Assessing, diagnosing, and treating 
SSRI-induced sexual dysfunction

Jennifer J. Montgomery, MSW

Jennifer J. Montgomery graduated from the University of Michigan School of Social Work with a MSW in Interpersonal Practice and Mental Health. Prior to graduate school, Jennifer attended Western Michigan University where she received her bachelor’s degree in Psychology and Women Studies. She is currently employed at the University Of Michigan Department Of Psychiatry working for The Heinz C. Prechter Bipolar Research Fund and the Adult Ambulatory Psychiatry Clinic. Her professional emphasis is clinical social work practice. She also has a strong interest in research stemming from previous experience working for the University of Michigan Addiction and Research Center.

Abstract

Selective serotonin re-uptake inhibitors (SSRIs) are common antidepressants prescribed for a broad spectrum of mental health concerns. While there are benefits of taking SSRIs such as mood improvement and increased motivation, negative side effects such as sexual dysfunction (SD) are a usual occurrence for individuals who are prescribed this class of antidepressants. This paper illustrated the assessment, formulation of diagnosis, and treatment planning process mental health practitioners should consider when working with an individual who presents SSRI induced SD. This paper also addressed implications and needs for future research that must be considered in order to further address this issue. Specific attention to this topic is needed to better understand and treat this disabling side effect.
Introduction

Selective serotonin re-uptake inhibitors (SSRIs) are common antidepressants prescribed for a broad spectrum of mental health concerns. SSRIs are known to be effective in treating symptoms of major depressive disorder, dysthymia, obsessive-compulsive disorder, panic disorder, social phobia, bulimia, weight reduction, alcoholism, behavioral disturbances associated with dementia, pre-menstrual dysphoric disorder, chronic fatigue syndrome, and schizophrenia (Lane, Baldwin, & Preskorn, 1995). While there are benefits of taking SSRIs such as mood improvement and increased motivation, negative side effects such as sexual dysfunction (SD) are a usual occurrence for individuals who are prescribed this class of antidepressants.

SSRIs may have an impact on any or all aspects of the sexual cycle which may involve decreased or no libido, impaired sexual arousal, erectile dysfunction, absence or delayed orgasm as well as delayed ejaculation (Balon, 2006). Side effects such as reduction in desire, arousal, and or release occur in 30% to 50% or more of individuals treated with SSRIs (Keltner, McAfee, & Taylor, 2002). Due to SSRI induced SD many patients become noncompliant with this form of pharmaceutical treatment.

This paper illustrates the assessment, formulation of diagnosis, and treatment planning process mental health practitioners should consider when working with an individual who presents SSRI induced SD. Some discussion was given to the treatment of SSRI induced SD among couples. Lastly, this paper addresses implications and needs for future research that must be considered in order to further address this issue. Specific attention to this topic is needed to better understand and treat this disabling side effect.

Assessment

Assessing symptoms

A detailed description of the patient’s symptoms is crucial for assessing SSRI induced SD. Therefore, the clinician should first ask the patient to provide a clear description of any difficulties in
his/her sexual functioning. However, this issue must be brought up with the upmost concern and respect for the client due to its sensitive nature. A clinician may choose to bring up the issue of sexual dysfunction by stating “just like your general health and well-being your sexual health is very important as well. So how is your sexual health?”

**Evaluate sexual history and explore alternative causes**

The greatest difficulty in the assessment process for mental health practitioners is that although SD is a common pharmaceutical side effect, SD is also a symptom of many other possible variables. Therefore, gathering an in-depth assessment of the symptoms prior to using SSRIs is essential to the assessment and diagnosis of SSRI induced SD, ruling out alternative causes of SD. A thorough examination of the patient’s sexual history can be conducted by asking about the phases of sexual function, sexual fantasies, frequency of intercourse and or masturbation, and satisfaction with overall sexual functioning.

There are multiple alternative factors that can have an effect on the onset of SD. For example, patients suffering from depression frequently complain about a lack or decrease in sexual desire. *Mental disorders*, such as depression is found to be associated with erectile dysfunction, impaired female arousal, delayed orgasm/ejaculation, and anorgasmia (Clayton & Balon, 2009). Similarly, the assessment of SD in clients with anxiety disorders should focus particular attention to factors such as baseline anxiety, performance anxiety, interpersonal anxiety, and the role of possible past sexual trauma which all impact SD (Clayton et al., 2009). Complicating assessment even more, the greater severity of symptoms from mental illness the more frequent and severe the SD can be (Clayton et al., 2009).

Preexisting SD due to a mental disorder is not the only factor that must be considered. A number of other factors can contribute to the onset of SD. Sexual desire can be affected by *various emotional states or interpersonal factors* such as joy, sorrow, mutual affection, and disagreement (Balon, 2006). In addition, *physical illnesses* as well as recreational drugs and social stressors are all known to cause SD. Conditions such as adrenal disease,
alcoholism, atherosclerosis, cardiac disease, central nervous system disease, diabetes, liver disease, peripheral nervous system disease, pituitary disease, and thyroid disease are all associated with SD (Keltner et al., 2002). Substance use including nicotine, alcohol, heroin, methadone, and marijuana must also be evaluated, particularly amongst individuals who may use these substances to self medicate Clayton et al., 2009). Lastly, social stressors such as the effect of mental illness on relationships and behavior, present home life, capacity to experience pleasure, and development must be assessed because human sexual behavior is subject to social and cultural influences that may vary with time, place, ethnic group, and social class (Balon, 2006). As such, the assessment of the exact cause for SD can be particularly challenging.

Patient perspectives

A part from gathering information on the onset of the SD, it is also important to collect information regarding the patient’s understanding of cause and maintenance of the sexual difficulty. As previously discussed, mental illnesses can contribute greatly to the development of SD. Patients must consider the source of their sexual problems and be careful not to automatically blame medications as the root of their issue (Girodano, 2001). Having this patient understanding will play greatly into the treatment planning process, as proper psycho-education surrounding the diagnosis would be necessary. Past history of medical, psychological, and self-help treatment would also be needed in order to establish a person centered plan. Finally, asking the patient about their expectations for treatment is an essential aspect of the assessment process. Given the complexity of SSRI induced SD it is imperative that patients have both reasonable and clear expectations for treatment outcomes. This includes discussion surrounding the patient’s tolerability to the sexual side effect. Tolerability is determined by comparing the severity of the side effect to the degree of therapeutic benefit the patient gains from the medication, including the suffering the patient experiences from the illness itself (Rivas-Vazquez, Blais, Roy, & Rivas-Vazquez, 2000). Knowing the patient’s level of tolerability will allow a determination for what intervention is necessary.
Formulation of diagnosis

Lack of disclosure and noncompliance

While SD is a common side effect for many individuals prescribed SSRIs for mental health concerns, disclosure of this issue is rare. As a consequence, this may impede the clinician’s formulation of a diagnosis. Studies show that men are more likely than women to report SD (Meston, 2004). Many women either feel too self-conscious to raise sexual issues with their doctors (Giordano, 2001) or they attribute their sexual side effects to interpersonal issues instead of their medication (Meston, 2004). This lack of disclosure has negative implications for SSRI users, such as noncompliance. A recent study found that in patients with major depressive disorder, who were being treated with SSRIs, diminished libido and orgasmic dysfunction were among the top five reasons for medication noncompliance (Clayton et al., 2009). Another negative implication of SD contributing to noncompliance is that it acts as an additional stressor and represents yet another loss to the depressed patient (Keltner et al., 2002). Therefore, clinicians must feel comfortable approaching the subject of SSRI induced SD without initial patient disclosure.

Underlying biological mechanisms related to SD

According to the American Psychiatric Association (DSM-IV-TR), SD associated with medications is characterized by disturbances in the sexual response cycle, determining marked distress, or interpersonal difficulties (2000). SSRI induced SD is known to cause difficulty in all stages of the sexual response cycle including desire, arousal, and orgasm. “Although the precise mechanism of action by which antidepressants influence sexual function is unknown, central serotonergic and dopaminergic systems have been implicated most frequently” (Meston, 2004). This is because drugs that enhance serotonin or block dopamine tend to decrease sexual activity (Keltner et al., 2002). Dopamine influences sexual desire, sexual motivation, and sustained desire or cognitive arousal. Norepinephrine also plays a role in both cognitive and genital arousal (Clayton et al., 2009). This is theorized as to why
delayed ejaculation/orgasm is considered the most specific sexual side effect of SSRIs. Due to the influence that SSRIs and other serotonergic antidepressants have on the serotonin system, delayed ejaculation and orgasm are known to occur (Clayton et al., 2009). The influence of SSRIs on an individual’s ability to orgasm is speculated to then impact the other areas of sexual response.

Identify orgasmic disorder

When reported, men and women utilizing SSRIs are known to have a severely diminished or even eliminated ability to orgasm/ejaculate (Girordano, 2001). This issue is called orgasmic disorder and it is characterized by a persistent or recurrent delay in or absence of orgasm following a normal sexual excitement phase and causes marked distress or interpersonal difficulties (DSM-IV-TR, 2000). Orgasmic disorder is thought to then contribute to psychological factors that inhibit other areas of the sexual response cycle. For example, performance anxiety is the most common psychological disturbance in men with SD. This corresponds to a fear of sexual acts where anxiety regarding sexual activity becomes an overriding block of sexual feelings and thoughts (Corona, Ricca, Bandini, Mannucci, Lotti, Boddi, Rastrelli, Sforza, Faravelli, Forti, & Maggi, 2009). Emotional disturbances such as performance anxiety can have direct effect on the arousal phase. Negative emotional states determined by depressive, anxiety, or obsessive symptoms can primarily contribute to erectile dysfunction in men (Corona et al., 2009). In correlation to this occurrence, delayed desire can occur. The onset of erectile dysfunction due to performance anxiety may then lead to an avoidance of sex, loss of self-esteem, and depressed mood (Corona et al., 2009).

Focus on chief complaint

Although this perpetuation of SD throughout the sexual response cycle makes diagnosis difficult, there are clinical considerations to identify this issue. In order to diagnose an individual as experiencing SSRI induced SD attention should be given to the chief complaint. Depending on the main issue of sexual dysfunction, a determination can sometimes be made whether the
symptom is due to SSRI’s or mental illness such as depression. Clinicians must be aware that delayed ejaculation and orgasm, which are symptoms most frequently associated with SSRIs, are not usually associated with depression itself, whereas decreased sexual desire is (Balon, 2006). With this understanding, practitioners will have better clinical judgment of assessing what role SSRIs or depressive symptoms are playing on sexual difficulty. According to a recent study by Hensley and Nurnburg, 50% of female subjects and 42% of male subjects reported decreased sexual interest prior to starting treatment for depression (2002). After starting treatment with SSRIs, women report significant improvements in sex drive and psychological arousal. In contrast, men show worsening of ability to ejaculate and or orgasm satisfaction (Hensley et al., 2002). This difference in response could be the result of the marked performance anxiety found in men. It could also be the result of medication itself as research shows that 40–80% of sexual dysfunction is due to antidepressant treatment and not mental illness itself (Gregorian, Golden, Bahce, Goodman, Kwong, & Khan, 2002). In conclusion, focusing on the main concern of sexual difficulty can be a very telling sign. While SSRIs are known to be responsible for delayed ejaculation and orgasm, depression is found to be more responsible for decreased desire. Although SSRIs can result in SD throughout all phases of sexual response, evaluating depressive symptoms must be a major component of diagnosis.

**Treatment Planning**

*Employ medication management strategies*

Treatment for SSRI induced SD has primarily been focused on the management of SSRI medication. First, doctors prescribing medication may sometimes ask clients to “wait and see” what happens for a 4 to 6 week period post to beginning a SSRI because satisfactory sexual functioning is sometimes known to return. This reversal is due to tolerance but is inconsistent among patients (Keltner et al., 2002). Due to the inconsistency of side effect reversal, clinicians must be skeptical of this technique and be aware of false hope that could be instilled in clients. The 4 to 6 week period of sexual side effects may also be deemed too unbearable for
patients to wait out while tolerance to the medication is building. This prolonged period increases the chances that medication non-compliance will occur (Keltner et al., 2002). Second, many doctors will suggest drug augmentation that targets the mechanisms that cause SD as an alternative strategy. Dopamine enhancers that stimulate dopamine release or act as dopamine antagonists can improve sexual performance while the client continues taking SSRIs as prescribed (Keltner et al., 2002). Third, decreasing the dosage of SSRIs is sometimes a viable option because of something called a flat dose response curve. What this means is that if a person responds to a certain dose of SSRIs, they will not respond “more” to a larger dose but may actually respond just as well to a lower dose (Keltner et al., 2002). Although consideration must be given to how lowering dosage could affect antidepressants efficacy, it can also positively affect SD side effects. Fourth, another option for reversing SD side effects is for the client to take a “drug holiday.” Drug holidays are when a patient stops taking their medication for 1 to 3 days or longer, allowing the offending agent to decrease in their system and reducing the impact on sexual functioning (Keltner et al., 2002). Finally, many doctors may decide to change their patient’s antidepressant. Evidence supports that Paxil causes the highest level of sexual side effects followed by Prozac, Celexa, Zoloft, and Luvox (Keltner et al., 2002). While all of these options have been found to positively increase sexual functioning, many risks are posed to medication compliance. Attention must then be given to non-pharmaceutical means of treatment.

*Establishing a therapeutic alliance*

In a therapeutic setting, the interview itself is the first intervention of treatment. Therapists need to build an alliance with their client, normalize the problem, and validate the patient’s experience (McGloin, & Carey, 2006). This includes making the client feel that they are in a safe environment where they can discuss private sexual matters. Once a therapeutic alliance has been established, a treatment plan can be developed for addressing the sexual difficulties.
Psycho-Education for Patients

Therapists need to provide their clients with psycho-education regarding the possible causes of their SD and assure patients that SSRI induced dysfunctions are reversible (Keltner et al., 2002). The overall treatment plan should promote a healthy lifestyle, recommending weight reduction, exercise, smoking cessation, and treatment for substance use problems. This can help by enhancing sex image, sense of well being, overall health, and health of the physiological symptoms related to sexual response (Balon, 2006). In a recent study, men who were the most physically active had a lower risk of erectile dysfunction compared to those men doing less or no physical activity. In addition, men who watched television for more than 20 hours per week were significantly associated with erectile dysfunction (Larsen, Wagner & Heitmann, 2007). When pretreatment lifestyle related SD such as difficulties related to chronic use of substances are eliminated, this renders treatment for SSRI induced SD more manageable. Other education could include information regarding supplemental products such as lubrication. Women who experience diminished vaginal lubrication may find intercourse uncomfortable and irritating. This discomfort may instigate an additional resistance towards engaging in sex play with a partner, promoting other SD difficulties (Giordano, 2001).

Use of Cognitive Behavioral Therapy

Consider multiple aspects of functioning with CBT. After the client feels comfortable within the therapeutic setting and plans for treatment have been established, cognitive behavioral therapy (CBT) can be implemented to further target sexual difficulties. CBT is a well-regarded intervention modality for implementing behavior techniques to increase sexual functioning (McGloin, & Carey, 2006). “CBT focused on SD may help the patient cope with the dysfunction, reduce symptom severity, and help prevent symptoms from worsening due more to the presence of the SD than to the effect of the SSRI” (Balon, 2006). CBT takes into consideration all bio-psycho-social aspects of an individual’s functioning and has the most positive outcome research (McGloin & Carey, 2006). McGloin and Carey (2006) explain CBT by writing:
The premise of CBT is that cognition influences feelings and behavior. The patient learns to recognize maladaptive thought patterns and to stop them in their tracks. Goals for CBT in sexual dysfunction include cognitive change, decreased anxiety, increased orgasm, and increased positive thoughts associated with sexual behavior. Treatment is usually short term, an average of 12 to 15 sessions consisting of visits with a therapist and behavioral exercises assigned between sessions. (p. 584)

**Examples of CBT.** Examples of CBT approaches include, but are not limited to, use of desire checklists, fantasy exercise, self-help resources, vibrators, body work, sensate focused exercises; modification of sexual scripts; thought stopping/thought substitution; directed masturbation training; increased nonsexual activities and communication.

Table 1. Description and Example of Cognitive Behavioral Techniques

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<thead>
<tr>
<th>Cognitive Behavioral Techniques</th>
<th>Description</th>
<th>Example</th>
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<tbody>
<tr>
<td>Desire checklists</td>
<td>Making a list of desired intimate actions that the patient would like to engage in with partner.</td>
<td>Hugging, kissing, holding hands, etc.</td>
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<tr>
<td>Fantasy exercise</td>
<td>Patient uses fantasy (alone or with a partner) to explore sexual interests.</td>
<td>Using role play with a partner to act out a sexual fantasy or imagining a sexual scenario.</td>
</tr>
<tr>
<td>Self-help resources</td>
<td>Resources that provide information and support to the patient regarding their difficulty.</td>
<td>Books, internet website, and groups.</td>
</tr>
<tr>
<td>Body work</td>
<td>Using the body in ways to produce movement and generate sensations.</td>
<td>Yoga, dancing, and massage.</td>
</tr>
<tr>
<td>Communication</td>
<td>Learning to use words.</td>
<td>Telling your partner what you do and do not like. Explaining how you like to be pleasured.</td>
</tr>
<tr>
<td>Modification of sexual scripts</td>
<td>Coming to an agreed plan for sexual intimacy.</td>
<td>Making a plan for when, how, and where sex will happen.</td>
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Thought stopping/thought substation  | Stopping intrusive thoughts and or replacing these thoughts. | Yelling or thinking “stop” when unwanted thoughts are ruminating. Replacing unwanted thoughts with positive thoughts such as how good your partner smells.

All of these CBT techniques can be effective in treating SSRI induced SD but sensate focused exercises are a top option when working with couples. “Sensate focus exercises are performed alone with a partner and involve various levels of sensual touching without intercourse or orgasm, thus decreasing performance anxiety” (McGloin et al., 2006). Given that performance anxiety is known to be a contributing factor to the prevalence of erectile dysfunction among men prescribed SSRIs, this technique could help stop the influence of such difficulty.

In addition, when working with couples it is important to emphasize that sexual intimacy manifests itself in a multitude of ways and should not be limited to activities solely involving intercourse and orgasm (Giordano, 2001). According to Fisher, Aron, Mashek, Li, and Brown (2001), the “attractive system” is influenced by exhilaration and feelings of intrusive thinking about a partner, and craving for emotional union, and further, this is associated with elevated levels of dopamine and norepinephrine (Fisher et al., 2002). Therefore, encouraging couples to do nonsexual activities that raise dopamine can help with the sexual system. Examples of these activities include things that the couple did in the past but no longer do or it could involve new activities never tried before.

Directed masturbation is good CBT technique for both individuals and couples as it is often used in primary anorgasmia. Research shows that directed masturbation has success rates in excess of 80%, although lower in couples (McGloin et al., 2006). The importance of mutual masturbation is even more prevalent for anorganic women.

Studies show that couples with an anorgasmic female partner reported more troubled sexual communication than sexually functional couples. This difference relates most strongly to communication regarding direct clitoral stimulation activities (Kelly, Strassberg, Turner, 2010). Improving communication with use of
words between partners can play a big role in sexual responsiveness. In the case of female anorgasmia, the woman is commonly considered by both partners to be the “repository” of the problem. This is an important dynamic because the psychological, relational, and sexual patterns resulting may be relatively immutable (Kelly, Strassberg, Turner, 2010). While the primary cause of sexual difficulty maybe the SSRI, communication between couples regarding stimulation may be a contributing factor.

In sum, treating SSRI induced SD is a complex process that takes time, consideration, and patience for both the therapist and patient. Both behavior change and accommodation on behalf of the client is necessary for sexual difficulties to subside. The client must be accountable in treatment and take an active approach to meeting treatment goals. Motivation, flexibility, and resilience are all essential characteristics for an individual to be successful. Due to the lack of specific research on SSRI induced SD clinicians must use their best clinical judgment when implementing treatments for their client’s sexual concerns. Medication management, psycho-education, and CBT are all considered effective approaches to treat SSRI induced SD. Treatment must be customized to serve the client’s needs and take into consideration all biological, psychological, and social aspects of functioning. Clinicians must keep in mind that treatment can be a long challenging process. The pace of treatment must be determined by the presence of other problems such as chaotic family environment, alcoholism/substance abuse, mental health concerns, and trauma history. Therefore, integration of treatment modalities is an ongoing progression that will unfold over time as other factors related to treatment are addressed.

Limitations and needs for future research

Patients and SD disclosure

Although SSRI SD is far from rare it is still a highly unrecognized and understudied side effect (Corona et al., 2009). One of the main contributing factors of this is that clients are often hesitant to report sexual difficulties. However, it has been found that reports of sexual functioning increase when the patients are
directly asked of their sexual difficulties (Keltner et al., 2002). This exemplifies the importance for mental health practitioners to have an open and accepting outlook on addressing sexual health concerns. Clinicians should remember that even for patients suffering from mental illness associated with SD, having a good sex life is an important issue (Clayton et al., 2009). To some patients, having a healthy sex life is just as important as having good mental health. In order to insure that patients have access to sexual health resources we must first inform clients that this help is available. Furthermore, there is essentially no information regarding effects on culture, ethnicity, orientation, or other population groups in the research base. This may be because sexuality is an extremely sensitive and personal matter in some cultures such that SSRI-induced SD is severely under-reported, and therefore, impossible to be studied by researchers. In some cultures for example, women are not permitted to discuss sexual matters or engage in sexual intercourse for pleasure. Therefore, it is important for clinicians to perform culturally-sensitive assessments, diagnostics, and treatment for patients such that more incidences of SD caused by SSRI are identified among various racial and ethnic populations for future research.

Lack of psychotherapeutic models and research

Although there is some literature on pharmaceutical modalities of treatment (as discussed in this paper), there is very little available research on the use of psychotherapeutic modalities to treat SSRI induced SD. Therefore, clinicians are forced to use their best clinical judgment as to what psychotherapeutic approaches to utilize when working with patients that experience these side effects. Due to the lack of research on the issue, there are no evidence based models that exist to specifically treat SSRI induced SD. This is problematic as many of the pharmaceutical methods of treatment promote medication non-compliance in patients. In addition, many clients may feel cautious to consider medication management strategies which may require the client to take additional medication to reduce sexual side effects. This method would also have considerable limitations when working with elderly patients as many older adults are taking a multitude of other
prescription medication for health related concerns. As a result, future research must explore the effectiveness of psychotherapeutic approaches for treating SSRI induced sexual difficulties. If research does not focus on finding these evidence based treatments then mental health practitioners will continue to be left guessing as to what best meets their patient’s needs.

Limited understanding of the cause

Not only do mental health practitioners have little information regarding effectiveness of psychotherapeutic treatment approaches for SSRI induced SD but they also have a modest understanding on the cause. Theories have been posed regarding the medications effect on the central serotonergic and dopaminergic systems that are thought to effect delayed ejaculation/orgasm but speculation lacks in how SSRIs effect the other phases of sexual response. As discussed, performance anxiety among men is hypothesized to be a mitigating factor in the development of erectile dysfunction. While this conjecture could easily apply to individuals taking SSRIs, there is no research that poses this possibility. Furthermore, there is even less information regarding how a woman’s sexual response cycle could be effected. Despite the understanding that SSRIs are known to effect all phases of sexual response, literature focuses mainly on anorgasmia. The tendency to ignore the other phases of sexual response that are being effected by SSRIs leaves practitioners even more in the dark on how to help their patients. Overall, there is an enormous need for future research to focus on why SSRIs affect sexual response throughout all phases. More research in this direction should also take form in psychological and social aspects of functioning. While the biological effects that SSRIs have on sexual functioning should be a primary concern of understanding, many other factors could be at play as well.

Incorporation of social stigma and self concept

The study of SD due to SSRIs can also benefit by incorporating research concerning the development of social stigma and degradation of self-concept. With the medical model currently being the most common form of treatment for SSRI induced SD,
issues of self-concept and social stigma are ignored. The effect that social stigma has on an individual, in conjunction to facing the illness itself, has a great deal of effect on a person’s self-concept. The development of a self-concept is a distinct social process and anything that interferes directly with this social interaction will interfere with the construction of the self-concept (Knudsen, Hansen, Traulsen, & Eskildsen, 2002). Therefore, prescription to SSRIs can directly interfere with the construction of a person’s identity, because when a person is told that they have a mental illness and should take prescription medication, how they view themselves can quickly change.

An empirical analysis on women by Knudsen and colleagues (2002) revealed that SSRI users passed through stages, characterized by distress and needing help, conflict about taking the medication, improvement, and problems related to discontinuing the medication. These four stages related to the process of recognition of the problem and change in how the women saw themselves in terms of having emotional problems and taking SSRIs, all of which described the stress and difficulty with accepting the transition to taking SSRIs. This study showed how psychological and social factors impact an individual’s perception of taking SSRIs and can have implications for both medication compliance and sexual functioning. Furthermore, this empirical evidence gives great precedence to future research on how self-identity and social stigma could affect SD in SSRI users.

Conclusion

While the concerns surrounding SSRI induced SD is a known problem, little research has been done to understand and treat these side effects. The medical model is effective in delivering prescription medication and treating underlying biological mechanisms associated with SSRI induced SD. However, many psychological and social factors are not considered during this treatment process. Until research is conducted to render the best psychodynamic based practices for treating SSRI induced SD, clinicians must continue to use their best judgment and decision-making skills for treating this issue. In addition, clinicians need to be aware that this problem exists. Although SSRIs are known to be
a safe and effective class of antidepressants sexual difficulty is a common side effect that can drastically impact the quality of a user’s life. Therefore, the assessment, diagnosis, and treatment process as described in this paper should be considered when treating a patient prescribed SSRIs.

Clinicians must be conscious of the complexity of SSRI induced SD, making sure to collect a thorough baseline of biological, psychological and social functioning. During the assessment process the clinician wants to rule out any co-occurring causes such as substance abuse, mood symptoms, health concerns, and social issues that may otherwise impact sexual functioning. After a baseline has been determined clinicians can evaluate the factors that may be contributing to SD other than the SSRI and a proper diagnosis can be established. The treatment plan may involve an eclectic approach, incorporating multiple modalities to customize to the patients’ needs. These approaches will most commonly include medication management, psycho-education, and CBT. In addition, the treatment approach must start with a strong therapeutic alliance between the patient and practitioner. Most importantly, open discussion surrounding sexual side effects is essential to this process. Regardless of mental illness, practitioners must remember that sex still matters.

References


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