"I would have never touched them if I'd known": The impact of SSRI-related sexual side effects and the lived experience of post SSRI/SNRI sexual dysfunction (PSSD)

Seraj Brugi
Candidate Number: 100125306/5

Primary Supervisor: Dr Sarah Fish
Secondary Supervisor: Dr Bob Budd

Thesis submitted in partial fulfilment of the Degree of Doctorate in Clinical Psychology (ClinPsyD)

Submission Date: 3rd March 2026
Word count: 29,498

This copy of the thesis has been supplied on condition that anyone who consults it is understood to recognise that its copyright rests with the author and that use of any information derived there-from must be in accordance with current UK Copyright Law. In addition, any quotation or extract must include full attribution.

Where appropriate, materials previously used for the purpose of the Thesis Proposal assignment have been re-used throughout this thesis portfolio.

Access Condition and Agreement

Each deposit in the UEA Digital Repository is protected by copyright and other intellectual property rights, and duplication or sale of all or part of any of the Data Collections is not permitted, except that material may be duplicated by you for your research use or for educational purposes in electronic or print form. You must obtain permission from the copyright holder, usually the author, for any other use. Exceptions only apply where a deposit may be explicitly provided under a stated licence, such as a Creative Commons licence or Open Government licence.

Electronic or print copies may not be offered, whether for sale or otherwise to anyone, unless explicitly stated under a Creative Commons or Open Government license. Unauthorised reproduction, editing or reformatting for resale purposes is explicitly prohibited (except where approved by the copyright holder themselves) and UEA reserves the right to take immediate ‘take down’ action on behalf of the copyright and/or rights holder if this Access condition of the UEA Digital Repository is breached. Any material in this database has been supplied on the understanding that it is copyright material and that no quotation from the material may be published without proper acknowledgement.

Acknowledgements

I would like to say a massive thank you to my supervisors, Dr Sarah Fish and Dr Bob Budd, for your constant support, wisdom and faith in me. I have been very lucky to have you both throughout this journey, and I am grateful for all that I have learnt from you. I am especially grateful for your kindness, your responsiveness, and your shared passion for this project. Another massive thank you to Craig Mackie, your input into every aspect of this project has been invaluable. Thank you for everything you have taught me over the past two years.

Thank you to Edward Bell, for all your incredible hard work on the systematic review. More importantly, thank you for always believing in me even when I couldn't always believe in myself. Thank you to Zainul Marzuqi, for making sure I kept writing no matter what, and for making me laugh even when it felt hard to do so.

Thank you to the friends I have made on the course, I couldn't have asked for better company on this journey. A special thank you to Ashley, Amelia, Steph, and Ilze. The Clinical Psychology world is incredibly lucky to have kind, skilled, and compassionate people like you.

And finally, to the ten participants who made this research possible, I feel incredibly grateful and privileged that you offered your time to take part in this project. I have been deeply moved by hearing your stories, and I will never forget the conversations we had about your experiences. Thank you for trusting me.

Thesis Portfolio Abstract

Background. Selective serotonin reuptake inhibitors (SSRIs) are associated with sexual dysfunction (SD), potentially impacting patient wellbeing and treatment compliance. Occasionally, side effects can persist after medication has been discontinued. Little is known about how patient-reported SD has been reliably measured in SSRI research, or how post-SSRI sexual dysfunction (PSSD) may impact people's lives. **Objectives**. This thesis portfolio aims to synthesise the existing evidence base regarding the use of validated, patient-reported outcome measures (PROMs) in assessing SSRI-related SD. Moreover, this portfolio aims to explore the experiences of people living with PSSD. **Methods**. A systematic review of quantitative literature that utilised SD PROMs to assess SSRI-related SD was completed, and a qualitative study with ten participants, adopting an interpretive phenomenological analysis, was also completed. **Results**. Ten validated SD PROMs used across 27 studies were identified, with findings indicating that patient-reported SD occurs frequently following SSRIs, impacting relationships and sexual satisfaction. Moreover, PSSD can occur, significantly impacting individuals' lives including their trust in professionals and services, relationships, identities and mental health. **Conclusion**. Sexual side effects caused by SSRIs are prevalent and, in some instances, can persist long after treatment. Both SSRI-related SD and PSSD are important considerations for clinical practice.

Table of Contents

Access Condition and Agreement **2**
Acknowledgements **3**
Thesis Portfolio Abstract **4**
Chapter One: Introduction to Thesis Portfolio **8**
Introduction to Thesis Portfolio 9
Selective Serotonin Reuptake Inhibitors (SSRIs) 9
Sexual Dysfunction (SD) 9
Patient-Reported Outcome Measures (PROMs) 10
Post-SSRI Sexual Dysfunction (PSSD) 10
Outline of Thesis Portfolio 11
Chapter Two: Systematic Review **12**
Abstract 14
Introduction 15
Research Question 16
Methods 16
Search Strategy 16
Eligibility Criteria 17
Screening and Selection 18
Quality Assessment 18
Data Extraction 19
Data Synthesis 19
Results 19
Search Results 19
Study Characteristics 20
Quality Assessment 20
PROMs Assessing Sexual Dysfunction 25
Prevalence of Sexual Dysfunction 29
Tolerance of Sexual Dysfunction 31
Discussion 33
Overview 33
Strengths and Limitations 34
Clinical Implications 35
Recommendations for Future Research 35
Conclusion 36
References 37
Chapter Three: Bridging Chapter **48**
Bridging Chapter 49
Chapter Four: Empirical Study **50**
Abstract 52

Introduction 53
Methods 55
Ethical Approval 55
Patient and Public Involvement 55
Design 55
Participants 56
Materials 56
Procedure 57
Analysis 58
Reflexivity and Quality Assurance 58
Results 58
Participant Characteristics 58
Analysis 59
Distrustful of Professionals 60
A Changed Me 63
Living With the Impact 69
Discussion 73
Overview 73
Strengths and Limitations 75
Clinical Implications 76
Recommendations for Future Research 77
Conclusion 77
References 79
Chapter Five: Extended Methodology 84
Extended Methodology 85
Theoretical and Practical Underpinnings 85
Reflexivity and Quality Assurance 86
Ethical Considerations 87
Chapter Six: Discussion and Critical Evaluation 90
Discussion and Critical Evaluation 91
General Overview 91
Strengths and Limitations 93
Theoretical and Practical Implications 94
Implications for Research 94
Personal Reflections 95
Conclusion 96
Thesis Portfolio References 97
Appendices 115

List of Figures and Tables

Chapter Two: Systematic Review

Figure S1: PRISMA Flow Diagram……21
Figure S2: Harvest Plot……32
Table S1: Search Strategy……..17
Table S2: PICO Criteria…….....18
Table S3: Study Characteristics…….22
Table S4 (Appendix A): JBI Checklist RCTs……..…116
Table S5 (Appendix B): JBI Checklist non-RCTs……..120
Table S6: SD PROMs Utilised by Studies……25
Table S7 (Appendix C): Individual Study Outcomes……121

Chapter Four: Empirical Study

Table 1: Participant Characteristics……...59
Table 2: Representation of GETs Across Participants……...60

List of Appendices

Appendix A: JBI Checklist RCTs……..116
Appendix B: JBI Checklist non-RCTs……..120
Appendix C: Individual Study Outcomes……121
Appendix D: The Journal of Sexual Medicine Author Instructions……127
Appendix E: PRISMA Checklist…….....142
Appendix F: Evidence of Ethical Approval……145
Appendix G: Advertisement Poster……146
Appendix H: Participant Information Sheet……147
Appendix I: Participant Consent Form……151
Appendix J: Participant Debrief Sheet……153
Appendix K: The Journal of Sex Research Author Instructions……..155
Appendix L: Annotated Transcript Excerpt……161
Appendix M: Master List of PETs……162
Appendix N: Tabular Illustration of GETs Development……..173
Appendix O: SRQR Checklist……...175

Chapter One: Introduction to Thesis Portfolio

Introduction to Thesis Portfolio

The aim of this thesis portfolio is to understand how patient-reported outcome measures (PROMs) have been used to evaluate the presence and tolerance of sexual side effects associated with selective serotonin reuptake inhibitors (SSRIs), and what the experiences are of people whose side effects persist even after they have stopped taking the medication. The current chapter will provide a brief overview of key terms described in this research, as well as an outline of the portfolio.

Selective Serotonin Reuptake Inhibitors (SSRIs)

It has been almost 60 years since the monoamine hypothesis (Bunney & Davis, 1965) proposed that serotonin, a chemical neurotransmitter present throughout the body and in high quantities in the brain, may have a pivotal role in the regulation of mood. It was two decades later that the first SSRI, a medication which works by inhibiting the neuronal reuptake of serotonin (Nutt et al., 1999), was approved for use in patients with depression (Hillhouse et al., 2015). Since then, seven SSRIs have been approved for prescribing in the United Kingdom (UK) (British National Formulary, n.d.), and in line with guidance offered by most clinical commissioning groups, SSRIs are now the most widely prescribed class of antidepressants across the nation (Heald et al., 2020; Mars et al., 2017). For the purpose of the systematic review, studies administering any SSRI except Dapoxetine were considered eligible for inclusion; Dapoxetine is a fast-acting SSRI with a short half-life, used in the acute treatment of premature ejaculation (Russo et al., 2016), and is thus formulated for on-demand use rather than regular use for mental health concerns.

Sexual Dysfunction (SD)

The International statistical classification of diseases and related health problems (ICD-11) classifies sexual dysfunction (SD) as a range of syndromes in which any stage of the sexual response is impaired, making it is more difficult to experience personally satisfying sexual activity (World Health Organization, 2019). For the purpose of this thesis portfolio, SD refers to any physiological (e.g. erectile dysfunction, vaginal dryness) or psychological (e.g. loss of libido) impairment(s) that individuals might experience e.g. due to poor mental health or medication side effects. Treatment-emergent SD (TESD) specifically refers to SD that emerges or significantly worsens following SSRI use.

Despite the significant impact on people's quality of life, mood, and self-esteem (Williams et al., 2010), how patients tolerate SD has rarely been reported in SSRI trials. For this portfolio, "tolerance of SD" refers to how participants evaluate the impact of SD on any aspect of their wellbeing or quality of life, including overall sexual satisfaction, relationships, and sexual distress.

Patient-Reported Outcome Measures (PROMs)

PROMs are measures (e.g. questionnaires) which capture patients' health-related outcomes without requiring the interpretation of a clinician (Mayo, 2015), providing vital data on the individual's own assessment of their health. A systematic review by Ishaque et al. (2019) found that PROMs can be an effective tool in healthcare settings to identify patients' goals and needs. PROMs may be a valuable method of capturing information regarding SD in SSRI research, a question that will be addressed by the systematic review.

Post-SSRI Sexual Dysfunction (PSSD)

For some individuals, sexual side effects of SSRIs do not always alleviate even after the medication has been discontinued, a persistence of SD that has been reported to regulators since the 1990s (Healy, 2020). Post-SSRI sexual dysfunction (PSSD) continues to be underreported; it is only since 2019 that patient information leaflets included information regarding the risk of PSSD (European Medicines Agency, 2019), and whilst diagnostic criteria have been proposed by researchers (Healy et al., 2022), PSSD is not yet recognised as a formal diagnosis. Further research regarding its aetiology, prevalence and impact is thus highly needed.

For the purpose of the empirical study, PSSD is defined as any sexual side effects that persist after SSRIs have been discontinued; in keeping with proposed criteria, individuals should be free of medication for at least three months. Whilst PSSD is generally defined in the literature as persistent SD following SSRI use, to ensure consistency with the language used by the UK PSSD Association (who use the term post SSRI/SNRI sexual dysfunction), our recruitment criteria stipulated that participants who developed PSSD following SNRI use are also eligible for inclusion. That being said, all participants who took part in the study developed their symptoms following SSRI use.

Outline of Thesis Portfolio

Following the first introductory chapter, chapter two of the thesis portfolio entails a systematic review on the use of PROMs to assess the prevalence and tolerance of SSRI-related sexual dysfunction. Chapter three provides a bridge between the work completed for the systematic review and the work completed for the empirical study. Chapter four entails the empirical study, a qualitative analysis of the lived experience of PSSD for participants in the UK. Chapter five provides an extended methodology section, further exploring the analytical approach adopted in the empirical study. Finally, chapter six concludes the portfolio with an overall discussion and a critical evaluation of the thesis.

Chapter Two: Systematic Review

The use of patient-reported outcome measures in assessing the prevalence and tolerance of SSRI-related sexual dysfunction: A systematic review

Seraj Brugi[1], Edward Bell[2], Bob Budd[1] and Sarah Fish[1]

[1] Department of Clinical Psychology and Psychological Therapies, University of East Anglia, Norwich, Norfolk, NR4 7TJ

[2]Norfolk and Suffolk NHS Foundation Trust, Hellesdon Hospital, Drayton High Road, Norwich, Norfolk, NR6 5BE

Prepared for submission to The Journal of Sexual Medicine (no word limit)

Word count: 5263

Abstract

Background. Selective serotonin reuptake inhibitors (SSRIs) are associated with sexual dysfunction (SD) which can impact patient wellbeing and treatment compliance. Patient-reported outcome measures (PROMs) can be valuable in ensuring sexual functioning is robustly assessed in clinical trials. **Objectives.** To synthesise and evaluate the evidence base regarding the use of PROMs in assessing SSRI-related SD. **Methods.** A systematic literature review was conducted using EMBASE, MEDLINE Ultimate, PsycINFO, CINAHL Ultimate, and OpenDissertations to identify which sexual functioning PROMs have been used to assess SSRI-related SD, and what the results indicate regarding the prevalence and tolerance of SD. **Results.** 27 articles were eligible for inclusion, and the results were evaluated and summarised using a narrative and visual synthesis. Ten PROMs were identified, varying significantly in their comprehensiveness in assessing possible sexual concerns. SSRI-associated SD is prevalent across studies, though tolerance of SD was rarely assessed or reported. **Conclusion.** Existing PROMs are a feasible method for collecting patient-reported data on sexual functioning at baseline and post-treatment in clinical trials of SSRIs, though caution is advised when interpreting outcomes for patients with SD at baseline.

Introduction

Antidepressants are widely prescribed around the world, with prescription rates continuing to increase in many countries (Peano et al., 2025). Patient perspectives indicate that whilst antidepressants can provide significant therapeutic benefit, adverse events can be worrisome (Cartwright et al., 2016). Selective serotonin reuptake inhibitors (SSRIs), a commonly prescribed type of antidepressant, are particularly associated with sexual dysfunction (SD) (Khawam et al., 2006). Whilst side effects may be temporary, SD can be bothersome and may impact medication compliance, with patients often citing side effects, including SD, as a factor in decisions around adherence to treatment (Fortney et al., 2011; Rosenberg et al., 2003).

Despite the potential impact of SD on wellbeing and quality of life, patients with sexual difficulties can be reluctant to discuss these concerns with a clinician. Moreover, even when concerns are reported, they may not be adequately documented. In a survey at 13 general practices (GP), Nazareth et al. (2003) found that whilst almost 1 in 3 participants reported seeking sexual advice from their doctors, entries regarding sexual problems were found in only 3-4% of participants' GP records. Sexual side effects of antidepressant medication are similarly underestimated; in a study where patients were interviewed by telephone 75-105 days after receiving an SSRI and explicitly asked about adverse reactions, SD was among the most commonly cited side effects (Hu et al., 2004). Importantly, however, clinicians who were surveyed as part of this study had significantly underestimated both the prevalence of side effects and how impactful they may be for patients.

The use of patient-reported outcome measures (PROMs), which are instruments used to measure an aspect of patient health without requiring clinician interpretation (Mayo, 2015), provide a valuable opportunity to improve quality of care by promoting patient involvement and taking action based on feedback (Campbell et al., 2022). In mental health settings, for example, PROMs can highlight any discrepancies between clinician and patient perspectives in the outcomes/impact of care being provided (Roe et al., 2022). Given that the majority of patients with antidepressant-related SD may not spontaneously report these side effects to their clinicians (Montejo et al., 2019), the use of PROMs would allow a standardised measurement of sexual functioning before and after treatment to ensure that patient concerns can be taken into account when considering treatment options.

Research Question

Despite the significant association between SSRIs and sexual side effects, and the potential value of PROMs in providing a robust measurement, the extent to which PROMs have been used in clinical trials of SSRIs has not been, to our knowledge, previously described. This systematic review aims to synthesise existing research on SSRI-related SD that has utilised sexual functioning PROMs, equipping clinicians, services, researchers and patients with an understanding of what PROMs have been used in clinical trials, and what the results indicate regarding the prevalence and tolerance of SD as assessed by validated patient-completed questionnaires.

Methods

This systematic review was conducted according to the Preferred Reporting Guidelines for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Page et al., 2021). The protocol was previously registered with the International Prospective Register of Systematic Reviews (PROSPERO) on 21st July 2025 (CRD420251043649) (Brugi et al., 2025).

Search Strategy

A systematic search of the literature was conducted on 21st November 2025 using the following electronic databases: EMBASE (via OVID) and MEDLINE Ultimate, CINAHL Ultimate, OpenDissertations and PsycINFO (via EBSCOHost). A supplementary search was also completed using Google Scholar. Search terms related to PROMs, sexual dysfunction and medication were selected for their relevance to the research question (see Table S1).

Table S1.

Search terms utilised across EBSCOHost and OVID.

Term one	"Patient reported outcome measure*" OR "PROMS" OR "Questionnaire*" OR "Measure*" OR "Screening" OR "Scale"
AND	
Term two	"Sexual dysfunction" OR "Sexual side effects" OR "Sexual difficulties" OR "Sex* problems" OR "Erectile dysfunction" OR "Anorgasmia" OR "Genital numb*" OR "Loss of libido" OR "Low libido"
AND	
Term three	"Selective serotonin reuptake inhibitor*" OR "SSRI*"

Eligibility Criteria

The PICO (Population, Intervention, Comparison and Outcome) Framework (Richardson et al., 1995) was used to develop the review's selection criteria (see Table S2). English-language quantitative peer-reviewed studies in human participants of any design were considered eligible for inclusion if they met the criteria. Studies were excluded if participants were being treated for organic sexual dysfunction, or if non-SSRI medications, herbal remedies, psychological/psychosocial interventions or drug holidays were also prescribed in conjunction with SSRIs. Literature reviews and pooled analyses were excluded to avoid duplication of findings.

Table S2.
PICO Framework detailing paper selection criteria.

Population	Psychotropic drug-naïve participants
Intervention	Medications listed as SSRIs in the British National Formulary excluding Dapoxetine (Citalopram, Escitalopram, Fluoxetine, Fluvoxamine, Paroxetine or Sertraline)
Comparison	Baseline, placebo or other medication
Outcome	Sexual functioning as measured by a validated sexual functioning PROM, results for both pre- and post-SSRI are reported

Screening and Selection

Following the removal of duplicates, titles and abstracts of all search results were screened by the lead author to determine if an article should proceed to full-text screening. A second reviewer (EB), blind to the lead author's decisions, independently screened 20% of results at both stages. Any disagreements were discussed and resolved with consideration of the eligibility criteria.

Quality Assessment

Risk of bias assessments were conducted using the Joanna Briggs Institute (JBI) quality appraisal tools. Clinical trials in which participants were randomised to one of at least two intervention arms were classified as randomised controlled trials (RCTs) and appraised using the 13-item checklist for RCTs (Barker et al., 2023). Single arm trials and studies where randomisation did not occur were appraised using the 9-item checklist for quasi-experimental studies (Barker et al., 2024). Checklist items are answered with a nominal response of 'Yes', 'No', 'Unclear' or 'Not applicable'. The checklists do not provide an overall rating but instead facilitate careful critical evaluation of a study's strengths and weaknesses. All papers were initially appraised by the lead author, with a 20% random sample independently appraised by a second reviewer (EB). Checklist items were then jointly discussed, and a consensus was reached in all instances.

Data Extraction

Data extraction was completed by the lead author with the second reviewer verifying the extracted information for 20% of the studies. Details regarding the studied population, the utilised sexual dysfunction PROMs, the timepoints at which said PROMs were administered, and their findings (including prevalence of treatment-emergent SD if reported) were extracted. Additionally, details regarding the authors, year of publication, study design, country, SSRI administered, controls/comparators, sample size, mean age, and gender split were also extracted.

Data Synthesis

Due to anticipated heterogeneity in the literature including how SD is defined and assessed, a narrative synthesis in line with guidance established by Popay et al. (2006) is used to present and evaluate findings. Elements of a comprehensive narrative synthesis include organising relevant findings from selected studies, consideration of relationships within and between studies, and assessing the robustness of the synthesis. Information regarding utilised PROMs is presented in tabular and narrative format. In synthesising the evidence regarding the prevalence and impact of SD, studies are grouped by utilised PROM in tabular format and narratively discussed to evaluate patterns and relationships in the data. Additionally, a harvest plot (Ogilvie et al., 2008) was created using R Software (version 4.5.2; R Core Team, 2025) to synthesise results of studies reporting inferential analyses, highlighting patterns of methodological heterogeneity and variation in outcomes of SD by SSRI and gender.

Results

Search Results

The search strategy yielded 825 results after the removal of duplicates, and three additional relevant articles were identified and retrieved via Google Scholar. Retrieved articles were exported into Rayyan (Ouzzani et al., 2016), a reference management platform, and screening was completed manually. Following title and abstract screening, 112 articles proceeded to full-text screening, of which 27 articles were considered to meet all eligibility criteria. The inter-rater agreement coefficient for both title/abstract (Gwet's $AC_1 = 0.88$) and full-text screening (Gwet's $AC_1 = 0.84$) indicated excellent agreement. See Figure S1 for study selection procedure and reasons for exclusion.

Study Characteristics

The majority of studies (n = 21) utilised an RCT design, with all other studies (n = 6) utilising a quasi-experimental design. Studies were conducted in the United States (n = 12), India (n = 4), Canada (n = 3), the United Kingdom (n = 3), Germany (n = 2), France (n = 2), Iran (n = 2), Ireland (n = 2), Austria (n = 1), Belgium (n = 1), Denmark (n = 1), Italy (n = 1), Lithuania (n = 1), the Netherlands (n = 1), Spain (n = 1), and South Africa (n = 1), with some studies spanning multiple locations. Most studies (n = 19) were conducted in clinical populations recruiting participants with a primary diagnosis of depression (n = 15), women with vasomotor symptoms (n = 2), participants with a diagnosis of a depressive or anxiety disorder (n = 1), or participants with a primary diagnosis of generalised social anxiety disorder (n = 1). SSRIs were often compared with non-SSRI treatment (n = 16), placebo (n = 14), or both (n = 10). Individual study characteristics are reported in Table S3.

Quality Assessment

Many studies, including RCTs, utilised small sample sizes, likely affecting statistical power (see Table S3). Most RCTs were double-blinded and, where reported, appeared to use true randomisation for treatment allocation. Inclusion and exclusion criteria were generally well defined, however confounding variables (including baseline sexual functioning) were rarely controlled for, particularly in studies of clinical populations. Several studies reported no or few inferential analyses, and very few studies reported power analyses. PROMs were generally administered reliably across participant groups. Individual responses to critical appraisal checklist items per study are presented in Table S4 (appendix A) and Table S5 (Appendix B). The inter-rater agreement coefficient for quality appraisal checklist items (Gwet's $AC_1 = 0.67$) indicated substantial agreement.

Figure S1.

Flowchart of the study identification, screening and inclusion/exclusion process. Adapted from Page et al. (2021).

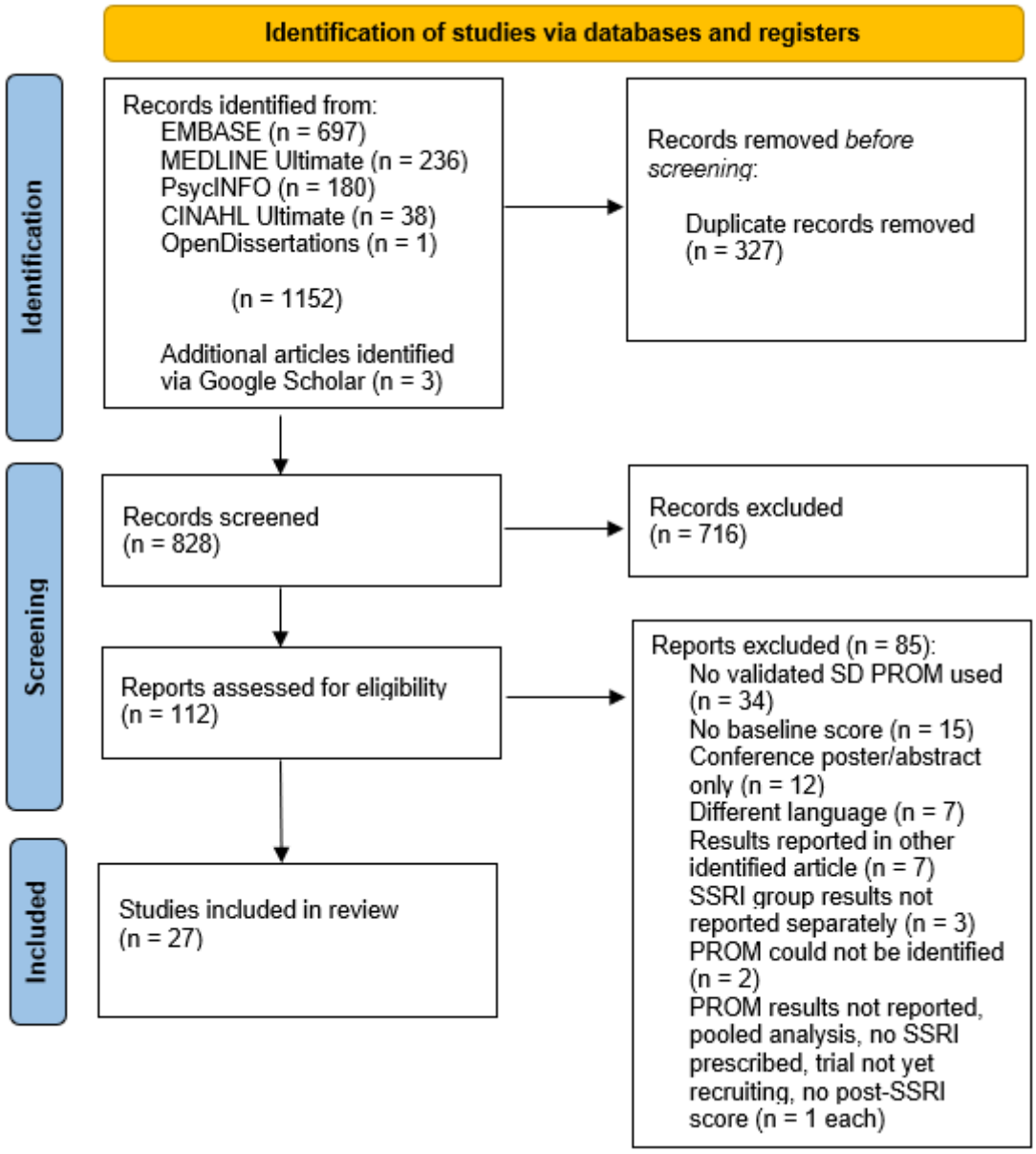


Table S3.
Study characteristics.

Authors	Year	Study design	Country	Participant group	SSRI medication and dosage (participants)	Non-SSRI comparators (participants)	Mean age (SD)	Gender split
Abbasinazari et al	2018	RCT	Iran	Depressed females with 'no history of SD'	Citalopram 20mg (11) and Fluoxetine 20mg (12)	-	Flu 30.4 (7.6), Cit 27.8 (7.3)	F
Abler et al	2011	RCT (crossover trial)	Germany	Healthy males	Paroxetine 20mg (23)	Bupropion and placebo (crossover trial)	25.4 (2.9)	M
Baldwin et al	2006	RCT	Europe (multi-site)	Depressed adults	Escitalopram 10-20mg (166) and Paroxetine 20-40mg (159)	-	Par 45.1 (13.2), Esc 44.9 (14.7)	F on Esc = 121, F on Par = 119
Bathla & Anjum	2020	RCT	India	Depressed married adults	Sertraline 50-200mg (30)	Vilazodone (30)	37.27 (4.25)	F = 15
Bathla et al	2018	RCT	India	Depressed married adults	Escitalopram 10-20mg (30)	Vilazodone (30)	37.27 (5.09)	F = 18
Clayton et al	2007	RCT	US	Depressed adults	Escitalopram 10mg (274)	Duloxetine (273) and placebo (137)	43.3 (13)	F = 186
Clayton et al	2015	RCT	US	Depressed adults	Citalopram 40mg (257)	Placebo (264) and Vilazodone (526)	42.9 (12.5)	F = '57.6%'
Clayton et al	2017	RCT	US	Healthy adults	Paroxetine 20mg (49)	Placebo (51) and Vilazodone (100)	31.3 (7.7)	F = 30
Detke et al	2004	RCT	US	Depressed adults	Paroxetine 20mg (86)	Duloxetine (188) and placebo (93)	42 (10.6)	F = 58
Dunn et al	2007	RCT	US	Healthy males	Paroxetine 20mg (33)	CP-448,187 (33) and placebo (33)	Total sample 31 (SD unreported)	M
Espinola et al	2022	Quasi-experiment	Canada	Depressed adults	Escitalopram 10-20mg (208)	-	35.1 (12.5)	F = '63%'

Note. 'Cit' = Citalopram, 'Esc' = Escitalopram, 'F' = Females, 'Flu' = Fluoxetine, 'M' = Males, 'Par' = Paroxetine, 'Pla' = Placebo, 'RCT' = Randomised controlled trial, 'Ser' = Sertraline, 'SD' = Standard deviation.

Table S3 continued.

Fabre et al	2012	RCT	US	Depressed males	Fluoxetine 20-40mg (unclear, total sample 181)	Gepirone-ER and placebo	Total sample 38.6 (11.2)	M
Jacobsen et al	2019	RCT	US	Healthy adults	Paroxetine 20mg (85)	Placebo (92) and Vortioxetine (184)	28.9 (5.96)	F = 42
Kennedy et al	2000	Quasi-experiment	Canada	Depressed adults	Paroxetine 10-80mg (30) and Sertraline 50-200mg (26)	Moclobemide (15) and Venlafaxine (36)	F on Par 36.9 (12.1) and Ser 37.7 (12.6), M on Par 36.6 (9.1) and Ser 38.5 (12.6)	F on Par = 10, F on Ser = 22
Kennedy et al	2006	RCT	Canada	Depressed adults 'reporting sexual interest'	Paroxetine 20mg-40mg (68)	Bupropion (65)	Total sample 37.8 (10.5)	F = 34
Khazaie et al	2015	RCT	Iran	Depressed adults	Fluoxetine 20-40mg (67) and Sertraline 200mg (64)	Trazodone (64)	Flu 37 (11), Ser 38 (11)	Total F = 93
Madeo et al	2008	RCT	Italy	Healthy males	Citalopram 40mg (16) and Fluoxetine 20mg (16)	Placebo (16)	Cit 31.1 (4.9), Flu 29.2 (4.7)	M
Montejo et al	2010	RCT	Spain	Healthy males	Paroxetine 20mg (23)	Agomelatine (46) and placebo (23)	24.7 (2.3)	M
Montejo et al	2015	RCT	UK	Healthy adults	Escitalopram 20mg (36)	Agomelatine (65) and placebo (32)	24.1 (4.1)	Unreported

Table S3 continued.

Piazza et al	1997	RCT	US	Depressed adults	Paroxetine (14) and Sertraline (11) (mean dose 25mg and 60mg for F, 20mg and 66.7mg for M)	-	F total sample 40.6 (10.3), M total sample 49.3 (9.7)	F on Par = 9, F on Ser = 5
Portman et al	2014	RCT	US	Postmenopausal females with vasomotor symptoms	Paroxetine 7.5mg (585)	Placebo (589)	Mean and SD not reported, median = 54	F
Preeti et al	2018	Quasi-experiment	India	Adults with a depressive or anxiety disorder	Escitalopram (47), Fluoxetine (41) and Sertraline (56) (dosage unspecified)	Desvenlafaxine (37) and Mirtazapine (28)	Total sample 36.5 (12.7)	Total F = 123
Reed et al	2012	RCT	US	Perimenopausal or postmenopausal females with vasomotor symptoms	Escitalopram 10-20mg (101)	Placebo (99)	53.3 (4.2)	F
Shah et al	2024	Quasi-experiment	India	Depression adults free of SD	Unspecified (100)	-	30.9 (8.14)	F = 47
Tanrikut et al	2010	Quasi-experiment	US	Healthy males	Paroxetine 10-30mg (35)	-	33.9 (11.1)	M
Weber et al	2023	Quasi-experiment	Denmark	Depressed adults	Escitalopram 5-20mg (92)	Healthy controls database (cross-sectional, baseline) (73)	26.8 (7.5)	F = 66
Westernberg et al	2004	RCT	South Africa, Europe (multi-site), US	Adults with generalised social anxiety disorder	Fluvoxamine controlled-release 100-300mg (149)	Placebo (151)	38.6 (SD unreported, standard error = 0.9)	F = 81

PROMs Assessing Sexual Dysfunction

10 standardised PROMs were utilised across studies to assess treatment-emergent SD. PROMs vary widely in length, domains covered, and items related to tolerance of SD (if any). See Table S6 for details regarding utilised PROMs.

Table S6.

Patient-reported outcome measures utilised by retrieved studies.

PROM	Usage in retrieved literature	Domains covered (as described by the PROM)	Number of items	Score range	Items related to tolerance (including satisfaction)
Changes in Sexual Functioning Questionnaire (CSFQ)	8/27	Pleasure, desire/frequency, desire/interest, arousal/excitement (F) or arousal/erection (M), orgasm/completion (F) or orgasm/ejaculation (M)	14 (Short Form)	14-70 (lower score being poorer sexual functioning)	-
Arizona Sexual Experience Scale (ASEX)	7/27	Sex drive, arousal, lubrication/erection, orgasm, orgasmic satisfaction	5	5-30 (higher being poorer sexual functioning)	1 item on orgasmic satisfaction
Psychotropic-Related Sexual Dysfunction Questionnaire (PRSexDQ)	3/27	Desire (libido), orgasm/ejaculation, erectile function/lubrication, tolerance of changes	2 screening items + 5 items	0-15 (higher being poorer sexual functioning)	1 item regarding tolerance of SD
Sex Effects Scale (SexFX)	2/27	Desire, arousal, orgasm, satisfaction. Some separate items for M and F responders	13	0-44 main scale (lower being poorer sexual functioning), 2 additional items scored 0-10	1 item on sexual satisfaction, 1 item on enjoyment of sexual romantic life

Sexual Function Questionnaire (SFQ)	2/27	Drive/desire, arousal/orgasm, sexual activity. Some separate items for M and F responders	10 for males, 8 for females	Each item in drive/desire and arousal/orgasm rated on 3-point scale, prevalence considered per item	-
Female Sexual Function Index (FSFI)	2/27	Female sexual functioning: Desire, arousal, lubrication, orgasm, satisfaction, pain	19	Range 2-36 (lower being poorer sexual functioning)	1 item on emotional closeness during sex, 1 item on satisfaction with sexual relationship, 1 item on overall sexual satisfaction
International Index of Erectile Dysfunction (IIEF)	2/27	Male sexual functioning: Erectile functioning, orgasmic functioning, sexual desire, intercourse satisfaction, overall satisfaction	15	6-75 (lower being poorer sexual functioning)	2 items on intercourse satisfaction, 2 items on overall sexual satisfaction
Massachusetts General Hospital-Sexual Functioning Questionnaire (MGH-SFQ)	1/27	Interest, arousal, orgasm, erection (M only item - no F equivalent), overall satisfaction	5	4-30 (higher being poorer sexual functioning)	1 item on sexual satisfaction
Brief Sexual Function Inventory (BSFI)	1/27	Male sexual functioning: Sexual drive, erections, ejaculation, problem assessment, overall satisfaction	11	0-44 (lower being poorer sexual functioning)	3 items on whether SD is a “problem”, 1 item on overall sexual satisfaction
Golombok Rust Inventory of Sexual Satisfaction (GRISS)	1/27	Non-communication, infrequency, avoidance, non-sensuality, dissatisfaction, anorgasmia (F), vaginismus (F), impotence (M), PE (M)	28	Answers transformed into score of 1-9 per domain (higher being poorer sexual functioning)	Various items across domains

Note. ‘F’ = Females, ‘M’ = Males, ‘PE’ = Premature ejaculation.

Gender-Inclusive PROMs

The Arizona Sexual Experiences Scale (ASEX) was developed as a quick, easy-to-administer tool for use in clinical settings (McGahuey et al., 2000) and is widely used in the identified papers (n = 7). The ASEX contains 5 items including 1 question which is divided into a sub-item on erections and a sub-item on vaginal lubrication, with individuals only answering the relevant sub-item. Whilst there are no items on sexual distress or overall sexual satisfaction, the final item pertains specifically to satisfaction with orgasms. Internal consistency was assessed by 1 study (Piazza et al., 1997), with the ASEX demonstrating good internal consistency in this cohort (Cronbach's Coefficient $\alpha = 0.88$).

The Sexual Functioning Questionnaire (SFQ) (Kennedy et al., 1999) was initially developed for use in unmedicated depressed individuals, comprising of items (10 for males and 8 for females) for which the individual can indicate whether a problem has been occurring less, the same, or more often than usual. The Sex Effects (SexFx) Scale (Kennedy et al., 2006) is a further refinement of the SFQ by the same research team, transforming it into a 13-item tool with more detailed options regarding the frequency of certain sexual experiences. Both the SFQ and the SexFx Scale were utilised by the same number of studies (n = 2 each) and contain some items applicable only to males or females. Unlike the SFQ, the SexFx Scale contains 2 items on satisfaction (assessing overall sexual satisfaction and enjoyment with sexual romantic life). In their cohort, Kennedy et al. (2006) also assessed the concurrent validity of the SexFx Scale with the Investigator-Rated Sexual Desire and Functioning Scale (IRSD-F) (Segraves et al., 2000). The researchers found that SexFx scores correlated significantly with IRSD-F scores at all timepoints.

The Massachusetts General Hospital Sexual Functioning Questionnaire (MGH-SFQ), partly derived from the ASEX (Fava et al., 1998), is a similarly brief 5-item questionnaire developed primarily for use in psychiatric outpatients (Labbate & Lare, 2001) and is utilised by 1 study. The questionnaire includes 1 item targeted at male responders, querying erectile functioning, with no alternative question for female respondents. Whereas the final item on the ASEX pertains to orgasmic satisfaction specifically, the final item on the MGH-SFQ asks responders to rate their overall sexual satisfaction.

Only 1 questionnaire, the Psychotropic-Related Sexual Dysfunction Questionnaire (PRSexDQ) (Montejo et al., 2000), is validated specifically for the measurement of SD secondary to psychotropic treatment and was utilised by 3 studies. In addition to 2 screening items asking if participants have observed any change in sexual functioning and whether any changes were spontaneously reported, the questionnaire contains 5 further items which are

primarily designed to assess changes in sexual functioning relative to a baseline (e.g. if the responder has observed any “decrease in [their] sexual desire”), and as such may be more suited to use in cross-sectional designs. The final item assesses responders’ tolerance to changes in sexual functioning, providing options to indicate if the changes have interfered with the person’s relationship.

Gender-Specific PROMs

In addition to the aforementioned questionnaires, several PROMs have been developed specifically for men or women, or entail separate male and female versions. The most widely used of these questionnaires is the Changes in Sexual Functioning Questionnaire (CSFQ) (Clayton et al., 1997) (n = 8), developed for the measurement of SD secondary to illness or medication. The CSFQ includes 2 versions (male and female) which are each 14 items in its short form (Keller et al., 2006), the form utilised by identified studies in the current review. Aside from an item related to enjoyment in sex, neither the male nor female version of the CFSQ contains any items pertaining to sexual distress, satisfaction or impact of SD.

2 questionnaires designed for use in male populations, the International Index of Erectile Function (IIEF) (Rosen et al., 1997) and the Brief Sexual Function Inventory (BSFI) (O’Leary et al., 1995), were utilised by studies (n = 2 and n = 1 respectively). The IIEF is a 15-item questionnaire developed to measure treatment-emergent male SD and is designed for use in clinical and non-clinical populations. It contains 4 items related to sexual satisfaction (2 items specific to intercourse satisfaction, and 2 items pertaining to overall satisfaction). The BSFI, an 11-item questionnaire encompassing similar domains, is also developed for similar purposes (O’Leary et al., 1995). It contains 4 items related to the tolerance of SD, querying whether individuals perceive any issues related to sex drive, erections or ejaculation as being a “problem” (3 items), and overall sexual satisfaction (1 item).

One questionnaire designed for use in female populations, the Female Sexual Function Index (FSFI) (Rosen et al., 2000), was utilised by most female-only studies (n = 2). The FSFI is a 19-item questionnaire developed for a comprehensive assessment of various aspects of female sexual functioning in clinical and non-clinical populations. The PROM contains 3 items related to the impact of SD, assessing individuals’ emotional closeness during sex, satisfaction with their sexual relationship, and overall satisfaction with their sex life.

PROMs for Sexual Satisfaction and Distress

Only 1 satisfaction questionnaire, the Golombok-Rust Inventory of Sexual Satisfaction (GRISS) (Rust & Golombok, 1985), was utilised in the retrieved literature (n = 1). The GRISS entails separate male and female versions (both 28 items) and was developed to evaluate sexual difficulties in heterosexual relationships. The questionnaire contains a combination of items pertaining to the presence and severity of any difficulties, as well as the impact of said difficulties (particularly in a relational context). In addition to the GRISS, 1 single item from the Female Sexual Distress Scale (FSDS) (Derogatis et al., 2002), pertaining to distress caused by the individual's sex life, was utilised by a separate study (n = 1). Furthermore, another study (n = 1) utilised a Visual Analogue Scale for Sexual Functioning Satisfaction (VAS-SFS) (Gracia-Portilla et al., 2011), allowing individuals to mark their overall sexual satisfaction on a vertical line.

Prevalence of Sexual Dysfunction

Individual study findings related to SD, grouped by utilised PROM, are presented in Table S7 (Appendix C). SSRIs were associated with significantly higher PROM-assessed SD relative to baseline and/or comparators in most studies. With regard to estimating the prevalence of new treatment-emergent SD, Detke et al. (2004) reported that 62.8% of participants on Paroxetine experienced sexual side effects compared to 40.5% of participants on placebo. Similarly, Montejo et al. (2010) reported that 85.7% of participants on Paroxetine experienced treatment-emergent SD at the 8-week mark. In contrast, Clayton et al. (2017) reported the prevalence of treatment-emergent SD at end of treatment (EOT) for participants with detectable plasma levels of Paroxetine to be 23.1% for men and 0% for women in their cohort. However, in addition to excluding participants with no detectable levels of the drug, the latter study was also briefer, with EOT figures representing the 5-week mark.

For Escitalopram, Clayton et al. (2007) reported that 48.7% and 43.6% of participants experienced treatment-emergent SD at the 8-week and 8-month mark, respectively. Similarly, Montejo et al. (2015) reported that 50% of participants on Escitalopram reported SD by EOT (approximately 8-week mark), however it is unclear how many participants in this group, albeit a minority, indicated they experienced sexual problems at baseline. In a study of participants on unspecified SSRIs, Shah et al. (2024) reported that 41% of participants experienced treatment-emergent SD by EOT (12-week mark). Prevalence rates were similar for both men (39.6%) and women (42.6%). Importantly, most studies estimating the prevalence of treatment-emergent SD had small sample sizes, with only Shah et al. (2024) recruiting at least 100 participants.

Sexual Dysfunction by Gender

Studies in which analyses are reported by sex highlight that men may be more likely to report worsening SD, as measured by PROMs, than women. 6 studies included only male participants; all 5 studies on healthy (no psychiatric diagnosis) males reported a significant worsening of sexual functioning following SSRI use. 1 study on depressed males (Fabre et al., 2012), however, found no change in SD scores amongst both SSRI responders and non-responders. For women, 3 studies included only female participants; whilst Abbasinazari et al. (2018) reported a decrease in FSFI scores following Citalopram and Fluoxetine use, no inferential analysis were reported. Portman et al. (2014) and Reed et al. (2012) found no significant impact for Paroxetine and Escitalopram respectively on sexual functioning. However, both studies reported mean PROM scores at baseline which indicated a high presence of SD in their female cohorts. Moreover, the dosage of Paroxetine in Portman et al.'s (2014) study (7.5mg) is below the usual starting dose of 20mg seen in most other studies.

When inferential analyses regarding outcomes were reported, studies most frequently reported an effect of SSRIs on sexual functioning in male participants or an overall effect across the whole cohort (see Figure S2). It is important to be mindful, however, that there are twice as many male-only studies in the retrieved literature compared to female-only studies. Moreover, several studies (n = 4) found that women reported significantly poorer sexual functioning at baseline than men, whereas no study reported poorer sexual functioning at baseline in men. This makes it difficult for some studies to ascertain whether men are more likely to experience treatment-emergent SD, or whether higher baseline levels of SD in women make it less likely that PROMs could detect further treatment-related deterioration in sexual functioning.

Sexual Dysfunction by Medication

SSRIs varied widely in the number of studies assessing their outcomes: Paroxetine (n = 12), Escitalopram (n = 8), Fluoxetine (n = 5), Sertraline (n = 5), Citalopram (n = 3), and Fluvoxamine (n = 1) (see Table S3 for medications utilised by each study). 1 further study (Shah et al., 2024) did not specify which SSRI(s) was administered to participants. Among studies reporting inferential analyses, the majority of studies on Paroxetine (n = 8) and Sertraline (n = 4) reported significantly poorer sexual functioning for at least 1 participant group (e.g. males, females or both) relative to baseline and/or control, including 1 study (Piazza et al., 1997) which analysed outcomes for the Paroxetine and Sertraline groups together. Half of the studies on Escitalopram (n = 4) reported significantly poorer sexual functioning in at least 1 group. Citalopram was associated with significantly poorer sexual

functioning in 1 study. The only retrieved study on Fluvoxamine (Westenberg et al., 2004) did not find a significant link between the SSRI and change in SD scores. Several other studies reported outcomes indicating potentially higher SD in the SSRI group(s) but did not report inferential analyses (see Table S7 (Appendix C)). Moreover, results regarding medication outcomes are strongly confounded by participant gender (see Figure S2).

Tolerance of Sexual Dysfunction

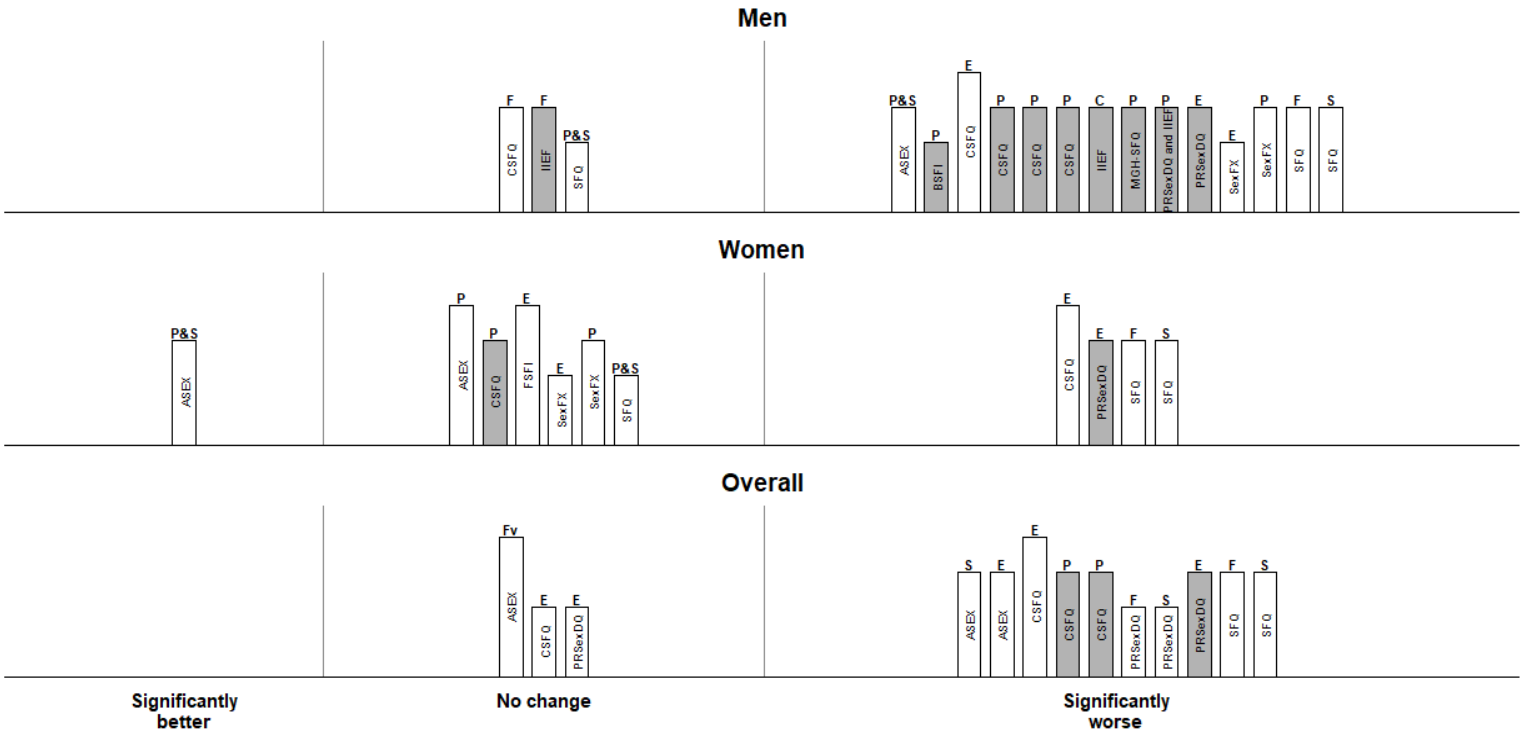
Only a minority of studies (n = 8) reported any findings regarding the tolerance of SSRI-related SD or its impact on any aspect of participant wellbeing, including satisfaction with overall sex life. 6 studies reported findings related to satisfaction items on their utilised PROMs, and 2 studies administered separate items (one question each) regarding sexual distress or satisfaction. Whilst 1 study (Madeo et al., 2008) also reports administering a sexual satisfaction questionnaire, the results of this are not reported. Unsurprisingly, in studies where there was no significant association between SSRI use and SD, there was no change in orgasm satisfaction (Portman et al., 2014) or sexual distress scores (Reed et al., 2012). 1 further study (Abler et al., 2011) also reported no changes in sexual satisfaction despite a significant increase in SD; however, participants completed SD measures after just one week of medication, meaning that any changes to sexual functioning had only occurred very recently.

Using the PRSexDQ, Preeti et al. (2018) reported that 40.7% of men and 14.6% of women with SD in their cohort reported their tolerance as ‘poor’ following SSRI use. Alternatively, Montejo et al. (2015) found that all participants experiencing SD in their cohort reported their tolerance as ‘well’ (42.3% of whole sample) or ‘fair’ (7.7% of whole sample). It should be noted, however, that the answer ‘fair’ on the PRSexDQ indicates the SD “interferes with the couple’s relationship”. Moreover, whilst no inferential analysis was reported, the researchers note that scores on the VAS-SFS decreased (indicating poorer sexual satisfaction) after SSRI use.

3 studies reported a significant change in participants’ satisfaction with their sex lives; Espinola et al. (2022) found that only SSRI responders and remitters had higher satisfaction scores after treatment, whilst Kennedy et al. (2006) found that men on Paroxetine who had reported sexual interest at baseline scored significantly lower on satisfaction items after treatment. Similarly, Madeo et al. (2008) found that healthy males on Citalopram reported significantly poorer satisfaction (both with intercourse and overall satisfaction with their sex lives) after treatment.

Figure S2.

Harvest plot depicting outcomes for sexual functioning following SSRI use for studies reporting inferential analyses.



Note. Harvest plot generated using R Software (R Core Team, 2025), coding script generated using Claude Sonnet 4.6 (Anthropic, 2026). Each bar represents a separate study (for studies analysing multiple SSRIs separately, separate analyses are represented by different bars). White bars = clinical populations, grey bars = nonclinical populations. Tallest bars = RCTs of ≥100 participants in SSRI arm, medium bars = RCTs of <100 participants in SSRI arm, shortest bars = non-RCTs. PROM listed inside bar. Letter above bar = SSRI ('C' = Citalopram, 'E' = Escitalopram, 'F' = Fluoxetine, 'Fv' = Fluvoxamine, 'P' = Paroxetine, 'S' = Sertraline).

Discussion

Overview

This systematic review describes the use of standardised, validated PROMs to assess sexual functioning in individuals taking SSRI medication. Various PROMs have been used in the literature to assess the prevalence of treatment-emergent SD, demonstrating acceptability of said measures in identifying medication-related sexual side effects. SSRIs are associated with a significant increase in SD scores, with prevalence rates of sexual side effects in studies of at least 8 weeks duration ranging from 41% to 85.7%. Whilst some PROMs contained items related to the impact of SD on the individual's sexual satisfaction or relationship, results for these items were seldom described separately. Where reported, it is evident that treatment-emergent SD can have a significant impact on individual's sexual satisfaction and, possibly, relationship quality. Most PROMs have been validated for the assessment of secondary SD, however only one PROM, the PRSexDQ (Montejo et al., 2000), has been developed specifically for the assessment of psychotropic-related SD.

The findings of studies described in this systematic review are consistent with the wider literature which has frequently highlighted the prevalence of SD following SSRI use (Jing & Straw-Wilson, 2016). Importantly, whilst baseline SD was often present in clinical populations, placebo-controlled studies in healthy adults with normal baseline sexual functioning support a causal association between SSRI treatment and worsening sexual functioning. Whilst prevalence rates were rarely reported, the findings indicate that Paroxetine may be more associated with SD than other SSRIs, a characteristic of Paroxetine that has previously been demonstrated in other clinical studies (AlBreiki et al., 2020; Montejo-González et al., 1997).

When examining gender differences in SD, findings highlight that male participants may be more likely to report sexual side effects compared to baseline and/or control. This is in contrast with cross-sectional research which report similar rates of SD in men and women who have been taking SSRIs or antidepressant medication (Montejo et al., 2019; Safak et al., 2025; Williams et al., 2010). However, as participants in these studies have no pre-SSRI baseline scores, there is a risk of attributing pre-existing sexual difficulties to treatment. A recent systematic review (Gonçalves et al., 2022) of SD prevalence in patients with major depressive disorder found that 82.75% of women experience SD, as measured by sexual function PROMs, compared to 63.26% of men. This is consistent with several studies described in the current systematic review who reported higher SD scores at baseline for

women. Thus, whilst women were less likely in some studies to report poorer sexual functioning after SSRI treatment, in some instances this may be at least partially explained by the presence of significant sexual problems before medication.

The interaction between SSRI use, mental health and gender is therefore an important consideration for any study assessing SSRI-related SD. Lee et al. (2013) reported that in a cohort of depressed individuals who were divided into those unmedicated and those medicated with antidepressants, only unmedicated women and medicated men scored significantly lower on the CSFQ (signifying higher SD) than healthy controls, indicating that SSRI use may impact sexual functioning differently across genders. Studies of medication-related SD without an assessment of baseline sexual functioning should therefore be interpreted with caution. Moreover, even in studies where pre-medication data has been obtained, the sensitivity of the utilised PROMs in detecting treatment-related change in sexual functioning for individuals with baseline SD is unclear. This is perhaps best illustrated by Shah et al.'s (2024) study, who reported similar rates of treatment-emergent SD for men and women with normal sexual functioning at baseline.

An under-explored consideration is the difference in SSRI-related SD amongst treatment responders and non-responders, or indeed how sexual side effects may interact with response to treatment. In addition to studies which highlight the impact of SD on sexual satisfaction (Espinola et al., 2022; Kennedy et al., 2006; Madeo et al., 2008), antidepressant-related SD has been shown to impact overall quality of life (Williams et al., 2010). Furthermore, in a cross-sectional survey, Jacobsen et al. (2020) reported that SD was correlated with depression severity and lower self-esteem in individuals taking antidepressants. Hence, whilst a reduction in SD following SSRI use may sometimes occur as a result of improved mental health, it is important to consider whether an apparent lack of response to SSRI treatment in some individuals may be at least partially explained by emerging or worsening sexual functioning.

Strengths and Limitations

To our knowledge, we describe the first systematic review on the use of PROMs to assess the prevalence and tolerance of SSRI-related SD. The findings demonstrate the feasibility of using SD PROMs in clinical trials of psychotropic medication, whilst also highlighting issues to consider when relying on PROMs to detect further SSRI-related changes in sexual functioning. In selecting only studies with baseline sexual functioning scores, this review synthesises the existing evidence base for a causal link between SSRIs and patient-rated SD, including in individuals with normal sexual functioning at baseline. The

findings also contribute to our understanding of the interaction between SSRIs, baseline SD and gender, demonstrating the importance of considering these factors when assessing SSRI-related sexual side effects and their impact on individuals.

There are several limitations to this review. Due to the selection criteria (for example, the exclusion of non-English articles), and the use of specific terms related to SSRIs and PROMs, it is possible that some relevant clinical trials may have fallen outside the scope of the review's search. Moreover, due to heterogeneity in the literature, there is considerable uncertainty regarding the prevalence of SD for different SSRIs in different populations. Additionally, as the primary focus of this review was to identify and appraise the use of PROMs in SSRI research, no studies were excluded due to methodological quality. Whilst this decision allows for a comprehensive assessment of the literature, it is unclear how many clinical trials were adequately powered to detect SD. Finally, whilst all utilised PROMs have been evaluated in the literature, this review did not consider their psychometric properties, or which PROMs may be most appropriate for use.

Clinical Implications

This review has several implications for clinicians prescribing and treating SSRI-medicated individuals. The use of validated PROMs before and during treatment would facilitate a patient-led assessment of sexual functioning which can inform discussions around possible side effects, particularly for individuals who may be reluctant to spontaneously report difficulties. Given the potential impact of SD on overall sexual satisfaction, assessing patients' tolerance and management of sexual side effects may also be an important consideration when evaluating treatment response and overall wellbeing. Various strategies to manage SSRI-related SD have been described (Taylor et al., 2005), and the use of PROMs could allow for prompt identification of any side effects as well as a robust method of measuring the effectiveness of any utilised strategies or interventions.

Recommendations for Future Research

Given the prevalence of SD seen in studies of people with depression, further research examining the sensitivity of existing PROMs - or the development of suitable PROMs - in detecting SSRI-related sexual side effects for individuals with baseline SD would be beneficial. Additionally, whilst some PROMs are comprehensive in covering various domains of sexual functioning, further work, including qualitative studies, should be conducted to consider whether existing PROMs capture aspects that are relevant and important to medicated patients. Finally, research on the psychological impact of sexual side effects is limited, and its potential to confound treatment response has not been widely

considered. Future research should thus explore the impact of SSRI-related SD on wellbeing, quality of life, relationships and treatment response.

Conclusion

To summarise, we identified 10 validated PROMs that have been used in the literature to evaluate the prevalence and tolerance of SSRI-related SD. PROMs are an acceptable and feasible method of collecting patient-reported data on sexual side effects, and the results highlight a clear causal relationship between SSRIs and SD. However, factors such as gender, baseline SD and sensitivity of the PROM in capturing further treatment-related decline in sexual functioning should be carefully considered; PROMs should thus form part of a wider assessment and conversation with patients. Additionally, PROMs could be utilised to assess the impact of SSRI-related SD, informing practitioners of patient tolerance of emergent side effects and supporting the development of patient-centred approaches to managing any concerns. Given the relatively low rates of spontaneous reporting of SD, standardised measures provide a valuable opportunity to reflect on changes in sexual functioning that could have a significant impact on patient wellbeing and compliance with treatment.

Conflicts of Interest Statement

The authors report there are no competing interests to declare.

Funding Statement

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

References

Peano, A., Calabrese, F., Pechlivanidis, K., Mimmo, R., Politano, G., Martella, M., & Gianino, M. M. (2025). International trends in antidepressant consumption: a 10-year comparative analysis (2010–2020). *Psychiatric Quarterly*, *96,* 241-255.

Cartwright, C., Gibson, K., Read, J., Cowan, O., & Dehar, T. (2016). Long-term antidepressant use: patient perspectives of benefits and adverse effects. *Patient Preference and Adherence*, *10*, 1401–1407. https://doi.org/10.2147/PPA.S110632

Khawam, E. A., Laurencic, G., & Malone, D. A. (2006). Side effects of antidepressants: an overview. *Cleveland Clinical Journal of Medicine*, *73*(4), 351-361.

Fortney, J. C., Pyne, J. M., Edlund, M. J., Stecker, T., Mittal, D., Robinson, D. E., & Henderson, K. L. (2011). Reasons for antidepressant nonadherence among veterans treated in primary care clinics. *Journal of Clinical Psychiatry*, *72*(6), 827-834.

Rosenberg, K. P., Bleiberg, K. L., Koscis, J., & Gross, C. (2003). A survey of sexual side effects among severely mentally ill patients taking psychotropic medications: impact on compliance. *Journal of Sex & Marital Therapy*, *29*(4), 289-296.

Nazareth, I., Boynton, P., & King, M. (2003). Problems with sexual function in people attending London general practitioners: cross sectional study. *BMJ*, *327*, Article 423 doi:10.1136/bmj.327.7412.423

Hu, X. H., Bull, S. A., Hunkeler, E. M., Ming, E., Lee, J. Y., Fireman, B., & Markson, L. E. (2004). Incidence and duration of side effects and those rated as bothersome with selective serotonin reuptake inhibitor treatment for depression: patient report versus physician estimate. *Journal of Clinical Psychiatry, 65*(7), 959-965.

Mayo, N. E. (2015). *Dictionary of quality of life and health outcomes measurement*. International Society for Quality of Life Research (ISOQOL).

Campbell, R., Ju, A., King, M. T., & Rutherford, C. (2022). Perceived benefits and limitations of using patient-reported outcome measures in clinical practice with individual patients: a systematic review of qualitative studies. *Quality of Life Research*, *31*(6), 1597-1620.

Roe, D., Slade, M., & Jones, N. (2022). The utility of patient-reported outcome measures in mental health. *World Psychiatry*, *21*(1), 56-57.

Montejo, A. L., Calama, J., Rico-Villademoros, F., Montejo, L., González-García, N., & Pérez, J. (2019). A real-world study on antidepressant-associated sexual dysfunction in 2144 outpatients: the SALSEX I study. *Archives of Sexual Behavior*, *48*(3), 923-933.

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., Shamseer, L., Tetzlaff, J. M., Akl, E. A., Brennan, S. E., Chou, R., Glanville, J., Grimshaw, J. M., Hróbjartsson, A., Lalu, M. M., Li, T., Loder, E. W., Mayo-Wilson, E., McDonald, S., … Moher, D. (2021). The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *BMJ,* 372:n71. https://doi.org/10.1136/bmj.n71.

Brugi, S., Bell, E., Budd, B., & Fish, S. (2025). The use of patient-reported outcome measures (PROMs) in assessing the prevalence and impact of SSRI-related sexual dysfunction: A systematic review. https://www.crd.york.ac.uk/PROSPERO/view/CRD420251043649

Richardson, W. S., Wilson, M. C., Nishikawa, J., & Hayward, R. S. (1995). The well-built clinical question: a key to evidence-based decisions. *ACP Journal Club*, *123*(3), A12-3.

Barker, T. H., Stone, J. C., Sears, K., Klugar, M., Tufanaru, C., Leonardi-Bee, J., Aromataris, E., & Munn, Z. (2023). The revised JBI critical appraisal tool for the assessment of risk of bias for randomized controlled trials. *JBI Evidence Synthesis*, *21*(3), 494-506.

Barker, T. H., Habibi, N., Aromataris, E., Stone, J. C., Leonardi-Bee, J., Sears, K., Hasanoff, S., Klugar, M., Tufanaru, C., Moola, S., & Munn, Z. (2024). The revised JBI critical appraisal tool for the assessment of risk of bias for quasi-experimental studies. *JBI Evidence Synthesis*, *22*(3), 378-388.

Popay, J., Roberts, H., Sowden, A., Petticrew, M., Arai, L., Rodgers, M., Britten, N., Roen, K., Duffy, S. (2006). *Guidance on the conduct of narrative synthesis in systematic reviews: A product from the ESRC Methods Programme*. Lancaster University. http://dx.doi.org/10.13140/2.1.1018.4643

Ogilvie, D., Fayter, D., Petticrew, M., Sowden, A., Thomas, S., Whitehead, M., & Worthy, G. (2008). The harvest plot: a method for synthesising evidence about the differential effects of interventions. *BMC Medical Research Methodology*, *8*. https://doi.org/10.1186/1471-2288-8-8

R Core Team. (2025). *R: A language and environment for statistical computing*. R Foundation for Statistical Computing. https://www.R-project.org/

Ouzzani, M., Hammady, H., Fedorowicz, Z., & Elmagarmid, A. (2016). Rayyan—a web and mobile app for systematic reviews. *Systematic Reviews*, *5*. https://doi.org/10.1186/s13643-016-0384-4

Abbasinazari, M., Heidari-Kord, M., Mazaheri-Meybodi, A., Eshraghi, A., & Bayati, N. (2018). Plasma oxytocin level and sexual dysfunction in depressed women treated by either fluoxetine or citalopram: A pilot clinical trial. *Iranian Journal of Pharmaceutical Research: IJPR, 17*(1), 408-414.

Abler, B., Seeringer, A., Hartmann, A., Grön, G., Metzger, C., Walter, M., & Stingl, J. (2011). Neural correlates of antidepressant-related sexual dysfunction: a placebo-controlled fMRI study on healthy males under subchronic paroxetine and bupropion. *Neuropsychopharmacology*, *36*(9), 1837-1847.

Baldwin, D. S., Cooper, J. A., Huusom, A. K., & Hindmarch, I. (2006). A double-blind, randomized, parallel-group, flexible-dose study to evaluate the tolerability, efficacy and effects of treatment discontinuation with escitalopram and paroxetine in patients with major depressive disorder. *International Clinical Psychopharmacology*, *21*(3), 159-169.

Bathla, M., & Anjum, S. (2020). A 12-week prospective randomized controlled comparative trial of vilazodone and sertraline in Indian patients with depression. *Indian Journal of Pharmacology*, *52*(1), 10-15.

Bathla, M., Anjum, S., Singh, M., Panchal, S., & Singh, G. P. (2018). A 12-week comparative prospective open-label randomized controlled study in depression patients treated with vilazodone and escitalopram in a tertiary care hospital in North India. *Indian Journal of Psychological Medicine*, *40*(1), 80-85.

Clayton, A., Kornstein, S., Prakash, A., Mallinckrodt, C., & Wohlreich, M. (2007). Changes in sexual functioning associated with duloxetine, escitalopram, and placebo in the treatment of patients with major depressive disorder. *The Journal of Sexual Medicine*, *4*(4), 917-929.

Clayton, A. H., Gommoll, C., Chen, D., Nunez, R., & Mathews, M. (2015). Sexual dysfunction during treatment of major depressive disorder with vilazodone, citalopram, or placebo: results from a phase IV clinical trial. *International Clinical Psychopharmacology*, *30*(4), 216-223.

Clayton, A. H., Durgam, S., Li, D., Chen, C., Chen, L., Mathews, M., Gommoll, C. P., & Szegedi, A. (2017). Effects of vilazodone on sexual functioning in healthy adults:

results from a randomized, double-blind, placebo-controlled, and active-controlled study. *International Clinical Psychopharmacology*, *32*(1), 27-35.

Detke, M. J., Wiltse, C. G., Mallinckrodt, C. H., McNamara, R. K., Demitrack, M. A., & Bitter, I. (2004). Duloxetine in the acute and long-term treatment of major depressive disorder: a placebo-and paroxetine-controlled trial. *European Neuropsychopharmacology*, *14*(6), 457-470.

Dunn, J. A., Arakawa, R., Greist, J. H., & Clayton, A. H. (2007). Assessing the onset of antidepressant-induced sexual dysfunction using interactive voice response technology. *Journal of Clinical Psychiatry*, *68*(4), 525-532.

Espinola, C. W., Khoo, Y., Parmar, R., Demchenko, I., Frey, B. N., Milev, R. V., Ravindran, A. V., Parikh, S. V., Ho, K., Rotzinger, S., Lou, W., Lam, R. W., Kennedy, S. H., & Bhat, V. (2022). Males and females differ in reported sexual functioning with escitalopram treatment for major depressive disorder: A CAN-BIND-1 study report. *Journal of Psychopharmacology*, *36*(5), 604-613.

Fabre, L. F., Clayton, A. H., Smith, L. C., Goldstein, I., & Derogatis, L. R. (2012). The effect of Gepirone-ER in the treatment of sexual dysfunction in depressed men. *The Journal of Sexual Medicine, 9*(3), 821-829.

Jacobsen, P., Zhong, W., Nomikos, G., & Clayton, A. (2019). Paroxetine, but not vortioxetine, impairs sexual functioning compared with placebo in healthy adults: a randomized, controlled trial. *The Journal of Sexual Medicine*, *16*(10), 1638-1649.

Kennedy, S. H., Eisfeld, B. S., Dickens, S. E., Bacchiochi, J. R., & Bagby, R. M. (2000). Antidepressant-induced sexual dysfunction during treatment with moclobemide, paroxetine, sertraline, and venlafaxine. *Journal of Clinical Psychiatry*, *61*(4), 276-281.

Kennedy, S. H., Fulton, K. A., Bagby, R. M., Greene, A. L., Cohen, N. L., & Rafi-Tari, S. (2006). Sexual function during bupropion or paroxetine treatment of major depressive disorder. *The Canadian Journal of Psychiatry*, *51*(4), 234-242.

Khazaie, H., Rezaie, L., Payam, N. R., & Najafi, F. (2015). Antidepressant-induced sexual dysfunction during treatment with fluoxetine, sertraline and trazodone; a randomized controlled trial. *General Hospital Psychiatry*, *37*(1), 40-45.

Madeo, B., Bettica, P., Milleri, S., Balestrieri, A., Granata, A. R., Carani, C., & Rochira, V. (2008). The effects of citalopram and fluoxetine on sexual behavior in healthy men: Evidence of delayed ejaculation and unaffected sexual desire. A randomized, placebo-controlled, double-blind, double-dummy, parallel group study. *The Journal of Sexual Medicine*, *5*(10), 2431-2441.

Montejo, A. L., Prieto, N., Terleira, A., Matias, J., Alonso, S., Paniagua, G., Naval, S., Parra, D.G., Gabriel, C., Mocaër, E., & Portolés, A. (2010). Better sexual acceptability of agomelatine (25 and 50 mg) compared with paroxetine (20 mg) in healthy male volunteers. An 8-week, placebo-controlled study using the PRSEXDQ-SALSEX scale. *Journal of Psychopharmacology*, *24*(1), 111-120.

Montejo, A. L., Deakin, J. F. W., Gaillard, R., Harmer, C., Meyniel, F., Jabourian, A., Gabriel, C., Gruget, C., Klinge, C., MacFayden, C., Milligan, H., Mullings, E., & Goodwin, G. (2015). Better sexual acceptability of agomelatine (25 and 50 mg) compared to escitalopram (20 mg) in healthy volunteers. A 9-week, placebo-controlled study using the PRSexDQ scale. *Journal of Psychopharmacology*, *29*(10), 1119-1128.

Piazza, L. A., Markowitz, J. C., Kocsis, J. H., Leon, A. C., Portera, L., Miller, N. L., & Adler, D. (1997). Sexual functioning in chronically depressed patients treated with SSRI antidepressants: a pilot study. *American Journal of Psychiatry*, *154*(12), 1757-1759.

Portman, D. J., Kaunitz, A. M., Kazempour, K., Mekonnen, H., Bhaskar, S., & Lippman, J. (2014). Effects of low-dose paroxetine 7.5 mg on weight and sexual function during

treatment of vasomotor symptoms associated with menopause. *Menopause*, *21*(10), 1082-1090.

Preeti, S., Jayaram, S. D., & Chittaranjan, A. (2018). Sexual dysfunction in patients with antidepressant-treated anxiety or depressive disorders: A pragmatic multivariable longitudinal study. *East Asian Archives of Psychiatry*, *28*(1), 9-16.

Reed, S. D., Guthrie, K. A., Joffe, H., Shifren, J. L., Seguin, R. A., & Freeman, E. W. (2012). Sexual function in nondepressed women using escitalopram for vasomotor symptoms: a randomized controlled trial. *Obstetrics & Gynecology*, *119*(3), 527-538.

Shah, P., Naphade, N., Jagtap, A., Shetty, J., & Datar, M. (2024). A prospective study on incidence of sexual dysfunctions in patients newly prescribed SSRIs. *Frontiers in Health Informatics*, *13*(3), 11152-11163.

Tanrikut, C., Feldman, A. S., Altemus, M., Paduch, D. A., & Schlegel, P. N. (2010). Adverse effect of paroxetine on sperm. *Fertility and Sterility*, *94*(3), 1021-1026.

Weber, S., Frokjaer, V. G., Armand, S., Nielsen, J. H., Knudsen, G. M., Joergensen, M. B., Stenbaek, D. S., & Giraldi, A. (2023). Sexual function improves as depressive symptoms decrease during treatment with escitalopram: results of a naturalistic study of patients with major depressive disorder. *The Journal of Sexual Medicine*, *20*(2), 161-169.

Westenberg, H. G., Stein, D. J., Yang, H., Li, D., & Barbato, L. M. (2004). A double-blind placebo-controlled study of controlled release fluvoxamine for the treatment of generalized social anxiety disorder. *Journal of Clinical Psychopharmacology*, *24*(1), 49-55.

McGahuey, C. A., Gelenberg, A. J., Laukes, C. A., Moreno, F. A., Delgado, P. L., McKnight, K. M., & Manber, R. (2000). The Arizona sexual experience scale (ASEX): reliability and validity. *Journal of Sex & Marital Therapy*, *26*(1), 25-40.

Kennedy, S. H., Dickens, S. E., Eisfeld, B. S., & Bagby, R. M. (1999). Sexual dysfunction before antidepressant therapy in major depression. *Journal of Affective Disorders*, *56*(2-3), 201-208.

Segraves, R. T., Kavoussi, R., Hughes, A. R., Batey, S. R., Johnston, J. A., Donahue, R., & Ascher, J. A. (2000). Evaluation of sexual functioning in depressed outpatients: a double-blind comparison of sustained-release bupropion and sertraline treatment. *Journal of Clinical Psychopharmacology*, *20*(2), 122-128.

Fava, M., Rankin, M. A., Alpert, J. E., Nierenberg, A. A., & Worthington, J. J. (1998). An open trial of oral sildenafilin antidepressant-induced sexual dysfunction. *Psychotherapy and Psychosomatics*, *67*(6), 328-331.

Labbate, L. A., & Lare, S. B. (2001). Sexual dysfunction in male psychiatric outpatients: validity of the Massachusetts General Hospital Sexual Functioning Questionnaire. *Psychotherapy and Psychosomatics*, *70*(4), 221-225.

Anthropic. (2026). *Claude Sonnet 4.6* [Large language model]. https://claude.ai/new

Montejo, A. L., Garcia, M., Espada, M., Rico-Villademoros, F., Llorca, G., & Izquierdo, J. A. (2000). Psychometric characteristics of the psychotropic-related sexual dysfunction questionnaire. Spanish work group for the study of psychotropic-related sexual dysfunctions. *Actas Espanolas de Psiquiatria*, *28*(3), 141-150.

Clayton, A. H., McGarvey, E. L., & Clavet, G. J. (1997). The Changes in Sexual Functioning Questionnaire (CSFQ): development, reliability, and validity. *Psychopharmacology Bulletin*, *33*(4), 731–745.

Keller, A., McGarvey, E. L., & Clayton, A. H. (2006). Reliability and construct validity of the Changes in Sexual Functioning Questionnaire short-form (CSFQ-14). *Journal of Sex & Marital Therapy*, *32*(1), 43-52.

Rosen, R. C., Riley, A., Wagner, G., Osterloh, I. H., Kirkpatrick, J., & Mishra, A. (1997). The international index of erectile function (IIEF): a multidimensional scale for assessment of erectile dysfunction. *Urology*, *49*(6), 822-830.

O'Leary, M. P., Fowler, F. J., Lenderking, W. R., Barber, B., Sagnier, P. P., Guess, H. A., & Barry, M. J. (1995). A brief male sexual function inventory for urology. *Urology*, *46*(5), 697-706.

Rosen, C. Brown, J. Heiman, S. Leiblum, C. Meston, R. Shabsigh, D. Ferguson, R., & D'Agostino, R. (2000). The Female Sexual Function Index (FSFI): a multidimensional self-report instrument for the assessment of female sexual function. *Journal of Sex & Marital Therapy*, *26*(2), 191-208.

Rust, J., & Golombok, S. (1985). The Golombok-Rust Inventory of Sexual Satisfaction (GRISS). *The British Journal of Clinical Psychology*, *24*(1), 63-64.

Derogatis, L. R., Rosen, R., Leiblum, S., Burnett, A., & Heiman, J. (2002). The Female Sexual Distress Scale (FSDS): Initial validation of a standardized scale for assessment of sexually related personal distress in women. *Journal of Sex & Marital Therapy*, *28*(4), 317-330.

Garcia-Portilla, M. P., Saiz, P. A., Fonseca, E., Al-Halabi, S., Bobes-Bascaran, M. T., Arrojo, M., Benabarre, A., Goikolea, J. M., Sanchez, E., Sarramea, F., & Bobes, J. (2011). Psychometric properties of the Spanish version of the Changes in Sexual Functioning Questionnaire Short-Form (CSFQ-14) in patients with severe mental disorders. *The Journal of Sexual Medicine*, *8*(5), 1371-1382.

Jing, E., & Straw-Wilson, K. (2016). Sexual dysfunction in selective serotonin reuptake inhibitors (SSRIs) and potential solutions: A narrative literature review. *Mental Health Clinician*, *6*(4), 191-196.

AlBreiki, M., AlMaqbali, M., AlRisi, K., AlSinawi, H., Al Balushi, M., & Al Zakwani, W. (2020). Prevalence of antidepressant-induced sexual dysfunction among psychiatric outpatients attending a tertiary care hospital. *Neurosciences Journal*, *25*(1), 55-60.

Montejo-González, A. L., Llorca, G., Izquierdo, J. A., Ledesma, A., Bouso o, M., Calcedo, A., De la Gandara, J., Derecho, J., Franco, M., Gomez, M. J., Macias, J. A., Martin, T., Perez, V., Sanchez, J. M., Sanchez, S., & Vicens, E. (1997). SSRI-induced sexual dysfunction: fluoxetine, paroxetine, sertraline, and fluvoxamine in a prospective, multicenter, and descriptive clinical study of 344 patients. *Journal of Sex & Marital Therapy, 23*(3), 176-194.

Safak, Y., Inal Azizoglu, S., Alptekin, F. B., Kuru, T., Karadere, M. E., Kurt Kaya, S. N., Yilmaz, S., Yildrim, N. N., Kiliçtutan, A., Ay, H., & Burhan, H. S. (2025). Antidepressant-associated sexual dysfunction in outpatients. *BMC Psychiatry*, 25, Article 317. https://doi.org/10.1186/s12888-025-06751-1

Gonçalves, W. S., Gherman, B. R., Abdo, C. H. N., Coutinho, E. S. F., Nardi, A. E., & Appolinario, J. C. (2022). Prevalence of sexual dysfunction in depressive and persistent depressive disorders: a systematic review and meta-analysis. *International Journal of Impotence Research*, *35*(4), 340-349.

Lee, T. I., Issac, J., Lin, S. H., Yeh, T. L., Lee, I. H., Chen, P. S., Chen, K. C., & Yang, Y. K. (2013). Gender difference in antidepressant-related sexual dysfunction in Taiwan. *General Hospital Psychiatry*, *35*(4), 407-411.

Jacobsen, P. L., Thorley, E. M., & Curran, C. (2020). Real-world patient experience with sexual dysfunction and antidepressant use in patients with self-reported depression:

A cross-sectional survey study. *Neurology, Psychiatry and Brain Research*, *36*, 57-64.

Taylor, M. J., Rudkin, L., & Hawton, K. (2005). Strategies for managing antidepressant-induced sexual dysfunction: systematic review of randomised controlled trials. *Journal of Affective Disorders*, *88*(3), 241-254.

Chapter Three: Bridging Chapter

Bridging Chapter

As demonstrated by the systematic review, based on studies using validated PROMs before and after medication, it can be stated that there is a causal link between SSRIs and sexual dysfunction. Follow-up was often short-term, and no study identified in this systematic review completed long-term follow-up of sexual functioning after SSRI use had been discontinued. A growing body of literature, however, has shown that symptoms can persist long after SSRI use, a condition that is now known as post-SSRI sexual dysfunction (PSSD) (Healy, 2020).

There is little research on the impact of PSSD, and no study, to our knowledge, has attempted to explore the lived experience of individuals with PSSD in the UK. Expanding our understanding of the condition, particularly in the local context (e.g. people's experiences of navigating local healthcare settings with PSSD) will contribute to the literature new knowledge regarding the aspects of living with PSSD that require careful thought and attention. The purpose of the empirical study, described in the next chapter, is to therefore understand the lived experience of PSSD for participants living in the UK.

Chapter Four: Empirical Study

“It’s taken away the most fundamental things about being human”: What is the lived experience of post-SSRI sexual dysfunction? A qualitative study

Seraj Brugi[1], Bob Budd[1], Craig Mackie[2] and Sarah Fish[1]

[1] Department of Clinical Psychology and Psychological Therapies, University of East Anglia, Norwich, Norfolk, NR4 7TJ

[2]Norfolk and Suffolk NHS Foundation Trust, Hellesdon Hospital, Drayton High Road, Norwich, Norfolk, NR6 5BE

Prepared for submission to The Journal of Sex Research (no word limit)

Word count: 9776

Abstract

Sexual side effects of selective serotonin reuptake inhibitors (SSRIs) can persist long after medication has been discontinued, a condition known as post-SSRI sexual dysfunction (PSSD). Little is known about the lived experience of PSSD and its impact on people's lives, identities and mental health. This qualitative study aimed to understand the experiences of people living with PSSD in the UK. Ten participants were invited to take part in a semi-structured interview, and data was analysed using an interpretive phenomenological approach. Three themes, encompassing eight subthemes, were identified: 1) Distrustful of professionals; 2) A changed me; and 3) Living with the impact. Participants discussed their experiences of being dismissed and unheard, feeling emotionally numb, and making sense of the change and loss they have experienced. Implications for clinical practice include the importance of professionals being aware of PSSD and its potential impact. Strengths and limitations of the study, as well as recommendations for future research, are discussed.

Introduction

Medications used to treat common mental health problems are among the most widely prescribed drugs in the United Kingdom (UK), with the National Health Service's (NHS) quarterly summary estimating that over seven million patients had been prescribed an antidepressant between October and December 2025 (NHS Business Services Authority, 2026). With prevalence of common mental health problems continuing to increase since 2000 (McManus et al., 2016), it is no surprise that antidepressant prescription rates continue to rise in the UK population (Lalji et al., 2021), including a steady increase in children and adolescents (Dai Cao et al., 2021).

Psychotropic medication, including all serotonergic agents such as selective serotonin reuptake inhibitors (SSRIs) and serotonin and norepinephrine reuptake inhibitors (SNRIs), are known to have the potential to cause adverse reactions (Mayville, 2007). A meta-analysis comparing the efficacy and tolerability of SSRIs and tricyclic antidepressants found that whilst SSRIs were associated with better tolerability, experiencing adverse events was not uncommon (Anderson, 2000). Commonly reported side effects of serotonergic medication include sexual dysfunction, drowsiness, weight gain, dry mouth, and insomnia (Cascade et al., 2009).

Sexual dysfunction (SD) is an umbrella term that can refer to a variety of symptoms associated with a change in sexual experience, including loss of libido or desire, delayed or absent orgasms, and impotence (Jing & Straw-Wilson, 2016). It can be difficult to estimate the precise prevalence of SD amongst individuals using psychotropic medication; as many as half of patients experiencing sexual side effects may not discuss these with their healthcare provider (Rosenberg et al., 2003). Moreover, research has demonstrated that SD - particularly a loss of desire and interest in sex - can be a common symptom of depression and anxiety in unmedicated individuals (Thakurta et al., 2012), leading some researchers to emphasise the difficulty in ascertaining a distinct role for psychotropic medication in inducing SD (Montgomery et al., 2002). That being said, it is clear from research findings that a significant number of patients experience sexual side effects following the use of SSRIs, with as many as almost three quarters of individuals on some types of medication reporting concerns regarding SD (Montejo et al., 2001).

Whilst symptoms of SD are reported to usually resolve after the use of serotonergic medications has been discontinued, it has become increasingly accepted that this is not

always the case. Incidences of post-SSRI sexual dysfunction (PSSD) have been reported to regulators since as early as 1991 (Healy, 2020), but the term was not coined until Bahrick (2006) identified reports of persistent SD following SSRI use in online peer support communities. Since then, there has been a growing body of research aiming to establish the biological plausibility, aetiology and presentation of PSSD, with differing theories on how factors such as gene expression, dopamine-serotonin interactions and hormonal changes may be responsible for the development of the condition (Bala et al., 2018; Peleg et al., 2022). No correlation between factors such as treatment length, substance use or somatic comorbidities and PSSD has been found (Linke et al., 2025). Overall, however, literature on the prevalence, impact, and effective management/prevention of PSSD continues to be scarce.

There are several challenges in estimating the prevalence of PSSD, with a recent systematic review (Tarchi et al., 2023) concluding that its frequency could not be reliably established from the current literature. Not unlike the difficulties in establishing the incidence of psychotropic-related sexual side effects, there may be challenges in making a differential diagnosis, potential underreporting of experiences, and potential dismissal by healthcare professionals. Moreover, it is unclear how frequently healthcare providers may ask about experiences of PSSD when evaluating patients who discontinue their use of SSRIs. Healy et al. (2019) surveyed individuals from 23 countries on their experiences of speaking to healthcare professionals about PSSD, and found that patients often reported facing scepticism or invalidation when raising concerns about their symptoms, with some healthcare professionals denying the possibility that antidepressants could cause lasting changes in sexual functioning. Thus, whilst a recent retrospective cohort analysis estimated that the prevalence of PSSD may be 1 in 216 for individuals prescribed serotonergic agents (Ben-Sheetrit et al., 2023), underreporting by both patients and healthcare professionals is likely prevalent.

The impact of sexual side effects on quality of life can be significant. In a bid to understand coping strategies for sexual side effects of ongoing SSRI use, O'Mullan et al. (2014) interviewed ten women in Australia under the age of 45 who were currently in heterosexual relationships. The analysis highlighted broad themes of suffering in silence, attempting to self-manage without medical support, and acceptance of the situation. When side effects persist after medication has been discontinued, the impact can be even greater; in a survey aiming to characterise people's experiences of PSSD, the majority of individuals rated its impact on quality of life as very or extremely negative (Studt et al., 2021).

In a doctoral thesis, Stinson (2013) interviewed individuals with PSSD in America regarding the impact of persistent sexual side effects as well as the participants' perceptions of what a psychologist may be able to offer. Participants described various consequences to PSSD, including an impact on relationships, identity and feelings about SSRIs. Similarly, Rice et al. (2025) conducted a study on the experiences of the prescription and cessation processes, as well as the perceptions and experiences of discussing the condition with healthcare providers, for participants with PSSD in Canada. Participants indicated a lack of understanding or acceptance of PSSD by healthcare professionals, leaving them to feel alienated and distrustful of medical services.

Whilst both studies provide valuable insight into the experiences of people with PSSD, there remains a need to expand on our understanding of the condition. No study, to our knowledge, has attempted to explore the lived experience of PSSD for individuals in the UK. Moreover, the lived impact of PSSD on individuals' relationships with their mental health and their experiences of mental healthcare professionals has not been well-explored. Our study therefore aims to explore the impact PSSD can have on people's lives, mental health, identity and relationships, focusing on the lived experience of the condition for people in the UK.

Methods

Ethical Approval

This research was reviewed and approved by the University of East Anglia Faculty of Medicine and Health Sciences Research Ethics Subcommittee (ID ETH2425-0169).

Patient and Public Involvement

Embedding Patient & Public Involvement (PPI) in health research is essential to meeting people's needs, helping to improve the quality of the research and what it can achieve for patients (NHS Health Research Authority, 2024). This study incorporated PPI feedback during the design, recruitment and analysis stages, ensuring that the work can make a meaningful contribution to the evidence base that is in line with the priorities of those directly impacted by this work.

Design

This study adopted a qualitative approach to exploring the lived experience and impact of PSSD. An interpretive phenomenological analysis (IPA) framework (Smith et al., 2022) was used to give voice and interpretation to individuals' lived experiences in a

participant-oriented manner (Alase, 2017). Participants were invited to attend one semi-structured interview with the lead researcher (a male trainee clinical psychologist), lasting up to 90 minutes, with an interview guide used to prompt questions and further discussion.

Participants

Participants for this study were recruited via purposive and snowball sampling by liaising with and advertising via The UK PSSD Association, who aim to promote awareness and research into PSSD. The UK PSSD Association advertised this project on their website and social media. In keeping with the terminology and criteria used by the Association, participants who developed PSSD following SNRI use were also eligible for inclusion.

There are no specific criteria for determining sample size in IPA, with the emphasis being on data richness rather than quantity (Smith et al., 2022). This study aimed to recruit up to ten participants who met the following inclusion criteria:

1. Over 18 years of age;
2. Able to understand written and spoken English to a sufficient degree that would allow participation in an interview;
3. Self-identifies as experiencing sexual side effects that began after SSRI or SNRI use;
4. Sexual side effects persisted despite a period of cessation that lasted at least three months (as per suggested diagnostic criteria proposed by Healy et al., 2022).

Materials

Participants who expressed interest in the study were contacted and provided with an information sheet, consent form and an interview guide. Following appropriate consent, participants were invited to complete a brief demographic questionnaire including the questions below:

1. How old are you?
2. How would you describe your gender?
3. How would you describe your current relationship status?
4. When did you first use SSRIs/SNRIs? Please provide details of SSRIs/SNRIs you have been prescribed.
5. Did you experience sexual side effects which began after using SSRIs/SNRIs?
6. Have you had any gaps in using SSRIs/SNRIs? If so, how long?
7. Did the sexual side effects persist whilst you were not using SSRIs/SNRIs?

The interview schedule for this study was informed by Stinson's (2013) topic guide with amendments made by the research team in line with the aims of this study and PPI feedback:

1. Tell me about how you came to receive a prescription for antidepressants?
2. Tell me about what side effects you experienced when using antidepressants? Did you discuss any of these with a healthcare professional?
3. Tell me about how you came to realise that you were experiencing persistent, or ongoing, sexual side effects? What was that experience like?
4. How has post-SSRI/SNRI sexual dysfunction (or PSSD) impacted your life?
5. How has PSSD impacted your sense of self/identity? What is it like to be you?
6. How has PSSD impacted any relationships in your life? For example, how has PSSD impacted how you experience romantic relationships?
7. How has PSSD impacted your relationship with your mental health? What has that experience been like?
8. Thinking about what led to you receiving a prescription for antidepressants, tell me about how PSSD has impacted the way you cope with your mental health?
9. How has PSSD impacted how you feel about accessing support for your mental health? If you have accessed support since living with PSSD, how did you experience this?
10. Is there anything I haven't asked about that you would like to mention?

Procedure

Participants were invited to take part in this study via a research poster that was advertised on the UK PSSD Association network and social media pages. The research poster provided information about the study, including the researcher's contact details. Eligible participants who contacted the researcher to indicate an interest were provided an electronic information sheet and consent form, and the interview guide. Participants were given up to one week to review the forms and decide whether they wished to take part. Consenting participants were invited to complete a short questionnaire and schedule an audio-recorded online interview at a mutually agreeable time that may last up to 90 minutes.

Interviews began with an introduction by the researcher, who reiterated the purpose of the interview and reminded the participants that they can withdraw or decline to answer a question at any time. After completion of the interview, participants were provided with a debrief sheet thanking them for taking part with signposting information for participants to seek support should they wish to do so. Participants were electronically sent a £10 gift-card for their participation. An automated transcript of the interview was produced via Microsoft

Teams. The accuracy of the transcript was carefully checked and corrections were made whilst re-listening to the interview, and any identifying information was anonymised.

Analysis

An IPA approach was adopted to gain a deeper understanding of how participants make sense of their complex experiences (Smith et al., 2022). In line with the analytical procedure described by Smith et al. (2009, 2022), interview transcripts were read and re-read before in-depth initial notes were made throughout the transcript. Personal experiential statements which succinctly reflected the participant's experiences were then constructed from the initial notes and transcripts. Connections between experiential statements were explored, resulting in clusters of overlapping or converging statements which were then organised into personal experiential themes (PETs). This process was repeated for each case and once all transcripts had been analysed, patterns of convergence and divergence were identified across participants, resulting in the development of a set of group experiential themes (GETs) and subthemes. A coherent narrative, evidenced by the use of participant quotes and commentary on the data, is then produced to present the findings of the analytical process (Larkin & Thompson, 2012).

Reflexivity and Quality Assurance

A reflexive journal and research supervision were both utilised throughout the process to facilitate reflections on any pre-existing assumptions, perceptions or questions that may arise during any stage of the process. A co-researcher and supervisor (SF) reviewed two of the annotated transcripts, providing feedback on the exploratory noting, construction of experiential statements and labelling of PETs. Participants were provided copies of their interview transcripts for comment if desired.

Results

Participant Characteristics

Participant characteristics are presented in Table 1, with minimum details reported to further protect anonymity within the local PSSD community. Interviews lasted from approximately 28 minutes to 86 minutes. Age group and duration of PSSD are reported in ten-year and five-year ranges respectively. Whilst duration of PSSD refers to the length of time since PSSD was first experienced, when taking into account the time spent on medication, some participants have experienced SSRI-related SD for longer than the range indicated. All participants describe experiencing persistent genital numbness, a loss of

interest in sex, or, in most cases, both (as well as other sexual side effects such as anorgasmia, erectile dysfunction, and vaginal dryness).

Table 1.
Participant characteristics.

Pseudonym	Gender	Age (years)	Duration of PSSD (years)
Alicia	Female	20-29	5-9
Arthur	Male	40-49	10-14
Bethany	Female	40-49	25-29
Frank	Male	50-59	<5
Jo	Female	40-49	10-14
Lucas	Male	30-39	<5
Michael	Male	30-39	<5
Stacey	Female	30-39	<5
Thomas	Male	20-29	5-9
Tony	Male	30-39	15-19

Analysis

Three GETs comprising a total of eight subthemes emerged from the cross-analysis of participants' transcripts: 1) Distrustful of professionals; 2) A changed me; and 3) Living with the impact. Table 2 illustrates participant representation across said themes as well as the related subthemes.

Table 2.

Representation of group experiential themes and subthemes across participants. '✓' = theme was significantly represented in participant's account, 'O' = theme was partially represented in participant's account.

Theme	Alicia	Arthur	Bethany	Frank	Jo	Lucas	Michael	Stacey	Thomas	Tony
Distrustful of Professionals	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Not being informed	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dismissed and unheard	✓	✓	✓	✓	✓		✓	✓	✓	✓
A Changed Me	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
This emptiness inside me	✓	✓	O	✓	O	O	✓	✓	✓	✓
Struggling to relate	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Who am I now?	✓	✓	✓	✓	✓	O	✓	✓	✓	✓
Living With the Impact	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
What PSSD has taken away	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Taking PSSD to therapy	✓	✓			✓	✓	O	✓	O	✓
What helps me to cope		✓	✓	O		✓	✓	✓	✓	✓

Distrustful of Professionals

This theme encompasses participants' experiences of discussing persistent sexual side effects with medical and healthcare professionals, often resulting in participants feeling ignored and thus distrustful of healthcare. Two subthemes represent the various experiences: 1) Not being informed; and 2) Dismissed and unheard.

Not Being Informed

All participants described some sense of not feeling fully aware of the risks their medication potentially carried, with conversations around possible side effects (even whilst on the medication) being very brief or not taking place at all. For most participants, this conversation would have been relevant in the decision-making process; when asked how it

felt to realise that the sexual side effects were not subsiding, Frank said "*Devastated. Yeah, devastated because I'd never, I've never experienced – I would have never touched them if I'd known there was any slight [chance] of what was going to happen".* Frank is *devastated* not just because of the impact of PSSD, but because for him, the outcome could have been avoided.

Others also describe feeling uninformed of the risks, with some feeling intentionally misled. Arthur says it is "*heartbreaking"* that "*the clinical trials that proved SSRIs showed that PSSD was a thing and it was- it was covered up […] I mean, what are you supposed to think about that?".* Arthur poses a question here, but his own answer is clear: *"All these people whose lives have been completely wrecked by these drugs, and we've been reporting it for years and nobody does anything […] I just don't trust any of it".* Arthur's experiences have made him distrustful of professionals, who he can no longer rely on to be transparent. When talking about mental health and what led to antidepressants being prescribed, Michael expressed a similar sentiment, saying "*I just feel like I've been scammed, basically. It's like the mother of all scams".* The issue for Michael isn't that he simply didn't know PSSD was a risk, but that not knowing makes him, and others in his position, the victims of "*the mother of all scams".*

The lack of awareness around PSSD meant that participants felt confused and shocked by their experiences, rupturing relationships with professionals – and the wider systems – that intended to support them. Whilst discussing her current medication, Alicia offered the following reflection:

> *I'd say I'm a lot more wary of medications, really. So even now I'm kind of – I'm on Mirtazapine and I don't even know whether that could be making things worse or not, but I think I'm really reluctant to kind of increase the dosage […] I feel, yeah, distrusting of… even doctors, really, I suppose in that sense. And yeah, medication for mental health. Yeah, just feel, yeah, distrusting.* (Alicia)

Alicia describes an internal battle between accepting medication from her doctors and the *reluctance* she feels based on her past experiences. For most participants, it is understandable to blame the prescribers who, at best, had not heard of PSSD themselves or, at worst, did not disclose this risk. For Lucas, however, it became clear that he felt responsibility lies with himself; "*I'm not trying to seek to blame this [doctor], I put pressure on her, you know",* later saying "*if I Googled it, maybe I would have found [PSSD], but I was naïve, you know?".* As Lucas requested medication and "*put pressure"* on his GP, he is thus

responsible for making the decision to take SSRIs. Another possibly relevant factor here may be how prescribers respond when concerns around sexual dysfunction are raised; when mentioning PSSD, most participants felt their concerns were dismissed, whereas Lucas found his doctor to be "*kind of sympathetic, but I knew he wouldn't be able to do much*".

Dismissed and Unheard

Participants frequently described feeling like they have not been heard, particularly in the context of healthcare appointments. This understandably leads to feelings of dismissal, rejection and neglect. After watching a British Broadcasting Corporation (BBC) documentary on SSRIs and possible withdrawal effects, Stacey raised her concerns with a psychiatrist:

> *I was kind of a bit freaked out by that […] I was just like 'shit', like I don't want to take this […] she [psychiatrist] was just like the BBC – she said to me, you know […] the BBC don't know what they're talking about.* (Stacey)

Whilst Stacey's conversation with her psychiatrist wasn't explicitly about PSSD, she says it reassured her that there was "*nothing new to worry about"*, something she would disagree with today after multiple difficult encounters which have minimised her experiences: "*you're not really fully human. You feel less of a human. You feel completely dismissed".* Here, Stacey articulates the idea that to be human is to be heard and validated, meaning that she cannot be "*fully human"* when she is "*completely dismissed".* For Arthur, the fact dismissal came from within the healthcare system feels particularly difficult: "*you're just basically being told that you've made it up and it's- it's the result of some, like, the kind of institutions that are kind of there to kind of care for you and help you, supposedly".* Arthur's use of the word "*supposedly"* highlights his evident mistrust in healthcare. Similarly, Tony felt exasperated by his experiences with various healthcare professionals: "*I got sick of health professionals not believing me about this condition, so I put in a complaint".* He describes how this incident led to further difficulties with a local crisis team that he had been in contact with at the time:

> *I spoke to a woman [at the crisis team] and she was absolutely horrible. Like I mean, like really nasty. I started explaining to her how I was suicidal because of the sexual side effects that hadn't gone away from the medication […] and she was really cold and unfriendly with me.* (Tony)

For Jo, the intersecting aspects of her identity as a woman accessing healthcare and as a patient seeking answers felt poignant for her:

> *I think this is something maybe only women get: when I was [having counselling], they just kept telling me […] 'oh, well, sexual dysfunction in women is very common' […] made me feel like I'm some kind of weirdo for wondering where my sexuality went.* (Jo)

For Jo, she was made to feel *weird* for asking questions about her sexuality, meaning that her concerns regarding PSSD were not recognised. Given their invalidating experiences, it is unsurprising that some participants sought answers elsewhere; Thomas had been searching online regarding his side effects when he came across PSSD: *"So I went into that rabbit hole and that's when everything clicked".* For Tony, after his GP said *"it can't be the medication because it's out of your system",* he also turned to the internet: *"I started looking up online to see if there were other people who had suffered this, and I found other people".* The need to feel heard and believed was salient in participants' accounts. Dismissal – particularly from prescribers and health care professionals – betrayed their confidence and trust, adding to their distress and isolation.

In contrast, positive encounters with professionals could have a significant impact in helping participants feel seen. Describing a recent appointment, Thomas said: *"At the moment I'm seeing [practitioner at facility] and the woman on the phone straight away knew that it was PSSD. So, I'm really grateful for that".* Despite only having a phone call and not starting any treatment yet, being instantly seen and heard, an experience new to him in the healthcare context, has made Thomas "*really grateful".*

A Changed Me

This theme encompasses how participants describe experiencing their own internal sense, including identity, and how this relates to their ability to connect with themselves and others around them. Three subthemes represent these experiences: 1) This emptiness inside me; 2) Struggling to relate; and 3) Who am I now?

This Emptiness Inside Me

Many participants spoke at length regarding their experiences of emotional numbness following the use of SSRIs. In addition to persistent sexual side effects, Arthur said:

My emotions were completely numbed. It was like I no longer could feel excited in anything or, you know, just emotional numbness. And it was like- I was in a relationship at that time. It was, you know, a really kind of nice relationship and it just kind of felt like I went from being in this position where I was really happy that I'd met this person and it was going really well […] like literally overnight, I kind of like couldn't feel anything anymore for her. (Arthur)

Arthur's experience, which he describes as "*really horrible"*, is unfortunately not unique. When asked what emotions went through him when he realised his sexual side effects were not subsiding, Frank said "*That's the problem, it takes away your emotions, you know? I'm walking around like a statue [chuckle]".* Frank's use of the word *statue* emphasises to what extent he feels disconnected from any feeling and the world around him. Michael describes life now as "*like all the colour has gone"*, adding that "*it didn't take much to make me happy before. Now, nothing makes me happy".* The world now feels duller to Michael who describes himself as previously being a "*really passionate person".*

For Thomas, life has become so "*mechanical"* that "*there's not a condition that I know about that I wouldn't trade places with".* The burden of emotional incapacity is so great that any alternative reality feels more bearable:

For example, I have family members that have had cancer, and OK it's like, it's horrible. But you still have your emotions. If I could say I want my emotions for, like, I want to be with my emotions for five years and then after five years I can die. That's the condition, let's say. I will take that. (Thomas)

Thomas' statement that he would accept a condition of death if it meant he could temporarily "*be with"* his emotions is striking. For him, a life without the feelings he once had is a fate worse than dying. A similar sentiment was expressed by Frank, who said:

It's [PSSD] almost like a living death sentence to be honest, I can't think of anything worse. It's even worse than cancer because at least with cancer, you know- OK you're probably going to die with it, but at least you have your feelings intact. (Frank)

Other participants reflected on the "*hollow"* or "*empty"* nature of emotional experiences with PSSD. Alicia reflected that relationships have been difficult as she "*would go through things and come out kind of feeling kind of empty and, yeah, and just not kind of good enough".* Similarly, Tony describes feeling "*empty"* during life experiences he has had:

> *They were completely hollow experiences where I couldn't enjoy them or basically I couldn't experience them. If I was to give you an analogy, it's almost like eating chocolate when you've got a really bad cold or something. You can't taste it, you can eat the chocolate but you can't get any pleasure from it.* (Tony)

Alicia and Tony's statements help to reconcile the idea that PSSD can cause complete emotional numbness for individuals whilst said individuals are still able to reflect on the very difficult (e.g. *"really horrible"*) burden of the condition. Rather than complete apathy, a *"hollow"* and "*empty"* internal sense overshadows any capacity to experience other emotions. For Michael, he understands this as repressed feelings: "*I mean this [becoming emotional] is good. The fact I'm crying is good. I think I've got a lot of repressed emotion".* Despite getting upset as he spoke about there being "*no escape"* from PSSD, Michael is relieved to see himself able to connect with his emotions. There is no doubt, however, from participants' accounts that the ability to experience and engage with positive affect, or indeed any affect, has been significantly affected by SSRIs.

Struggling to Relate

All participants described an impact on relationships with others, whether that be romantic relationships, relationships with friends and/or families, or being able to relate to peers. Stacey said "*this condition really does, like, isolate you, because you can't relate. You cannot relate to people".* Arthur expressed a similar sentiment, saying that PSSD is "*very isolating […] when you're in this position where it's like you've lost your connection to life".* The level of difference and disconnection "*from life"* instilled by PSSD has isolated Stacey and Arthur from the world around them.

For some, because of this difference and disconnection, society itself can become a trigger; Tony said "*there's also a lot of triggers within friendship groups with people who don't have PSSD when they talk about sex, dating, you know? […] you have to be a bit like an actor".* For Tony, given that he now finds little in common with old friends, maintaining relationships has become a performance. Confiding in friends and family can also be a difficult experience; Frank says he only told one friend that he had "*no libido*":

> *He [friend] said "oh, yeah but most men our age lose a bit of their libido". But he doesn't understand that he might have lost a little bit of his libido because most men over 50 do, but [laughs] I've lost all of it, so it's a different aspect to what he's referring to.* (Frank)

Frank laughs, perhaps in exasperation, at a friend's attempt to relate to his experience of PSSD, emphasising the fact that for Frank, what he experiences does not feel like 'normal ageing'.

Whilst most participants were single at the time of the interview, some talked about the impact of PSSD on long-term relationships. Jo described how the condition led to her questioning a relationship she had been in for several years:

> *It never occurred to me that six months after I was off [medication], 12 months after I was off it, it never occurred to me that it was still the drug at this point. I was thinking [it] must be, I don't know, maybe it's a relationship issue, maybe it's me and my partner? […] It must be me, or it must be us, it must be him. It must be something going on*. (Jo)

Jo's relationship survived these questions, but others spoke about attempting to date without success. Thomas spoke about a relationship that ended after his sexual side effects impacted his partner's self-confidence: "*she became self-conscious because she thought it was her […] She was like 'oh, well with the numbness, like do you not feel pleasure?' And this is like- I don't feel pleasure. But I can't say that".* Thomas was mindful of his partner's experience in their relationship, and describes feeling that he "*can't say"* what he was truly thinking, adding to his shame around PSSD. He says that the "*pressure" to* hide the extent of his sexual side effects means he is "*very hesitant in trying to go into something else [relationship]".*

Two female participants spoke about how PSSD has increased their vulnerability in the context of relationships, leading to sexual encounters they found unsafe or demeaning. After talking about how it can be "*really, really challenging"* to bring up PSSD when dating, Alicia said:

> *There's been times where I've kind of - after sex, I've sort of like, been in tears. Like I've been crying and almost felt a bit like, sometimes I think I've almost felt a bit used as well at times. Because I've kind of gone along with things that sometimes I haven't been happy about just to please that person*. (Alicia)

Alicia's understandable reluctance to discuss her sexual side effects with prospective partners, combined with the fact she was not able to enjoy these experiences herself, meant

that it was more difficult to talk about sex and boundaries, leaving her vulnerable to feeling *"used"*. Bethany also recounted an unsettling experience with a "*really toxic"* partner:

> *The only way I can describe it now is like he was sexually abusing me […] If I haven't had this [PSSD], I wouldn't have even tolerated him for 5 minutes […] he said to me something that I didn't really understand at the time, and like it's only now since I've realised that I'm actually numb there [genitals] - basically what he said was he liked to be with me because, like, I guess I just didn't react [due to numbness], and like, so he could abuse me in a way*. (Bethany)

Alicia's and Bethany's difficult experiences highlight the scope and magnitude of impact that PSSD can have on relationships; in their case, the capacity to understand and engage in safe sexual relations was compromised by their dysfunction. For Bethany, who is now able to make sense of her experiences, PSSD played a significant role in keeping her "*trapped"* in a dynamic that was "*highly toxic and highly abusive".*

Partnerships can thus look very different with PSSD, leading some to think about how they can find new ways of relating and finding fulfilment in connecting with others. When reflecting on his current relationship, Lucas said:

> *I'm probably on the more optimistic side in terms of I would generally believe that one can always find someone […] I think relationships are always possible for anyone, you know? But it's just that there's a million roadblocks in the way for people with [PSSD], and it's going to be a relationship that's much more negotiated and much more based on compromise and practicalities, frankly, you know? More of a, maybe more of a functional than a romantic relationship.* (Lucas)

Who am I Now?

In light of the physical, emotional and relational impact of PSSD described so far, it is unsurprising that most participants spoke about how PSSD forced a fundamental change in what it meant to be themselves. Thomas reflected that "*in terms of identity […] I'm having to remember who I was to try and still be that person".* For Thomas, to preserve at least some sense of self, life has become a script. Similarly, when asked if he is the same person as before, Frank said *"I'm different. I'm totally different. It's not me. Every morning I'm looking in the mirror, I'm thinking it's just… this living nightmare continues"*. Frank does not say what he sees when he looks in the mirror, but he knows that it is not the person he once was. Arthur says "*there's all these aspects to my personality which are just not there anymore. It*

just feels like I've kind of got brain damage and just been like, yeah, just like kind of lobotomised". Arthur's PSSD has not only changed his personality, but it has "*lobotomised"* him; the use of this term, a controversial medical procedure, highlights the extent of the medical harm Arthur feels he has experienced.

The nature of PSSD means that it can have a significant impact on core aspects of self-identity, such as sexuality. Stacey described how her relationship with her sexuality has been forcefully altered by her experience:

> *I don't really consider myself asexual either because this is- No, I'm not asexual. But it's almost like they're forcing- I'm forced to be asexual in a way, if that makes sense. Because I never, you know, I don't identify like that, but the condition has made me feel like that*. (Stacey)

Stacey's statement conveys the incongruence between who she feels she actually is and who she has been "*forced"* to become, with her initial statement of "*they're forcing-"* implying that someone or something is to blame for what is an unwelcome conflict in self-identity. For Michael, who had been unsure of his sexual orientation before being prescribed SSRIs, the sexual side effects leave him with an unresolved question regarding his identity:

> *To have your sexuality blunted while you're trying to figure it out is like, makes things really, like, difficult. So I don't even bother now. I'm just, well, like I'm castrated now, so it doesn't really matter what I am […] there would have been a lot of other things I could have done to figure [my sexuality] out.* (Michael)

Some participants also described how PSSD impacts their sense of self in relation to gender and social norms. When asked why she felt PSSD had affected her self-esteem, Alicia explained that she feels "*less womanly, I suppose […] I feel out of touch with my sexuality a bit, yeah".* Expressing a similar sentiment, Stacey said that "m*y sense of self as a woman and a sexual being has been stripped away from me".* For Alicia and Stacey, to be disconnected from their sexuality as women meant that their sense of womanhood had been altered.

Male participants described similar experiences; Tony said "*I don't know if you can remember back to when before you went through puberty […] that's what it feels like having PSSD. You feel like a prepubescent child".* In this statement, Tony conveys a sense of being a 'boy' rather than a 'man', an experience echoed by Michael who said "*it just affects - it's*

like the core of your manhood […] it's like got me right in the centre and everything proliferates from that". PSSD fundamentally alters identity and sense of self in a way that, for Michael (and others), means its impact "*proliferates"* into every aspect of life.

Living With the Impact

This theme encompasses how participants experience the impact of PSSD on the lives they envisaged for themselves, and how they begin to make sense of this impact. Three subthemes represent these experiences: 1) What PSSD has taken away; 2) Taking PSSD to therapy; and 2) What helps me to cope.

What PSSD Has Taken Away

Participants frequently talked about the life and future they felt they had lost as a result of PSSD. Michael feels that SSRIs *"totally tear someone's life to shreds",* expressing his regret at the decision to take the medication:

> *Everyday I'm just like, why did you do that [take SSRIs]? That was so stupid […] There's just a million things I would have loved to have done, and now I'm basically just paralysed because there is no quality of life when you've got this condition. It's just shit*. (Michael)

Michael describes what feels like an altered course of life, leading to the loss of opportunities that were meaningful to him. Similarly, Lucas spoke about what PSSD has taken away from him: "*it's completely transformed my life on every measure from my day-to-day life […] to my spiritual, mental world - interior world - to my expectations for the future",* later adding that "*I do believe it's maybe possible to establish some sort of life with this […] it's not going to be the life you ever thought you would lead".* Whilst a meaningful life is absolutely possible with PSSD, Lucas reflects sincerely on the fact that this life is different to the one he expected to lead, requiring an enormous shift in perspective.

After "*seeing the impact over my life",* including what she had discussed regarding its impact on relationships, Bethany described what she felt PSSD had taken from her:

> *It's taken away the most fundamental things about being human […] about my experience to connect with another person emotionally, physically, sexually, it's like – it's probably taken away the right for me to be able to have a normal family life and have children with somebody else. I mean that's what you – that's what life is about, and I feel like that's been taken away from me.* (Bethany)

For Bethany, PSSD has "*tentacles"* that influence various aspects of life and its trajectory. Her use of the word *"tentacles"* speaks to the wide-reaching and forceful hold that PSSD has in her life. Similarly, when describing its impact on his life, Thomas articulates a sense of being engulfed by the condition:

> *PSSD reminds me of like a sphere. Like, it's so perfect in how it like – not perfect in a good way, but how it encompasses the whole system with like your sexual functioning, your emotions, it's just like this, yeah, like, perfect in how it affects everything.* (Thomas)

Tony said that even if he "*was to recover"* in the future, there would be no way of living the experiences he could have had in the past: "*I feel like the sort of experiences that I missed out on or that I couldn't enjoy […] I can't really replicate them in the same way"*, reflecting that experiences such as "*dating, sex life, [and] travelling as a young person"* would feel different should he have these opportunities later in life. PSSD has had a profound impact on participants' hopes and expectations from life whilst simultaneously shaping new narratives, as reflected by Jo who said: "*it's what [PSSD] has removed, then it's also what it's forced me to become".*

Taking PSSD to Therapy

Given the impact of PSSD on every aspect of individuals' lives, it is unsurprising that several participants discussed their experiences of seeking counselling or talking therapy in a bid to feel supported and validated. For Lucas, going to counselling - even if briefly - was helpful:

> *I found it useful with PSSD, you know, the six sessions I went to, I- you know, that was good. It was useful. I struggle to think how anyone couldn't find that useful in any situation, like being able to talk about your problem with someone who's listening*. (Lucas)

Arthur found cognitive behavioural therapy (CBT) helped him "*with the understanding […] the experiences in my sort of past that had caused me to kind of have these sort of recurring problems with anxiety and depression",* saying that PSSD *"pushed me to have to understand all the different factors that kind of go into, you know, keeping it kind of well mentally".* Having someone listen to what you are experiencing whilst also helping to create a shared understanding of your story can thus be validating, perhaps especially if one has

found little validation in other interactions and relationships, or where the veracity of one's experiences has been questioned.

Not all participants, however, described positive experiences with mental health professionals. When raising PSSD within a mental health service, Jo says her psychologist responded with "*I've heard of it, but it's not official, you know, I can't talk about this".* When thinking about how her experience could have been improved, Jo reflected that "*she [psychologist] could have wrote back to my GP and said this needs investigation, but she didn't"*. Stacey spoke at length about her experiences in therapy, saying she attended sessions with a mix of different mental health professionals. When reflecting on why she felt these sessions were "*useless",* Stacey said:

> *Because what happens is it ends up me having to educate them on my experience. I have to coach them […] to understand what's going on, and what I'm going through. And like, you know, the whole point of, you know, counselling is for them to help me understand what's going on, like going through my challenges, whereas I felt like it was just more about informing them.* (Stacey)

Educating her therapists on what PSSD meant was not the role Stacey wanted to assume in sessions. Conversations around the condition and its aetiology can invite questions which might be experienced as suspicious or invalidating. When asked what comes to her mind when she thinks about accessing therapy now, Stacey said "*not denying your experiences is really important […] I don't want any of those kind of questions that allude to 'are you sure?'".* For Stacey, and likely others, perhaps the issue is not that the therapist is asking questions, but that the question being posed here denotes the therapist is not *sure* themselves if PSSD is 'real'. A nuance illustrated by a conversation with Alicia, who when asked what she would hope from a therapist, said "*for them to know that [PSSD] does exist […] I suppose just for them to kind of be there and listen and just listen to people's experiences, and get an insight into how- what it's like to have the condition".*

What Helps Me to Cope

Several participants spoke about how they manage the impact of this debilitating condition. Arthur framed PSSD as "*like being in a horror movie that you can't escape from. That's the only way I can really describe it. But, you know, I've had to learn to kind of, to survive, you know?".* For him, in addition to having CBT sessions, this means "*managing"* what he can for his mental health:

> *I have focused on my diet a lot, which I think has a massive difference, so I don't drink alcohol anymore since I got PSSD. I don't drink caffeine anymore since I got PSSD, and also I try to really limit the amount of sugar that I consume […] and those things kind of limit the kind of up and down in my mood […] I've always done a lot of exercise, you know? […] I do a minimum sort of amount of exercise every day*. (Arthur)

After reflecting that the *"loss"* of his sexuality changed his "*conception of [himself]"*, Lucas says he "*started going to church, which is a bit of a Hail Mary move to be honest […] but when you're in the trenches, it's like you're clutching for something".* The fundamental change in identity has led Lucas to search for something deeper to offer some fulfilment. Later, he described "*positive coping mechanisms"* that have helped him:

> *I did read a bit of a book on Stoicism really early on in this [PSSD journey], and that gave me a few okay habits in terms of like, being really easy on myself, having generally low expectations and looking at any small win as a huge success. Not looking at the past, you know, we've talked a lot about the past today, but I don't generally beat myself up about it. I just, like, in Stoicism they would say there's nothing you can do. It's happened.* (Lucas)

When asked about her relationship with her mental health, Stacey said "*distractions"* are how she copes: "*I try to have a routine, I guess. I try to exercise as a distraction. Having a routine is good for distractions. It's just, I guess it's better than laying in bed all day".* Being able to do this, however, took time for her: "*the first year [of having PSSD], I just could not get out of bed"*. It understandably took Stacey some time to process the changes she had experienced. Tony also spoke of the time it took him to begin to accept the reality of what had occurred:

> *The first three years of having PSSD I was very suicidal and I didn't cope with it well […] but one thing I would say is having PSSD for a very long time, like [15-19] years, it's kind of built this sort of mental toughness […] I can deal with it a lot better now*. (Tony)

Tony also spoke of brief "*windows"* where he notices "*improvements"* in sexual functioning: "*My sexuality occasionally comes back - not completely to how it was before - but partially returns and then it just vanishes again. And it's like Heaven".* Tony's use of the word "*Heaven"* highlights the extent to which PSSD can feel like 'Hell'. Some other

participants also spoke of these brief glimmers of hope; Bethany said that she spent some time "*trying to do things"* to improve the dysfunction she was experiencing:

> *I started fasting and I started going in the sea and I noticed these little windows, and - when I was eating really well, like, and not eating any sugar or processed foods […] I was getting little windows of like 'ooh' […] I felt joy for the first time […] and I noticed, like, my libido kind of picked up a little bit.* (Bethany)

Michael spoke of "*tiny little moments where I feel something"* which are what keep him going: "*sometimes I'll get a little bit of pleasure out of listening to music still. It's nothing like it used to be, so like really, I'm – that's what I live for now".* For Frank, who said he experienced a "*little window"* of improved sexual functioning recently before "*[crashing] again",* the momentary change brought joy but also understandable distress as it dissipated: "*it's terrible [losing that window], I actually- because when I got the window, I was crying. I actually started crying with joy because I thought 'oh, I'm feeling better!', but it was just a brief window".* This brief window was a reminder of what Frank had lost and what he could still have, making it a bittersweet experience.

Given the fact that almost all participants expressed a sense of feeling isolated and dismissed, it is unsurprising that finding validation and support within the PSSD community can be important. After speaking about individuals with PSSD supporting each other with various tasks, Michael said "*There's a lot of, like, skills in the PSSD community that sort of, you know – it's something we've got that we can still help with".* There is significant value in connecting with people from the community who can offer peer support and validation, as reflected by Tony who said:

> *I do find I've got some support from the PSSD community. I don't know if you're aware of the PSSD Network? And they've been very supportive and that has helped […] they're the only people that I really- can really understand me.* (Tony)

Discussion

Overview

This study aimed to further our understanding of the lived experience and impact of PSSD for participants in the UK, with a focus on deepening our knowledge of how the condition affects people's mental health and their experiences of mental healthcare. An IPA

approach identified three group experiential themes across ten completed interviews: 1) Distrustful of professionals; 2) A changed me; and 3) Living with the impact.

Participants frequently spoke about how they felt uninformed regarding the possible risks of antidepressant use, as well as conversations with healthcare professionals that often felt dismissive and invalidating. No participant stated they were aware of PSSD before commencing medication, and all individuals described having no or very brief conversations about possible side effects. Our results are consistent with findings from Healy et al. (2019), Rice et al. (2025), and Stinson (2013) whose participants also described often feeling uninformed, ignored or devalued by healthcare providers involved in their care.

Several participants discussed their experiences of therapy, whilst some reflected on what they might hope and expect from a mental health professional should they engage in that work. Experiences differed widely between individuals; Lucas and Arthur, for example, respectively found counselling and CBT valuable. For Stacey, however, having to educate therapists on PSSD meant that sessions did not feel helpful. A common theme across conversations with participants highlighted the importance of feeling seen and believed by the professional. Research has shown that validation is central to fostering a sense of belonging and reducing negative affect (Benitez et al., 2019; Kim & Kim, 2013), and as many individuals with PSSD receive little validation in their experiences with professionals, it is understandable that some may feel reluctant to engage in therapy, or find that their experiences deepen their sense of invalidation.

Participants frequently spoke of feeling emotionally numb or blunted, describing their experiences of diminished positive and negative affect in various contexts. For some, whilst PSSD refers to persistent sexual side effects, it is fundamentally underpinned by a disconnection from one's previous emotional capacity, a disconnection that will inevitably also have an impact on sexual functioning. Emotional blunting has been widely reported in the literature as a potential side effect of antidepressants, however there is some disagreement as to whether patients' experiences reflect a property of the antidepressants or a symptom of depression (Jawad et al., 2023). For participants with PSSD, however, it is clear that antidepressants have had a profound impact on experiences of emotion, an impact that has persisted long after the medication.

Most participants discussed at length the consequences of persistent sexual and emotional side effects on their identity and relationships, a finding that has been noted in previous research (Rice et al., 2025; Stinson, 2013). However, the present study goes

beyond this to highlight an increased vulnerability to problematic intimate relationship dynamics for some individuals as a result of PSSD. Alicia recounted her experiences of sometimes “[feeling] used” as she had been reluctant to name or discuss PSSD with partners, making conversations around sexual boundaries and desires difficult. Bethany recounted “highly abusive” experiences which she attributes both to her physical experience of genital numbness and a lack of understanding of what constitutes a “normal” relationship. This ultimately created an unequal sexual partnership and a difficulty in recognising what she now considers to be abusive sexual encounters.

Alicia’s and Bethany’s stories could indicate a gendered dimension of PSSD; a study investigating differences in elicited cognitive appraisals during sexual activity found that women with sexual dysfunction report experiencing thoughts related to feeling abused, disrespected or violated during sexual activity significantly more often than sexually healthy women (Nobre & Pinto-Gouveia, 2008). Thus, whilst PSSD has a marked impact on the sexual experiences of both men and women, the nature of this impact may be experienced differently.

Participants spoke of significant loss as a result of PSSD, a condition that can fundamentally change one’s life entirely. For some, there was no reprieve from the enormity of what they face on a daily basis. Others, however, were able to reflect on what has become important to their wellbeing. Talking therapy that is compassionate and validating, whilst being centred on the individual’s unique story, was helpful in some cases. Additionally, focusing on what one can control (e.g. diet and exercise), and having distractions and a routine can also be useful. It is also clear that community is important to many people with PSSD. Research has shown that a sense of belonging is central to positive mental wellbeing (Allen et al., 2021), and some participants spoke of how important the PSSD community had become in their lives. Whilst it is recognised that it can be difficult to hear and/or read about others’ difficult experiences (necessitating boundaries around this), participants also felt that being part of a supportive network can provide a sense of feeling understood when others around you may be dismissive, an experience that people with PSSD know very well.

Strengths and Limitations

To our knowledge, this project constitutes the first qualitative study on PSSD in the UK, giving a voice to participants who have been living with PSSD – some for many years – and navigating NHS services with the condition. Participants’ accounts also provide a lens into the attitudes of local prescribers and other healthcare professionals towards PSSD, highlighting gaps in knowledge regarding the condition and/or willingness to engage in

conversations about possible persistent side effects with patients. Recruiting ten participants also provided a rich data set and valuable insight into how PSSD impacts people's lives. Importantly, participants were able to share deeply personal and meaningful reflections which have contributed to our understanding of how SSRI-related sexual dysfunction affects identity, emotions, relationships, and experiences with professionals and therapy in the NHS.

There are several limitations to this study. Most participants identified as being of the same ethnic background (White British). Attitudes towards sex and sex-related problems can differ significantly across different cultures (Hall, 2019), and the inclusion of more participants from diverse backgrounds may have further enriched the findings of this study. That being said, given that generalisability is not the aim, homogeneous samples are typically considered helpful and appropriate for IPA research (Smith et al., 2022). Additionally, the majority of participants were single at the time of the interview, meaning that there were very few current accounts of the impact PSSD has on romantic relationships. However, this is likely reflective of the wider community, with recent research indicating that the majority of people living with PSSD identified as single (Linke et al., 2025).

Clinical Implications

This study poses several considerations for clinical practice, including for psychologists and therapists. Healthcare professionals, including prescribers such as GPs, should be mindful of the impact PSSD can have on patients in their care, as well as the distress caused both by persistent side effects and any automatic rejection of said side effects. It is clear from participants' interviews that an honest, transparent conversation regarding SSRI-related sexual dysfunction would have made a significant difference to their experience.

Talking therapy that is person-centred, compassionate and validating may be beneficial to some people with PSSD. Given the number of SSRI prescriptions filled each year in the UK, mental health professionals will frequently work with individuals experiencing SSRI-related sexual dysfunction. It is important that practitioners educate themselves on the nature of these side effects, the potential for these side effects to persist following SSRI use, and the impact this experience can have on individuals. Importantly, practitioners should be aware of the impact PSSD can have on experiences of emotion and the implications this may have for the individual's treatment goals and the appropriate intervention plan. Additionally, practitioners should be sensitive to possible vulnerabilities that can be caused by experiencing sexual dysfunction, ensuring that individuals have a safe space to discuss any concerns they may have regarding their sex lives or relationships.

Recommendations for Future Research

Whilst the literature on PSSD is expanding, there is still a great need for more research to help us understand the condition. From a psychological perspective, further studies to help unpick individuals' experiences of therapy, including people from diverse backgrounds or characteristics, could be useful in ascertaining what helpful interventions could precisely entail. Clinical trials of psychological interventions for individuals distressed by PSSD could also be highly beneficial for people living with the condition, with a potential focus on therapies designed to increase emotional awareness allowing us to consider whether these interventions may be of any benefit. Moreover, no research, to our knowledge, has investigated the beliefs and attitudes of prescribers and healthcare professionals in the UK regarding PSSD. This research could be impactful in identifying gaps in knowledge, barriers to discussing PSSD with patients, and thoughts or concerns regarding possible treatment options.

Conclusion

This study investigated the lived experience and impact of PSSD for ten participants in the UK using an IPA methodology. The findings from this study highlight the distressing experiences people with PSSD often have when raising their concerns in NHS settings, and the impact this dismissal can have on their wellbeing and trust in healthcare services. Additionally, participants spoke of the impact of PSSD on every aspect of daily life, from one's personal identity and sense of self, to relationships with others including friends, family and professionals. Mental health professionals can be helpful or harmful when interacting with people with PSSD, and this study identified clear recommendations – such as offering validation and being informed on the condition – for practitioners working with people who take SSRIs or other psychotropic medications. Participants' accounts also highlighted strategies they have utilised to manage their own wellbeing, using what they can to cope with the gravity of what they have experienced. Overall, this study offered an opportunity for participants to share their experiences of living with PSSD and, importantly, an opportunity for their stories to be heard.

Disclosure Statement

The authors report there are no competing interests to declare.

Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author [SB]. The data are not publicly available due to containing information that could compromise the privacy of research participants.

Funding Statement

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

Acknowledgements

We would like to express a sincere thank you to the UK PSSD Association for their support with recruitment, and a sincere thank you to the ten participants who made this research possible. Thank you for giving your time and sharing your experiences with us.

References

Alase, A. (2017). The interpretative phenomenological analysis (IPA): A guide to a good qualitative research approach. *International Journal of Education and Literacy Studies, 5*(2), 9-19.

Allen, K. A., Kern, M. L., Rozek, C. S., McInereney, D., & Slavich, G. M. (2021). Belonging: A review of conceptual issues, an integrative framework, and directions for future research. *Australian Journal of Psychology*, *73*(1), 87–102.

Anderson, I. M. (2000). Selective serotonin reuptake inhibitors versus tricyclic antidepressants: a meta-analysis of efficacy and tolerability. *Journal of Affective Disorders*, *58*(1), 19-36.

Bahrick, A. S. (2006). Post SSRI sexual dysfunction. *American Society for the Advancement of Pharmacotherapy Tablet, 7*(3), 2-3.

Bala, A., Nguyen, H. M. T., & Hellstrom, W. J. (2018). Post-SSRI sexual dysfunction: a literature review. *Sexual Medicine Reviews, 6*(1), 29-34.

Benitez, C., Southward, M. W., Altenburger, E. M., Howard, K. P., & Cheavens, J. S. (2019). The within-person effects of validation and invalidation on in-session changes in affect. *Personality Disorders: Theory, Research, and Treatment*, *10*(5), 406-415.

Ben-Sheetrit, J., Hermon, Y., Birkenfeld, S., Gutman, Y., Csoka, A. B., & Toren, P. (2023). Estimating the risk of irreversible post-SSRI sexual dysfunction (PSSD) due to serotonergic antidepressants. *Annals of General Psychiatry, 22*. https://doi.org/10.1186/s12991-023-00447-0

Cascade, E., Kalali, A. H., & Kennedy, S. H. (2009). Real-world data on SSRI antidepressant side effects. *Psychiatry (Edgmont), 6*(2), 16-18.

Dai Cao, T. X., Fraga, L. F. C., Fergusson, E., Michaud, J., Dell'Aniello, S., Yin, H., Rej, S., Azoulay, L., & Renoux, C. (2021). Prescribing trends of antidepressants and psychotropic coprescription for youths in UK primary care, 2000-2018. *Journal of Affective Disorders, 287*, 19-25.

Fava, G. A., Gatti, A., Belaise, C., Guidi, J., & Offidani, E. (2015). Withdrawal symptoms after selective serotonin reuptake inhibitor discontinuation: a systematic review. *Psychotherapy and Psychosomatics, 84*(2), 72-81.

Hall, K. S. (2019). Cultural differences in the treatment of sex problems. *Current Sexual Health Reports*, *11*(1), 29-34.

Healy, D. (2020). Post-SSRI sexual dysfunction & other enduring sexual dysfunctions. *Epidemiology and psychiatric sciences*, *29*, e55. https://doi.org/10.1017/S2045796019000519

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., ... & Waraich, A. (2022). Diagnostic criteria for enduring sexual dysfunction after treatment with antidepressants, finasteride and isotretinoin. *International Journal of Risk & Safety in Medicine*, *33*(1), 65-76.

Healy, D., Le Noury, J., & Mangin, D. (2019). Post-SSRI sexual dysfunction: Patient experiences of engagement with healthcare professionals. *International Journal of Risk & Safety in Medicine, 30*(3), 167-178.

Jawad, M. Y., Fatima, M., Hassan, U., Zaheer, Z., Ayyan, M., Ehsan, M., Khan, M. H. A., Qadeer, A., Gull, A. R., Asif, M. T., & Shad, M. U. (2023). Can antidepressant use be associated with emotional blunting in a subset of patients with depression? A scoping review of available literature. *Human Psychopharmacology: Clinical and Experimental*, *38*(4), e2871. https://doi.org/10.1002/hup.2871

Jing, E., & Straw-Wilson, K. (2016). Sexual dysfunction in selective serotonin reuptake inhibitors (SSRIs) and potential solutions: A narrative literature review. *Mental Health Clinician, 6*(4), 191-196.

Kim, E., & Kim, C. (2013). Comparative effects of empathic verbal responses: Reflection versus validation. *Journal of Counseling Psychology*, *60*(3), 439-444.

Lalji, H. M., McGrogan, A., & Bailey, S. J. (2021). An analysis of antidepressant prescribing trends in England 2015–2019. *Journal of Affective Disorders Reports, 6*, Article 100205. https://doi.org/10.1016/j.jadr.2021.100205

Larkin, M. & Thompson, A. R. (2012). Interpretative phenomenological analysis in mental health and psychotherapy research. in A. Thompson & D. Harper (Eds.), *Qualitative research methods in mental health and psychotherapy: a guide for students and practitioners*. John Wiley & Sons. https://doi.org/10.1002/9781119973249

Linke, J., Majcherek, E., Leszyńska, A., Wawrzyniak, M., Gałczyńska-Rusin, M., Niemczyńska, A., & Ferensztajn-Rochowiak, E. (2025). *Characteristics and risk factors of post SSRI sexual dysfunction (PSSD).* Research Square. https://doi.org/10.21203/rs.3.rs-7750807/v1

Mayville, E. A. (2007). Psychotropic medication effects and side effects. *International Review of Research in Mental Retardation*, *34*, 227-251.

McManus, S., Bebbington, P., Jenkins, R., & Brugha T. (2016, September 29) *Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014.* NHS Digital. https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/adult-psychiatric-morbidity-survey-survey-of-mental-health-and-wellbeing-england-2014

Montejo, A. L., Llorca, G., Izquierdo, J. A., & Rico-Villademoros, F. (2001). Incidence of sexual dysfunction associated with antidepressant agents: a prospective multicenter study of 1022 outpatients. *Journal of Clinical Psychiatry, 62*, 10-21.

Montgomery, S. A., Baldwin, D. S., & Riley, A. (2002). Antidepressant medications: a review of the evidence for drug-induced sexual dysfunction. *Journal of Affective Disorders, 69*(1-3), 119-140.

NHS Business Services Authority (2026, March 5). *Medicines used in mental health – England quarterly summary statistics October to December 2025.* https://www.nhsbsa.nhs.uk/statistical-collections/medicines-used-mental-health-england/medicines-used-mental-health-england-quarterly-summary-statistics-20252026/medicines-used-mental-health-england-quarterly-summary-statistics-october-december-2025

NHS Health Research Authority (2024, May 20). *Putting people first - embedding public involvement in health and social care research.* https://www.hra.nhs.uk/planning-and-improving-research/best-practice/public-involvement/putting-people-first-embedding-public- involvement-health-and-social-care-research/

Nobre, P. J., & Pinto-Gouveia, J. (2008). Differences in automatic thoughts presented during sexual activity between sexually functional and dysfunctional men and women. *Cognitive Therapy and Research*, *32*(1), 37-49.

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

Peleg, L. C., Rabinovitch, D., Lavie, Y., Rabbie, D. M., Horowitz, I., Fruchter, E., & Gruenwald, I. (2022). Post-SSRI sexual dysfunction (PSSD): biological plausibility, symptoms, diagnosis, and presumed risk factors. *Sexual Medicine Reviews, 10*(1), 91-98.

Rice, E. E., Kleinplatz, P. J., Richardson, H. M., DiCaita, H., D'souza, K., Charest, M., & Rosen, L. (2025). Understanding the Experiences of People with Post-SSRI Sexual Dysfunction. *Journal of Sex & Marital Therapy*, *51*(5), 447–461. https://doi.org/10.1080/0092623X.2025.2495959

Rosenberg, K. P., Bleiberg, K. L., Koscis, J., & Gross, C. (2003). A survey of sexual side effects among severely mentally ill patients taking psychotropic medications: impact on compliance. *Journal of Sex & Marital Therapy, 29*(4), 289-296.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research* (1st ed.). Sage.

Smith, J. A., Flowers, P., & Larkin, M. (2022). *Interpretative phenomenological analysis: Theory, method and research* (2nd ed.). Sage.

Stinson, R. (2013). *The impact of persistent sexual side effects of selective serotonin reuptake inhibitors after discontinuing treatment: a qualitative study* [doctoral thesis, University of Iowa].

https://citeseerx.ist.psu.edu/document?repid=rep1&type=pdf&doi=b324fa58f0a309c87b8032be133588c5a79e7ab7

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*(4), 321-329.

Tarchi, L., Merola, G. P., Baccaredda-Boy, O., Arganini, F., Cassioli, E., Rossi, E., Maggi, M., Baldwin, D. S., Ricca, V., & Castellini, G. (2023). Selective serotonin reuptake inhibitors, post-treatment sexual dysfunction and persistent genital arousal disorder: A systematic review. *Pharmacoepidemiology and Drug Safety*, *32*(10), 1053-1067.

Thakurta, R. G., Singh, O. P., Bhattacharya, A., Mallick, A. K., Ray, P., Sen, S., & Das, R. (2012). Nature of sexual dysfunctions in major depressive disorder and its impact on quality of life. *Indian Journal of Psychological Medicine, 34*(4), 365-370.

Chapter Five: Extended Methodology

Extended Methodology

This chapter extends the description and explanation of the methodological approach adopted in chapter two, the empirical study.

Theoretical and Practical Underpinnings

Ontology and Epistemology

Adopting a position on the nature of reality ('ontology') and the nature of what we can know about it ('epistemology') is central to informing the theoretical underpinnings and the appropriate methodology for a research question (Al-Ababneh, 2020). For this study, a critical realist approach is taken, postulating that the world exists independently, but what we can know about it is constructed by and through our own lenses (Pilgrim, 2019). In line with this stance, an interpretive phenomenological methodology, rooted in critical realism and a hermeneutic epistemology, was adopted to give voice and interpretation to individuals' lived experiences and perspectives in a participant-oriented manner (Alase, 2017).

Analytical Process

As described in chapter two, the empirical study adopted an IPA approach to give voice to participants' experiences whilst also making sense of their accounts (Larkin & Thompson, 2012). A diverse range of analytical methods can be utilised for this purpose (Larkin & Thompson, 2012), and for this study, a six-step approach, adapted from Smith et al. (2009, 2022), was undertaken to complete this analysis.

Firstly, recorded interviews were listened to again and transcripts were re-read to allow the researcher to immerse himself in the data. Next, the researcher completed thorough noting throughout the transcript, with comments on the data being descriptive (describing the content of the interview), linguistic (considering the participant's use of language), or conceptual (interpreting underlying concepts and subtext). Then, themes which emerge from the notes, referred to as personal experiential statements, are named, allowing the researcher to begin making sense of the participant's experiences. Connections across statements are then identified; related statements that are relevant to the research question are re-organised and clustered into appropriate personal experiential themes (PETs) and subthemes. This process is then repeated for each individual case and, finally, patterns of convergence and divergence across all ten participants' list of PETs and subthemes were identified; related themes were then organised, appropriately renamed and clustered into group experiential themes (GETs) and subthemes.

An automated transcript was initially produced by Microsoft Teams and accuracy was thoroughly checked when the researcher re-listened to recordings. Exploratory noting and naming/clustering of experiential statements and PETs for each participant was completed using Microsoft Word (e.g. using lists), whilst identification of GETs across participants was then completed by hand (e.g. using printed lists and markers). An annotated transcript excerpt (Appendix L), a master list of PETs and subthemes (Appendix M), and a tabular illustration of GETs and example contributing PETs (Appendix N) are produced in the appendices.

Reflexivity and Quality Assurance

Being aware of one's own biases and preconceptions is particularly important when completing research that involves a significant interpretive element. Bracketing refers to the process by which researchers attempt to mitigate the influence of said preconceptions on the research process (Tufford & Newman, 2010). The lead researcher is a male trainee clinical psychologist who has worked in various NHS settings with people taking SSRIs and other psychotropic medications. As such, there will inherently be preconceived notions about the role of SSRIs in mental healthcare. Using a reflexive journal, which was maintained throughout the project to reflect on thoughts and feelings that arise during data collection and analysis, can help aid learning and ensure the researcher is aware of their own biases (Vicary et al., 2016). Additionally, research supervision was utilised throughout the project to reflect on the process. Thus, whilst it may not be possible to completely remove oneself from the impact of our own biases, reflexive journalling and supervision played a significant role throughout the analysis to ensure a robust and high-quality study that can contribute meaningfully to existing literature.

Yardley (2000) described four essential characteristics of 'good' qualitative research: Sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance. The section below details the methods by which the researchers adhered to these characteristics.

Sensitivity to Context

The team are familiar with existing research regarding PSSD and patient experiences. Patient and public involvement (PPI) was central to this project's methodology, and the researchers were sensitive to ethical issues that are implicated by this study. A reflexive journal and supervision were utilised throughout the project.

Commitment and Rigour

In-depth engagement with topic and data was achieved through studying relevant literature on the methodology, careful consideration and interpretation of themes, and the use of supervision to discuss and appraise findings. Member checking was achieved through providing participants with the opportunity to comment on transcripts. Triangulation was achieved through supervisory review of 20% of the transcripts, ensuring notes, personal experiential statements and PETs were congruent with the data and participants' lived experiences.

Transparency and Coherence

The aim and methodology of the research was well-described in the information sheet provided to participants, who were also provided an opportunity to feedback on transcripts. Feedback on the cohesion of the themes and narrative was obtained through PPI.

Impact and Importance

This study enriches our understanding of PSSD, giving voice to an understudied population and providing important considerations for clinical practice and future research.

Ethical Considerations

Informed Consent

There are several ethical dilemmas which may deserve particular attention when conducting qualitative clinical research that delves into highly personal experiences, the first of which is valid informed consent. Prospective participants have a right to free and voluntary participation and to withdraw or modify consent within agreed and consented time constraints (Oates et al., 2021). It was important that this study's information sheet and consent form were clear regarding the nature and method of the study, the participants' data protection rights, how the participants' data will be used, and the proposed time constraints regarding withdrawal of consent. Importantly, participants were given a direct opportunity to ask any questions regarding the study or the use of their data. Participants were also provided with the interview guide ahead of the interview, benefits of which can include a reduction in interview anxiety (Haukås & Tishakov, 2024). Whilst there can also be potential downsides (e.g. an increase in predetermined answers), on balance it allows individuals to have an awareness of the nature of the discussion that will arise during the interview, and make informed decisions regarding their participation.

Confidentiality

When conducting this research, it is important that every effort is made to ensure participant identity is protected and their participation is anonymous. An issue can arise, however, when participants are identifiable through "deductive disclosure", where unique demographic details or information provided could potentially lead to the participant being identifiable by some individuals in their lives (Kaiser, 2009). For example, in an interview study where quotations may be used in publications, information shared by participants regarding their lives and/or experiences could lead to deductive disclosure. Using verbatim quotations is standard in qualitative research (Corden & Sainsbury, 2006), helping to give space and a voice to participants' spoken word. Positively, exploratory research has indicated that participants generally welcome the use of verbatim quotations, but stress that anonymity remains important (Corden & Sainsbury, 2006).

For the current study, it was essential that participants were made aware of the use of verbatim quotations through the information sheet and were made aware that every effort will be taken to maintain anonymity (e.g. omitting highly specific references such as names of doctors or towns). Importantly, participants were provided the opportunity to review the transcript of their interview before analysis, allowing them to view their spoken word and reflect on the inclusion of this data in the analysis/publication if desired.

On the topic of confidentiality, a further ethical consideration is how the researchers handle disclosures which indicate that the participant, or someone else, may be at risk of serious harm. The British Psychological Society's (BPS) Code of Human Research Ethics is clear that the right to confidentiality is not absolute in law, and that there may be exceptional circumstances where a researcher may need to consider sharing information that can keep the participant or someone else safe (Oates et al., 2021). Participants were thus made aware before any information is divulged that there are ethical and legal limits to confidentiality, and that the researcher may need to discuss any such disclosure with their supervisors to ensure the appropriate process is followed. This may, for example, include asking to contact the participant's GP, or informing the local authorities if there is a disclosure of potential serious risk to the public. There were no immediate risk or safeguarding concerns raised throughout the interview process and information sharing for the purpose of risk management was not required.

The Role of a Researcher

As a clinician, a (trainee) clinical psychologist's experience of conducting psychological assessments can blur the differences between a clinical interview and a

research interview (Thompson & Russo, 2012), leading to possible ethical dilemmas for psychologists conducting qualitative research. Recognising the purpose and limitations of a research interview, for example, is essential in ensuring that the clinician does not attempt to 'therapise' or clinically formulate participants' responses, which could violate the participants' expectations from the interview and cloud the subsequent qualitative analysis. Similarly, it was important that participants were fully aware of the clinician's role in this project as a researcher and not as a therapist. This was also facilitated by ensuring that appropriate signposting is included in the debrief sheet should participants wish to explore avenues for support.

Another important consideration for conducting research ethically as a trainee clinical psychologist is recognising the asymmetry of power. Research interviews are not equal two-way dialogues; the interviewer determines and poses the questions, the time and ending of the conversation, and the ultimate analysis of the data (Brinkmann & Kvale, 2005). It is thus important to empower and give voice to the participants as much as possible by, for example, ensuring that their rights with regard to participation and withdrawal are clear, and ensuring that there is ample opportunity for participants to ask questions, review the interview guide ahead of the interview, and review the interview transcript ahead of analysis. Furthermore, by incorporating PPI at every stage of the project (e.g. providing feedback on the research aims, interview questions, and the narrative analysis), the researchers aimed to dismantle the inherent power imbalance in research by amplifying the voice and role of lived experience in research.

Chapter Six: Discussion and Critical Evaluation

Discussion and Critical Evaluation

The aim of this chapter is to summarise, appraise and critically evaluate the systematic review and empirical paper presented in this thesis portfolio, situating the research findings within the context of the wider literature and considering the theoretical and clinical implications of the work undertaken.

General Overview

This thesis portfolio aimed to evaluate the prevalence and impact of SSRI-related sexual side effects as measured by standardised patient-reported outcome measures, and to understand the lived experience of individuals whose side effects persist after treatment has ended. Chapter two entails a systematic literature review which synthesises the evidence base regarding the use of PROMs to assess SSRI-related SD. We identified ten PROMs of sexual functioning used across 27 studies, varying significantly in their intended use, comprehensiveness and length. PROMs can be a valuable tool in estimating the effects of SSRIs on sexual functioning, providing data on the changes that can occur as a result of the medication. Whilst most PROMs contained items related to the impact of SD on overall sexual satisfaction or relationship quality, the results of these items were rarely reported separately. However, based on the few studies that did report this information, SSRI-related SD can have an impact on people's satisfaction with their sex lives and relationships.

Perhaps surprisingly, whilst cross-sectional studies across multiple countries have indicated that SSRI-related SD occurs at similar rates in men and women (Montejo et al., 2019; Safak et al., 2025; Williams et al., 2010), our systematic review highlights potential gender differences in the emergence or worsening of SD when validated PROMs are administered before and after SSRI use. In some cases, this discrepancy might be explained by a higher level of baseline SD in depressed women (Gonçalves et al., 2022; Lee et al., 2013), meaning that assessments of SD in women who have been taking SSRIs for some time could be at risk of misattributing baseline mental health-related SD to medication side effects. Additionally, however, some existing PROMs may not be suitably designed to detect further medication-related changes in sexual functioning for women with pre-existing SD.

Whilst side effects associated with SSRIs are often temporary, there is a growing body of literature describing the potential for sexual side effects to persist even after SSRI use has stopped (Bahrick, 2006). Chapter four thus entails a qualitative study into the lived experience of post-SSRI sexual dysfunction. ten participants (six men) were interviewed, and transcripts were analysed using an interpretive phenomenological analysis. Three group

experiential themes (GETs) encompassing ten subthemes were identified: 1) Distrustful of professionals; 2) A changed me; And 3) Living with the impact.

The first GET, *Distrustful of professionals,* entails the lived experience of navigating healthcare services and discussing PSSD with clinicians, which often left participants feeling dismissed and invalidated. Positive, affirming interactions were rarely described, but they can be meaningful and therapeutic for participants when they occur. The second GET, *A changed me*, delves into the impact of PSSD on participants' internal sense and ability to relate to others; many felt isolated as a result of the condition, with participants also describing feeling emotionally numb and disconnected, both from themselves and loved ones. Understandably, these experiences led to some participants pondering the question of who they are now, and how can they continue to fit into their old lives. The final GET, *Living with the impact*, captures the enormous sense of loss that comes with PSSD, and the change it thrusts upon people's life stories. Seeking support for the impact of PSSD led some participants to therapy, the experiences of which were mixed. Amid all these experiences, however, this theme also captures what some participants find helps them to cope with all that has changed, highlighting the potential benefits of finding tools and strategies that work for the individual.

Importantly, the empirical paper builds on previous qualitative PSSD research (Rice et al., 2025; Stinson, 2013) in several ways. We describe the first empirical study, to our knowledge, on PSSD conducted with participants in the UK, allowing us to also begin to understand people's experiences of UK healthcare settings and practitioners when presenting with PSSD. Participants' responses to interview questions on mental health/healthcare also provide important awareness of how psychological therapy or counselling is experienced and/or perceived in the local context. Moreover, our findings also highlight the potential vulnerabilities that can come with PSSD in intimate relationships. Given societal norms around gender identity and relationship roles, some participants' stories shed light on how PSSD might impact men and women in different ways, particularly in the context of relationship dynamics.

Together, whilst it has long been understood that SSRIs can cause sexual side effects (Khawam et al., 2006), the systematic review and empirical study contribute to the literature by providing a deeper understanding of how patient-reported SSRI-related SD is a common experience with the potential to affect patients' lives both during and, in some cases, long after treatment. PSSD, whilst much less common, is particularly significant, and participants' lived experiences highlight the magnitude of its impact. Moreover, the findings

of the thesis portfolio draw attention to gendered aspects of the relationship between SSRIs and sexual functioning, highlighting the importance of considering individuals' sex when evaluating outcomes for SSRI use.

Strengths and Limitations

There are notable strengths to the work conducted for this thesis portfolio. To our knowledge, we describe the first systematic review synthesising the evidence base on the use of PROMs in assessing SSRI-related SD. The eligibility criteria used in this review (namely the administration of standardised, validated SD PROMs before and during SSRI use) instils confidence in the conclusions of the work and the appraisal of findings, whilst also being mindful of confines both within the literature and our own methodology. High inter-rater reliability between the lead author and second reviewer also demonstrates the robustness of the screening, selection, quality appraisal and data extraction procedures. With regard to the empirical study, our cohort of ten participants provided a rich database, allowing for a thorough analysis of the lived experience of PSSD. Moreover, PPI feedback was a crucial component throughout the project and played an especially important role at key stages, including shaping and refining the study aims. This ensured that our study was conducted in line with what is important to people who are most affected by this condition, creating impactful and meaningful research.

There are also several limitations to consider when reading this portfolio. Whilst the systematic review describes a comprehensive search of PROMs utilised in SSRI trials, it does not consider the psychometric properties of said PROMs. As such, the current review does not address the question of which PROM may be most suitable when assessing SSRI-related SD. Similarly, due to significant clinical and methodological heterogeneity in the obtained studies, a meta-analysis was not conducted. Whilst it is often the default synthesis method in quantitative reviews, there are many cases where a meta-analysis may not be an appropriate tool or provide interpretable findings (Lensen, 2023). As a result, it is not possible to provide a pooled prevalence for SSRI-related SD based on the current review's selection criteria and findings, likely limiting the generalisability of our conclusions. Similarly, with regard to the empirical study, the generalisability of findings is likely limited by the in-depth analysis undertaken within a relatively homogeneous sample, which is typical for IPA research (Smith et al., 2022). It is therefore important to interpret the transferability of participants' accounts with caution, as others from different populations, backgrounds and life stories may have offered unique perspectives on the impact of PSSD on their lives.

Theoretical and Practical Implications

There are several implications for the work described in this portfolio. The systematic review's findings demonstrate the feasibility of SD PROMs in assessing sexual functioning before, during and after SSRI use, allowing for a patient-centred evaluation of side effects. However, limitations exist regarding their applicability. Whilst traditionally used to conceptualise how much a measure reflects the construct it intends to capture, validity theory has evolved to consider the emphasis as being on the interpretation of a score rather than the validity of the measure per se (Wolming & Wikström, 2010). The evidence base synthesised in the review highlights the value of this development, as the ability of validated SD PROMs to detect SSRI-related changes in sexual functioning for women and people with baseline SD is not clear. Scores should thus be interpreted with caution and PROMs, whilst useful, should form part of a wider assessment of sexual functioning. Moreover, whilst the impact of SD on sexual satisfaction and distress was rarely reported, it is evident that SSRIs can impact patients' sex lives. The effect this may have on overall patient wellbeing and treatment adherence should also be considered carefully in any course of treatment.

Similarly, the impact of PSSD on wellbeing and quality of life is clearly identified in the empirical study, which has several implications for clinical practice. It was Tajfel and Turner (1979) who first described social identity theory, which postulates that individuals define themselves based on group membership and belongingness. Participants with PSSD experienced invalidation and rejection, both from healthcare professionals and from peers who could not relate to or understand their experiences. Given this, it is unsurprising that participants experienced distress in relation to their identity (e.g. *who am I now?*) and sought validation where possible, for example in therapy or within the PSSD community. The research findings highlight the importance of informed conversations and risk awareness regarding PSSD; healthcare professionals who work with SSRI consumers should be educated regarding the risk, symptoms and impact of the condition. Person-centred talking therapy may be helpful for some individuals, and, importantly, potential increased vulnerability (e.g. to problematic relationship dynamics) as a result of persistent SD should also be considered when working with anyone living with the condition.

Implications for Research

Based on the outcomes of the research described in this portfolio, further work is needed to address unanswered questions in the wider literature surrounding SSRI-related SD and PSSD. Developing or validating existing PROMs for the assessment of further SSRI-related deterioration in sexual functioning for patients with baseline SD is instrumental to ensuring that robust patient-focused measures can be used in research and clinical work.

Moreover, it is unclear how beneficial PROMs may be in the assessment of PSSD or associated treatment, and further research should investigate whether existing measures can be used to provide insight into appropriate norms and cutoff scores/ranges for sexual functioning following SSRI-use.

Further research should be undertaken to explore the lived experience of PSSD for individuals from diverse backgrounds, cultures, sexualities and gender identities. Additionally, exploring the beliefs and attitudes of healthcare professionals regarding PSSD could also provide valuable insight into awareness around the condition, any concerns regarding assessment or treatment of PSSD, and any training/professional development needs. Finally, whilst talking therapy may be helpful in some cases, it is unclear what models of therapy may be effective in treating PSSD-related concerns or distress. Further research, including randomised controlled trials, would be beneficial in contributing to the evidence base an understanding of which psychological interventions can be successfully utilised to support people with PSSD.

Personal Reflections

The research undertaken for this portfolio has been interesting, rewarding and, at times, challenging. Around 1 in 8 people in the UK are prescribed antidepressants (NHS Business Services Authority, 2026), meaning that a significant proportion of patients accessing mental health services will likely be taking SSRIs. Whilst there is no doubt that PSSD is not a universal outcome of SSRI use, the body of literature demonstrating its prevalence and harms continues to grow. As a trainee clinical psychologist working on an almost daily basis with individuals who could be at risk of PSSD, the experiences of participants interviewed for this portfolio are often at the forefront of my mind. Completing this work has highlighted the dichotomy that comes with being both a (trainee) clinician, often working with individuals who consider their medication lifesaving, and a researcher, hearing the stories of people whose lives were changed by the medication for very different reasons. The use of supervision and reflexive journalling has been instrumental in ensuring that I have space to reflect on these issues thoughtfully, allowing me to complete my roles with the rigour and compassion that both patients and participants deserve.

The impact of invalidating experiences with professionals was evident in participants' interviews. It was necessarily transparent to participants that the researcher undertaking this project is a trainee clinical psychologist working in NHS settings. Whilst every effort was made to ensure the interview could be a safe space for participants to share their stories, some participants may have understandably found it difficult to be fully open during our

interviews. Given the sensitivity of the topics discussed in the interview, I was also mindful of my identity as a male healthcare professional, and how this may impact recruitment of female participants. On reflection, ensuring that participants were aware of the questions in advance and that they could decline to answer and/or withdraw at any point was likely important in ensuring they felt safe and able to be interviewed.

The processes we instilled in our recruitment procedure, such as being clear about the aims and motivation for our work, sharing the interview guide ahead of time, and giving participants an opportunity to review transcripts, likely had an impact on fostering trust in our research project and the associated research team, allowing us to meet our recruitment target with a good balance of both male and female participants. On reflection, one of the most important aspects of this research design was ensuring that the participant's perspective remains at the centre. PPI involvement has been instrumental to this, allowing us to create a project that is aligned with the community's best interests. The core aim of research in clinical psychology is to better understand the people we work with, allowing us to better understand how we can support them (Ehring et al., 2022). Incorporating their voices into all aspects of the work we do can therefore help us meet this goal, ensuring collaborative and safe research that facilitates meaningful outcomes.

Conclusion

Sexual dysfunction is a prevalent side effect of SSRIs, and validated PROMs are a feasible way of measuring sexual functioning before and during SSRI use. PROMs outcomes should, however, be interpreted with caution, particularly in people with baseline sexual problems. In some cases, SSRI-related sexual dysfunction can persist even after SSRIs have been discontinued, significantly affecting people's lives. People with PSSD described invalidating experiences with healthcare professionals and services, emotional numbness, changed identity and significant loss. Personalised coping strategies, validating therapy, and community can be important to maintaining wellbeing. Clinicians treating individuals who use SSRIs should be aware of the potential side effects, their potential to persist even after cessation, and the associated impact on people's quality of life.

Thesis Portfolio References

Abbasinazari, M., Heidari-Kord, M., Mazaheri-Meybodi, A., Eshraghi, A., & Bayati, N. (2018). Plasma oxytocin level and sexual dysfunction in depressed women treated by either fluoxetine or citalopram: A pilot clinical trial. *Iranian Journal of Pharmaceutical Research: IJPR, 17*(1), 408-414.

Abler, B., Seeringer, A., Hartmann, A., Grön, G., Metzger, C., Walter, M., & Stingl, J. (2011). Neural correlates of antidepressant-related sexual dysfunction: a placebo-controlled fMRI study on healthy males under subchronic paroxetine and bupropion. *Neuropsychopharmacology*, *36*(9), 1837-1847.

Al-Ababneh, M. (2020). Linking ontology, epistemology and research methodology. *Science & Philosophy, 8*(1), 75-91.

Alase, A. (2017). The interpretative phenomenological analysis (IPA): A guide to a good qualitative research approach. *International Journal of Education and Literacy Studies, 5*(2), 9-19.

AlBreiki, M., AlMaqbali, M., AlRisi, K., AlSinawi, H., Al Balushi, M., & Al Zakwani, W. (2020). Prevalence of antidepressant-induced sexual dysfunction among psychiatric outpatients attending a tertiary care hospital. *Neurosciences Journal*, *25*(1), 55-60.

Allen, K. A., Kern, M. L., Rozek, C. S., McInereney, D., & Slavich, G. M. (2021). Belonging: A review of conceptual issues, an integrative framework, and directions for future research. *Australian Journal of Psychology*, *73*(1), 87–102.

Anderson, I. M. (2000). Selective serotonin reuptake inhibitors versus tricyclic antidepressants: a meta-analysis of efficacy and tolerability. *Journal of Affective Disorders*, *58*(1), 19-36.

Anthropic. (2026). *Claude Sonnet 4.6* [Large language model]. https://claude.ai/new

Bahrick, A. S. (2006). Post SSRI sexual dysfunction. *American Society for the Advancement of Pharmacotherapy Tablet, 7*(3), 2-3.

Bala, A., Nguyen, H. M. T., & Hellstrom, W. J. (2018). Post-SSRI sexual dysfunction: a literature review. *Sexual Medicine Reviews, 6*(1), 29-34.

Baldwin, D. S., Cooper, J. A., Huusom, A. K., & Hindmarch, I. (2006). A double-blind, randomized, parallel-group, flexible-dose study to evaluate the tolerability, efficacy and effects of treatment discontinuation with escitalopram and paroxetine in patients with major depressive disorder. *International Clinical Psychopharmacology*, *21*(3), 159-169.

Barker, T. H., Habibi, N., Aromataris, E., Stone, J. C., Leonardi-Bee, J., Sears, K., Hasanoff, S., Klugar, M., Tufanaru, C., Moola, S., & Munn, Z. (2024). The revised JBI critical appraisal tool for the assessment of risk of bias for quasi-experimental studies. *JBI Evidence Synthesis*, *22*(3), 378-388.

Barker, T. H., Stone, J. C., Sears, K., Klugar, M., Tufanaru, C., Leonardi-Bee, J., Aromataris, E., & Munn, Z. (2023). The revised JBI critical appraisal tool for the assessment of risk of bias for randomized controlled trials. *JBI Evidence Synthesis*, *21*(3), 494-506.

Bathla, M., & Anjum, S. (2020). A 12-week prospective randomized controlled comparative trial of vilazodone and sertraline in Indian patients with depression. *Indian Journal of Pharmacology*, *52*(1), 10-15.

Bathla, M., Anjum, S., Singh, M., Panchal, S., & Singh, G. P. (2018). A 12-week comparative prospective open-label randomized controlled study in depression patients treated with vilazodone and escitalopram in a tertiary care hospital in North India. *Indian Journal of Psychological Medicine*, *40*(1), 80-85.

Benitez, C., Southward, M. W., Altenburger, E. M., Howard, K. P., & Cheavens, J. S. (2019). The within-person effects of validation and invalidation on in-session changes in affect. *Personality Disorders: Theory, Research, and Treatment*, *10*(5), 406-415.

Ben-Sheetrit, J., Hermon, Y., Birkenfeld, S., Gutman, Y., Csoka, A. B., & Toren, P. (2023). Estimating the risk of irreversible post-SSRI sexual dysfunction (PSSD) due to serotonergic antidepressants. *Annals of General Psychiatry, 22*. https://doi.org/10.1186/s12991-023-00447-0

Brinkmann, S., & Kvale, S. (2005). Confronting the ethics of qualitative research. *Journal of Constructivist Psychology, 18*(2), 157-181.

British National Formulary. (n.d.). *Antidepressant drugs.* National Institute for Health and Care Excellence. Retrieved March 01, 2026. https://bnf.nice.org.uk/treatment-summaries/antidepressant-drugs/

Brugi, S., Bell, E., Budd, B., & Fish, S. (2025). The use of patient-reported outcome measures (PROMs) in assessing the prevalence and impact of SSRI-related sexual dysfunction: A systematic review. https://www.crd.york.ac.uk/PROSPERO/view/CRD420251043649

Bunney, W. E., & Davis, J. M. (1965). Norepinephrine in depressive reactions: A review. *Archives of General Psychiatry, 13*(6), 483-494.

Campbell, R., Ju, A., King, M. T., & Rutherford, C. (2022). Perceived benefits and limitations of using patient-reported outcome measures in clinical practice with individual patients: a systematic review of qualitative studies. *Quality of Life Research*, *31*(6), 1597-1620.

Cartwright, C., Gibson, K., Read, J., Cowan, O., & Dehar, T. (2016). Long-term antidepressant use: patient perspectives of benefits and adverse effects. *Patient Preference and Adherence*, *10*, 1401–1407. https://doi.org/10.2147/PPA.S110632

Cascade, E., Kalali, A. H., & Kennedy, S. H. (2009). Real-world data on SSRI antidepressant side effects. *Psychiatry (Edgmont), 6*(2), 16-18.

Clayton, A. H., Durgam, S., Li, D., Chen, C., Chen, L., Mathews, M., Gommoll, C. P., & Szegedi, A. (2017). Effects of vilazodone on sexual functioning in healthy adults: results from a randomized, double-blind, placebo-controlled, and active-controlled study. *International Clinical Psychopharmacology*, *32*(1), 27-35.

Clayton, A. H., Gommoll, C., Chen, D., Nunez, R., & Mathews, M. (2015). Sexual dysfunction during treatment of major depressive disorder with vilazodone, citalopram, or placebo: results from a phase IV clinical trial. *International Clinical Psychopharmacology*, *30*(4), 216-223.

Clayton, A. H., McGarvey, E. L., & Clavet, G. J. (1997). The Changes in Sexual Functioning Questionnaire (CSFQ): development, reliability, and validity. *Psychopharmacology Bulletin*, *33*(4), 731–745.

Clayton, A., Kornstein, S., Prakash, A., Mallinckrodt, C., & Wohlreich, M. (2007). Changes in sexual functioning associated with duloxetine, escitalopram, and placebo in the treatment of patients with major depressive disorder. *The Journal of Sexual Medicine*, *4*(4), 917-929.

Corden, A., & Sainsbury, R. (2006). Exploring 'quality': Research participants' perspectives on verbatim quotations. *International Journal of Social Research Methodology, 9*(2), 97-110.

Dai Cao, T. X., Fraga, L. F. C., Fergusson, E., Michaud, J., Dell'Aniello, S., Yin, H., Rej, S., Azoulay, L., & Renoux, C. (2021). Prescribing trends of antidepressants and psychotropic coprescription for youths in UK primary care, 2000-2018. *Journal of Affective Disorders, 287*, 19-25.

Derogatis, L. R., Rosen, R., Leiblum, S., Burnett, A., & Heiman, J. (2002). The Female Sexual Distress Scale (FSDS): Initial validation of a standardized scale for assessment of sexually related personal distress in women. *Journal of Sex & Marital Therapy*, *28*(4), 317-330.

Detke, M. J., Wiltse, C. G., Mallinckrodt, C. H., McNamara, R. K., Demitrack, M. A., & Bitter, I. (2004). Duloxetine in the acute and long-term treatment of major depressive disorder: a placebo-and paroxetine-controlled trial. *European Neuropsychopharmacology*, *14*(6), 457-470.

Dunn, J. A., Arakawa, R., Greist, J. H., & Clayton, A. H. (2007). Assessing the onset of antidepressant-induced sexual dysfunction using interactive voice response technology. *Journal of Clinical Psychiatry*, *68*(4), 525-532.

Espinola, C. W., Khoo, Y., Parmar, R., Demchenko, I., Frey, B. N., Milev, R. V., Ravindran, A. V., Parikh, S. V., Ho, K., Rotzinger, S., Lou, W., Lam, R. W., Kennedy, S. H., & Bhat, V. (2022). Males and females differ in reported sexual functioning with escitalopram treatment for major depressive disorder: A CAN-BIND-1 study report. *Journal of Psychopharmacology*, *36*(5), 604-613.

European Medicines Agency. (2019, June 11). *New product information wording - extracts from PRAC recommendations on signals.* https://www.ema.europa.eu/en/documents/prac-recommendation/new-product-information-wording-extracts-prac-recommendations-signals-adopted-13-16-may-2019-prac_en.pdf

Fabre, L. F., Clayton, A. H., Smith, L. C., Goldstein, I., & Derogatis, L. R. (2012). The effect of Gepirone-ER in the treatment of sexual dysfunction in depressed men. *The Journal of Sexual Medicine, 9*(3), 821-829.

Fava, G. A., Gatti, A., Belaise, C., Guidi, J., & Offidani, E. (2015). Withdrawal symptoms after selective serotonin reuptake inhibitor discontinuation: a systematic review. *Psychotherapy and Psychosomatics, 84*(2), 72-81.

Fava, M., Rankin, M. A., Alpert, J. E., Nierenberg, A. A., & Worthington, J. J. (1998). An open trial of oral sildenafilin antidepressant-induced sexual dysfunction. *Psychotherapy and Psychosomatics*, *67*(6), 328-331.

Fortney, J. C., Pyne, J. M., Edlund, M. J., Stecker, T., Mittal, D., Robinson, D. E., & Henderson, K. L. (2011). Reasons for antidepressant nonadherence among veterans treated in primary care clinics. *Journal of Clinical Psychiatry*, *72*(6), 827-834.

Garcia-Portilla, M. P., Saiz, P. A., Fonseca, E., Al-Halabi, S., Bobes-Bascaran, M. T., Arrojo, M., Benabarre, A., Goikolea, J. M., Sanchez, E., Sarramea, F., & Bobes, J. (2011). Psychometric properties of the Spanish version of the Changes in Sexual Functioning Questionnaire Short-Form (CSFQ-14) in patients with severe mental disorders. *The Journal of Sexual Medicine*, *8*(5), 1371-1382.

Gonçalves, W. S., Gherman, B. R., Abdo, C. H. N., Coutinho, E. S. F., Nardi, A. E., & Appolinario, J. C. (2022). Prevalence of sexual dysfunction in depressive and persistent depressive disorders: a systematic review and meta-analysis. *International Journal of Impotence Research*, *35*(4), 340-349.

Hall, K. S. (2019). Cultural differences in the treatment of sex problems. *Current Sexual Health Reports*, *11*(1), 29-34.

Haukås, Å. & Tishakov, T. (2024). Sharing interview questions in advance: Methodological considerations in applied linguistics research. *European Journal of Applied Linguistics, 12*(1), 54-68. https://doi-org.uea.idm.oclc.org/10.1515/eujal-2023-0045

Heald, A. H., Stedman, M., Davies, M., Livingston, M., Taylor, D., & Gadsby, R. (2020). Antidepressant prescribing in England: patterns and costs. *The Primary Care*

Companion for CNS Disorders, 22(2), Article 19m02552. https://doi.org/10.4088/PCC.19m02552

Healy, D. (2020). Post-SSRI sexual dysfunction & other enduring sexual dysfunctions. *Epidemiology and psychiatric sciences*, *29*, e55. https://doi.org/10.1017/S2045796019000519

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., ... & Waraich, A. (2022). Diagnostic criteria for enduring sexual dysfunction after treatment with antidepressants, finasteride and isotretinoin. *International Journal of Risk & Safety in Medicine*, *33*(1), 65-76.

Healy, D., Le Noury, J., & Mangin, D. (2019). Post-SSRI sexual dysfunction: Patient experiences of engagement with healthcare professionals. *International Journal of Risk & Safety in Medicine, 30*(3), 167-178.

Hillhouse, T. M., & Porter, J. H. (2015). A brief history of the development of antidepressant drugs: from monoamines to glutamate. *Experimental and Clinical Psychopharmacology, 23*(1), 1-21.

Hu, X. H., Bull, S. A., Hunkeler, E. M., Ming, E., Lee, J. Y., Fireman, B., & Markson, L. E. (2004). Incidence and duration of side effects and those rated as bothersome with selective serotonin reuptake inhibitor treatment for depression: patient report versus physician estimate. *Journal of Clinical Psychiatry, 65*(7), 959-965.

Ishaque, S., Karnon, J., Chen, G., Nair, R., & Salter, A. B. (2019). A systematic review of randomised controlled trials evaluating the use of patient-reported outcome measures (PROMs). *Quality of Life Research*, *28*(3), 567-592.

Jacobsen, P. L., Thorley, E. M., & Curran, C. (2020). Real-world patient experience with sexual dysfunction and antidepressant use in patients with self-reported depression:

A cross-sectional survey study. *Neurology, Psychiatry and Brain Research*, *36*, 57-64.

Jacobsen, P., Zhong, W., Nomikos, G., & Clayton, A. (2019). Paroxetine, but not vortioxetine, impairs sexual functioning compared with placebo in healthy adults: a randomized, controlled trial. *The Journal of Sexual Medicine*, *16*(10), 1638-1649.

Jawad, M. Y., Fatima, M., Hassan, U., Zaheer, Z., Ayyan, M., Ehsan, M., Khan, M. H. A., Qadeer, A., Gull, A. R., Asif, M. T., & Shad, M. U. (2023). Can antidepressant use be associated with emotional blunting in a subset of patients with depression? A scoping review of available literature. *Human Psychopharmacology: Clinical and Experimental*, *38*(4), e2871. https://doi.org/10.1002/hup.2871

Jing, E., & Straw-Wilson, K. (2016). Sexual dysfunction in selective serotonin reuptake inhibitors (SSRIs) and potential solutions: A narrative literature review. *Mental Health Clinician, 6*(4), 191-196.

Kaiser, K. (2009). Protecting respondent confidentiality in qualitative research. *Qualitative Health Research, 19*(11), 1632-1641.

Keller, A., McGarvey, E. L., & Clayton, A. H. (2006). Reliability and construct validity of the Changes in Sexual Functioning Questionnaire short-form (CSFQ-14). *Journal of Sex & Marital Therapy*, *32*(1), 43-52.

Kennedy, S. H., Dickens, S. E., Eisfeld, B. S., & Bagby, R. M. (1999). Sexual dysfunction before antidepressant therapy in major depression. *Journal of Affective Disorders*, *56*(2-3), 201-208.

Kennedy, S. H., Eisfeld, B. S., Dickens, S. E., Bacchiochi, J. R., & Bagby, R. M. (2000). Antidepressant-induced sexual dysfunction during treatment with moclobemide, paroxetine, sertraline, and venlafaxine. *Journal of Clinical Psychiatry*, *61*(4), 276-281.

Kennedy, S. H., Fulton, K. A., Bagby, R. M., Greene, A. L., Cohen, N. L., & Rafi-Tari, S. (2006). Sexual function during bupropion or paroxetine treatment of major depressive disorder. *The Canadian Journal of Psychiatry*, *51*(4), 234-242.

Khawam, E. A., Laurencic, G., & Malone, D. A. (2006). Side effects of antidepressants: an overview. *Cleveland Clinical Journal of Medicine*, *73*(4), 351-361.

Khazaie, H., Rezaie, L., Payam, N. R., & Najafi, F. (2015). Antidepressant-induced sexual dysfunction during treatment with fluoxetine, sertraline and trazodone; a randomized controlled trial. *General Hospital Psychiatry*, *37*(1), 40-45.

Kim, E., & Kim, C. (2013). Comparative effects of empathic verbal responses: Reflection versus validation. *Journal of Counseling Psychology*, *60*(3), 439-444.

Labbate, L. A., & Lare, S. B. (2001). Sexual dysfunction in male psychiatric outpatients: validity of the Massachusetts General Hospital Sexual Functioning Questionnaire. *Psychotherapy and Psychosomatics*, *70*(4), 221-225.

Lalji, H. M., McGrogan, A., & Bailey, S. J. (2021). An analysis of antidepressant prescribing trends in England 2015–2019. *Journal of Affective Disorders Reports, 6*, Article 100205. https://doi.org/10.1016/j.jadr.2021.100205

Larkin, M. & Thompson, A. R. (2012). Interpretative phenomenological analysis in mental health and psychotherapy research. in A. Thompson & D. Harper (Eds.), *Qualitative research methods in mental health and psychotherapy: a guide for students and practitioners*. John Wiley & Sons. https://doi.org/10.1002/9781119973249

Lee, T. I., Issac, J., Lin, S. H., Yeh, T. L., Lee, I. H., Chen, P. S., Chen, K. C., & Yang, Y. K. (2013). Gender difference in antidepressant-related sexual dysfunction in Taiwan. *General Hospital Psychiatry*, *35*(4), 407-411.

Lensen, S. (2023). When to pool data in a meta-analysis (and when not to)? *Fertility and Sterility*, *119*(6), 902-903.

Linke, J., Majcherek, E., Leszyńska, A., Wawrzyniak, M., Gałczyńska-Rusin, M., Niemczyńska, A., & Ferensztajn-Rochowiak, E. (2025). *Characteristics and risk factors of post SSRI sexual dysfunction (PSSD).* Research Square. https://doi.org/10.21203/rs.3.rs-7750807/v1

Madeo, B., Bettica, P., Milleri, S., Balestrieri, A., Granata, A. R., Carani, C., & Rochira, V. (2008). The effects of citalopram and fluoxetine on sexual behavior in healthy men: Evidence of delayed ejaculation and unaffected sexual desire. A randomized, placebo-controlled, double-blind, double-dummy, parallel group study. *The Journal of Sexual Medicine*, *5*(10), 2431-2441.

Mars, B., Heron, J., Kessler, D., Davies, N. M., Martin, R. M., Thomas, K. H., & Gunnell, D. (2017). Influences on antidepressant prescribing trends in the UK: 1995–2011. *Social Psychiatry and Psychiatric Epidemiology, 52*, 193-200.

Mayo, N. E. (2015). *Dictionary of quality of life and health outcomes measurement*. International Society for Quality of Life Research (ISOQOL).

Mayville, E. A. (2007). Psychotropic medication effects and side effects. *International Review of Research in Mental Retardation*, *34*, 227-251.

McGahuey, C. A., Gelenberg, A. J., Laukes, C. A., Moreno, F. A., Delgado, P. L., McKnight, K. M., & Manber, R. (2000). The Arizona sexual experience scale (ASEX): reliability and validity. *Journal of Sex & Marital Therapy*, *26*(1), 25-40.

McManus, S., Bebbington, P., Jenkins, R., & Brugha T. (2016, September 29) *Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014.* NHS Digital. https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-

morbidity-survey/adult-psychiatric-morbidity-survey-survey-of-mental-health-and-wellbeing-england-2014

Montejo, A. L., Calama, J., Rico-Villademoros, F., Montejo, L., González-García, N., & Pérez, J. (2019). A real-world study on antidepressant-associated sexual dysfunction in 2144 outpatients: the SALSEX I study. *Archives of Sexual Behavior*, *48*(3), 923-933.

Montejo, A. L., Deakin, J. F. W., Gaillard, R., Harmer, C., Meyniel, F., Jabourian, A., Gabriel, C., Gruget, C., Klinge, C., MacFayden, C., Milligan, H., Mullings, E., & Goodwin, G. (2015). Better sexual acceptability of agomelatine (25 and 50 mg) compared to escitalopram (20 mg) in healthy volunteers. A 9-week, placebo-controlled study using the PRSexDQ scale. *Journal of Psychopharmacology*, *29*(10), 1119-1128.

Montejo, A. L., Garcia, M., Espada, M., Rico-Villademoros, F., Llorca, G., & Izquierdo, J. A. (2000). Psychometric characteristics of the psychotropic-related sexual dysfunction questionnaire. Spanish work group for the study of psychotropic-related sexual dysfunctions. *Actas Espanolas de Psiquiatria*, *28*(3), 141-150.

Montejo, A. L., Llorca, G., Izquierdo, J. A., & Rico-Villademoros, F. (2001). Incidence of sexual dysfunction associated with antidepressant agents: a prospective multicenter study of 1022 outpatients. *Journal of Clinical Psychiatry, 62*, 10-21.

Montejo, A. L., Prieto, N., Terleira, A., Matias, J., Alonso, S., Paniagua, G., Naval, S., Parra, D.G., Gabriel, C., Mocaër, E., & Portolés, A. (2010). Better sexual acceptability of agomelatine (25 and 50 mg) compared with paroxetine (20 mg) in healthy male volunteers. An 8-week, placebo-controlled study using the PRSEXDQ-SALSEX scale. *Journal of Psychopharmacology*, *24*(1), 111-120.

Montejo-González, A. L., Llorca, G., Izquierdo, J. A., Ledesma, A., Bouso o, M., Calcedo, A., De la Gandara, J., Derecho, J., Franco, M., Gomez, M. J., Macias, J. A., Martin, T., Perez, V., Sanchez, J. M., Sanchez, S., & Vicens, E. (1997). SSRI-induced sexual dysfunction: fluoxetine, paroxetine, sertraline, and fluvoxamine in a prospective,

multicenter, and descriptive clinical study of 344 patients. *Journal of Sex & Marital Therapy, 23*(3), 176-194.

Montgomery, S. A., Baldwin, D. S., & Riley, A. (2002). Antidepressant medications: a review of the evidence for drug-induced sexual dysfunction. *Journal of Affective Disorders, 69*(1-3), 119-140.

Nazareth, I., Boynton, P., & King, M. (2003). Problems with sexual function in people attending London general practitioners: cross sectional study. *BMJ*, *327*, Article 423 doi:10.1136/bmj.327.7412.423

NHS Business Services Authority (2026, January 15). *Medicines used in mental health – England – 2015/16 to 2024/25*. https://www.nhsbsa.nhs.uk/statistical-collections/medicines-used-mental-health-england/medicines-used-mental-health-england-201516-202425#:~:text=92.6%20million%20antidepressant%20items%20were,24%20to%20190%2C000%20identified%20patients

NHS Business Services Authority (2026, March 5). *Medicines used in mental health – England quarterly summary statistics October to December 2025.* https://www.nhsbsa.nhs.uk/statistical-collections/medicines-used-mental-health-england/medicines-used-mental-health-england-quarterly-summary-statistics-20252026/medicines-used-mental-health-england-quarterly-summary-statistics-october-december-2025

NHS Health Research Authority (2024, May 20). *Putting people first - embedding public involvement in health and social care research.* https://www.hra.nhs.uk/planning-and-improving-research/best-practice/public-involvement/putting-people-first-embedding-public- involvement-health-and-social-care-research/

Nobre, P. J., & Pinto-Gouveia, J. (2008). Differences in automatic thoughts presented during sexual activity between sexually functional and dysfunctional men and women. *Cognitive Therapy and Research*, *32*(1), 37-49.

Nutt, D. J., Forshall, S., Bell, C., Rich, A., Sandford, J., Nash, J., & Argyropoulos, S. (1999). Mechanisms of action of selective serotonin reuptake inhibitors in the treatment of psychiatric disorders. *European Neuropsychopharmacology, 9*, 81-86.

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

Oates, J., Carpenter, D., Fisher, M., Goodson, S., Hannah, B., Kwiatkowski, R., Prutton, K., Reeves, D., & Wainwright, T. (2021, April). *BPS code of human research ethics*. https://explore.bps.org.uk/content/report-guideline/bpsrep.2021.inf180

Ogilvie, D., Fayter, D., Petticrew, M., Sowden, A., Thomas, S., Whitehead, M., & Worthy, G. (2008). The harvest plot: a method for synthesising evidence about the differential effects of interventions. *BMC Medical Research Methodology*, *8*. https://doi.org/10.1186/1471-2288-8-8

O'Leary, M. P., Fowler, F. J., Lenderking, W. R., Barber, B., Sagnier, P. P., Guess, H. A., & Barry, M. J. (1995). A brief male sexual function inventory for urology. *Urology*, *46*(5), 697-706.

Ouzzani, M., Hammady, H., Fedorowicz, Z., & Elmagarmid, A. (2016). Rayyan—a web and mobile app for systematic reviews. *Systematic Reviews*, *5*. https://doi.org/10.1186/s13643-016-0384-4

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., Shamseer, L., Tetzlaff, J. M., Akl, E. A., Brennan, S. E., Chou, R., Glanville, J., Grimshaw, J. M., Hróbjartsson, A., Lalu, M. M., Li, T., Loder, E. W., Mayo-Wilson, E., McDonald, S., … Moher, D. (2021). The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *BMJ,* 372:n71. https://doi.org/10.1136/bmj.n71.

Peano, A., Calabrese, F., Pechlivanidis, K., Mimmo, R., Politano, G., Martella, M., & Gianino, M. M. (2025). International trends in antidepressant consumption: a 10-year comparative analysis (2010–2020). *Psychiatric Quarterly*, *96,* 241-255.

Peleg, L. C., Rabinovitch, D., Lavie, Y., Rabbie, D. M., Horowitz, I., Fruchter, E., & Gruenwald, I. (2022). Post-SSRI sexual dysfunction (PSSD): biological plausibility, symptoms, diagnosis, and presumed risk factors. *Sexual Medicine Reviews, 10*(1), 91-98.

Piazza, L. A., Markowitz, J. C., Kocsis, J. H., Leon, A. C., Portera, L., Miller, N. L., & Adler, D. (1997). Sexual functioning in chronically depressed patients treated with SSRI antidepressants: a pilot study. *American Journal of Psychiatry*, *154*(12), 1757-1759.

Pilgrim, D. (2019). *Critical realism for psychologists*. Routledge.

Popay, J., Roberts, H., Sowden, A., Petticrew, M., Arai, L., Rodgers, M., Britten, N., Roen, K., Duffy, S. (2006). *Guidance on the conduct of narrative synthesis in systematic reviews: A product from the ESRC Methods Programme*. Lancaster University. http://dx.doi.org/10.13140/2.1.1018.4643

Portman, D. J., Kaunitz, A. M., Kazempour, K., Mekonnen, H., Bhaskar, S., & Lippman, J. (2014). Effects of low-dose paroxetine 7.5 mg on weight and sexual function during treatment of vasomotor symptoms associated with menopause. *Menopause*, *21*(10), 1082-1090.

Preeti, S., Jayaram, S. D., & Chittaranjan, A. (2018). Sexual dysfunction in patients with antidepressant-treated anxiety or depressive disorders: A pragmatic multivariable longitudinal study. *East Asian Archives of Psychiatry*, *28*(1), 9-16.

R Core Team. (2025). *R: A language and environment for statistical computing*. R Foundation for Statistical Computing. https://www.R-project.org/

Reed, S. D., Guthrie, K. A., Joffe, H., Shifren, J. L., Seguin, R. A., & Freeman, E. W. (2012). Sexual function in nondepressed women using escitalopram for vasomotor symptoms: a randomized controlled trial. *Obstetrics & Gynecology*, *119*(3), 527-538.

Rice, E. E., Kleinplatz, P. J., Richardson, H. M., DiCaita, H., D'souza, K., Charest, M., & Rosen, L. (2025). Understanding the Experiences of People with Post-SSRI Sexual Dysfunction. *Journal of Sex & Marital Therapy*, *51*(5), 447–461. https://doi.org/10.1080/0092623X.2025.2495959

Richardson, W. S., Wilson, M. C., Nishikawa, J., & Hayward, R. S. (1995). The well-built clinical question: a key to evidence-based decisions. *ACP Journal Club*, *123*(3), A12-3.

Roe, D., Slade, M., & Jones, N. (2022). The utility of patient-reported outcome measures in mental health. *World Psychiatry*, *21*(1), 56-57.

Rosen, C. Brown, J. Heiman, S. Leiblum, C. Meston, R. Shabsigh, D. Ferguson, R., & D'Agostino, R. (2000). The Female Sexual Function Index (FSFI): a multidimensional self-report instrument for the assessment of female sexual function. *Journal of Sex & Marital Therapy*, *26*(2), 191-208.

Rosen, R. C., Riley, A., Wagner, G., Osterloh, I. H., Kirkpatrick, J., & Mishra, A. (1997). The international index of erectile function (IIEF): a multidimensional scale for assessment of erectile dysfunction. *Urology*, *49*(6), 822-830.

Rosenberg, K. P., Bleiberg, K. L., Koscis, J., & Gross, C. (2003). A survey of sexual side effects among severely mentally ill patients taking psychotropic medications: impact on compliance. *Journal of Sex & Marital Therapy, 29*(4), 289-296.

Russo, A., Capogrosso, P., Ventimiglia, E., La Croce, G., Boeri, L., Montorsi, F., & Salonia, A. (2016). Efficacy and safety of dapoxetine in treatment of premature ejaculation: an evidence-based review. *International Journal of Clinical Practice*, *70*(9), 723-733.

Rust, J., & Golombok, S. (1985). The Golombok-Rust Inventory of Sexual Satisfaction (GRISS). *The British Journal of Clinical Psychology*, *24*(1), 63-64.

Safak, Y., Inal Azizoglu, S., Alptekin, F. B., Kuru, T., Karadere, M. E., Kurt Kaya, S. N., Yilmaz, S., Yildrim, N. N., Kiliçtutan, A., Ay, H., & Burhan, H. S. (2025). Antidepressant-associated sexual dysfunction in outpatients. *BMC Psychiatry*, 25, Article 317. https://doi.org/10.1186/s12888-025-06751-1

Segraves, R. T., Kavoussi, R., Hughes, A. R., Batey, S. R., Johnston, J. A., Donahue, R., & Ascher, J. A. (2000). Evaluation of sexual functioning in depressed outpatients: a double-blind comparison of sustained-release bupropion and sertraline treatment. *Journal of Clinical Psychopharmacology*, *20*(2), 122-128.

Shah, P., Naphade, N., Jagtap, A., Shetty, J., & Datar, M. (2024). A prospective study on incidence of sexual dysfunctions in patients newly prescribed SSRIs. *Frontiers in Health Informatics*, *13*(3), 11152-11163.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research* (1st ed.). Sage.

Smith, J. A., Flowers, P., & Larkin, M. (2022). *Interpretative phenomenological analysis: Theory, method and research* (2nd ed.). Sage.

Stinson, R. (2013). *The impact of persistent sexual side effects of selective serotonin reuptake inhibitors after discontinuing treatment: a qualitative study* [doctoral thesis, University of Iowa]. https://citeseerx.ist.psu.edu/document?repid=rep1&type=pdf&doi=b324fa58f0a309c87b8032be133588c5a79e7ab7

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*(4), 321-329.

Tajfel, H., & Turner, J. C. (1979). An integrative theory of intergroup conflict. In W. G. Austin, & S. Worchel (Eds.), *The social psychology of intergroup relations* (pp. 33-37). Brooks/Cole.

Tanrikut, C., Feldman, A. S., Altemus, M., Paduch, D. A., & Schlegel, P. N. (2010). Adverse effect of paroxetine on sperm. *Fertility and Sterility*, *94*(3), 1021-1026.

Tarchi, L., Merola, G. P., Baccaredda-Boy, O., Arganini, F., Cassioli, E., Rossi, E., Maggi, M., Baldwin, D. S., Ricca, V., & Castellini, G. (2023). Selective serotonin reuptake inhibitors, post-treatment sexual dysfunction and persistent genital arousal disorder: A systematic review. *Pharmacoepidemiology and Drug Safety*, *32*(10), 1053-1067.

Taylor, M. J., Rudkin, L., & Hawton, K. (2005). Strategies for managing antidepressant-induced sexual dysfunction: systematic review of randomised controlled trials. *Journal of Affective Disorders*, *88*(3), 241-254.

Thakurta, R. G., Singh, O. P., Bhattacharya, A., Mallick, A. K., Ray, P., Sen, S., & Das, R. (2012). Nature of sexual dysfunctions in major depressive disorder and its impact on quality of life. *Indian Journal of Psychological Medicine, 34*(4), 365-370.

Thompson, A. R., & Russo, K. (2012). Ethical dilemmas for clinical psychologists in conducting qualitative research. *Qualitative Research in Psychology, 9*(1), 32-46.

Tufford, L., & Newman, P. (2010). Bracketing in qualitative research. *Qualitative Social Work, 11*(1), 80-96.

Vicary, S., Young, A., & Hicks, S. (2016). A reflective journal as learning process and contribution to quality and validity in interpretative phenomenological analysis. *Qualitative Social Work, 16*(4), 550-565.

Weber, S., Frokjaer, V. G., Armand, S., Nielsen, J. H., Knudsen, G. M., Joergensen, M. B., Stenbaek, D. S., & Giraldi, A. (2023). Sexual function improves as depressive symptoms decrease during treatment with escitalopram: results of a naturalistic study

of patients with major depressive disorder. *The Journal of Sexual Medicine*, *20*(2), 161-169.

Westenberg, H. G., Stein, D. J., Yang, H., Li, D., & Barbato, L. M. (2004). A double-blind placebo-controlled study of controlled release fluvoxamine for the treatment of generalized social anxiety disorder. *Journal of Clinical Psychopharmacology*, *24*(1), 49-55.

Williams, V. S. L., Edin, H. M., Hogue, S. L., Fehnel, S. E., & Baldwin, D. S. (2010). Prevalence and impact of antidepressant-associated sexual dysfunction in three European countries: replication in a cross-sectional patient survey. *Journal of Psychopharmacology*, 24(4), 489-496.

Wolming, S., & Wikström, C. (2010) The concept of validity in theory and practice. *Assessment in Education: Principles, Policy & Practice, 17*(2), 117-132.

World Health Organization. (2019). *International statistical classification of diseases and related health problems* (11th ed.). https://icd.who.int/

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and health*, *15*(2), 215-228.

Appendices

Table S4.
JBI checklist items for randomised controlled trials.

	Abbasinazari et al 2018	Abler et al 2011	Baldwin et al 2006	Bathla & Anjum 2020	Bathla et al 2018	Clayton et al 2007	Clayton et al 2015	Clayton et al 2017	Detke et al 2004	Dunn et al 2007	Fabre et al 2012
1. Was true randomization used for assignment of participants to treatment groups?	U	U	Y	Y	U	Y	Y	Y	U	U	U
2. Was allocation to treatment groups concealed?	N	Y	Y	Y	N	Y	Y	Y	Y	Y	Y
3. Were treatment groups similar at the baseline?	Y	U	Y	Y	Y	N	Y	Y	Y	U	U
4. Were participants blind to treatment assignment?	N	Y	Y	N	N	Y	Y	Y	Y	Y	Y
5. Were those delivering the treatment blind to treatment assignment?	N	Y	Y	N	N	Y	Y	Y	Y	Y	Y
6. Were treatment groups treated identically other than the intervention of interest?	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y
7. Were outcome assessors blind to treatment assignment?	N	Y	Y	N	N	Y	Y	Y	Y	Y	Y
8. Were outcomes measured in the same way for treatment groups?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
9. Were outcomes measured in a reliable way?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
10. Was follow up complete and if not, were differences between groups in terms of their	Y	Y	Y	Y	Y	N	Y	N	N	U	Y

follow up adequately described and analysed?											
11. Were participants analysed in the groups to which they were randomized?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
12. Was appropriate statistical analysis used?	U	U	U	U	U	N	N	U	U	U	N
13. Was the trial design appropriate and any deviations from the standard RCT design (individual randomization, parallel groups) accounted for in the conduct and analysis of the trial?	U	U	Y	U	U	Y	Y	Y	Y	Y	Y

Note. 'Y' = Yes, 'N' = No, 'U' = Unclear.

Table S4 continued.

	Jacobsen et al 2019	Kennedy et al 2006	Khazaie et al 2015	Madeo et al 2008	Montejo et al 2010	Montejo et al 2015	Piazza et al 1997	Portman et al 2014	Reed et al 2012	Westenberg et al 2004
1. Was true randomization used for assignment of participants to treatment groups?	U	U	Y	U	Y	U	U	Y	Y	U
2. Was allocation to treatment groups concealed?	U	U	Y	Y	Y	Y	U	Y	Y	Y
3. Were treatment groups similar at the baseline?	Y	Y	Y	Y	Y	U	U	Y	Y	Y
4. Were participants blind to treatment assignment?	Y	Y	Y	Y	Y	Y	U	Y	Y	Y
5. Were those delivering the treatment blind to treatment assignment?	Y	Y	N	Y	Y	U	U	Y	Y	U
6. Were treatment groups treated identically other than the intervention of interest?	Y	Y	Y	Y	Y	Y	U	Y	Y	U
7. Were outcome assessors blind to treatment assignment?	Y	Y	Y	Y	Y	Y	U	Y	Y	U
8. Were outcomes measured in the same way for treatment groups?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
9. Were outcomes measured in a reliable way?	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
10. Was follow up complete and if not, were differences between groups in terms of their follow up adequately described and analysed?	Y	N	Y	Y	Y	Y	Y	N	Y	Y

11. Were participants analysed in the groups to which they were randomized?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
12. Was appropriate statistical analysis used?	Y	U	Y	U	U	U	U	U	Y	U
13. Was the trial design appropriate and any deviations from the standard RCT design (individual randomization, parallel groups) accounted for in the conduct and analysis of the trial?	Y	Y	U	Y	Y	N	U	Y	Y	Y

Appendix B

Table S5.
JBI checklist items for quasi-experimental studies.

	Espinola et al 2022	Kennedy et al 2000	Preeti et al 2018	Shah et al 2024	Tanrikut et al 2010	Weber et al 2023
1. Is it clear in the study what is the "cause" and what is the "effect" (i.e. there is no confusion about which variable comes first)?	Y	Y	Y	Y	Y	Y
2. Was there a control group?	N	Y	Y	N	N	Y
3. Were participants included in any comparisons similar?	N/A	N	U	N/A	N/A	N
4. Were the participants included in any comparisons receiving similar treatment/care, other than the exposure or intervention of interest?	N/A	N	N	NA	N/A	U
5. Were there multiple measurements of the outcome, both pre and post the intervention/exposure?	Y	Y	Y	Y	Y	Y
6. Were the outcomes of participants included in any comparisons measured in the same way?	N/A	Y	Y	N/A	Y	N
7. Were outcomes measured in a reliable way?	Y	Y	Y	Y	Y	Y
8. Was follow-up complete and if not, were differences between groups in terms of their follow-up adequately described and analyzed?	N	N	N	N	Y	Y
9. Was appropriate statistical analysis used?	U	U	U	U	U	U

Note. 'Y' = Yes, 'N' = No, 'U' = Unclear, 'N/A' = Not applicable.

Appendix C

Table S7.
Sexual dysfunction outcomes per study, grouped by utilised PROM.

Authors	Year	SD PROMs utilised	Timepoints administered (weeks unless otherwise specified)	SD outcomes	Tolerance of SD outcomes (including satisfaction items)
Baldwin et al	2006	ASEX	0, 2, 4, 8, 16, 27	Mean baseline score above cutoff. Graphs show slight acute (up to week 4) increase in ASEX score for all groups before reducing for everyone except males on Paroxetine. eventual decline below baseline for all other groups. Significance not reported	Satisfaction outcome not reported
Bathla & Anjum	2020		0, 4, 12	Sertraline associated with significant increase in score both relative to baseline ($p < 0.001$) and to Vilazodone ($p < 0.001$) overall. Outcomes not reported by gender	Satisfaction outcome not reported
Bathla et al	2018		0, 4, 12	Escitalopram associated with significantly higher score after treatment relative to Vilazodone ($p < 0.001$). Outcomes not reported by gender	Satisfaction outcome not reported
Detke et al	2004		0, 8 and once during 6-month continuation phase	62.8% had TESD at week 8, 19.4% of those with baseline SD resolved. Unclear if TESD rate significant relative to placebo, not significant relative to Duloxetine ($p = .265$). 21.6% of those who entered continuation phase experienced TESD (reported to be not significant relative to placebo). Outcomes not reported by gender	Satisfaction outcome not reported

Piazza et al	1997		0, 6	Females had poorer baseline sexual functioning. ASEX score improved significantly in females (p = .05) but worsened significantly in males (p = .02)	Satisfaction outcome not reported
Portman et al	2014		0, 4, 12, 24	Baseline SD in 58.7% of participants. No change in SD relative to placebo (p = .474 at week 12, p = .855 at week 24)	No change in orgasm satisfaction score relative to placebo (p = .906 at week 12, p = .302 at week 24)
Westernberg et al	2004		0, 2, 4, 6, 8, 10, 12	No significant change in score relative to placebo (p = .247). Outcomes not reported by gender	Satisfaction outcome not reported
Tanrikut et al	2010	BSFI	0, 4 and 1 month after end	Up to 35% experienced significantly worse erectile function (p < .003), 47% experienced significantly worse ejaculatory function (p ≤ .002). Most returned to normal or near normal functioning 1 month post treatment	Satisfaction outcome not reported
Clayton et al	2007	CSFQ	Baseline and monthly (8-week study + 6-month continuation phase)	Rate of TESD 48.7% at week 8 (significantly higher than placebo, p = 0.01), 43.6% at 8 months (not significantly different to placebo). Effect is overall and by gender (Escitalopram vs placebo significant for change in scores in females, Escitalopram vs placebo significant for rates of TESD in males)	-
Clayton et al	2015		0, 4, 8, 10	Some improvement in scores for patients with baseline SD, mostly no change in score for patients with no baseline SD - no inferential statistics reported. Higher baseline SD score in females, significance not reported	-

Clayton et al	2017	(Days) 0, 8, 15, 22, 35	Significant decrease in score (indicating greater SD) at day 35 overall and for males specifically (both $p < .05$) for those with detectable plasma levels of drug relative to placebo. 23.1% of males with detectable levels of Paroxetine had SD at EOT (not significantly different to other groups). 0% of women in detectable plasma group had SD at EOT	-
Fabre et al	2012	0, 2, 4, 8 and end of treatment	Fluoxetine not associated with a significant change in score relative to placebo in neither responders ($p = 0.7$) nor non-responders ($p = 0.236$) at EOT	-
Jacobsen et al	2019	0 and weekly up to week 5	Decrease in score for Paroxetine significantly greater than placebo ($p = .007$), and Vortioxetine 10mg ($p = .009$) at week 5. Significantly more patients with 'clinically meaningful' decrease in Paroxetine (44.6%) vs Vortioxetine 10mg (23.5%) ($p = .004$). Results significant overall and for males, unclear if significant for females	-
Shah et al	2024	0, 2, 4, 12	41% had SD in at least 1 domain at week 12 (no control group, significance in scores vs baseline not reported though patients with SD at baseline excluded). Similar rates in males and females	-
Weber et al	2023	0, 4, 8, 12	Can only use baseline-week 4 data as unclear who may have then started Duloxetine. No significant change in scores (overall, unclear by	-

				gender). Baseline score significantly lower (indicating more SD) in females than males (both patients and controls group, p < .0001)	
Dunn et al	2007		(Days) 0, 8, 15 and 21 (paper and IVR), additionally on day 2, 4 and 6 (IVR)	Paroxetine associated with significant decrease in total score (indicating greater SD) (p < .0001) and in all domains (all p < .001) relative to placebo	-
Abbasinazari et al	2018	FSFI	0, 1 month	FSFI scores reduced for both groups though significance not reported	Satisfaction outcomes not reported
Reed et al	2012	FSFI and one item from FSDS	0, 4, 8	Baseline median scores indicate potentially high SD levels in participants. No difference between Escitalopram and placebo in total at end (p =.18 overall, p = .47 for those sexually active at baseline)	No increase in sexually related distress for Escitalopram relative to placebo (p = .73)
Madeo et al	2008	IIEF and GRISS	Baseline and approximately weekly until end of treatment (36 days)	Citalopram associated with significant decrease in all IIEF domains (indicating greater SD) at some point relative to placebo (p < .05), Fluoxetine not significant relative to placebo (p > .05)	Intercourse satisfaction and overall satisfaction domains of IIEF-15 decreased significantly for Citalopram relative to placebo on some visits (p ≤ .01). GRISS data not reported, researchers note 'sporadic' significant changes
Abler et al	2011	MGH-SFQ	0, 1	Paroxetine group average score significantly worse (p < 0.05) compared to placebo at EOT	No significant change in satisfaction outcome (p > .05)
Preeti et al	2018	PRSexDQ	0, 2, 6	Fluoxetine (p < .001) and Sertraline (p = .03) associated with 'impaired' SD, though unclear how much of this is due to unresolved	Only reported overall for study: 15.1% of males and 6.3% of females reported tolerance as "poor" at week

				baseline SD which was in 29% of overall cohort. Significantly higher PRSexDQ scores (indicating greater SD) at week 6 relative to baseline for both medications. Individual medication results not reported by gender	6 mark (p = 0.05 for M vs F), for cohort of people 'with SD' this increases to 40.7% and 14.6% of males and females respectively
Montejo et al	2010	PRSexDQ and IIEF	0, 2, 4, 8, and 7 days post last study drug intake	Paroxetine associated with significantly higher rates of SD relative to placebo and Agomelatine at every timepoint (all $p < 0.01$), 85.7% had SD at the post 8-week assessment. IIEF score significantly lower (indicating greater SD) relative to placebo and Agomelatine (various doses) at last assessment (all $p < 0.01$)	Satisfaction outcome not reported
Montejo et al	2015	PRSexDQ and VAS-SFS (one item)	0, 2, 5, 8 and 5-7 days post last study drug intake	Escitalopram associated with significant increase in total score (indicating greater SD) relative to Agomelatine and placebo overall and for both males and females (all $p < .05$), largely mediated by delay or absence of orgasm. According to item 5, 50% experienced SD at week 8 (may include those who had some SD at baseline)	All rated tolerance of changes as 'well' or 'fair'. VAS-SFS scores declined, significance not reported
Espinola et al	2022	SexFX	0, 8	Total score significantly worse at week 8 for non-responders ($p = .029$) and non-remitters ($p = .009$) among males relative to baseline, no change for females (who had significantly worse scores at baseline). Better sexual functioning at baseline associated with better sexual functioning at week 8	Global satisfaction score significantly better at week 8 for SSRI responders and remitters compared to baseline amongst both males ($p < .001$) and females ($p < .05$), no change for non-responders and non-remitters

Kennedy et al	2006		0, 2, 4, 6, 8	Total score and all domains significantly decreased (indicating greater SD) for males (all $p < 0.05$), but not females, relative to baseline and Bupropion. Females had significantly lower baseline scores	Males significantly worse on satisfaction relative to baseline ($p < 0.01$)
Kennedy et al	2000	SFQ	0, 8 or 14	No significant difference by medication group (both males and females) for overall SD (all $p < .05$)	-
Khazaie et al	2015		0, 14	Sertraline associated with significant increase in prevalence of SD across every SFQ item (all $p < 0.05$), and Fluoxetine associated with sig increase on majority of items ($p < 0.05$ on 8/12 items), all relative to baseline. Most aspects significantly more impaired for SSRIs than Trazodone. Significantly greater SD for both males and females	-

Note. 'ASEX' = Arizona Sexual Experience Scale, 'BSFI' = Brief Sexual Function Inventory, 'CSFQ' = Changes in Sexual Functioning Questionnaire, ' 'EOT' = End of treatment, 'FSDS' = Female Sexual Distress Scale, 'FSFI' = Female Sexual Function Index, 'GRISS' = Golombok Rust Inventory of Sexual Satisfaction, 'IIEF' = International Index of Erectile Dysfunction, 'IVR' = Interactive voice response, 'MGH-SFQ' = Massachusetts General Hospital-Sexual Functioning Questionnaire, 'PRSexDQ' = Psychotropic-Related Sexual Dysfunction Questionnaire, 'SD' = Sexual dysfunction, 'SexFX' = Sex Effects Scale, 'SFQ' = Sexual Function Questionnaire, 'TESD' = Treatment-emergent sexual dysfunction, 'VAS-SFS' = Visual Analogue Scale for Sexual Functioning Satisfaction.

Appendix D

Submission instructions for The Journal of Sexual Medicine:

General Comments

Although every manuscript is evaluated individually, key criteria that are used to evaluate the worthiness of publication include the following:

- Is it novel? Topics that have been published extensively are much less likely to get published. If the article is on a topic that has been heavily discussed previously, it needs to provide new information or otherwise represent a more definitive study than prior works.
- Are the methods appropriate? The study methods need to be designed in a way to specifically address the study hypothesis. For example, if the intent is to prove whether a certain therapy achieves an effect, this would require an interventional study design such as a randomized controlled trial.
- Is the study interesting? The study needs to be applicable for the journal's readership. Topics that are very niche, vague, or have little broad applicability will be considered lower than those that have more broad appeal.
- Does it change practice or alter the current paradigm? Studies may report findings that are statistically significant that may not be clinically relevant or in any way alter our current understanding of a disease state or process. Studies that highlight findings that are more likely to impact current medical practice or significantly advance the scientific field are more likely to be considered.

How We Publish

The *Journal of Sexual Medicine* (*JSM*) is a peer-reviewed journal that publishes 12 issues per year online. After copyediting and review of the final proof, the Version of Record of the paper will publish on the Advance articles page. The Version of Record will be removed from Advance articles when it is published into an issue.

Please read these instructions carefully and follow them closely. The Editors may return manuscripts that do not follow these instructions.

Scope of the Journal

The *Journal of Sexual Medicine* (*JSM*) publishes multidisciplinary basic science and clinical research to define and understand the scientific basis of male, female, and couple's sexual function and dysfunction. As an official journal of the International Society for Sexual Medicine and the International Society for the Study of Women's Sexual Health, it provides healthcare professionals in sexual medicine with essential educational content and promotes the exchange of scientific information generated from experimental and clinical research.

JSM includes basic science and clinical research studies in the psychologic and biologic aspects of male, female, and couple's sexual function and dysfunction, and highlights new observations and research, results with innovative treatments and all other topics relevant to clinical sexual medicine. At the present time, with few exceptions, JSM does not routinely publish articles in the infertility, sexually transmitted infection, or obstetric space unless there is a specific sexual medicine component to the research.

The objective of *JSM* is to serve as an interdisciplinary forum to integrate the exchange among disciplines concerned with the whole field of human sexuality. The journal accomplishes this objective by publishing original articles, as well as other scientific and educational documents that support the mission of the International Society for Sexual Medicine (ISSM).

Specifically, the ISSM aims: To establish a scientific Society to benefit the public by encouraging the highest standards of practice, education, and research in the field of human sexuality; To develop and assist in developing scientific methods for the diagnosis, prevention and treatment of conditions affecting human sexual function; To promote the publication and encourage contributions to the medical and scientific literature in the field of sexual function.

Editorial Policies

Peer Review Process

The Journal operates with double-anonymized peer review, meaning that the identity of the authors is hidden from reviewers, and the reviewers' identities are hidden from the authors. The editors know the identity of both the reviewers and the authors.

Appeals and Complaints

Authors may appeal an editorial decision. To do so, please contact the editorial office (jsmeditorialstaff@gmail.com), providing as much specific detail as possible about why the original decision should be reconsidered. Every appeal will receive a response within a reasonable timeframe. Please do not resubmit your manuscript in the interim.
To register a complaint regarding non-editorial decisions, the Journal's policies and procedures, editors, or staff, please contact us (jnls.author.support@oup.com). Complaints will be taken seriously and will be carried forward following COPE guidelines and processes and/or sanctions will be enacted if deemed appropriate.

Self-Archiving Policy

Self-archiving refers to posting a copy of your work on a publicly accessible website or repository. Under certain circumstances, you may self-archive versions of your work on your own webpages, on institutional webpages, and in other repositories. For information about the Journal's policy, and to learn which version(s) of your paper are acceptable for self-archiving, please see our Author self-archiving policy.

Availability of Data and Materials

Where ethically feasible, the Journal strongly encourages authors to make all data and software code on which the conclusions of the paper rely available to readers. Whenever possible, data should be presented in the main manuscript or additional supporting files or deposited in a public repository. Visit OUP's Research data page for information on general repositories for all data types, and resources for selecting repositories by subject area. When data and software underlying the research article are available in an online source, authors should include a full citation in their reference list. For details of the minimum information to be included in data and software citations see the OUP guidance on citing research data and software.

Publication and Research Ethics

Authorship

Authorship is confined to those who have made a significant contribution to the design and execution of the work described. The Journal will contact all listed authors at the point of submission to confirm their role. Any contributors whose participation does not meet the criteria for authorship should be acknowledged but not listed as an author. For a detailed definition of authorship, please see the International Committee of Medical Journal Editors (ICMJE) definitions of authors and contributors.
The Journal does not allow ghost authorship, where an unnamed author prepares the article with no credit, or guest/gift authorship, where an author who made little or no contribution is listed as an author. The Journal follows Committee on Publication Ethics (COPE) guidance on investigating and resolving these cases. For more information, please see the OUP Publication Ethics page.
After manuscript submission, no authorship changes (including the authorship list, author order, and who is designated as the corresponding author) should be made without the approval of the editor. All co-authors must agree on the change(s), and neither the Journal nor the publisher mediates such disputes. If individuals cannot agree on the authorship of a submitted manuscript, contact the editorial office (jsmeditorialstaff@gmail.com). The dispute must be resolved among the individuals and their institution(s) before the manuscript can be accepted for publication. If an authorship dispute or change arises after a paper is accepted, contact OUP's Author Support team (jnls.author.support@oup.com). COPE provides guidance for authors on resolving authorship disputes.
JSM limits the number of authors to 8 except in certain circumstances. When submitting papers with longer author lists, the senior should notify the Chief Editor and request permission for such.

ORCID

Authors are encouraged to provide their ORCID iDs (Open Researcher and Contributor IDs) at submission and take advantage of the benefits of participating in ORCID. If you do not already have an ORCID iD, you can register for free via the ORCID website.
As ORCID identifiers are collected, they are included in papers and displayed online, both in the HTML and PDF versions of the publication, in compliance with recommended practice issued by ORCID. ORCID functionality online allows users to link to the ORCID website to view an author's profile and list of publications. ORCID iDs are displayed on web pages and are sent downstream to third parties in data feeds, where supported.
If you have registered with ORCID, you can associate your ORCID iD with your submission system account by going to your account details, entering your ORCID iD, and validating your details. Learn more about ORCID and how to link it to your account.

CRediT

Contributor roles taxonomy (CRediT) allows authors to describe the contributor roles in a standardized, transparent, and accurate way. Authors should choose from the contributor roles outlined on the CRediT website and supply this information on the title page upon submission. You may choose multiple contributor roles per author. Individuals who do not meet the authorship criteria and made less substantive contributions should be listed in your manuscript as non-author contributors with their contributions clearly described and listed only in the Acknowledgments section on the title page. Following manuscript submission, any changes to author/contributor roles require the approval of the editor; the editorial office would supply instructions for the documentation required.
The submitting/corresponding author is asked to declare the contributions of each author to the article following the CRediT taxonomy. This Statement of Authorship is to be added to the separately uploaded Title Page.

Disclosure of Potential Conflicts of Interest

Authors

The Journal requires all authors to disclose any potential conflict of interest at the point of submission. Conflicts of interest should be clearly labeled and included on the title page and in the appropriate box of the ScholarOne submission system. Additionally, conflicts should be listed in a de-identified way in the manuscript itself. These statements will be published if the article is accepted. It is the responsibility of the corresponding author to ensure that conflicts of interest of all authors are declared to the Journal.
A conflict of interest exists when the position, activities, or relationships of an individual, whether direct or indirect, financial, or non-financial, could influence or be seen to influence the opinions or activities of the individual. For more information, refer to OUP's definition of conflict of interest. The Journal follows the COPE guidance for any undisclosed conflict of interest that emerges during peer review, production, or after publication.
If an undisclosed competing interest comes to light after publication, the journal will take action in accordance with COPE guidelines in consultation with journal, publisher, and society policies; after investigation, this could include the publication of a correction notice or complete retraction of the article. Repeated occurrences of undisclosed conflicts of interest may lead to more significant consequences.
Although authors are not expected or required to submit conflicts of interest that do not relate to the current study being published, if in doubt, disclose.

Peer Reviewers

Individuals that have a conflict of interest relating to a submitted manuscript should recuse themselves and will not be assigned to oversee, handle, or peer review the manuscript.
If during peer review an editor, reviewer, or author becomes aware of a conflict of interest that was not previously known or disclosed they must inform the Editor-in-Chief immediately.

Editors and Editorial Board Members

At initial submission, the corresponding author must declare if the Editor-in-Chief, an Editor, or an Editorial Board Member of the Journal is an author of or contributor to the manuscript. Another Editor without a conflict of interest will oversee the peer review and decision-making process.

Previously Published Material

You should only submit your manuscript(s) to the Journal if:

- It is original work by you and your co-author(s).
- It is not under consideration, in peer review, or accepted for publication in any other publication.
- It has not been published in any other publication.
- It contains nothing abusive, defamatory, derogatory, obscene, fraudulent, or illegal.

The submitting author must disclose in their cover letter and provide copies of all related or similar preprints, dissertations, manuscripts, published papers, and reports by the same authors (i.e., those containing substantially similar content or using the same, similar, or a subset of data) that have been previously published or posted electronically or are under consideration elsewhere at the time of manuscript submission. You must also provide a concise explanation of how the submitted manuscript differs from these related manuscripts and papers. All related previously published papers should be cited as references and described in the submitted manuscript.
For previously published materials including tables and figures, please see the Reusing copyrighted materials section.

Preprints

As an author, you retain the right to make an Author's Original Version (preprint) available through various channels and this does not prevent submission to the Journal. If accepted, the authors are

required to update the status of any preprint, including adding your published paper's DOI. If accepted, the authors are required to update the status of any preprint, including adding your published paper's DOI. For full details on allowed channels and updating your preprint, please see our Author Self-Archiving policy page.

Reusing Copyrighted Material / Third Party Permissions

As an author, you must obtain permission for any material used within your manuscript for which you are not the rightsholder, including quotations, tables, figures, or images. In seeking permissions for published materials, first contact the publisher rather than the author. For unpublished materials, start by contacting the creator. Copies of each grant of permission should be provided to the editorial office of the Journal. The permissions agreement must include the following:

- Nonexclusive rights to reproduce the material in your paper in *JSM*
- Rights for use in print and electronic format at a minimum, and preferably for use in any form or medium
- Lifetime rights to use the material
- Worldwide English-language rights

If you have chosen to publish under an open access license but have not obtained open access re-use permissions for third-party material contained within the manuscript, this must be stated clearly by supplying a credit line alongside the material with the following information:

- Title of content
- Author, Original publication, year of original publication, by permission of [rightsholder]
- This image/content is not covered by the terms of the Creative Commons license of this publication. For permission to reuse, please contact the rights holder.

Our publisher, Oxford University Press, provides detailed Copyright and Permissions Guidelines, and a summary of the fundamental information.

Misconduct

Authors should observe high standards with respect to research integrity and publication ethics as set out by the Committee on Publication Ethics (COPE). Falsification or fabrication of data including inappropriate image manipulation, plagiarism, including duplicate publication of the author's own work without proper citation, and misappropriation of work are all unacceptable practices. Allegations of ethical misconduct, both directly and through social media, are treated seriously and will be investigated in accordance with the relevant COPE guidance.

If misconduct has been established beyond reasonable doubt, this may result in one or more of the following outcomes, among others:

- If a submitted manuscript is still under consideration, it may be rejected and returned to the author.
- If a paper has already been published online, depending on the nature and severity of the infraction, either a correction notice will be published and linked to the paper, or retraction of the paper will occur, following the COPE Retraction Guidelines.
- The relevant party's institution(s) and/or other journals may be informed.

Manuscripts submitted to the Journal may be screened with plagiarism-detection software. Any manuscript may be screened, especially if there is reason to suppose that part or all of the manuscript has been previously published.

Plagiarism includes self-plagiarism or text recycling from authors' own published work.

COPE defines redundant/overlapping publication as "when a published work (or substantial sections from a published work) is/are published more than once (in the same or another language) without adequate acknowledgment of the source/cross-referencing/justification, or when the same (or substantially overlapping) data is presented in more than one publication without adequate cross-referencing/justification, particularly when this is done in such a way that reviewers/readers are unlikely to realize that most or all the findings have been published before."

COPE defines citation manipulation as "behaviors intended to inflate citation counts for personal gain, such as: excessive self-citation of an authors' own work, excessive citation to the journal publishing the citing article, and excessive citation between journals in a coordinated manner."

Data fabrication is defined as intentionally creating fake data or misrepresenting research results. An example includes making up data sets.

Data falsification is defined as manipulating research data with the purpose of intentionally giving a false representation. This can apply to images, research materials, equipment, or processes. Examples include cropping of gels/images to change context and omission of selected data.

If notified of a potential breach of research misconduct or publication ethics, the Journal editor and editorial office staff may inform OUP and/or the author's institutional affiliation(s).

Manuscripts may also be screened, including with services provided by third parties, to help detect integrity issues such as inappropriate image alteration and papermill activity.

Ethical Research

The Journal follows Committee on Publication Ethics (COPE) guidelines on ethical oversight. We take research integrity seriously, and all research published in the Journal must have been conducted in a fair and ethical manner. Wherever appropriate, the Journal requires that all research be done according to international and local guidelines.

Authors' Professional and Ethical Responsibilities

Should possible scientific misconduct or dishonesty in research submitted for review be suspected or alleged, *JSM* reserves the right to forward any submitted manuscript to the sponsoring or funding institution or to other appropriate authorities for investigation. The journal also screens manuscripts for incidents of plagiarism; please ensure that manuscripts present original data written in unique language.

Human Subjects

When reporting on human subjects, authors should indicate whether the procedures followed were in accordance with the ethical standards of the Helsinki Declaration, which were developed by the World Medical Association. For non-interventional studies, where ethical approval is not required or where a study has been granted an exemption by an ethics committee, this should be stated within the manuscript with a full explanation. Otherwise, manuscripts must include a statement in the Methods section that the research was performed after approval by a local ethics committee, institutional review board and/or local licensing committee, or that such approval was not required. The name of the authorizing body and any reference/permit numbers (where available) should also be stated there. Please be prepared to provide further information to the editorial office upon request.

Human subjects must give written informed consent, or if they are minors or incapacitated, such consent must be obtained from their parents or guardians. Consent forms should cover not only study participation but also the publication of the data collected. Also, any patient or provider information should be anonymized to the extent possible; names and ID numbers should not be used in the text and must be removed from any images (X-rays, photographs, etc.). Please note, censoring an individual's eyes in a photograph is not an effective way to conceal their identity. In studies where verbal, rather than written, informed consent was obtained, this must be explained and stated within the manuscript. If informed consent is not required or where a study has been granted an exemption, this must be included in the Methods section along with the name of the authorizing body. Please be prepared to provide written consent forms signed by the participants or other appropriate documentation to the editorial office upon request.

Clinical Trials

Clinical trials should be registered before enrollment of the first subject in accordance with the criteria outlined by the International Committee of Medical Journal Editors (ICMJE). When reporting primary or secondary analyses from a clinical trial, follow these criteria:

- Provide the trial registration number at the end of the Abstract.
- When the trial acronym is first used in the manuscript, provide the registration number and a link to the trial registration, which should be cited as a reference.
- If your data have been deposited in a public repository and/or are being used in a secondary analysis, please state at the end of the Abstract the unique, persistent data set identifier, and repository name and number.
- When submitting the manuscript, you must disclose any protocol alterations and all posting of results of the submitted work or closely related work in registries.

In general, randomized, interventional, prospective clinical trials that were not previously registered with an entity such as clinicaltrials.gov or an equivalent will not be considered acceptable for publication.

Animal Subjects

Studies involving animals require approval from the relevant institutional ethics committee or institutional animal use and care committee, and the research must be conducted in accordance with applicable national and international guidelines. All such manuscripts must include a statement in the Methods section providing details of the name of the committee(s) that approved the study, as well as the permit or animal license numbers where available. Where a study has been granted an exemption, this must be stated in the Methods section along with the name of the authorizing body. Please be prepared to provide further information to the editorial office upon request.

You are encouraged to consult the ARRIVE guidelines recommended by the National Centre for the Replacement, Refinement and Reduction of Animals in Research (NC3R).

Where applicable, any euthanasia or anesthesia methods must be carried out in accordance with applicable veterinary guidelines. These methods must be described in detail in the manuscript. Manuscripts describing research involving laboratory-based animals must include details on housing, husbandry, and steps taken to reduce suffering. In studies where experimental animals were euthanized, details must be provided on humane endpoints. Details on the planned behavioral observations or physiological measurements used to determine the humane endpoint must be described. You are advised to consult the NC3Rs guide on Humane Endpoints and the American Veterinary Medical Association (AVMA) Guidelines for the Humane Slaughter of Animals.

Submission

We will consider your manuscript as long as:

- It is your own original work and does not duplicate any previously published work, including your own;
- It, and any part of it, is not under consideration, in peer review, or accepted for publication in any journal other than *JSM*;
- It has not been published in any other journal in English or any other language; and
- It contains nothing abusive, defamatory, libelous, obscene, fraudulent, or illegal.

Authors should observe high ethical standards and obey publication best practices. The following are all unacceptable:

- Data falsification or fabrication
- Plagiarism, including duplicate publication of your own work without proper citation
- Misappropriation of work

We treat any case of ethical or publication malpractice very seriously. We will address them in accordance with the Committee on Publication Ethics (COPE) guidelines. Further information about OUP's ethical policies is available.

How to Submit

You must submit your paper via our web-based submission system ScholarOne. If you have not published with *JSM* before, you will need to create an account. More information is available on the ScholarOne Manuscripts FAQ and help page. Questions about submitting can be sent to the editorial office at jsmeditorialstaff@gmail.com.

Article Types

This journal publishes several article types:

Original Research—Approximate Word Count: 2,500

Original research papers are scientific reports from original research in sexual medicine. Please note: the word count is a guide; we will consider papers over this word limit.

Each submission should include:

- Title Page
- Abstract
- References—no limit on number
- Tables and figures—no limit on number
- Conflicts of interest and funding statements: de-identified in the manuscript file (e.g., *** - Consultant for Boston Scientific and Coloplast) and complete statements on the separately uploaded Title Page.
- Completed reporting guideline checklist to demonstrate the completeness of reporting in your manuscript.
- Failure to adhere to reporting best practices will result in revisions being requested ahead of publication. For more information on relevant reporting guidelines, please see the section below entitled Reporting Standards Required.

Review—No length limit

In general, JSM only accepts systematic and meta-analytic reviews. Review articles should represent a timely, in-depth treatment of an issue. Systematic reviews should adhere to PRISMA and PRISMA-S reporting guidelines.

Each submission should include:

- Title Page
- Abstract
- References—no limit on number
- Tables and figures—no limit on number
- Conflicts of interest and Funding statements: de-identified in the manuscript file (e.g., *** - Consultant for Boston Scientific and Coloplast) and complete statements on the separately uploaded Title Page.

- Completed reporting guideline(s) to demonstrate the completeness of reporting in your manuscript.
- Failure to adhere to reporting best practices will result in revisions being requested ahead of publication. For more information on relevant reporting guidelines, please see the section below entitled Reporting Standards Required.

Brief Communication—Maximum Word Count: 1,200

Brief communication papers are appropriate for things such as negative clinical studies, studies with limited data, studies that were closed early due to poor enrollment, or otherwise highly niche topics which may not otherwise be published.

Each submission should include:

- Title Page
- No abstract
- Executive Summary uploaded as supplemental material (please see the section below entitled Executive Summary for content, structure, and length)
- The manuscript should not use structured headings (e.g., Introduction, Methods, etc.), but should use narrative text only
- Any figures / tables can only be included as supplementary materials (and must be referred to in the text as supplemental material, eg, Figure S1, Table S1, etc.)
- Conflicts of interest and Funding statements: de-identified in the manuscript file (e.g., *** - Consultant for Boston Scientific and Coloplast) and complete statements on the separately uploaded Title Page.
- Maximum number of references 4

Complications and Cases (C&C) – Maximum Word Count: 1,200

This article type is reserved for things such as case reports, descriptions of previously unreported complications, or other similar types of studies. These are not in-depth reviews and do not meet the rigorous criteria of an original article. Rather, they are areas where authors can report uncommon findings and observations.

Each submission should include:

- Title Page
- No abstract
- Executive Summary uploaded as supplemental material (please see the section below entitled Executive Summary for content, structure, and length)
- The manuscript should not use structured headings (e.g., Introduction, Methods, etc.), but should use narrative text only
- Any figures / tables can only be included as supplementary materials (and must be referred to in the text as supplemental material, eg, Figure S1, Table S1, etc.)
- Conflicts of interest and Funding statements: de-identified in the manuscript file (e.g., *** - Consultant for Boston Scientific and Coloplast) and complete statements on the separately uploaded Title Page.
- Maximum number of references 4

Expert Opinion—Maximum Word Count: 1,200

Opinions present potentially controversial viewpoints, with the aim of encouraging debate. These are science-based, opinion pieces that may either be commissioned or directly submitted to *JSM* and are subjected to peer review.

Each submission should include:

- Title Page
- No abstract
- The manuscript should not use structured headings (e.g., Introduction, Methods, etc.), but should use narrative text only
- Any figures / tables can only be included as supplementary materials (and must be referred to in the text as supplemental material, eg, Figure S1, Table S1, etc.)
- Conflicts of interest and Funding statements: de-identified in the manuscript file (e.g., *** - Consultant for Boston Scientific and Coloplast) and complete statements on the separately uploaded Title Page.
- Maximum number of references 4

How I Do It – Unlimited Word Count

The How I Do It section is by invitation only. In this section, we will invite experts who have contemporary publications on a particular subject to describe their technique with given procedures. The author selection will be done in a methodological manner to minimize bias. All authors who are

invited to submit will be included on the manuscript and will be considered as having equal status on the manuscript (i.e., shared first author). The submission will be performed by a single author and will collate the information gathered from the various experts.
Each submission should include:

- Title Page
- Abstract
- References—no limit on number
- Tables and figures—no limit on number
- Conflicts of interest and Funding statements: de-identified in the manuscript file (e.g., *** - Consultant for Boston Scientific and Coloplast) and complete statements on the separately uploaded Title Page.

Innovations – Maximum Word Count: 1,200
The Innovation section is intended to be used for novel descriptions of treatments, techniques, or other similar, first-of-its kind descriptions. The articles are not comprehensive reviews but rather just first types of descriptions. They are peer reviewed and do need to meet the criteria of being a substantive improvement overall. As such, authors are welcome to present preliminary data demonstrating superiority over existing techniques or otherwise describing how this builds upon prior techniques and procedures. These do not need to be limited to surgical techniques and could include descriptions of novel classification systems, etc.
Each submission should include:

- Title Page
- No abstract
- Executive Summary uploaded as supplemental material (please see the section below entitled Executive Summary for content, structure, and length)
- The manuscript should not use structured headings (e.g., Introduction, Methods, etc.), but should use narrative text only
- Any figures / tables can only be included as supplementary materials (and must be referred to in the text as supplemental material, eg, Figure S1, Table S1, etc.)
- Conflicts of interest and Funding statements: de-identified in the manuscript file (e.g., *** - Consultant for Boston Scientific and Coloplast) and complete statements on the separately uploaded Title Page.
- Maximum number of references 4

Letter to the Editor—Maximum Word Count: 1,000
Letters to the Editor generally consist of unsolicited or solicited comments on particular *JSM* articles. The Letters may be critical, laudatory, or just provide perspective or commentaries on the articles themselves. Letters will be considered by the Editors and may be published after consultation or peer review. The authors of the original article will be given the option of providing a Response.
Each submission should include:

- Title Page
- No abstract
- The letter should not use structured headings (e.g., Introduction, Methods, etc.), but should use narrative text only
- Any figures / tables can only be included as supplementary materials (and must be referred to in the text as supplemental material)
- Conflicts of interest and Funding statements: de-identified in the manuscript file (e.g., *** - Consultant for Boston Scientific and Coloplast) and complete statements on the separately uploaded Title Page.
- Maximum number of references 4

Surveys – Maximum Word Count: 1,200
The Surveys section is intended to be used to report results of surveys. In many cases, these types of studies are not large enough or representative enough to merit an Original Article, and this area allows for reporting of these types of studies. Specifically, whenever a convenience sample is used, online forums, relatively low response rates, small overall numbers, or other similar limitations are present, the Survey article type would be preferred.
Each submission should include:

- Title Page
- No abstract
- Executive Summary uploaded as supplemental material (please see the section below entitled Executive Summary for content, structure, and length)

- The manuscript should not use structured headings (e.g., Introduction, Methods, etc.), but should use narrative text only
- Any figures / tables can only be included as supplementary materials (and must be referred to in the text as supplemental material, eg, Figure S1, Table S1, etc.)
- Maximum number of references 4

Manuscript Formatting Guidelines

Specific instructions for *JSM* can be found below. General guidelines on preparing your manuscript for publication can be found on OUP's Preparing and submitting your manuscript page.

Title Page

- Upload a title page for your manuscript that is separate from the rest of the main document (uploaded as a Title Page submission item in .doc format), including:
    1. Full author names and the highest qualifications (PhD, MD, etc.) for all authors
    2. Institution, city, and country details for each author
    3. Address of corresponding author (including the email address for the person to whom the proof notification is to be sent).
    4. 4-10 keywords (MeSH headings should be used whenever possible)
    5. Acknowledgements (e.g., providing language help, writing assistance, etc.)
    6. Funding statement
    7. Other statements: complete conflict of interest disclosures, author contributions, other statements, etc.
        - If any: Preprints, presentation/s of work at conferences, etc.

Abstract

- Abstracts are not required for all article types. Please reference the section, Article Types for information as to whether an abstract is required for your specific article type.
- Maximum word count: 400
- Abstracts for Original Research submissions should be structured as follows:
    - Background
    - Aim
    - Methods
    - Outcomes
    - Results
    - Clinical Implications
    - Strengths & Limitations
    - Conclusion
- Abstracts for Review submissions should be structured as follows:
    - Introduction
    - Objectives
    - Methods
    - Results
    - Conclusion

Executive Summary

- An Executive Summary is not required for all article types. Please reference the section, Article Types for information as to whether an Executive Summary is required for your specific article type.

For relevant article types, provide an Executive Summary of approximately 400 words, uploaded as supplemental material, following the structure below. Please note that a bulleted format is preferred for the Executive Summary rather than narrative text paragraphs. The content that would go into the Executive Summary would be similar to the content typically included in an abstract.

Background

- Background detail related to hypothesis and need for study
- Background detail related to hypothesis and need for study
- Etc.

Objective

- Primary objective
- Secondary objectives

Methods

- Method detail 1
- Method detail 2

- Method detail 3
- Etc.

Results

- Key finding 1
- Key finding 2
- Key finding 3
- Etc.

Clinical Impact

- Importance of findings and impact on clinical practice

Notable Comments

- Other notable comments, e.g., largest series of its kind
- Strengths / weaknesses / limitations

Conclusions

- 1-3 conclusion statements that are based solely on the data provided in the manuscript

Manuscript

- Use continuous line numbering throughout the manuscript.
- Please upload the main manuscript in .doc format with no identifying author information.
- Although exceptions are permitted depending on article type and based on specific topic circumstances, in general the manuscript should be structured as follows:
    1. Introduction
    2. Materials and Methods
    3. Results
    4. Discussion
    5. Conclusion
    6. Conflicts of interest and Funding statements: de-identified in the manuscript file (e.g., *** - Consultant for Boston Scientific and Coloplast) and complete unblinded statements on the separately uploaded Title Page.
    7. References
    8. Figure legend/s

Tables and Figures

- Upload each *table* (as a word processing document file) and each *figure* (in .tif, .jpg, or .eps) as a separate file under the appropriate submission item type.
- Tables and figures should be numbered in the order that the callouts appear in the text (e.g., Table 1, Table 2, etc.), including any supplementary material.
- Ideally, wherever appropriate, a figure should be provided for the key study findings.
- For interventional or cohort type studies, a demographics table should be provided.
- Please pay attention to the quality of all figures and artwork supplied:
    1. Figures should be submitted in one of the following file formats: .jpeg, .jpg, .tif or .eps. Images prepared as .bmp, .gif, .doc/.docx or .pdf files will not be accepted. You must include figure titles, legends, and captions within the manuscript file - they should not be included in the image files. Submit all panels of a multi-panel figure as one single figure file; each panel should be labeled with a letter (A, B, C, D, etc.) in the upper-left corner of each panel.
    2. Images of maps, charts, graphs, shapes, and diagrams are best rendered digitally as vector graphics. These file types do not use pixels; therefore, resolution does not apply to vector images. Save vector images as .eps files and embed the fonts.
    3. Images of photographs, paintings, or scans can be provided as raster images. Raster images should be saved as uncompressed .tiff files to avoid quality loss; .jpg/.png file formats are acceptable for raster images but may result in a lower resolution. The resolution of raster files is measured by the number of dots or pixels in a given area, referred to as “dpi” or “ppi.”
    4. Minimum resolution required for color half-tones: 300dpi
    5. Minimum resolution for grayscale half-tones: 600dpi
    6. Minimum resolution for combination half-tones and line art: 600-900dpi
    7. Minimum resolution for monochrome line art (complex or finely drawn): 1200dpi
    8. Please also consider accessibility when designing your figure, so that your images can be easily understood by color-blind and visually-impaired readers. Guidelines for preparing different image-types, including recommendations for color palettes, color contrast, image layout, and text accessibility.

9. Should your figures originate in a PowerPoint presentation, please remove: any previous presentation effects, such as line-art color that is not of didactic value; background color or shading effects and 3-dimensional views where 2D can convey results with equal effectiveness.
10. All text included in figure labels must be of a sufficient size to be legible should the figure be resized during typesetting.
11. Do not include the figure title or figure identification number within the figure itself. This does not reproduce effectively and typically does not fit journal style.

References

- All references must be displayed sequentially based upon order of citation.
- You may format references in any readable style at submission; references can be in any format as long as the format is consistent and the information is correct and complete. You are responsible for the accuracy of reference information.
- In general, references to unpublished manuscripts should not be used except in rare circumstances. In those cases, the unpublished nature of the work should be highlighted in the text.
- References at the end of each manuscript should be listed in the order in which they are first cited in the text.
- References to articles in press must state name of journal and if possible, volume and year.

Supplementary Material

- Supplementary material must be cited in the text of the main manuscript (eg, Supplemental Details S1, Figure S1, Table S1, etc.).
- Supplementary materials will be published exactly as they are received (Excel or PowerPoint files will appear as such online).
- Style and formatting of supplementary material should be consistent with that of the manuscript.
- Supplementary material should be formatted to function on any internet browser.
    - Documentation and online appendices should be submitted in PDF file format.
    - Data files should be submitted in a .zip file format.
- Supplementary material, such as applications, images, and sound clips, can be published with your article to enhance it.
- Please submit your material together with the article and supply a concise, descriptive caption for each supplementary file. If you wish to make changes to supplementary material during any stage of the process, provide an updated file.
- Do not include author-identifying information in supplementary material.

Reporting Guideline Checklist

- Depending on article type, a reporting guideline checklist should be included with the manuscript.
- The specific checklist required based on article type is listed below in the Reporting Standards Required Section

Other Formatting Topics

Style

The journal generally follows AMA style. Please refer to these requirements when preparing your manuscript. More information on the style guide is available. US spelling should be used throughout, except in quotations and in references.

Abbreviations

Please define nonstandard abbreviations at the first occurrence. A list of acceptable abbreviations is published in the Uniform Requirements for Manuscripts submitted to Biomedical Journals (also known as the Declaration of Vancouver). For more information, refer to: International Committee of Medical Journal Editors. Uniform requirements for manuscripts submitted to biomedical journal (Ann Intern Med 1997;126:36-47). You may contact the Editor or publisher directly with questions.

Units

Follow internationally accepted rules and conventions: use the international system of units (SI). If other units are mentioned, please give their equivalent in SI.

Math Formulae

Please submit math equations as editable text and not as images. Present simple formulae in line with normal text where possible and use the solidus (/) instead of a horizontal line for small fractional terms, e.g., X/Y. In principle, variables are to be presented in italics. Powers of e are often more

conveniently denoted by exp. Number consecutively any equations that have to be displayed separately from the text.

Use of Inclusive Language

Inclusive language acknowledges diversity, conveys respect to all people, is sensitive to differences, and promotes equal opportunities. Content should make no assumptions about the beliefs or commitments of any reader; contain nothing which might imply that one individual is superior to another on the grounds of age, gender, race, ethnicity, culture, sexual orientation, disability, or health condition; and use inclusive language throughout. Authors should ensure that writing is free from bias, stereotypes, slang, reference to dominant culture and/or cultural assumptions. We advise to seek gender neutrality by using plural nouns ("clinicians, patients/clients") as default/wherever possible to avoid using "he, she," or "he/she." We recommend avoiding the use of descriptors that refer to personal attributes such as age, gender, race, ethnicity, culture, sexual orientation, disability, or health condition unless they are relevant and valid. When coding terminology is used, we recommend to avoid offensive or exclusionary terms such as "master", "slave", "blacklist" and "whitelist". We suggest using alternatives that are more appropriate and (self-) explanatory such as "primary", "secondary", "blocklist" and "allowlist". These guidelines are meant as a point of reference to help identify appropriate language but are by no means exhaustive or definitive.

Figure accessibility and alt text

When submitting your manuscript, we require you to provide alt text (alternative text) descriptions for all images, figures, illustrations, and photographs included in the main article.

Please consider accessibility when designing each figure, so that all images can be easily understood by visually impaired readers. OUP provides detailed guidance on figure accessibility, including contrast, text accessibility and alt text. It is also best practice for the information or data represented in the image to be fully described by the caption and/or surrounding text.

Please include each alt text description in your main manuscript file, directly under the figure legend for the relevant figure, preceded by 'Alt text:'.

Detailed guidance on how to draft and submit alt text.

Including alt text in your manuscript helps make your work more accessible to all readers. Good alt text ensures that individuals with visual impairments or those using screen readers can understand the content and context of your figures. The aim of alt text is to give concise and informative descriptions of your figures so all readers can understand and benefit from the visuals in your manuscript. Including alt text demonstrates a commitment to accessibility and enhances the overall impact and reach of your work.

Alt text is only accessible via e-reader and will not appear as part of the typeset article.

Statistical Guidelines

All submitted manuscripts containing data analyses will be evaluated for the integrity of the statistical methods as well as a sufficient description of the methodological approach. This will entail evaluation of the study design, statistical analysis and presentation and interpretation of study results. As a general guideline, readers of the manuscript should be able to replicate the analysis with the same data based on the description given in the Methods section. Authors are encouraged to carefully select language in the Discussion that is appropriate given the study design and refrain from causal inferences from observational (nonrandomized) studies.

Authors should also be explicit about the limitations of the study. Failure to disclose important limitations upon submission will be viewed with greater scrutiny than those clearly discussed. Key elements which should be consistent for all submitted manuscripts include the following:

- Report the sample size n for each study and each analysis
- Describe the power analysis to justify the sample size if appropriate
- Identify all statistical methods and verify the assumptions for all statistical tests
- Provide alpha (the probability of a Type I error) for all statistical tests
- Specify whether tests are one- or two-sided
- When multivariate analysis is used, a univariate analysis table should also be presented
- Report the descriptive statistics (n, mean, median, and standard deviation) for all continuous variables
- Report n and the sample proportion for binary variables
- Adequately explain complex statistical procedures such a multivariate logistic regression and the Cox proportional hazards regression model and verify the assumptions of each such procedure
- Report the actual P-values to two decimal places and explain what is meant by statistical significance. For p-values <0.01, the following should be used: <0.01, <0.001, or <0.0001.
- Discuss and describe adjustments for multiple testing

- State the name, version, manufacturer, and manufacturer location for all statistical or other data management software used as part of the research project

Drugs and Devices

Use of generic drug names (or generic name followed by trade name in parentheses) may be used. Include manufacturer and their location (city and country) for drugs and devices.

Cell Line Authentication

To ensure the highest standards of quality and accuracy, The Journal of Sexual Medicine strongly encourages the authentication of cell lines used in the research submitted. Manuscripts based on research using cell lines must include a statement addressing the following points in the Methods section of the manuscript:

- Where the cells were obtained from;
- Whether the cell lines have been tested and authenticated via the method by which the cells were tested

If cells were obtained directly from a cell bank that performs cell line characterizations and passaged in the user's laboratory for fewer than 6 months after receipt or resuscitation, re-authorization is not required. In these cases, please include the method of characterization used by the cell bank. If the cell lines were obtained from an alternate source, authors must provide authentication of the origin and identity of the cells. This is best achieved by DNA (STR) profiling. The DNA profile should be cross-checked with the DNA profile of the donor tissue (in case of a new cell line) or with the DNA profile of other continuous cell lines.

Gene Names and Genetic Profiling Data

Please mark all gene names in italics. However, only the gene names should be written in italics, to distinguish them from gene products, gene segments, clusters, families, complexes, or groups. Authors should only use the official gene name as assigned by the respective gene nomenclature committee. Regarding comprehensive data sets of genetic profiling (microarray) studies, raw data must be in a publicly available database that requires MIAME format (for example, “GEO” or “Array Express”) upon submission of a paper. Nucleotide sequence data can be submitted in electronic form to any of the three major collaborative databases: DDBJ, EMBL or GenBank. It is only necessary to submit to one database as data are exchanged between DDBJ, EMBL and GenBank on a daily basis. The suggested wording for referring to accession-number information is: ‘These sequence data have been submitted to the DDBJ/EMBL/GenBank databases under accession number U12345.’

Reporting Standards Required

Trial Registrations

All prospective, randomized, controlled trials with patient enrollment must be registered in a public database that meets the requirements of the World Health Organization. Currently, such registries include the following:

- Australian Clinical Trials
- ClinicalTrials.gov
- ISRCTN Registry
- UMIN Clinical Trials Registry (UMIN CTR)

For more information, please refer to the ICMJE Clinical Trials guidelines. Upon submission, please provide the registration identification number and the URL for the trial’s registry in your cover letter.

Submission Checklists

For Reviews and Original Research articles, authors are required to complete one of the reporting checklists listed below. Authors should upload a completed copy of the reporting checklist(s) with their submission.

Study type	Study type category	Checklist for reporting standards	Checklist name
Randomized controlled pharmacotherapy trials	RCT (Pharmacotherapy)	CONSORT-Consolidated Standards of Reporting Trials	CONSORT Statement
Other pharmacotherapy and herbal medicinal trials (noninferiority	RCT (Other)	CONSORT extensions (tailored versions of the main	CONSORT Checklist

trials, pragmatic trials, cluster trials, reporting of harms)		CONSORT Statement produced by	
Observational epidemiology studies	Observational Epidemiological Studies	STROBE- Strengthening the reporting of observational studies in epidemiology	STROBE Checklist
Qualitative Research	Qualitative Research	COREQ- Consolidated criteria for reporting qualitative research	COREQ Checklist
Diagnostic Accuracy Studies	Diagnostic Accuracy Studies	STARD- Standards for reporting diagnostic accuracy	STARD Checklist
Systematic reviews	Systematic Reviews	PRISMA (formerly known as QUOROM)- Improving the quality of reports of meta-analyses of randomized controlled trials and PRISMA-S	PRISMA Checklist
Meta-analyses of controlled trials	Meta-analysis of controlled Trials	PRISMA (formerly known as QUOROM)- Improving the quality of reports of meta-analyses of randomized controlled trials and PRISMA-S	PRISMA Checklist
Quality improvement reports	Quality Improvement Reports	SQUIRE- Standards for quality improvement reporting excellence	SQUIRE Checklist
Erectile Function Recovery analysis following radical pelvic surgery	All relevant studies	ERF-Erectile Function Recovery Checklist	ERF Checklist
Pre-Clinical Studies	Animal Studies	Animal Research: Reporting In Vivo Experiments	ARRIVE

JSM Guidelines for Protein Detection and PCR	JSM Guidelines for Protein Detection and PCR	JSM Guidelines + MIQE Checklist	JSM PCR Guidelines and MIQE Checklist
Transgender-Related Research	Transgender-Related Research	JSM Instructions for Authors of Transgender-Related Research	JSM Instructions for Authors of Transgender-Related Research

Appendix E

PRISMA 2020 Checklist

Section and Topic	Item #	Checklist item	Location where item is reported
TITLE			
Title	1	Identify the report as a systematic review.	13
ABSTRACT			
Abstract	2	See the PRISMA 2020 for Abstracts checklist.	14
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of existing knowledge.	15-16
Objectives	4	Provide an explicit statement of the objective(s) or question(s) the review addresses.	16
METHODS			
Eligibility criteria	5	Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses.	17-19
Information sources	6	Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted.	16
Search strategy	7	Present the full search strategies for all databases, registers and websites, including any filters and limits used.	17
Selection process	8	Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of automation tools used in the process.	18
Data collection process	9	Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of automation tools used in the process.	19
Data items	10a	List and define all outcomes for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (e.g. for all measures, time points, analyses), and if not, the methods used to decide which results to collect.	19
	10b	List and define all other variables for which data were sought (e.g. participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information.	19
Study risk of bias assessment	11	Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of automation tools used in the process.	18-19
Effect measures	12	Specify for each outcome the effect measure(s) (e.g. risk ratio, mean difference) used in the synthesis or presentation of results.	19
Synthesis methods	13a	Describe the processes used to decide which studies were eligible for each synthesis (e.g. tabulating the study intervention characteristics and comparing against the planned groups for each synthesis (item #5)).	19, 32
	13b	Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary statistics, or data conversions.	-
	13c	Describe any methods used to tabulate or visually display results of individual studies and syntheses.	19
	13d	Describe any methods used to synthesize results and provide a rationale for the choice(s). If meta-analysis was performed, describe the model(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used.	19

Section and Topic	Item #	Checklist item	Location where item is reported
	13e	Describe any methods used to explore possible causes of heterogeneity among study results (e.g. subgroup analysis, meta-regression).	19, 32
	13f	Describe any sensitivity analyses conducted to assess robustness of the synthesized results.	-
Reporting bias assessment	14	Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting biases).	-
Certainty assessment	15	Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome.	33
RESULTS			
Study selection	16a	Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram.	19-21
	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded.	-
Study characteristics	17	Cite each included study and present its characteristics.	22-24
Risk of bias in studies	18	Present assessments of risk of bias for each included study.	116-120
Results of individual studies	19	For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots.	32, 121-126
Results of syntheses	20a	For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies.	29-32
	20b	Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g. confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect.	32
	20c	Present results of all investigations of possible causes of heterogeneity among study results.	29-32
	20d	Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results.	-
Reporting biases	21	Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed.	-
Certainty of evidence	22	Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed.	29-32
DISCUSSION			
Discussion	23a	Provide a general interpretation of the results in the context of other evidence.	33-34
	23b	Discuss any limitations of the evidence included in the review.	35
	23c	Discuss any limitations of the review processes used.	35
	23d	Discuss implications of the results for practice, policy, and future research.	35-36
OTHER INFORMATION			
Registration and protocol	24a	Provide registration information for the review, including register name and registration number, or state that the review was not registered.	16
	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared.	16
	24c	Describe and explain any amendments to information provided at registration or in the protocol.	-
Support	25	Describe sources of financial or non-financial support for the review, and the role of the funders or sponsors in the review.	36

Section and Topic	Item #	Checklist item	Location where item is reported
Competing interests	26	Declare any competing interests of review authors.	36
Availability of data, code and other materials	27	Report which of the following are publicly available and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review.	-

From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71. This work is licensed under CC BY 4.0. To view a copy of this license, visit https://creativecommons.org/licenses/by/4.0/

Appendix F

University of East Anglia
Norwich Research Park
Norwich. NR4 7TJ

Email: ethicsmonitor@uea.ac.uk
Web: www.uea.ac.uk

Study title: What is the lived experience and impact of living with Post-SSRI/SNRI Sexual Dysfunction (PSSD)?

Application ID: ETH2425-0169

Dear Seraj,

Your application was considered on 13th November 2024 by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee).

The decision is: **approved**.

You are therefore able to start your project subject to any other necessary approvals being given.

If your study involves NHS staff and facilities, you will require Health Research Authority (HRA) governance approval before you can start this project (even though you did not require NHS-REC ethics approval). Please consult the HRA webpage about the application required, which is submitted through the IRAS system.

This approval will expire on **30th September 2026**.

Please note that your project is granted ethics approval only for the length of time identified above. Any extension to a project must obtain ethics approval by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) before continuing.

It is a requirement of this ethics approval that you should report any adverse events which occur during your project to the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) as soon as possible. An adverse event is one which was not anticipated in the research design, and which could potentially cause risk or harm to the participants or the researcher, or which reveals potential risks in the treatment under evaluation. For research involving animals, it may be the unintended death of an animal after trapping or carrying out a procedure.

Any amendments to your submitted project in terms of design, sample, data collection, focus etc. should be notified to the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) in advance to ensure ethical compliance. If the amendments are substantial a new application may be required.

Approval by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) should not be taken as evidence that your study is compliant with the UK General Data Protection Regulation (UK GDPR) and the Data Protection Act 2018. If you need guidance on how to make your study UK GDPR compliant, please contact the UEA Data Protection Officer (dataprotection@uea.ac.uk).

Please can you send your report once your project is completed to the FMH S-REC (fmh.ethics@uea.ac.uk).

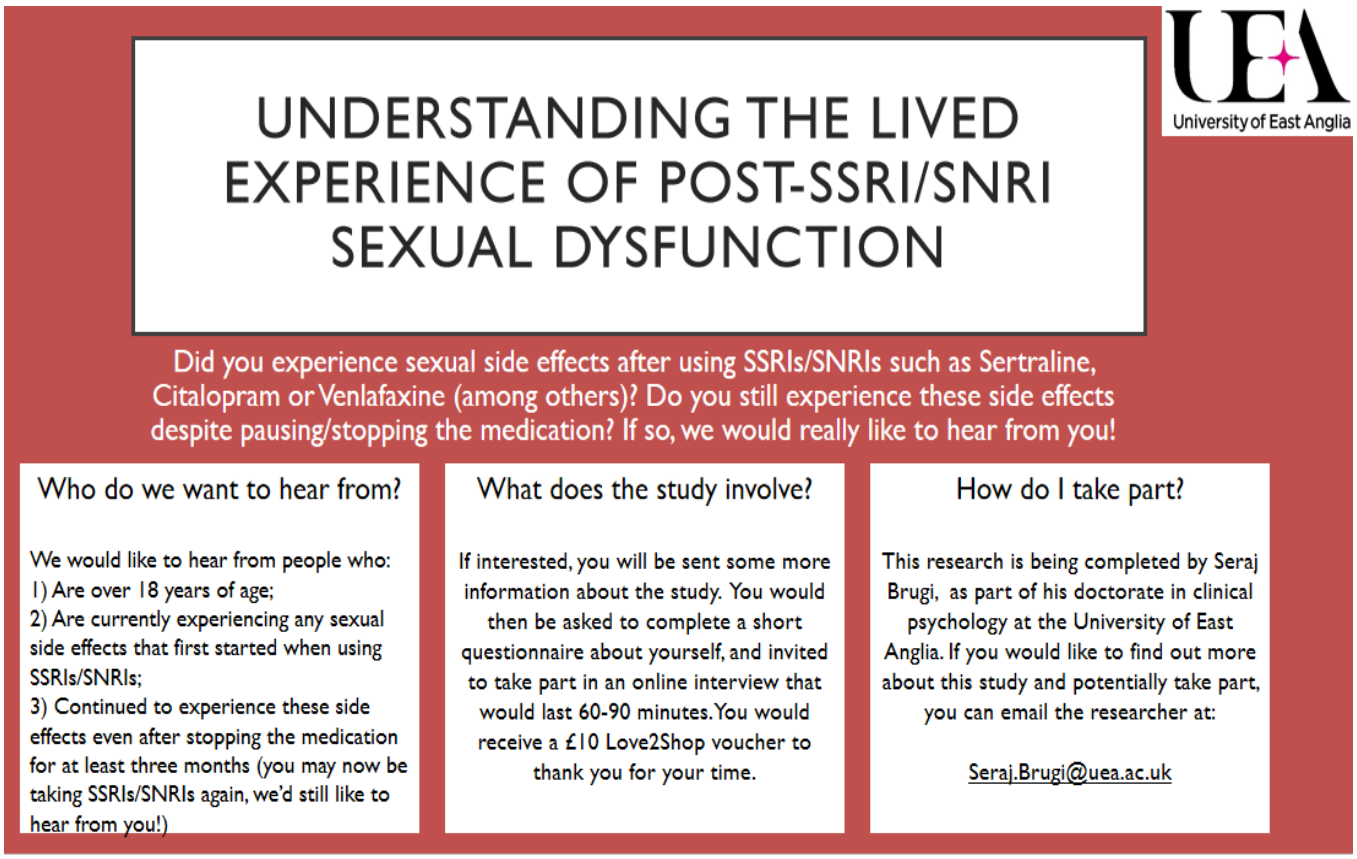
I would like to wish you every success with your project.

On behalf of the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee)

Yours sincerely,

Dr Paul Linsley

Appendix G


UNDERSTANDING THE LIVED EXPERIENCE OF POST-SSRI/SNRI SEXUAL DYSFUNCTION
University of East Anglia
Did you experience sexual side effects after using SSRIs/SNRIs such as Sertraline, Citalopram or Venlafaxine (among others)? Do you still experience these side effects despite pausing/stopping the medication? If so, we would really like to hear from you!
Who do we want to hear from?
We would like to hear from people who:
1) Are over 18 years of age;
2) Are currently experiencing any sexual side effects that first started when using SSRIs/SNRIs;
3) Continued to experience these side effects even after stopping the medication for at least three months (you may now be taking SSRIs/SNRIs again, we'd still like to hear from you!)
What does the study involve?
If interested, you will be sent some more information about the study. You would then be asked to complete a short questionnaire about yourself, and invited to take part in an online interview that would last 60-90 minutes. You would receive a £10 Love2Shop voucher to thank you for your time.
How do I take part?
This research is being completed by Seraj Brugi, as part of his doctorate in clinical psychology at the University of East Anglia. If you would like to find out more about this study and potentially take part, you can email the researcher at:
Seraj.Brugi@uea.ac.uk

Appendix H

Version 2.1
11/11/2024

PARTICIPANT INFORMATION SHEET

Understanding the lived experience of Post-SSRI/SNRI Sexual Dysfunction (PSSD)

What is this study about?

You are invited to take part in a research study that aims to understand the impact of living with persistent sexual side effects following the use of antidepressants. SSRIs (selective serotonin reuptake inhibitors) and SNRIs (selective serotonin and norepinephrine reuptake inhibitors) are widely prescribed antidepressants, and common brand names include Sertraline, Citalopram and Venlafaxine. It can be very common to experience sexual side effects (such as loss of libido or erectile dysfunction) when using SSRIs/SNRIs, and some individuals who experience these sexual side effects report that these side effects do not improve when the medication has been discontinued. This is often called Post-SSRI/SNRI Sexual Dysfunction, or PSSD for short. Very little research has been undertaken to help understand the experiences of people living with PSSD. This study aims to improve our understanding of the impact PSSD can have on someone's life.

This Participant Information Sheet tells you about the research study. Knowing what is involved will help you decide if you want to take part in the study. Please read this sheet carefully and ask questions about anything that you don't understand or want to know more about.

Participation in this research study is voluntary. By giving consent to take part in this study you are telling us that you:

- ✓ Understand what you have read.
- ✓ Agree to take part in the research study as outlined below.
- ✓ Agree to the use of your personal information as described.
- ✓ You have received a copy of this Participant Information Sheet to keep.

Who is running the study?

The study is being carried out by the following researcher: Seraj Brugi, Trainee Clinical Psychologist. Based at the Norwich Medical School, University of East Anglia.

This study will take place under the supervision of Dr Sarah Fish (University of East Anglia, sarah.fish@uea.ac.uk) and Dr Bob Budd (University of East Anglia, bob.budd@uea.ac.uk).

This study is being completed as part of the researcher's doctoral training in clinical psychology. The researcher is employed by the Cambridge and Peterborough NHS Foundation Trust, and the research is sponsored by the University of East Anglia.

Am I eligible to take part?

To take part in this study, you need to:

1) Be over 18 years old;
2) Understand/speak English enough to be able to participate in an interview;
3) Self-identify as experiencing sexual side effects that started when using SSRIs/SNRIs;
4) Have continued to experience these side effects even when you stopped the medication for a period of at least three months (if you have since resumed taking SSRIs/SNRIs, you are still eligible for this study).

If you experienced persistent sexual dysfunction before starting SSRIs/SNRIs, you would unfortunately not be eligible to take part in this study.

We are aiming to recruit 10 participants, and may unfortunately be unable to interview all individuals who express interest.

What will the study involve for me?

If you would like to take part in this study, you will be sent a consent form to electronically sign and return to the lead researcher. Following this, you will be sent a link to a short questionnaire that will ask you some questions about yourself, such as your age and gender. Following this, you will be invited to participate in an online interview with the researcher that will last approximately 60-90 minutes which will take place at a mutually convenient time. The interview will be guided by the questions enclosed in the interview guide (attached separately), but further follow-up questions may arise during the interview. This interview will take place via Microsoft Teams. This interview will be audio-recorded to ensure that the researcher can accurately transcribe the interview and analyse the data.

The researcher will go through your transcript to remove or change information that you mention in your interview which could identify you, such as changing any names or details of where you live or work. You will be provided with access to an electronic copy of your interview transcript within two weeks of completing the interview, providing you an opportunity to add any comments or further reflections on this transcript should you wish to do so. The researchers will not analyse the transcripts until participants have been given two weeks to review their copy. If no response is received after two weeks, the researcher will assume that the participant has no comments. Audio recordings of interviews will be deleted once the interviews have been transcribed.

How much of my time will the study take?

The short questionnaire should take around five minutes to complete. The research interview will last approximately 60-90 minutes. You will also have an opportunity to review the interview transcript and provide any additional comments should you wish to do so.

Do I have to be in the study? Can I withdraw from the study once I have started?

Being in this study is completely voluntary and you do not have to take part. Your decision whether to participate will not affect your current or future relationship with the researchers or anyone else at the University of East Anglia now or in the future.

If you decide to take part in the study, you can withdraw your consent up to the point that data analysis on interview transcripts commences. Data analysis will begin once participants have had an opportunity to review and return any comments on their transcripts. This means that participants will have four weeks from the date of their interview to withdraw their data. You can do this by contacting the researcher via email: seraj.brugi@uea.ac.uk.

What are the consequences if I withdraw from the study?

You are free to stop the interview at any time. Unless you say that you want us to keep them, any recordings will be erased and the information you have provided will not be included in the study results. You may also refuse to answer any questions that you do not wish to answer during the interview. If you decide at a later time

to withdraw from the study your information will be removed from our records and will not be included in any results. Please note that this may not be possible if your data has already been analysed and/or we have published our findings (this would include the submission of the dissertation for assessment purposes).

Are there any risks or costs associated with being in the study?

This interview may explore difficult themes and experiences that some people may find challenging. We would encourage you to review the enclosed interview guide when considering whether you would like to take part in this study. During the interview, you have the right to refuse to answer any question, and you can withdraw from this study at any time without providing any reason. You can also pause the interview at any time, and you will be offered a chance to debrief with the researcher and hear about services that can offer support.

Are there any benefits associated with being in the study?

Participants will receive a £10 Love2Shop voucher to thank you for taking part in this study. We also aim to publish our findings and contribute to the growing body of research on PSSD, giving a voice to the individuals whose lives are impacted.

What will happen to information provided by me and data collected during the study?

Your personal data and information will only be used as outlined in this Participant Information Sheet, unless you consent otherwise. Data management will follow the Data Protection Act 2018 (DPA 2018) and UK General Data Protection Regulation (UK GDPR), and the University of East Anglia's Research Data Management Policy.

The information you provide will be stored securely on a password protected server that can only be accessed by the researchers in this study, and your identity will be kept strictly confidential, except as required by law. Study findings may be published and may also be used for other scholarly and educational purposes such as in teaching. Although every effort will be made to protect your identity, any publications will use demographic information and direct quotes from the interview transcript (with key identifying details such as names removed or changed). Coupled with the small sample size, there is therefore a small risk that you may be identifiable to yourself or to individuals who are aware of your circumstances. In line with university regulations, the data will be kept for at least 10 years beyond the last date the data were used.

What if I would like further information about the study?

When you have read this information, the lead researcher (Seraj Brugi) will be available to discuss it with you further and answer any questions you may have about the study. You can contact the researcher using the email address at the top of this form.

Will I be told the results of the study?

You have a right to receive feedback about the overall results of this study. You can tell us that you wish to receive feedback by indicating this on the consent form. This feedback will be in the form of an overall analysis of the completed interviews, highlighting key themes and patterns that emerged in the data.

What if I have a complaint or any concerns about the study?

If there is a problem please let me know. You can contact me via the University at the following address:

Seraj Brugi
The Department of Clinical Psychology and Psychological Therapies
Norwich Medical School
University of East Anglia
NORWICH NR4 7TJ
Seraj.brugi@uea.ac.uk

If you are concerned about the way this study is being conducted or you wish to make a complaint to someone independent from the study, please contact Professor Niall Broomfield, Head of the Department of Clinical Psychology and Psychological Therapies, N.Broomfield@uea.ac.uk.

How do I know that this study has been approved to take place?

To protect your safety, rights, wellbeing and dignity, all research in the University of East Anglia is reviewed by a Research Ethics Body. This research was approved by FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee).

What is the general data protection information I need to be informed about?

According to data protection legislation, we are required to inform you that the legal basis for processing your data as listed in Article 6(1) of the UK GDPR is because this allows us to process personal data when it is necessary to perform our public tasks as a University.

Our processing of your personal data will be based on Article 9(2)(j), which relates to archiving, research and statistics purposes, and Schedule 1, Part 1(4) of the DPA 2018, which relates to research.

In addition to the specific information provided above about why your personal data is required and how it will be used, there is also some general information which needs to be provided for you:

- The data controller is the University of East Anglia.
- For further information, you can contact the University's Data Protection Officer at dataprotection@uea.ac.uk
- You can also find out more about your data protection rights at the Information Commissioner's Office (ICO).
- If you are unhappy with how your personal data has been used, please contact the University's Data Protection Officer at dataprotection@uea.ac.uk in the first instance.

OK, I want to take part – what do I do next?

You need to fill in one copy of the consent form and return this via email to Seraj Brugi, seraj.brugi@uea.ac.uk. Please keep the information sheet and the second copy of the consent form for your information.

Further information

This information was last updated on 11/11/2024.

If there are changes to the information provided, you will be notified via email.

Appendix I

Version 2.1
11/11/2024

PARTICIPANT CONSENT FORM

I, ... [PRINT NAME], agree to take part in this research study.

In giving my consent I state that:

- I understand the purpose of the study, what I will be asked to do, and any risks/benefits involved.
- I have read the Participant Information Sheet, which I may keep, for my records, and have been able to discuss my involvement in the study with the researchers if I wished to do so.
- The researchers have answered any questions that I had about the study and I am happy with the answers.
- I understand that being in this study is completely voluntary and I do not have to take part. My decision whether to be in the study will not affect my relationship with the researchers or anyone else at the University of East Anglia now or in the future.
- I understand that I may stop the interview at any time if I do not wish to continue, and that unless I indicate otherwise any recordings will then be erased and the information provided will not be included in the study results. I also understand that I may refuse to answer any questions I don't wish to answer.
- I understand that the results of this study will be used in the way described in the information sheet.
- I understand that personal information about me that is collected over the course of this project will be stored securely and will only be used for purposes that I have agreed to. I understand that information about me will only be told to others with my permission, except as required by law.

I consent to:

Attending an online interview	YES	☐	NO	☐
Audio-recording	YES	☐	NO	☐
Reviewing transcripts	YES	☐	NO	☐
The use of quotes in publications	YES	☐	NO	☐

Would you like to receive feedback about the overall results of this study?

YES ☐ NO ☐

If you answered **YES**, please indicate your preferred form of feedback and address:

☐ Postal: _____

_____

☐ Email: _____

.....

Signature

....

PRINT name

.....

Appendix J

Version 2.1
11/11/2024

University of East Anglia

Participant Debrief Sheet

Understanding the lived experience of Post-SSRI/SNRI Sexual Dysfunction (PSSD)

Thank you for taking the time to participate in this study. To thank you for your time, we will be sending a £10 Love2Shop voucher to the email address you provided on your consent form.

Purpose of the Research

The aim of this research is to increase our understanding of the impact living with PSSD can have on people like yourself. We aim to publish our findings and contribute to the growing body of research on PSSD, giving a voice to the individuals whose lives are impacted. We hope the findings of this research may help to inform clinical practice, staff training, and future research. Your contribution to this is very valuable and the research team will strive to give a sensitive portrayal of matters identified within the research.

What happens next

The lead researcher will now transcribe your interview and aim to remove or replace any key identifiable details. You will then be emailed a copy of your transcript, and you will have two weeks to add any comments or reflections. If we do not hear from you within two weeks, we will assume you are happy with the transcript.

Your right to withdraw

If you no longer wish to be involved in this study, then you must email the researcher to let them know. You may withdraw from the study at any point prior to data analysis, which is

four weeks from the date of your interview. If you do choose to withdraw, you will not be asked to explain or provide a reason required for your withdrawal.

Contact details

If you have any questions, you may ask one of the investigators, please feel free to contact the lead researcher: Seraj Brugi, seraj.brugi@uea.ac.uk.

If you had any concerns that you would like to discuss with a staff member who is not part of the research team, please contact Professor Niall Broomfield, Head of the Department of Clinical Psychology and Psychological Therapies, N.Broomfield@uea.ac.uk.

Who can I turn to for support?

It can be normal to want to talk to someone about some of the issues we have discussed. If you would like any further support at all, It may be useful to speak to your GP regarding what support may be available locally.

You can find out how to self-refer to your local NHS Talking Therapies service here: https://www.nhs.uk/service-search/mental-health/find-an-NHS-talking-therapies-service/

The Samaritans are available 24/7 to talk to anyone who requires some support for their mental health, and you can call them for free on 116 123.

The research team thanks you for your participation in the study.

Appendix K

Submission instructions for The Journal of Sex Research:

Instructions for authors
Thank you for choosing to submit your paper to us. These instructions will ensure we have everything required so your paper can move through peer review, production and publication smoothly. Please take the time to read and follow them as closely as possible, as doing so will ensure your paper matches the journal's requirements.
We offer a range of editing, manuscript preparation and post publication services to assist you in preparing your manuscript for submission, increase your chance of acceptance, or broaden the readership of your article. General guidance on every stage of the publication process is available at our Author Services website.
SCHOLARONE MANUSCRIPTS™
This journal uses ScholarOne Manuscripts (previously Manuscript Central) to peer review manuscript submissions. Please read the guide for ScholarOne authors before making a submission. Complete guidelines for preparing and submitting your manuscript to this journal are provided below.

About the Journal
The Journal of Sex Research is an international, peer-reviewed journal publishing high-quality, original research. Please see the journal's Aims & Scope for information about its focus and peer-review policy.
Please note that this journal only publishes manuscripts in English.
The Journal of Sex Research accepts the following types of article: original articles, brief reports, registered reports.
The Journal of Sex Research (JSR) is a scholarly journal devoted to the publication of articles relevant to the variety of disciplines involved in the scientific study of sexuality. JSR is designed to stimulate research and promote an interdisciplinary understanding of the diverse topics in contemporary sexual science. JSR publishes empirical reports, brief reports, theoretical essays, review articles, methodological articles, commentaries, and letters to the editor. We do not accept personal narratives or case reports. Each year we publish the Annual Review of Sex Research, an issue devoted to comprehensive reviews of current topics in sexual science. JSR actively seeks submissions from researchers outside of North America.
Open Access
You have the option to publish open access in this journal via our Open Select publishing program. Publishing open access means that your article will be free to access online immediately on publication, increasing the visibility, readership and impact of your research. Articles published Open Select with Taylor & Francis typically receive 35% more citations* and over 5 times as many downloads** compared to those that are not published Open Select.
Your research funder or your institution may require you to publish your article open access. Visit our Author Services website to find out more about open access policies and how you can comply with these.
You will be asked to pay an article publishing charge (APC) to make your article open access and this cost can often be covered by your institution or funder. Use our APC finder to view the APC for this journal. Please note that only the corresponding author is eligible to request funding from their institution, and it is not possible to change the corresponding author to achieve eligibility after submission. For further information, please see details here.
Please visit our Author Services website if you would like more information about our Open Select Program.
*Citations received up to 7th August 2024 for articles published in 2019-2023. Data obtained on 7th August 2024, from Digital Science's Dimensions platform, available at https://app.dimensions.ai
**Usage in 2021-2023 for articles published in 2019-2023.
Peer Review and Ethics
Taylor & Francis is committed to peer-review integrity and upholding the highest standards of review. Once your paper has been assessed for suitability by the editor, it will then be triple anonymous peer reviewed by one independent, anonymous expert. If you have shared an earlier version of your Author's Original Manuscript on a preprint server, please be aware that anonymity cannot be

guaranteed. Further information on our preprints policy and citation requirements can be found on our Preprints Author Services page. Find out more about what to expect during peer review and read our guidance on publishing ethics.

Preparing Your Paper

All authors submitting to medicine, biomedicine, health sciences, allied and public health journals should conform to the Uniform Requirements for Manuscripts Submitted to Biomedical Journals, prepared by the International Committee of Medical Journal Editors (ICMJE).

Structure

Your paper should be compiled in the following order: title page; abstract; keywords; main text introduction, materials and methods, results, discussion; acknowledgments; declaration of interest statement; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figures; figure captions (as a list).

Word Limits

Please include a word count for your paper. There are no word limits for papers in this journal.

Image Descriptions

This journal now adds image descriptions (alternative text, alt text), to all images conveying information necessary for an understanding of your work. Image descriptions are typically used by systems such as pronouncing screen readers to make images accessible to people that cannot read or see the object due to a visual disability. Image descriptions can also provide better image context/descriptions to search engines, helping them to index an image properly and improve the discoverability of your research.

Taylor & Francis uses advanced Artificial Intelligence (AI) technologies to produce image descriptions and include them in your published content. You will have the opportunity to review image descriptions during the proofing process.

Authors have the option to include image descriptions as part of your submitted manuscript. If you choose to provide image descriptions, please follow our guidelines.

Style Guidelines

Please refer to these quick style guidelines when preparing your paper, rather than any published articles or a sample copy.

Please use American spelling style consistently throughout your manuscript.

Please use double quotation marks, except where “a quotation is ‘within’ a quotation”.

Please note that long quotations should be indented without quotation marks.

Formatting and Templates

Papers may be submitted in Word format. Figures should be saved separately from the text. To assist you in preparing your paper, we provide formatting template(s).

Word templates are available for this journal. Please save the template to your hard drive, ready for use.

If you are not able to use the template via the links (or if you have any other template queries) please contact us here.

The cover letter should include the following information: (a) a description of the ethical review process employed by the authors; (b) a statement that the manuscript has not been published and is not currently under consideration elsewhere. If the data has been published in some form elsewhere, the authors should indicate how the content of the submitted manuscript provides new information not available in previously published articles written by the authors.

All inquiries regarding journal policy and manuscript preparation/submission should be sent to the Editor:

The Journal of Sex Research
Cynthia A. Graham, PhD
Editor-in-Chief
The Journal of Sex Research
Professor, Department of Gender Studies
Senior Scientist, The Kinsey Institute
Indiana University
E-mail: cygraham@indiana.edu

Please also read the free to access editorial: Promoting Transparent Reporting of Conflicts of Interests and Statistical Analyses at the Journal of Sex Research for more information and guidelines on conflict of interests and statistical analyses when preparing your manuscript for submission.

Registered Reports

Registered Reports are a new form of submission offered at *Journal of Sex Research* (JSR) in which the proposed methods and analyses of one or more samples of primary data collection are reviewed

prior to research being conducted. High quality protocols are then provisionally accepted for publication following preregistration of the agreed upon proposal, but before data collection and analysis commences. This format is designed to promote the publication of methodologically rigorous, yet "result-agnostic" research, by minimizing both sources of researcher- and journal-induced bias in hypothesis-driven research (e.g., hypothesizing after results are known, "p-hacking", and selecting for significant effects [i.e., "the file drawer problem" and "publication bias"). Simultaneously, the format affords flexibility to conduct and report exploratory (unregistered) analyses when warranted (e.g., a strong, unexpected pattern of moderation).

The review process for Registered Reports is divided into two stages. At Stage 1, reviewers assess the proposed study(ies)—along with any unregistered study(ies) accompanying them–before data for the registered study(ies) are collected or analyzed. If a Stage 1 proposal is sufficiently strong, authors will be granted an "In Principle Acceptance" (IPA)—a commitment to publish the eventual Stage 2 paper, irrespective of whatever pattern of results is identified, providing the authors preregister and follow exactly the agreed upon Stage 1 protocol. At Stage 2, reviewers consider the full paper, inclusive of all unregistered and registered components, and their appraisal is more selectively focused on gauging fidelity to the Stage 1 protocol and a clear and reasonable interpretation of results.

JSR currently supports the consideration of Registered Reports for four different types of investigations:

1. Novel Hypothesis-Driven Study(ies)
2. JSR Replication Study
3. Study(ies) of Measurement/Assessment Development and Validation
4. Study(ies) of Small *n* Community Samples

Any of these Registered Report Types may be undertaken by a single research group executing their research design, or with a shared design executed/replicated across multiple labs (with effects reported both by the individual lab and synthesized across labs).

Finally, authors may apply for "Rapid Review" evaluation of their Registered Report proposal (e.g., for projects requiring fixed, expedited deadlines [e.g., thesis projects], involving rare time-limited data collection, etc.,).

Details of all supported Registered Report types, the Registered Reports process, and Rapid Review are described in the downloadable document of Comprehensive Guidelines for JSR Registered Reports. Prospective Authors are also encouraged to review our summary recommendations for Designing Compelling Stage 1 Registered Reports for JSR. Further questions about Registered Reports at JSR can be directed to jsr.registered.reports@gmail.com.

Ethics Approval

When reporting a study that involved human participants, their data or biological material, authors should include a statement in the Method section that confirms that the study was approved (or granted exemption) by the appropriate institutional and/or national research ethics committee. As our peer-review system is masked (blinded), please do not include the name of the ethics committee in the submitted manuscript; this can be added if the paper is accepted. However, in the online submission process, there is a question that asks authors to provide name and location of the IRB/ethics committee. If your manuscript does not report on any empirical study (for example, if it is a review, commentary, or theoretical article), please type in "N/A".

Retrospective ethics approval:

If a study has not been granted ethics committee approval prior to commencing, retrospective ethics approval cannot be obtained and it will not be possible to consider the manuscript for publication.

Taylor & Francis AI policy

Taylor & Francis is offering guidance to authors, editors, and reviewers on the use of such tools, which may evolve given the swift development of the AI field. Please use this link to find out more information and carefully review policies for authors.

References

Please use this reference style when preparing your paper. An EndNote output style is also available to assist you.

Taylor & Francis Editing Services

To help you improve your manuscript and prepare it for submission, Taylor & Francis provides a range of editing services. Choose from options such as English Language Editing, which will ensure that your article is free of spelling and grammar errors, Translation, and Artwork Preparation. Taylor & Francis Editing Services can also help you create research promotion materials, including infographics, video abstracts, lay summaries and graphical abstracts, to support your article's impact. For more information, including pricing, visit this website.

Checklist: What to Include

1. **Author details.** Please ensure everyone meeting the International Committee of Medical Journal Editors (ICMJE) requirements for authorship is included as an author of your paper. Please ensure all listed authors meet the Taylor & Francis authorship criteria. All authors of a manuscript should include their full name and affiliation on the cover page of the manuscript. Where available, please also include ORCiDs and social media handles (Facebook, X or LinkedIn). One author will need to be identified as the corresponding author, with their email address normally displayed in the article PDF (depending on the journal) and the online article. Authors' affiliations are the affiliations where the research was conducted. If any of the named co-authors moves affiliation during the peer-review process, the new affiliation can be given as a footnote. Please note that no changes to affiliation can be made after your paper is accepted. Read more on authorship.
2. Should contain an unstructured abstract of 200 words. Read tips on writing your abstract.
3. You can opt to include a **video abstract** with your article. Find out how these can help your work reach a wider audience, and what to think about when filming. Taylor & Francis Editing Services provides a video abstract creation service for a fee.
4. Between 3 and 5 **keywords**. Read making your article more discoverable, including information on choosing a title and search engine optimization.
5. **Funding details.** Please supply all details required by your funding and grant-awarding bodies as follows:
   For single agency grants
   This work was supported by the [Funding Agency] under Grant [number xxxx].
   For multiple agency grants
   This work was supported by the [Funding Agency #1] under Grant [number xxxx]; [Funding Agency #2] under Grant [number xxxx]; and [Funding Agency #3] under Grant [number xxxx].
6. **Disclosure statement.** This is to acknowledge any financial or non-financial interest that has arisen from the direct applications of your research. If there are no relevant competing interests to declare please state this within the article, for example: *The authors report there are no competing interests to declare*. Further guidance on what is a conflict of interest and how to disclose it.
7. **Data availability statement.** If there is a data set associated with the paper, please provide information about where the data supporting the results or analyses presented in the paper can be found. Where applicable, this should include the hyperlink, DOI or other persistent identifier associated with the data set(s). Templates are also available to support authors.
8. **Data deposition.** If you choose to share or make the data underlying the study open, please deposit your data in a recognized data repository prior to or at the time of submission. You will be asked to provide the DOI, pre-reserved DOI, or other persistent identifier for the data set.
9. **Supplemental online material.** Supplemental material can be a video, fileset, audio file or anything which supports (and is pertinent to) your paper. Articles with extenders, such as infographics or video summaries, are up to 108% more likely to be downloaded (based on data in May 2024 from Plain Language Summary of Publication and Clinical Trial Protocol articles published in Future Oncology in 2023). We publish supplemental material online via Figshare. Find out more about supplemental material and how to submit it with your article. Taylor & Francis Editing Services can help you create research promotion materials, including infographics, video abstracts, lay summaries and graphical abstracts, to support your article's impact. For more information, including pricing, visit this website.
10. **Figures.** Figures should be high quality (1200 dpi for line art, 600 dpi for grayscale and 300 dpi for colour, at the correct size). Figures should be supplied in one of our preferred file formats: PS, JPEG, TIFF, or Microsoft Word (DOC or DOCX) files are acceptable for figures that have been drawn in Word. For information relating to other file types, please consult our Submission of electronic artwork document.
11. **Tables.** Tables should present new information rather than duplicating what is in the text. Readers should be able to interpret the table without reference to the text. Please supply editable files.
12. **Equations.** If you are submitting your manuscript as a Word document, please ensure that equations are editable. More information about mathematical symbols and equations.
13. **Units.** Please use SI units (non-italicized).

Using Third-Party Material

You must obtain the necessary permission to reuse third-party material in your article. The use of short extracts of text and some other types of material is usually permitted, on a limited basis, for the

purposes of criticism and review without securing formal permission. If you wish to include any material in your paper for which you do not hold copyright, and which is not covered by this informal agreement, you will need to obtain written permission from the copyright owner prior to submission. More information on requesting permission to reproduce work(s) under copyright.

Disclosure Statement

Please include a disclosure statement, using the subheading "Disclosure of interest." If you have no interests to declare, please state this (suggested wording: *The authors report there are no competing interests to declare*). For all NIH/Welcome-funded papers, the grant number(s) must be included in the declaration of interest statement. Read more on declaring conflicts of interest.

Clinical Trials Registry

In order to be published in a Taylor & Francis journal, all clinical trials must have been registered in a public repository, ideally at the beginning of the research process (prior to participant recruitment). Trial registration numbers should be included in the abstract, with full details in the methods section. Clinical trials should be registered prospectively – i.e. before participant recruitment. However, for clinical trials that have not been registered prospectively, Taylor & Francis journals requires retrospective registration to ensure the transparent and complete dissemination of all clinical trial results which ultimately impact human health. Authors of retrospectively registered trials must be prepared to provide further information to the journal editorial office if requested. The clinical trial registry should be publicly accessible (at no charge), open to all prospective registrants, and managed by a not-for-profit organization. For a list of registries that meet these requirements, please visit the WHO International Clinical Trials Registry Platform (ICTRP). The registration of all clinical trials facilitates the sharing of information among clinicians, researchers, and patients, enhances public confidence in research, and is in accordance with the ICMJE guidelines.

Ethics of Experimentation

Please ensure that all research reported in submitted papers has been conducted in an ethical and responsible manner, and is in full compliance with all relevant codes of experimentation and legislation. All original research papers involving humans, animals, plants, biological material, protected or non-public datasets, collections or sites, must include a written statement in the Methods section, confirming ethical approval has been obtained from the appropriate local ethics committee or Institutional Review Board and that where relevant, informed consent has been obtained. For animal studies, approval must have been obtained from the local or institutional animal use and care committee. All research studies on humans (individuals, samples, or data) must have been performed in accordance with the principles stated in the Declaration of Helsinki. In settings where ethics approval for non-interventional studies (e.g. surveys) is not required, authors must include a statement to explain this. In settings where there are no ethics committees in place to provide ethical approval, authors are advised to contact the Editor to discuss further. Detailed guidance on ethics considerations and mandatory declarations can be found in our Editorial Policies section on Research Ethics.

Consent

All authors are required to follow the ICMJE requirements and Taylor & Francis Editorial Policies on privacy and informed consent from patients and study participants. Authors must include a statement to confirm that any patient, service user, or participant (or that person's parent or legal guardian) in any type of qualitative or quantitative research, has given informed consent to participate in the research. For submissions where patients or participants can be potentially identified (e.g. a clinical case report detailing their medical history, identifiable images or media content, etc), authors must include a statement to confirm that they have obtained written informed consent to publish the details from the affected individual (or their parents/guardians if the participant in not an adult or unable to give informed consent; or next of kin if the participant is deceased). The process of obtaining consent to publish should include sharing the article with the individual (or whoever is consenting on their behalf), so that they are fully aware of the content of the article before it is published. Authors should familiarise themselves with our policy on participant/patient privacy and informed consent. They may also use the Consent to Publish Form, which can be downloaded from the same Author Services page.

Health and Safety

Please confirm that all mandatory laboratory health and safety procedures have been complied within the course of conducting any experimental work reported in your paper. Please ensure your paper contains all appropriate warnings on any hazards that may be involved in carrying out the experiments or procedures you have described, or that may be involved in instructions, materials, or formulae.

Please include all relevant safety precautions; and cite any accepted standard or code of practice. Authors working in animal science may find it useful to consult the International Association of Veterinary Editors' Consensus Author Guidelines on Animal Ethics and Welfare and Guidelines for the Treatment of Animals in Behavioural Research and Teaching. When a product has not yet been approved by an appropriate regulatory body for the use described in your paper, please specify this, or that the product is still investigational.

Submitting Your Paper

This journal uses ScholarOne Manuscripts to manage the peer-review process. If you haven't submitted a paper to this journal before, you will need to create an account in ScholarOne. Please read the guidelines above and then submit your paper in the relevant Author Centre, where you will find user guides and a helpdesk.

Please note that *The Journal of Sex Research* uses Crossref™ to screen papers for unoriginal material. By submitting your paper to *The Journal of Sex Research* you are agreeing to originality checks during the peer-review and production processes.

On acceptance, we recommend that you keep a copy of your Accepted Manuscript. Find out more about sharing your work.

Data Sharing Policy

This journal applies the Taylor & Francis Basic Data Sharing Policy. Authors are encouraged to share or make open the data supporting the results or analyses presented in their paper where this does not violate the protection of human subjects or other valid privacy or security concerns.

Authors are encouraged to deposit the dataset(s) in a recognized data repository that can mint a persistent digital identifier, preferably a digital object identifier (DOI) and recognizes a long-term preservation plan. If you are uncertain about where to deposit your data, please see this information regarding repositories.

Authors are further encouraged to cite any data sets referenced in the article and provide a Data Availability Statement.

At the point of submission, you will be asked if there is a data set associated with the paper. If you reply yes, you will be asked to provide the DOI, pre-registered DOI, hyperlink, or other persistent identifier associated with the data set(s). If you have selected to provide a pre-registered DOI, please be prepared to share the reviewer URL associated with your data deposit, upon request by reviewers. Where one or multiple data sets are associated with a manuscript, these are not formally peer-reviewed as a part of the journal submission process. It is the author's responsibility to ensure the soundness of data. Any errors in the data rest solely with the producers of the data set(s).

Publication Charges

There are no submission fees, publication fees or page charges for this journal.

Color figures will be reproduced in color in your online article free of charge. If it is necessary for the figures to be reproduced in color in the print version, a charge will apply.

Charges for color figures in print are £300 per figure ($400 US Dollars; $500 Australian Dollars; €350). For more than 4 color figures, figures 5 and above will be charged at £50 per figure ($75 US Dollars; $100 Australian Dollars; €65). Depending on your location, these charges may be subject to local taxes.

Copyright Options

Copyright allows you to protect your original material, and stop others from using your work without your permission. Taylor & Francis offers a number of different license and reuse options, including Creative Commons licenses when publishing open access. Read more on publishing agreements.

My Authored Works

On publication, you will be able to view, download and check your article's metrics (downloads, citations and Altmetric data) via My Authored Works on Taylor & Francis Online. This is where you can access every article you have published with us, as well as your free eprints link, so you can quickly and easily share your work with friends and colleagues.

We are committed to promoting and increasing the visibility of your article. Here are some tips and ideas on how you can work with us to promote your research.

Queries

If you have any queries, please visit our Author Services website or contact us here.

Updated 11th February 2026

Appendix L

Excerpt - Arthur's transcript.

Personal experiential statements	Transcript	Exploratory notes (descriptive, *linguistic* [including pertinent phrases] and conceptual)
I'm now a different person Isolated and disconnected	**Arthur:** Because prior to, prior to that happening, you know I'd been working full time and I'd been doing a [degree] as well and I- in my spare time- and when I, you know, like when I look back and I see like how I was able to write then compared to what I'm able to do now, you know, it's like I just, I don't know how I would be able to write like that. It's just like my brain just hasn't got that kind of capability anymore. But yeah, it's just literally it's, it's, it's horrifying. And it's very isolating when you're kind of- to be and when you're in this position where it's like you've lost your connection to life. You've lost your connection to, you know, people and everything that matters, you know. **Interviewer***:* Yeah, yeah, yeah.	Changes in "*capability"* since PSSD re: writing. He is describing some big changes to himself, looking back must be difficult? "*I don't know how I would be able to write like that"* - Struggles to recognise parts of who he was. Must come with such a big shift in identity? *It's "horrifying", "very isolating".* Describes losing his "*connection to life… people and everything that matters".* How can he be connected to a world that doesn't believe or understand him?
Not believed Hurt by those meant to help	**Arthur:** And, and, you're just basically being told that you've made it up and it's, it's the result of some of, like, the kind of institutions that are kind of there to kind of care for you and help you supposedly.	"*Made it up"* - not only is he not believed, he is being made to feel bad for this. Disappointment in healthcare institutions that are meant to "*care for you… supposedly".*

Appendix M

Master list of participants' personal experiential themes, subthemes and *excerpts from indicative quotes*.

Frank:

Done to me, not with me.

I didn't consent to this. *"I would have never touched them if I'd known…" (6:10)*

The system betrayed me. *"He's [doctor] still prescribing medication that can destroy someone…" (11:50)*

Regret. "*So foolishly I went along with that [taking SSRIs]…" (0:24)*

Disconnected from others.

An emotional statue. *"It takes away your emotions, you know, I'm walking around like a statue [light chuckle]…" (7:07)*

Disbelieved and rejected. *"He [doctor] turned around and said 'impossible' […] As if I was making it up, kind of thing…" (2:01)*

A burden on loved ones. *"I felt a bit of a burden, so I kind of ended that…" (10:20)*

Unlike my peers. *"He [friend] doesn't understand that he might have lost a little bit of libido because most men over 50 do... but [laughs] I've lost all of it" (22:07)*

A different man.

Who am I now? "*Nah I'm different, totally different. It's not me…" (21:05)*

What PSSD has taken away from me. *"Yeah, it's taken away - almost like a death sentence…" (21:21)*

A brief window into who I was. *"A lot of [the genital numbness] seemed to lift… but then it was just a window…" (9:01)*

Alicia*:*

I can't trust the professionals

Not being taken seriously. *"I just felt, yeah, like there wasn't much importance placed on it…" (11:22)*

Healthcare can't be trusted. "*I feel, yeah, distrusting of… even doctors, really…" (28:44)*

Who have I got?

An isolating condition. *"I suppose I felt kind of isolated, and the fact that there's no treatment for it is - it's a worry…" (14:52)*

Wanting to be heard. *"I suppose just for them [therapists] to kind of be there and to listen and just listen to people's experiences…" (35:02)*

Going along with things just for connection. *"Sometimes I think I've almost felt a bit used as well at times, because I've kind of gone along with things…" (24:05)*

Something is wrong with me

Embarrassed by the condition. "*I tend to just mainly talk about other mental - my other difficulties (to counsellor), because it's [PSSD] embarrassing…" (31:01)*

Am I good enough? *"So I suppose at times it's made me quite low, and feel like I'm not good enough…" (17:21)*

Relationships are now confusing. *"It's made me question the relationships I've been in, made me think 'well is it them or is it this'…" (16:09)*

Less womanly. *"I would say less, like [pause] sort of like less womanly, I suppose…" (18:01)*

Disconnected from feelings

Feeling numb. "*I just didn't feel anything in that way… come out kind of feeling kind of empty…" (26:48)*

Going through the motions. "*It's just kind of like going through the motions and not really feeling anything and just feeling numb really…" (12:29)*

Lucas:

Why didn't I know?

I should have known better. "*If I Googled it, maybe I would have found it [PSSD]. But I was naive, you know?..." (3:48)*

I'm responsible. "*I should have done my research, frankly, you know. It's my fault…" (3:07)*

Wariness of mental health 'revolution'. "*Anything that leads to an SSRI is bad in my opinion…" (44:01)*

Self-forgiveness. "*I don't beat myself up about it…" (37:36)*

All that I've lost

The loss is enormous. *"I can't deal with just being anymore…. because it's so harrowing, like the enormity of what's happened…" (36:49)*

A new, unexpected future - and me. *"It's not going to be the life you ever thought you would lead..." (39:40)*

Permanently injured. *"What feels like a permanent injury…" (3:48)*

My place in the world

Alone in this world. *"What is the life of just never having a family…" (16:48)*

I can't trust people. *"I know that people who say they're [SSRIs] safe and - I know them to be wrong…" (42:06)*

Hope remains

Yearning for more. *"I've started going to church… it's like you're clutching for something…" (25:45)*

Finding new ways of relating. "*I think relationships are possible for anyone… much more negotiated and based on compromise and practicalities…" (32:11)*

Validating experiences. *"I found it [counselling] useful with PSSD…" (47:42)*

Arthur:

A different, changed me

Enormous loss. *"It's hard to put into words like the kind of loss…" (23:57)*

Identity crisis. *"I'm not the same person anymore…" (25:37)*

‘Damaged goods’. *“It just feels like I’ve kind of got brain damage…” (30:11)*

Rejected by medicine

Unheard and disbelieved. *“And you’re just basically being told that you’ve made it up…” (19:51)*

Hurt by the helpers. *“They’ve known about it [PSSD] … just decided not to tell anybody…” (47:31)*

I can’t trust the professionals. *“I just don’t trust any of it… they’ve [doctors] been fed this dogma…” (49:20)*

The horror movie that is now life

My feelings are gone. “*My emotions were completely numbed. It was like I no longer could feel excited…” (12:51)*

Isolated and alone. “*It’s very isolating when… you’ve lost your connection to life… people and everything that matters (18:55)*

Judged by others and self. *“I feel like other people have judged me and my circumstances” (26:42)*

Doing what I can

I’m in survival mode. “*It’s like being in a horror movie…. I’ve had to learn to kind of, to survive…” (39:40)*

Controlling what I can. *“In terms of managing my mental health, it had been sort of like, greatly improved…” (35:29)*

Self-care is important. *“I’m in the kind of- I’m in great shape, so that helps…” (37:07)*

Positive experiences of therapy. “*I’ve done [CBT] to kind of help me with the understanding… the experiences in my sort of past…” (37:07)*

Jo:

Unhelped by the helpers

They don’t believe me. *“She [doctor] just said ‘I’m sceptical that happened’…” (5:23)*

Missed opportunities for validation. “*When I tell them [doctors] about it, they’re like ‘well I haven’t officially been told’, not ‘oh thanks for telling me about this’…” (35:42)*

Distrustful of services. “*I wouldn’t trust these people as far as I could throw them…” (52:46)*

The ‘hysterical’ woman. “*They’re [NHS staff wearing lanyards] very concerned about sexuality and identity… yet when they talk to women [laughs]…” (35:42)*

Something’s wrong

Doubting myself and relationship. *“It must be me or it must be us, it must be him, it must be something going on…” (30:29)*

Parts of me removed. “*My sexuality has been removed…” (35:42)*

An altered path in life

Stuck in time. *“If I look at what development has happened with me over the past 10-15 [years], literally nothing has happened…” (49:28)*

Fighting for myself. *“It’s what it’s removed, then it’s also what it’s forced me to become...” (35:42)*

Bethany:

The tentacles of PSSD

An altered life in every way. “*It’s like it’s one thing, but then it’s like - it has these, like, tentacles…” (33:47)*

What PSSD has taken from me. *“Will I ever experience that [a relationship?], you know?…” (27:48)*

Vulnerabilities to abuse. “*He could abuse me basically, you know, and it’s like, and I didn’t react [because of numbness/PSSD]…” (47:57)*

The hindered self

Broken parts of me. *“If my body’s not working…” (27:48)*

Not fully human. “*It’s taken away the most fundamental things about being human...” (31:55)*

Not relating to other women. *“It’s so mad at this age… having to go and ask your [female] friends…” (12:01)*

What could have been

Missed opportunities for help. “*I could have just done with some counselling or someone to talk to…” (0:12)*

Wrongly labelled. "*They referred me to the mental health team… I don't have a mental health problem…" (15:13)*

Glimmers of hope. *"I noticed these little windows… I felt joy for the first time" (12:01)*

The lightbulb moment

Wading through smoke. "*I've been wading through smoke…" (17:51)*

Seeking answers. "*I'm trying to explore options of what's available…" (16:22)*

Things falling into place. "*There's so many aspects of my life that like now make sense and fall into place…" (50:19)*

Making sense of new experiences. *"I was really [mind blown]….but it's probably like a normal thing…" (12:01)*

Thomas:

Let down by the system

Losing faith in healthcare. "*I haven't been to my GP since then, because like to me that was ridiculous…" (1:10:38)*

Medical gaslighting. "*This was another like, I guess episode of being gaslit…" (1:12:23)*

I'm in this alone. "*No one's, I guess, going to help me…" (58:58)*

The injustice of PSSD. "*Now I'm harmed, like, do I not deserve the same treatment as a depressed patient…" (1:23:34)*

Some positive experiences. *"The [person at facility] straight away knew that it was PSSD, so I'm, I'm really grateful for that…" (1:12:23)*

The nothingness that is life with PSSD

An unemotional existence. *"If I could say I want my emotions for like… 5 years and then… I can die… I will take that…" (50:43)*

Engulfed by the condition. "*PSSD reminds me of like a sphere… perfect in how it affects everything…" (43:00)*

Anything is better than this. "*Cancer is not a nice disease, but I would much, much prefer it…" (50:43)*

There is no 'mental health'. "*When you have PSSD, you don't have 'mental health'…" (58:18)*

Pretend mode

Life is now a script. "*I'm having to remember who I was to try and still be that person…" (46:11)*

I'm acting from memory. "*I was still able to somewhat function because the pre-PSSD me was like the memory…" (42:16)*

PSSD makes me ashamed. "*I haven't had sex since, and I don't want to put myself through the humiliation…" (39:29)*

Be a man. "*It's your duty as a man to shoulder the burden…" (0:28)*

A changed person

Not moving forward in life. "*When you have PSSD, your life is on pause…" (34:03)*

I'm just a corpse now. "*If I [prospective partner] want, like, this [kind of relationship], I'll go date a corpse…" (39:29)*

This isn't what sex felt like for me before. "*That [erectile dysfunction] was different to what I had experienced on the SSRI… I've been so confident, I've never had issues ever…" (15:09)*

Tony:

Dismissed by professionals.

Feeling dismissed and targeted. *"I got sick of health professionals not [believing] me about this condition…" (59:07)*

Regretting the decision. "*It's like, left me with regrets that I will have to live with for the rest of my life…" (25:07)*

Needing to be seen

Seeking answers. *"I started looking up online to see if there was other people who suffered this…" (16:01)*

Taking PSSD to therapy. "*We [Tony and psychologist] used to end up basically talking about the PSSD more than [other problems]…" (59:07)*

Imprisoned in my own body

A hollow internal world. "*I had some sex and stuff, and I did do a bit of travelling, but it was completely hollow…" (24:32)*

Life is sometimes not worth living. "*In the first three years of having PSSD I was very suicidal, and I didn't cope with it well…" (48:17)*

A boy not a man. "*Like that part of you hadn't developed yet…" (32:46)*

Missing out on life. "*I also kind of feel like, like everything is sort of second or even third best…" (23:32)*

Navigating society with PSSD is difficult

Ashamed and embarrassed. "*There's a lot of awkward, embarrassing questions…" (37:51)*

Alone in this. "*The isolation aspect of it is very, very unpleasant…" (21:01)*

Triggered by society and others. "*There's also a lot of triggers within friendship groups with people who don't have PSSD…" (39:42)*

PSSD as Hell

Take me back to Heaven. *"If I could go back to my life, you know, before having PSSD… Heaven.." (42:51)*

Nightmares. "*I have nightmares about never recovering…" (43:34)*

Windows into what life could be. "*[My sexuality] partially returns and then it just vanishes again…" (43:16)*

The upside of Hell. "*Having PSSD for a very long time… built this sort of mental toughness…" (48:57)*

Michael:

A problem dismissed

Dismissed by medics. "*It's easy to dismiss when people do genuinely get harmed by them…" (50:28)*

Angry and let down. *"I don't understand why they clearly did so much damage… and you [family] did nothing…" (30:18)*

Regret

What I wish I did instead of SSRIs. "*I could have just gone travelling or I could have done a million things…" (1:00)*

I've been scammed. "*I feel like I've been scammed basically…" (22:56)*

Assaulted by the condition

A life ripped to shreds. "*If you want to totally tear someone's life to shreds, putting them on SSRIs is a pretty good way…" (9:41)*

Paralysed by PSSD. "*There's just a million things I would have loved to have done, and now I'm just basically paralysed…" (10:32)*

Dead whilst alive. "*It's literally like finding out you're dead…" (16:16)*

Who am I?

I'll never figure myself out. "*To have your sexuality blunted while you're trying to figure it out…" (15:16)*

A changed manhood. "*It's like the core of your manhood, like or whatever the heart, the nucleus…" (25:00)*

I'm stuck in time. "*You can't grow as a person anymore…" (29:26)*

No more feeling

Emotionally repressed. *"I mean this [being emotional] is good, the fact I'm crying is good. I think I've got a lot of repressed emotion…" (7:32)*

Life has no colour. *"It's just like all the colour has gone…" (20:39)*

Empty with no drive. "*It's almost like… [if you] masturbate 10 times in a row and you're completely empty… that's how I feel 24/7…" (28:24)*

Small mercies that keep me going

Focusing on what I can do. "*So I'm just sort of thinking now what's the best I can do…" (37:04)*

Comradery in fellow sufferers. "*There's a lot of, like, skills in the PSSD community…" (22:56)*

Moments of joy. "*That's what I live for now, just those tiny little moments…" (42:54)*

What helpful therapy might look like. "*The best thing you can do is find ways to, like, get out of your head…" (53:24)*

Stacey:

Distrustful of professionals

Full of regret. "*Angry, more angry at myself like, you really wasn't even that bad…" (58:44)*

Feeling dismissed. *"You feel completely dismissed…" (21:15)*

Unheard by the doctors. *"And then when you also try to go to a doctor…" (16:35)*

Let down by the system. *"Would the NHS fund me to have fertility treatment? That's the question, you know, and then- no, they're not…" (48:23)*

I'm not who I was

Forcefully changed sexual identity. "*I'm forced to be asexual in a way…" (55:01)*

Not fully human. "*You feel like you're not human…" (21:15)*

Am I a woman? *"My sense of self as a woman and a sexual being has been stripped away from me…" (43:07)*

What PSSD has done to me

Permanently damaged. "*There's no amount of therapy, no amount of [doctors] will ever give that back to me…" (28:30)*

PSSD is unfair. "*This shouldn't be happening to me…" (50:14)*

What could have been. "*I just think I'm missing out on all that…" (55:01)*

Relating to myself and others

Disconnected and isolated. "*This condition really does, like, isolate you…" (23:29)*

An alien body. "*You don't want the body that you're in…" (19:27)*

Emotionally and physically numb. "*When I just look at it, I just feel so numb…" (26:55)*

Therapy can't help me

Therapy "is useless". "*They [therapists] were all useless…" (28:30)*

Don't patronise me. *"I don't want any of those kind of questions that allude to 'are you sure?'… that just isolates you even more…" (1:05:28)*

Feeling dismissed and invalidated. *"For me there's like, a complete refusal almost to hear what I'm saying…" (28:30)*

Educating the therapists. "*It ends up me having to educate them [therapists]…" (28:30)*

What has actually helped. "*I try to have a routine I guess, I try to exercise…" (1:02:06)*

Appendix N

Group experiential themes (GETs), subthemes and examples of participants' personal experiential themes and subthemes which contributed to the GET/subtheme development.

Group experiential theme	Subtheme	Examples of contributing personal experiential themes and subthemes
Distrustful of Professionals	Not being informed	Why didn't I know?: I should have known better (Lucas) Done to me, not with me: I didn't consent to this (Frank) Regret: I've been scammed (Michael)
	Dismissed and unheard	I can't trust the professionals: Not being taken seriously (Alicia) Rejected by medicine: Unheard and disbelieved (Arthur) Unhelped by the helpers: They don't believe me (Jo)
A Changed Me	This emptiness inside me	The nothingness that is life with PSSD: An unemotional existence (Thomas) No more feeling: Emotionally repressed (Michael) Relating to myself and others: Emotionally and physically numb (Stacey)
	Struggling to relate	The hindered self: Not relating to other women (Bethany) Navigating society with PSSD is difficult: Triggered by society and others (Tony) Disconnected from others: Unlike my peers (Frank)
	Who am I now?	A different, changed me: Identity crisis (Arthur) Who am I?: I'll never figure myself out (Michael) I'm not who I was: Am I a woman? (Stacey)

Living With the Impact	What PSSD has taken away	The tentacles of PSSD: What PSSD has taken from me (Bethany) Imprisoned in my own body: Missing out on life (Tony) Assaulted by the condition: Paralysed by PSSD (Michael)
	Taking PSSD to therapy	Therapy can't help me: Educating the therapists (Stacey) Doing what I can: Positive experiences of therapy (Arthur) Hope remains: Validating experiences (Lucas)
	What helps me to cope	Doing what I can: Self-care is important (Arthur) PSSD as Hell: The upside of Hell (Tony) Therapy can't help me: What has actually helped (Stacey)

Appendix O

Standards for Reporting Qualitative Research (SRQR)*

http://www.equator-network.org/reporting-guidelines/srqr/

Page/line no(s).

Title and abstract

Title - Concise description of the nature and topic of the study Identifying the study as qualitative or indicating the approach (e.g., ethnography, grounded theory) or data collection methods (e.g., interview, focus group) is recommended	51
Abstract - Summary of key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results, and conclusions	52

Introduction

Problem formulation - Description and significance of the problem/phenomenon studied; review of relevant theory and empirical work; problem statement	53-54
Purpose or research question - Purpose of the study and specific objectives or questions	55

Methods

Qualitative approach and research paradigm - Qualitative approach (e.g., ethnography, grounded theory, case study, phenomenology, narrative research) and guiding theory if appropriate; identifying the research paradigm (e.g., postpositivist, constructivist/ interpretivist) is also recommended; rationale**	55, 58
Researcher characteristics and reflexivity - Researchers' characteristics that may influence the research, including personal attributes, qualifications/experience, relationship with participants, assumptions, and/or presuppositions; potential or actual interaction between researchers' characteristics and the research questions, approach, methods, results, and/or transferability	56, 58
Context - Setting/site and salient contextual factors; rationale**	57
Sampling strategy - How and why research participants, documents, or events were selected; criteria for deciding when no further sampling was necessary (e.g., sampling saturation); rationale**	56
Ethical issues pertaining to human subjects - Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security issues	55, 58
Data collection methods - Types of data collected; details of data collection procedures including (as appropriate) start and stop dates of data collection and analysis, iterative process, triangulation of sources/methods, and modification of procedures in response to evolving study findings; rationale**	55-58

Data collection instruments and technologies - Description of instruments (e.g., interview guides, questionnaires) and devices (e.g., audio recorders) used for data collection; if/how the instrument(s) changed over the course of the study	56-58
Units of study - Number and relevant characteristics of participants, documents, or events included in the study; level of participation (could be reported in results)	58-59
Data processing - Methods for processing data prior to and during analysis, including transcription, data entry, data management and security, verification of data integrity, data coding, and anonymization/de-identification of excerpts	57-58
Data analysis - Process by which inferences, themes, etc., were identified and developed, including the researchers involved in data analysis; usually references a specific paradigm or approach; rationale**	58
Techniques to enhance trustworthiness - Techniques to enhance trustworthiness and credibility of data analysis (e.g., member checking, audit trail, triangulation); rationale**	58

Results/findings

Synthesis and interpretation - Main findings (e.g., interpretations, inferences, and themes); might include development of a theory or model, or integration with prior research or theory	60-73
Links to empirical data - Evidence (e.g., quotes, field notes, text excerpts, photographs) to substantiate analytic findings	60-73

Discussion

Integration with prior work, implications, transferability, and contribution(s) to the field - Short summary of main findings; explanation of how findings and conclusions connect to, support, elaborate on, or challenge conclusions of earlier scholarship; discussion of scope of application/generalizability; identification of unique contribution(s) to scholarship in a discipline or field	73-75
Limitations - Trustworthiness and limitations of findings	75-76

Other

Conflicts of interest - Potential sources of influence or perceived influence on study conduct and conclusions; how these were managed	77
Funding - Sources of funding and other support; role of funders in data collection, interpretation, and reporting	78

*The authors created the SRQR by searching the literature to identify guidelines, reporting standards, and critical appraisal criteria for qualitative research; reviewing the reference lists of retrieved sources; and contacting experts to gain feedback. The SRQR aims to improve the transparency of all aspects of qualitative research by providing clear standards for reporting qualitative research.

**The rationale should briefly discuss the justification for choosing that theory, approach, method, or technique rather than other options available, the assumptions and limitations implicit in those choices, and how those choices influence study conclusions and transferability. As appropriate, the rationale for several items might be discussed together.

Reference:

O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. **Standards for reporting qualitative research: a synthesis of recommendations.** *Academic Medicine*, Vol. 89, No. 9 / Sept 2014
DOI: 10.1097/ACM.0000000000000388