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ORIGINAL ARTICLE

Psychological and sexual functioning of persons suffering from post-SSRI sexual dysfunction – cases study

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BACKGROUND
Post-SSRI syndrome is a condition following the discontinuation of selective serotonin reuptake inhibitors (SSRIs) where, despite ceasing to take the pharmacological agents, the effects persist – and they may develop upon drug initiation. While most research has focused on identifying and classifying the main somatic symptoms, the psychological consequences of post-SSRI sexual dysfunction (PSSD) syndrome are insufficiently explored.

PARTICIPANTS AND PROCEDURE
The report presents descriptions of two cases of PSSD, as well as two contrasting cases in which the effects of taking SSRI drugs seem to have had a positive impact on the mental and sexual sphere.

RESULTS
The results of the study indicate a wide range of sexual side effects of taking SSRI drugs. The four cases discussed are evidence, on the one hand, of the frequent occurrence of side effects in the form of sexual disorders that may persist without a guarantee of return to previous sexual performance. On the other hand, the presented cases show, in some situations, a positive increase in human sexual functioning.

CONCLUSIONS
The study provides new information on the discussed issue and at the same time highlights the still insufficient scientific knowledge on this topic. In light of the present results, further systematic research is needed to explore the pathogenesis of the syndrome and develop effective interventions and treatments. Subsequent research should take into account, in particular, clinical trials.

KEY WORDS
post-SSRI syndrome; post-SSRI sexual dysfunction; PSSD; psychological functioning of persons suffering from post-SSRI sexual dysfunction

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BACKGROUND

Post-SSRI syndrome is a condition following the discontinuation of serotonin reuptake inhibitors or serotonin-norepinephrine reuptake inhibitors where, despite ceasing to take the pharmacological agents, the effects persist – and they may develop upon drug initiation (Jakima & Rawińska, 2019; Pukall, 2023). This syndrome consists of various symptoms, the most common being decreased sensation in the genital area, absence or weakening of orgasm, decreased libido, erectile dysfunction, reduced lubrication, and decreased sensitivity of the mammary glands.

In recent years, the number of studies on the subject has increased. In 2021, a team of researchers from around the world, based on an analysis of many cases of people struggling with prolonged sexual dysfunctions, developed a criteria scheme that allows for a more accurate diagnosis of post-SSRI sexual dysfunction (Healy et al., 2022). These criteria included selective serotonin reuptake inhibitors (SSRIs) and all types of drugs based on 5-HT reuptake. Serotonin reuptake inhibitors (SRIs) include SSRIs, serotonin and norepinephrine reuptake inhibitors (SNRIs), tricyclic SRI antidepressants, SRI antihistamines, tetracycline antibiotics, for example, doxycycline, and painkillers such as tramadol (Healy et al., 2022). However, most research has focused on identifying and classifying the main somatic symptoms, which would allow for the diagnosis of PSSD to be made, as well as to look for its possible causes (for example, see: Bala et al., 2018; Klaas et al., 2023). The psychological consequences of post-SSRI sexual dysfunction syndrome are insufficiently understood. There is still a lack of research on the Polish population of people with PSSD. For this reason, the study investigated the basic psychological aspects of Polish people suffering from PSSD. In addition, we conducted a preliminary qualitative analysis of the described phenomenon, especially in terms of psychological effects.

Sexual dysfunctions associated with taking SSRIs usually develop after the first or one of the first uses (Bala et al., 2018) and sometimes do not resolve upon termination of pharmacotherapy (Bala et al., 2018; Pukall, 2023). Despite ceasing use of SSRIs, the sexual symptoms can last for months or even years (Reisman, 2017). Some researchers report the occurrence of sexual disorders in individuals taking SSRIs as less than 10% (Reisman, 2017). Other studies indicate that between 5% and 15% of individuals taking medications from this group have observed side effects in the sexual sphere (Bala et al., 2018). As regards experiencing sexual dysfunction after treatment with SSRIs, the issue is much more complicated. The Netherlands Pharmacovigilance Center (Lareb), in 2012, recorded in its database 19 cases (13 men and 6 women) of persistent sexual dysfunction in patients who had stopped using SSRIs 2 months to 3 years earlier and still had not recovered their former level of sexual functioning (Ekhart & van Puijenbroek, 2014). Another study reported 90 cases in which the potential clinical syndrome was PSSD (Hogan et al., 2014). A comprehensive description of the frequency of the phenomenon, based on an analysis of most of the studies focusing on the described issue, was presented by Healy (2018). These data suggest that post-SSRI syndrome as a set of symptoms occurs (or is diagnosed!) much less frequently than individual disorders caused by serotonin reuptake inhibitors.

PSYCHOLOGICAL CONSEQUENCES OF PSSD

Sexual dysfunctions, listed as symptoms of post-SSRI sexual dysfunction, have many negative psychological consequences for those affected.

In the case of orgasm dysfunction, a man suffering from PSSD may experience strong negative emotions, which may even provoke an aversion to continuing sexual activity (Zakliczyńska, 2019). The problem becomes all the more serious (from the affected man's perspective) if the couple wants to have children. The man may also experience distress (resulting from the inability to reach orgasm or ejaculate), leading to anxiety about his sexual health and health in general. Jakima (2019) pointed out that the negative consequences when it comes to the psychological sphere include suffering, anxiety, frustration or avoiding sexual intimacy. In the case of psychological consequences of potential orgasm disorders in women, many consequences are similar to those noted in men. They include stress, interpersonal difficulties, and unrest, leading to anxiety about one's sexual health or frustration.

In the case of erectile dysfunctions, dysfunctional beliefs about one's sexual performance, such as "I will probably have erection problems again", "A real man has an erection on request", "I am a bad lover", can be disruptive to both the person experiencing these sexual problems and the couple as a whole (Cysarz, 2019). All such and similar beliefs and dysfunctional cognitive patterns "support" the persistence of sexual dysfunction.

THE NEED FOR DEEPER AND MORE COMPLEX RESEARCH

To date, research on sexual dysfunction following SSRI use has primarily concentrated on the pharmacological and biological aspects (see, for example, Bala et al., 2018; Waraich et al., 2021). While there is substantial evidence of an association between SSRI use and sexual dysfunction, few studies have employed qualitative methods to elucidate patients' individual experiences, particularly in the context

of their subjective emotional and psychological responses. For example, in 2021, an analysis on the effects on quality of life among people who identified as suffering from PSSD was published. As a result of analysing the data obtained electronically (online survey), the authors observed a significant deterioration in the quality of life in the mentioned group. This is one of the few studies so far that has addressed the psychological aspects associated with post-SSRI syndrome (Studt et al., 2021).

This paper builds upon existing literature to examine the individual experiences of those affected by sexual dysfunction following SSRI pharmacotherapy and its termination. In particular, it aims to enhance understanding of patients' emotional and psychological responses to changes in their sexual lives.

PARTICIPANTS AND PROCEDURE

STUDY DESIGN

The study was conducted in the autumn of 2021. In preparing the study as well as the qualitative tool, the APA guidelines for qualitative research were taken into account. Due to the coronavirus pandemic and difficult access to the subjects, the researchers decided to conduct the study in the form of a paper interview, with open questions and a place for a written answer. As part of the study, the researchers focused on the qualitative form of collecting and analysing information. Therefore, the sample was limited to four persons who reported SSRI treatment and sexual dysfunction related to it, whose answers were analysed in line with common standards of case analysis. The four individuals who participated in the study were young adults aged 22-27, either pursuing or having completed higher education. All were residents of the Pomeranian Voivodeship, mainly associated with the Tricity urban area. Each participant provided consent to take part in the study, and no compensation was given for their participation. Some of the respondents were excluded because, despite their declaration of meeting the criteria, this turned out to be untrue during the study. Also, individuals who were taking medications other than SSRIs; had not completed their pharmacological treatment; or had not observed any changes in their sexuality were excluded from the study. These were the primary exclusion criteria. Respondents were recruited from students of the University of Gdansk, after the announcement of the ongoing study. Psychotherapists who might have provided care to the potential subjects were also contacted. The study received approval of the Ethics Committee from the University of Zielona Góra.

In order to conduct the study in such a way as to obtain as much information as possible from the respondents, the researchers decided to construct their own tool – an interview. The tool was based on 15 open-ended questions and a demographic table. Its development drew from the methods described by Ben-Sheetrit and colleagues (2015). The participants answered the written questions themselves.

The data were collected via a semi-structured psychological interview, which consisted of a scenario containing 15 fixed questions. These were supplemented, if necessary, with auxiliary questions to address any difficulties the participants may have encountered in answering the questions or to clarify the content of their statements.

The choice of a qualitative method – the interview – is based on several premises. Firstly, the qualitative interview method allows for an in-depth understanding of the individual experiences of the study participants. Psychological consequences can be diverse and subtle. A qualitative interview enabled a more direct insight and detailed picture of the experiences, feelings, and thoughts of the subjects. Secondly, this method promotes building trust and comfort among participants, which is particularly important in research involving sensitive topics such as sexual disorders, allowing for a less mechanical and dehumanized research atmosphere. Finally, qualitative interviews are flexible and adaptive, allowing for the adjustment of questions during the study in response to emerging threads and themes. This is evident, for instance, in case 4, where this approach revealed the theme of hypothetical gender incongruence.

The questions were divided into six main areas. The first area of enquiry was the reasons for commencing treatment and the subject's general mental and physical health. The second area of enquiry was the subject's sexual functioning prior to drug treatment. The third area of enquiry was the subject's sexual functioning during treatment. The fourth area of enquiry was the subject's functioning following treatment. The fifth area of enquiry was the potential specific sexual dysfunctions that arose as a result of pharmacotherapy. The sixth area of enquiry was the subject's emotions and feelings about the difficulties discussed.

Once the transcriptions had been created from the interviews, a selection of excerpts was made from the interviews that related sequentially to the areas listed above.

Following the selection of excerpts pertaining to the aforementioned issues, the statements of the interviewees were categorised according to their content. This process enabled the extraction of the structure of the analysis and the identification of the most representative issues (statements) for inclusion in the subsequent analysis. In the description of individuals, issues were identified that allowed for the reflection of the diversity of statements and the most significant, most prevalent themes in the statements

of the interviewees, with the aim of providing a comprehensive overview.

Wherever possible, the data obtained were compared with existing scientific findings.

In the case of the analysis of statements regarding the subjects' emotions and feelings, it proved impossible to compare the responses obtained due to the lack of scientific literature documenting such issues by SSRI-treated subjects who continued to experience treatment-induced sexual dysfunction after completing pharmacotherapy.

Each interview was subjected to individual analysis in order to identify the distinctive experiences of each participant. An approach focusing on the differences between cases was employed to more accurately capture the specificity and variation of experiences of sexual dysfunction following SSRI and PSSD use. For instance, in Violette's case, the analysis primarily focused on her emotional difficulties and psychological tensions. This approach facilitated a more profound comprehension of the individual mechanisms underlying the participants' experiences.

The aforementioned method of analysis was employed in the study due to its capacity to identify and analyse content in a manner that elucidates pertinent variables within the context of the subjects' psychological experiences. This approach was informed by the tenets of thematic analysis, which offers an accessible and theoretically flexible methodology for analysing qualitative data (Braun & Clarke, 2006). In particular, the data should be broken down in terms of particular themes (i.e., initial codes) and the study participants' interpretations of their experiences of PSSD should be examined in detail. This is in line with the approach proposed by Braun and Clarke (2006). Although the analysis was not conducted in accordance with the specified method, it permitted a flexible examination of the content of the participants' statements while simultaneously maintaining the context and individual experiences of the respondents. Furthermore, it facilitated the identification of subtle differences in individual experiences, which is essential for comprehending the phenomenon under investigation.

A consent form for participation in the study was included in the interview. Participants were assured anonymity – any data enabling their identification underwent masking and alterations. The study excluded individuals who were taking medications other than SSRIs, had not completed pharmacological treatment, or had not observed changes in their sexuality.

RESULTS

CASE 1

The patient Vanessa was 23 years old, with secondary education, a resident of the Pomeranian Voivodship. She had started taking SSRIs (Zoloft at a dose of 50 mg) less than two years previously. The pharmacological treatment was started due to her difficult family situation, which caused a significant decrease in mood, anhedonia and sleep problems. She took SSRIs for about a year, and the pharmacotherapy had been completed half a year previously. In the interview, she reported no other current mental or physical symptoms.

She evaluated her sexual functioning before the start of treatment as good. She reported "average" sexual excitability, and, in an attempt to clarify, she stated that she felt a desire for sex about 1-2 times a week, often having orgasms. She said she positively evaluated her sex life from that period. About 2-3 weeks after the start of the pharmacotherapy, she began to experience problems with achieving orgasm; she felt that "she had completely lost it". Her libido also decreased, and sexual contact between Vanessa and her partner was initiated by the other party. The woman sometimes refused because of a lack of desire to engage in sexual activities. Throughout treatment, the symptoms got "a little" worse. Now, after drug discontinuation, she perceived her sex life as almost the same as before the treatment, although the decrease in orgasm persisted – "It's back, but it's weaker than before". She did not identify any current life circumstances that might have been affecting her sexual life and health (after pharmacotherapy and improvement of mental state) other than the potential effect of SSRI treatment.

The woman had not revealed to anyone other than her partner that she suffered from sexual and other psychological issues. She perceived her partner as a strong support; during "the most difficult period" (the initial period of pharmacological treatment and therapy), her partner showed her a lot of understanding and support. When a better moment came, but the sexual difficulties persisted, Vanessa said that thanks to her partner, she still felt attractive; she mentioned that along with the sexual difficulties, she felt she was losing something important for the relationship and missed the (sexual) satisfaction she once had.

CASE 2

Samantha was 27 years old and had completed higher education. Six months previously, she had completed two years of pharmacotherapy with SSRI, also Zoloft. The reasons for the treatment were attention problems, lowered mood and excessive crying. In addition, the situation significantly worsened due to her father's death.

The respondent pointed out that before the start of treatment, her sexual excitability and sensitivity were within the normative range. The only thing that bothered her was the difficulty of reaching orgasm, and the intercourse at the beginning (probably the begin-

ning of penetration) was painful for her. At the start of treatment, she noticed that her desire for sex and libido significantly decreased, and her sexual functioning "decreased". She did not specify precisely when these changes occurred but generally stated that she noticed them a few months after starting pharmacotherapy. It should be noted that, given the time of becoming aware of new sexual difficulties, they were not caused by the described difficulties and life situations which were the reason for the initiation of pharmacotherapy. After stopping medication, Samantha believed that her sexual functioning had not returned to its pre-treatment state. She stated that if the discussed difficulties were to persist despite the passage of time, she would visit a doctor and seek advice from a specialist. However, at the time of the interview, she claimed that the mentioned ailments did not bother herRegarding other issues that, besides pharmacological treatment, could affect sexual difficulties, the woman mentioned having numerous obligations and her job. However, she did not mention since when she had had these numerous obligations or how they constituted a burden affecting her sexual sphere.

CASE 3

The third case is that of Violette, a 23-year-old woman with secondary education. She had stopped treatment with SSRIs seven months prior and took SSRIs for almost two years. The first disturbing symptoms appeared at age 15 – social withdrawal, suicidal thoughts, self-harm, and self-closure. She was also diagnosed with hypothyroidism and cysts associated with the described symptoms at that time. She first reported to a psychiatrist at age 21 with conditions such as anhedonia, suicidal ideation, self-harm, mood swings, panic attacks and anxiety, low motivation to act and reluctance to be among people. An earlier attempt to report to a psychiatrist (when she was about 17) ended when the doctor had downplayed the problem. At that time, she also started a relatively short course of psychotherapy (about three months).

When analysing the respondent's sexual functioning before treatment, attention should be paid to the sexual sensitivity to stimuli described as "not fully complete" but intense. Libido was high, and sexual behaviour brought relaxation. The intercourse was painful; there were problems with lubrication. In addition, she also mentioned a high tendency to be distracted, caused even by small stimuli, such as crackling. About five months after the respondent started taking SSRI, she noticed that the intercourse became more "easy-going" and less painful. However, orgasm concentrated around and was possible only with clitoral stimulation; libido increased. In addition, after 1.5 years from the start of pharmacotherapy, she changed her sexual partner, which resulted in a further positive change in sexual satisfaction. Since the end of pharmacotherapy, Violette believed that her satisfaction with intercourse had changed and increased; there was no pain with penetration, abrasions were less frequent, and sensations were more comprehensive. Remembering the past, the woman describes those experiences as "everything a bit behind the glass".

When asked about other issues that could have influenced her sexual dysfunction, she mentioned that from the very beginning it could have been caused by religious beliefs and the "endless" feeling of guilt associated with it, but at the time of the interview the woman had stopped caring about it.

CASE 4

The fourth person examined was Eleanor, from northeast Poland, 22 years old and having a secondary education. She had begun taking SSRIs about five years previously. The reason for this was suspected depressive states, the severity of which was additionally increased by stress related to the secondary school final exam and the so-called minority stress. Pharmacological treatment lasted about six months. After its discontinuation, the respondent, on the advice of a doctor, began meetings with a therapist. She described her mental and physical well-being as good and having improved recently.

She evaluated her sexual functioning before starting treatment as good and satisfying. She had a "fairly large" libido and a desire for sexual behaviour, mainly addressed toward her and sensitivity to sexual stimuli. During the treatment, her libido increased, and she began practising oral sex, of which she was not previously convinced. After the end of pharmacotherapy, she stated that at some point, sex "focused on her" began to stress her, and since then, it had been sporadic. There had been a "significant" decrease in libido, and the woman focused on sexual contact to satisfy her partner.

When asked to name other things that could have influenced her sexual dysfunction, she suggested that she had problems with her gender identity and this could be the other cause – she said that sometimes she felt that the lack of desire for behaviour focused on her may result from this.

SUMMATIONS

Each case illustrates unique experiences with SSRIs affecting sexual function, highlighting varying impacts on libido, orgasm attainment, and overall sexual satisfaction. Psychosocial support, partner understanding, and personality trait issues also play crucial roles in coping with and understanding these post-

treatment challenges. All subjects reported initially good sexual functioning before starting SSRI therapy, but became aware of issues with libido, difficulty achieving orgasm, and reduced sexual satisfaction after starting it. After discontinuing the treatment, some symptoms persisted, as with Vanessa, who was still experiencing weaker orgasms, or Samantha. In the other two cases, treatment alleviated sexual dysfunctions during or after pharmacotherapy, which is an interesting observation.

DISCUSSION

This study aims to address a gap in the existing literature on the psychological consequences of PSSD. The results obtained are of particular relevance as this pre-post study is one of the first to address the psychological consequences of PSSD after SSRIs in a more detailed and qualitative manner. The stabilisation of Violette's psychological state, including a reduction in anxiety, panic and an increase in motivation, had a positive impact on her sex life. In contrast, Eleanor's case illustrates a more intricate interrelationship between pharmacotherapy and sexuality, which is especially pertinent in the context of PSSD. Despite an improvement in her mental state following the cessation of medication, her sexual function exhibited a decline. This resulted in Eleanor experiencing distress due to sexual contact that was directed towards her. This kind of observation suggests that SSRI withdrawal may nevertheless lead to permanent changes in the area of sexuality, with long-term psychological effects, including a significant deterioration in quality of life. This is in line with the findings of the few studies to date on this psychological aspect of PSSD (Studt et al., 2021).

These results indicate that a comprehensive understanding of PSSD necessitates the consideration of not only physiological but also psychological changes that may elucidate seemingly contradictory effects, such as the deterioration of sexual function despite improvements in mental status. In conclusion, this study introduces new avenues for discussion on PSSD, emphasising the necessity for further research that considers the intricacies of this phenomenon, particularly in its psychological aspect. Such an approach may facilitate the development of more personalised treatment strategies for patients with PSSD, which is crucial for clinical practice.

LIMITATIONS

The study has several limitations. Firstly, the small sample size limits the generalizability of the findings, and the retrospective design of the study may introduce bias. Human memory is unreliable and tends to remember things more positively, which may have influenced the answers. On the other hand, respondents may have consciously concealed certain facts. The size of the sample may have further increased bias. Secondly, the results mainly consist of descriptive case reports, with a consequent lack of deeper analysis in certain areas. In further studies, there is a need for a much broader exploration of the topics discussed. Without this, it is difficult to draw any serious conclusions, especially for the entire population of people suffering from PSSD. Another element that has not been explored sufficiently is the personality aspects of the study participants. Gender incongruence, tendencies towards mood swings, religious beliefs and the feeling of guilt (which may suggest links with, for example, neuroticism or consciousness) are important factors that are linked to participants' personality traits. In further analysis of collected data, expanded to include additional people with PSSD and their experience, these factors have to be significantly expanded.

FUTURE STUDIES

It is important to conduct long-term observations to assess the stability and long-term side effects, primarily in the psychological domain, after discontinuation of SSRI treatment. Additionally, future studies should consider the psychosocial aspect and social support in the context of sexual problems related to SSRIs. It is crucial to examine how partner support and other psychosocial factors can influence patients' experiences with sexual issues during and after pharmacological therapy. Although these themes were preliminarily addressed in this study, they require further development in subsequent clinical research.

CONCLUSIONS

SSRIs are extremely frequently prescribed pharmacological agents. They constitute a large percentage of drugs prescribed for various mental disorders, such as depression and anxiety disorders (Bala et al., 2018). Based on the analysis of the presented cases of individuals using SSRIs, several significant conclusions can be drawn. The four cases discussed are evidence, on the one hand, of the frequent occurrence of side effects in the form of sexual disorders – which do not necessarily resolve with drug discontinuation and may persist without a guarantee of return to previous sexual performance. On the other hand, the presented cases show, in some situations, an improvement in human sexual functioning. In conclusion, the present analysis appears to be a small but valuable contribution to studies on the consequences of SSRIs, including PSSD. Integrating various perspec-

tives, biological and psychological, will aid in refining management strategies for these issues in clinical practice.

Disclosures

This research received no external funding.
The study was approved by the Bioethics Committee of the University of Zielona Góra (Approval No. 1/01/2024).
The authors declare no conflict of interest.

References

Bala, A., Nguyen, H. M. T., & Hellstrom, W. J. (2018). Post-SSRI sexual dysfunction: a literature review. *Sexual Medicine Reviews, 6*, 29–34. https://doi.org/10.1016/j.sxmr.2017.07.002

Ben-Sheetrit, J., Aizenberg, D., Csoka, A. B., Weizman, A., & Hermesh, H. (2015). Post-SSRI sexual dysfunction: Clinical characterisation and preliminary assessment of contributory factors and dose-response relationship. *Journal of Clinical Psychopharmacology, 35*, 273–278. https://doi.org/10.1097/JCP.0000000000000300

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77–101. https://doi.org/10.1191/1478088706qp063oa

Cysarz, D. (2019). Wybrane modele pracy terapeutycznej z psychogennymi zaburzeniami erekcji [Selected models of therapeutic work with psychogenic erectile dysfunction]. In M. Rawińska (Ed.), *Zaburzenia seksualne a psychoterapia poznawczo-behawioralna* [Sexual disorders and cognitive-behavioral psychotherapy] (pp. 259–276). PZWL Wydawnictwo Lekarskie.

Ekhart, G. C., & van Puijenbroek, E. P. (2014). Does sexual dysfunction persist upon discontinuation of selective serotonin reuptake inhibitors? *Tijdschrift voor Psychiatrie, 56*, 336–340.

Healy, D. (2018). Citizen petition: Sexual side effects of SSRIs and SNRIs. *International Journal of Risk & Safety in Medicine, 29*, 135–147. https://doi.org/10.3233/JRS-180745

Healy, D., Bahrick, A., Bak, M., Barbato, A., Calabrò, R. S., Chubak, B. M., Cosci, F., Csoka, A. B., D'Avanzo, B., Diviccaro, S., Giatti, S., Goldstein, I., Graf, H., Hellstrom, W. J. G., Irwig, M. S., Jannini, E. A., Janssen, P. K. C., Khera, M., Kumar, M. T., Le Noury, J., … Waraich, A. (2022). Diagnostic criteria for enduring sexual dysfunction after treatment with antidepressants, finasteride and isotretinoin. *International Journal of Risk & Safety in Medicine, 33*, 65–76. https://doi.org/10.3233/JRS-210023

Hogan, C., Le Noury, J., Healy, D., & Mangin, D. (2014). One hundred and twenty cases of enduring sexual dysfunction following treatment. *International Journal of Risk & Safety in Medicine, 26*, 109–116. https://doi.org/10.3233/JRS-140617

Jakima, S. (2019). *Dysfunkcje seksualne. Poradnik dla lekarzy* [Sexual dysfunction. A guide for doctors]. PZWL Wydawnictwo Lekarskie.

Jakima, S., & Rawińska, M. (2019). Farmakoterapia w seksuologii [Pharmacotherapy in sexology]. In M. Rawińska (Ed.), *Zaburzenia seksualne a psychoterapia poznawczo-behawioralna* [Sexual disorders and cognitive-behavioral psychotherapy] (pp. 37–44). PZWL Wydawnictwo Lekarskie.

Klaas, S., Siva, J. B., Bak, M., Govers, M., & Schreiber, R. (2023). The pathophysiology of post SSRI sexual dysfunction – lessons from a case study. *Biomedicine & Pharmacotherapy, 161*, 114166. https://doi.org/10.1016/j.biopha.2022.114166

Pukall, C. (2023). Post-SSRI/SNRI sexual dysfunction: a review. *The Journal of Sexual Medicine, 20*, qdad068-019. https://doi.org/10.1093/jsxmed/qdad068.019

Reisman, Y. (2017). Sexual consequences of post-SSRI syndrome. *Sexual Medicine Reviews, 5*, 429–433. https://doi.org/10.1016/j.sxmr.2017.05.002

Studt, A., Gannon, M., Orzel, J., Vaughan, A., & Pearlman, A. M. (2021). Characterizing post-SSRI sexual dysfunction and its impact on quality of life through an international online survey. *International Journal of Risk & Safety in Medicine, 32*, 321–329. https://doi.org/10.3233/JRS-210039

Waraich, A., Yih, J., Goldstein, S., & Goldstein, I. (2021). Post-SSRI sexual dysfunction (PSSD): Ten year retrospective chart review. *The Journal of Sexual Medicine, 18*, S41. https://doi.org/10.1016/j.jsxm.2021.01.046

Zakliczyńska, H. (2019). Zaburzenia orgazmu u mężczyzn [Orgasmic disorders in men]. In M. Rawińska (Ed.), *Zaburzenia seksualne a psychoterapia poznawczo-behawioralna* [Sexual disorders and cognitive-behavioral psychotherapy] (pp. 231–244). PZWL Wydawnictwo Lekarskie.