects of the sexual response.

Patient P074

A 49-year old married man with two adult children, and a family history (mother, sister) of depression. At the age of 35 years he developed anxiety and depressive symptoms and agoraphobia, and started to abuse alcohol. He was referred by his general practitioner, having not responded to amitriptyline, paroxetine, fluoxetine, sertraline or reboxetine. The psychiatric diagnosis was panic disorder with secondary depression and previous alcohol dependence. His medical history was limited to nasal polyposis. His current treatment was amitriptyline 100 mg nocte; diazepam 5 mg b.d.; lorazepam 1 mg p.r.n.; and propranolol 25 mg p.r.n. Interview with the MINI generated DSM-IV diagnoses of current major depressive episode, current panic disorder with agoraphobia, and current social phobia. He and his wife had infrequent sexual relations; he reported loss of sexual interest for two years, and described considerable difficulty in achieving and maintaining erection, some difficulty in ejaculation, and considerable reduction in ability to enjoy sex.

Patient P075

A 40-year old married woman with a teenage son, and a family history of depression and panic attacks (mother, sister). She first developed depressive symptoms when aged 24 years, soon after delivery, and responded to lofepramine treatment. She experienced further depressive episodes over the next ten years, and was referred to mental health services. The psychiatric diagnosis was

recurrent depressive disorder. She responded to fluoxetine treatment, but relapsed within three months, and was referred after phenelzine treatment proved unhelpful. She responded partly to combination treatment with lofepramine 140 mg nocte, flupenthixol 0.5 mg mane and diazepam 5 mg p.r.n., this being her treatment at interview. Interview with the MINI generated DSM-IV diagnoses of current major depressive episode, current panic disorder with agoraphobia, current social phobia, and current specific phobia (flying). She and her husband had infrequent sexual relations: she reported a decline in sexual interest since the onset of depression, and described considerable reduction in sexual desire and arousal, slight difficulty and dissatisfaction with orgasm, and considerable reduction in ability to enjoy sex.

Patient P076

A 50-year old married man with three adult children. He developed anxiety and depressive symptoms and visual illusions at the age of 35 years, but did not seek help for 13 years. He did not respond to amitriptyline treatment prescribed by his general practitioner, and was referred to mental health services. Despite treatment with a series of antidepressant drugs (lofepramine, fluoxetine, venlafaxine, tranylcypromine), some in combination with antipsychotic drugs (thioridazine, chlorpromazine) or lithium, he remained troubled by frequent panic attacks and marked agoraphobic avoidance. Anxiety management sessions and exposure therapy were also unhelpful. He was referred for a second opinion at the age of 49 years. The psychiatric diagnosis was panic disorder with secondary depression. High-dose clomipramine treatment proved unhelpful. His current treatment was clomipramine 75 mg q.d.s.; chlorpromazine 100 mg nocte; diazepam 5 mg b.d.; and lithium carbonate 1000 mg nocte. Interview with the MINI generated DSM-IV diagnoses of current major depressive episode, previous bipolar disorder, current panic disorder with agoraphobia, current social phobia, and lifetime psychotic syndrome. He and his wife had infrequent sexual relations; he reported long-standing (10 years) loss of sexual interest, and described considerable reduction in sexual desire, considerable difficulty in achieving and maintaining erection, considerable decrease in ease of ejaculation, and considerable reduction in ability to enjoy sex.

Patient P077

A 31-year old single man with a family history (mother) of anxiety and depression. He was sexually abused during childhood, and was troubled by panic attacks between the ages of 14 and 22 years. He developed anxiety and depressive symptoms and limited symptom attacks at the age of 29 years, did not respond to combination treatment of dothiepin prescribed by his general practitioner or to anxiety management sessions conducted by a community mental health nurse, and was referred. He described periods of depersonalisation and derealisation: an electroencephalogram revealed minor non-specific abnormalities over the right fronto-midtemporal area. He did not respond to paroxetine, but made a partial improvement with nefazodone treatment. The psychiatric diagnosis was panic disorder with secondary depression. His treatment was nefazodone 200 mg b.d. Interview with the MINI generated DSM-IV diagnoses of current major depressive episode, and current panic disorder with agoraphobia. He and his girlfriend had frequent sexual relations; he

described increased ease in achieving erection but reported no other changes in his sexual response.

Patient P078

A 41-year old married man with three children. He developed depressive and anxiety symptoms, agoraphobia and alcohol abuse at the age of 39 years; these problems worsened one year later, after multiple bereavement. He did not respond to private counselling, or to fluoxetine prescribed by his general practitioner, and was referred. The psychiatric diagnosis was depressive illness with secondary agoraphobia. His medical history was limited to previous vasectomy and current obesity and leg ulceration. His treatment at referral was fluoxetine 20 mg mane. Interview with the MINI generated DSM-IV diagnoses of current major depressive episode, current panic disorder with agoraphobia, current social phobia and current alcohol dependence. His wife and he had infrequent sexual relations. He reported loss of sexual interest and difficulty in achieving erection, and described considerable reduction in sexual desire, considerable difficulty in achieving and maintaining erection and in ejaculation, and considerable reduction in ability to enjoy sex.

Patient P079

A 50-year old married man with one adult son with learning disability, and a family history (three sisters) of phobic disorders. He developed irritability, affective lability and visual illusions for three weeks at the age of 24 years, and received the possible diagnosis of schizophrenia. He was well for 25 years, but developed depressive and anxiety symptoms and panic attacks at the age of the age of 50 years. He did not respond to fluoxetine treatment prescribed by his general practitioner, or to inpatient treatment with paroxetine, and was referred for a second opinion. The psychiatric diagnosis was depressive illness with secondary panic attacks. His treatment was paroxetine 50 mg mane and zopiclone 15 mg nocte. Interview with the MINI generated DSM-IV diagnoses of current major depressive episode, current panic disorder with agoraphobia, and current social phobia. He and his wife reported some reduction in frequency of sexual relations; he reported reduced sexual desire prior to starting fluoxetine treatment, and described some reduction in sexual desire, considerable difficulty in achieving and maintaining erection and in ejaculation, and some reduction in ability to enjoy sex.

Patient P080

A 42-year old married woman with four children and a family history (mother) of depression. At the age of 20 years she developed depressive symptoms and health concerns, which waxed and waned in severity over the next 22 years. Her symptoms worsened considerably after delivery, with the development of hypochondriacal delusions, but she responded briefly to combination antidepressant-antipsychotic treatment, with electroconvulsive therapy. Her symptoms returned and did not respond to many different antidepressant or antipsychotic drugs or cognitive-behaviour therapy. Her psychiatric diagnosis rested between depressive illness with mood-congruent psychotic features, and schizoaffective disorder. Her treatment was paroxetine 10 mg mane. Interview with the

MINI generated DSM-IV diagnoses of current major depressive episode, current agoraphobia, lifetime panic disorder, and current generalised anxiety disorder. She and her husband had infrequent sexual relations; she described considerable reduction in sexual desire and arousal, slightly greater ease in achieving orgasm, some dissatisfaction with intensity of orgasm, and considerable reduction in ability to enjoy sex.

Patient P081

A 49-year old married woman with an adult son. She was sexually abused repeatedly before the age of 11 years. She experienced her first depressive episode and attempted suicide at the age of 20 years, and developed an episodic recurring depressive disorder, with gradually worsening agoraphobia. She was referred at the age of 46 years, in her seventh depressive episode, which responded to treatment with lofepramine and thioridazine. She developed hypothyroidism when aged 48 years, and experienced a further episode, which responded to reboxetine treatment. Her medical history was limited to Caesarean section. The psychiatric diagnosis was recurrent depressive disorder with agoraphobia. Her current treatment was reboxetine 4 mg b.d. and thyroxine 200 mcg mane. Interview with the MINI generated DSM-IV diagnoses of current dysthymia, current agoraphobia, lifetime panic disorder, and current social phobia. She and her husband had not had sexual relations for many years; she described considerable problems in all areas of the sexual response.

Patient P082

A 44-year old married woman with one daughter and a family history (father) of depression. She experienced her first depressive episode at the age of 18 years, following parental divorce and termination of pregnancy. Her second episode developed when aged 30 years: she was treated with antidepressants and marital therapy and improved after two years. Her third episode occurred at the age of 41 years. She did not respond to amitriptyline prescribed by her general practitioner and was referred. The psychiatric diagnosis was recurrent depressive disorder. Her medical history was limited to termination of pregnancy and ovarian cystectomy. She responded to fluoxetine treatment, and then underwent marital therapy followed by group psychotherapy. Interview with the MINI generated the DSM-IV diagnosis of current generalised anxiety disorder. Her treatment was fluoxetine 20 mg, then 40 mg on alternate mornings. She and her husband had sexual relations only very infrequently; she reported a long-standing lack of interest in sexual activity, and described considerable reduction in sexual desire, some reduction in sexual arousal, some difficulty in achieving orgasm and some reduction in ability to enjoy sex.

Patient P083

A 31-year old single woman with one daughter and a family history (mother) of anxiety and depression. She was sexually abused by a first-degree male relative when aged 12 years, began to experience severe anxiety symptoms in social settings as a teenager, and attempted suicide at the age of 21 years. She underwent cognitive behaviour therapy over three years. She experienced a

depressive episode when aged 27 years, and was admitted to hospital, the psychiatric diagnosis being social phobia with secondary depression. She responded to lofepramine treatment, but experienced a recurrence of depressive symptoms after four years; she did not improve with citalopram treatment and was referred. Her current treatment was citalopram 40 mg mane. Interview with the MINI generated DSM-IV diagnoses of current major depressive episode, current panic disorder with agoraphobia, current social phobia, and current generalised anxiety disorder. She had no sexual partner and reported a loss of sexual interest with the recurrence of depression; she described considerable reduction in sexual desire and arousal, considerable difficulty in achieving and dissatisfaction with orgasm, and considerable reduction in ability to enjoy sex.

Appendix 5.1

MODIFIED RUSH SEXUAL INVENTORY SCALE (RSI)

1. Have you ever experienced sexual dysfunction while taking any medication?

   No Yes, explain

2. Do you and/or your sexual partner(s) presently use birth control?

   No
   Not applicable (no partner)
   Yes, check all that apply

condom	birth control pills
diaphragm	intrauterine device
foam	sterilisation (vasectomy, tubal ligation, hysterectomy)
rhythm method	withdrawal of penis from vagina prior to ejaculation
other, explain	

3. Have you ever had any surgical or medical procedure performed on your reproductive organs (for example, hysterectomy, prostate surgery, penile implant, hymenectomy, etc.)?

   No Yes, explain

f

4. Have you ever had a non-routine investigation of your reproductive organs?

   No Yes, explain

5a. Have you ever been evaluated for a sexual dysfunction?

   No Yes, explain

5b. Have you ever received treatment for a sexual dysfunction?

   No Yes, explain

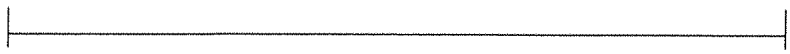
6. Please list any circumstances in your life that you feel may have affected your sexual experience (either positively or negatively). Include dates, when appropriate:

7. Rate each item as it applies in the PAST 4 WEEKS. For each item below, place a mark on the line where you would place yourself.

Example:

infrequent very frequent

a. How frequently do you have pleasurable sexual thoughts?



infrequent very frequent

b. Rate your ability to become sexually excited

unable always able

c. How frequently do you have desires to initiate sexual activity?

infrequent very frequent

d. How often do you initiate sexual activity?

infrequent very frequent

e. Rate your overall degree of satisfaction attained:

low high

8. How many times on average in the PAST 4 WEEKS did you engage in the following sexual activities?

	Masturbation (solitary or by partner)	Intercourse (anal or vaginal)	Oral sex
Never			
Once per week			
2-4 times per week			
5-10 times per week			
More than 10 times per week			

9a. **Males only**

Please check Yes or No for each item as it applies to you over the PAST 4 WEEKS (one of the 2 choices must be checked for each item).

		Yes	No
1.	spontaneous daytime erections		
2.	painful erections		
3.	erection when sexually aroused		
4.	difficulty getting an erection when sexually stimulated		
5.	difficulty maintaining an erection to complete sexual act		
6.	waking up from sleep with an erection		
7.	requiring more stimuli than usual to achieve an erection		
8.	requiring more stimuli than usual to maintain an erection		
9.	decreased fullness of erection		
10.	increased sensitivity of genitals upon physical stimulation		
11.	decreased sensitivity of genitals upon physical stimulation		
12.	orgasm		
13.	ejaculation		
14.	painful orgasm/ejaculation		
15.	orgasm without ejaculation		
16.	delay in achieving orgasm/ejaculation but eventually doing so		
17.	inability to achieve orgasm/ejaculation		
18.	orgasm without erection		
19.	orgasm during sleep		
20.	genital pain during sexual contact		
21.	orgasm/ejaculation occurring earlier than desired		
22.	experiencing orgasm without sexual provocation (except in sleep)		
23.	generally decreased intensity of orgasm		

9b. Females only

Please check Yes or No for each item as it applies to you over the PAST 4 WEEKS (one of the 2 choices must be checked for each item).

		Yes	No
1.	increased sensitivity, other than pain, in breasts upon physical contact		
2.	increased sensitivity of genitals, other than pain, upon physical contact		
3.	pain in breasts upon physical contact		
4.	pain in genitals upon physical contact		
5.	decreased sensitivity in breasts upon physical contact		
6.	decreased sensitivity in genitals upon physical contact		
7.	inadequate swelling or vaginal lubrication during arousal		
8.	orgasm		
9.	multiple orgasm		
10.	difficulty achieving orgasm, but eventually being able to		
11.	inability to achieve orgasm		
12.	experiencing orgasm without sexual provocation (spontaneously)		
13.	painful orgasm		
14.	decreased intensity of orgasm		
15.	involuntary vaginal contractions that prevent vaginal penetration		
	if Yes, check one: always intermittently		
16.	physical pain during sexual activity		

What was the first day of your last menstrual period?

- - / - - / - - - - Not applicable

Appendix 6.1

Arizona Sexual Experiences Scale for Men

For each item, please indicate your OVERALL level during the PAST WEEK including TODAY.

1. **How strong is your sex drive?**

1 Extremely strong	2 Very strong	3 Somewhat strong	4 Somewhat weak	5 Very weak	6 No sex drive

2. **How easily are you sexually aroused (turned on)?**

1 Extremely easily	2 Very easily	3 Somewhat easily	4 Somewhat difficult	5 Very difficult	6 Never aroused

3. **Can you easily get and keep an erection?**

1 Extremely easily	2 Very easily	3 Somewhat easily	4 Somewhat difficult	5 Very difficult	6 Never

4. **How easily can you reach an orgasm?**

1 Extremely easily	2 Very easily	3 Somewhat easily	4 Somewhat difficult	5 Very difficult	6 Never reach orgasm

5. **Are your orgasms satisfying?**

1 Extremely satisfying	2 Very satisfying	3 Somewhat satisfying	4 Somewhat unsatisfying	5 Very unsatisfying	6 Can't reach orgasm

Appendix 6.2

Arizona Sexual Experiences Scale for Women

For each item, please indicate your OVERALL level during the PAST WEEK including TODAY.

6. **How strong is your sex drive?**

1 Extremely strong	2 Very strong	3 Somewhat strong	4 Somewhat weak	5 Very weak	6 No sex drive

7. **How easily are you sexually aroused (turned on)?**

1 Extremely easily	2 Very easily	3 Somewhat easily	4 Somewhat difficult	5 Very difficult	6 Never aroused

8. **How easily does your vagina become moist or wet during sex?**

1 Extremely easily	2 Very easily	3 Somewhat easily	4 Somewhat difficult	5 Very difficult	6 Never

9. **How easily can you reach an orgasm?**

1 Extremely easily	2 Very easily	3 Somewhat easily	4 Somewhat difficult	5 Very difficult	6 Never reach orgasm

10. **Are your orgasms satisfying?**

1 Extremely satisfying	2 Very satisfying	3 Somewhat satisfying	4 Somewhat unsatisfying	5 Very unsatisfying	6 Can't reach orgasm

Appendix 7.1

Daily diary card used in treatment study

At what time did you take your fluoxetine or paroxetine?

At what time did you take your study medication? (Day 15 to Day 42)

Did you have any food or drink (other than water) up to 1 hour before taking your study medication?

No

Yes If Yes, at what time?

Did you have any food or drink (other than water) up 1 hour after taking your study medication?

No

Yes If Yes at what time?

Were you sexually active today?

No

Yes If Yes, please indicate approximate time(s) by ticking the relevant box(es):

5-6 p.m.
6-7 p.m.
7-8 p.m.
8-9 p.m.
9-10 p.m.
10-11 p.m.
11 p.m.- midnight
after midnight

Sexual activity is defined as any sexual activity, either with a partner or through masturbation, that has the potential to lead to orgasm.

Did you experience any unusual symptoms today? #

No

Yes If Yes, please record them on page *.

Did you take any medication other than your fluoxetine and study medication today?

No

Yes If Yes, please record details on page *.

* Diary card included one page per day, with Day and Date recorded at the top. Adverse events and concomitant medications were recorded on 'global' pages at the back of each diary.

\# Information recorded: symptoms, onset date and time, date and time resolved. Severity was assessed by questioning of the patient by the study investigator.

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