Killing Your Libido: Antidepressants Can Ruin Sexual Appetite and Function

What You Need to Know About the Silent SSRI Epidemic (PSSD)

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Introduction

By the first decade of the new century, Americans were already deep into antidepressant use.[1] The Millenial Generation (1981–1996) had already its fits and starts with depression and were the first generation to experience being put on antidepressants like Prozac as young adolescents. Their parents, Boomers (1946–1964) and Gen Xers (1965–1980), had already experienced sedatives and antidepressants themselves, a wave that began with women being hypnotized by Valium in the 1950's—60's, a *benzodiazepine* to calm the anxiety of housewives with "the problem that had no name."[2]

Fast forward to 2018 and the beginnings of our 21st century COVID pandemic. Of course, we now well know COVID's emotional effects, especially on young Gen Z'ers, who were isolated from friends and many times family members; who witnessed family deaths; friends with illnesses and sometimes their own COVID repeats; who had to endure online "everything," including deep dives into the netherworld of gaming to engage *some sort* of excitement, to the detriment of their real-time social lives. It is not surprising, then, that Gen Z wound up being one of the most depressed generations in American history, a generation with the most mental health problems on record, a good amount of it being depression.

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[1] Sharpe, Katherine. *Coming of Age on Zoloft*. Harper Perennial, 2012.

[2] Friedan, Betty. *The Feminine Mystique,* Chapter 1: "The Problem that Has No Name." W.W. Norton, 1963.

Concern for Young Adults

Between 2016 and 2022, the rate of antidepressants being dispensed to young people (12 to 25) increased by more than 64%, and amounted to approximately 221 million prescriptions written for these.[3] Nearly three in five (57%) of Gen Z'ers with mental health conditions are now taking antidepressant medication.[4] Most of the antidepressant meds prescribed are taken long(er) term, with about 62% of users relying on the drug prescribed for more than two years—some have taken antidepressants for over 10 years.

Especially for young adults, this trend raises heavy concerns, and not just about self and identity (as being antidepressant-dependent), but about the underlying threat to their sexual ability. The most prescribed antidepressants—*selective serotonin reuptake inhibitors*, or SSRIs—have a good chance of killing one's libido and sexual function—during, and well after stopping their use.[5] Just imagine, then, the perplexity involved: For teens on SSRIs who experience PSSD symptoms, and who struggle with depression, loss of sexual desire and function becomes a personal embarrassment which is not willingly shared, even with intimate friends. Moreover, lacking a reliable conception of what it is like to feel "like themselves," young people especially have no way to gauge the effects of the drugs on their developing bodies. For young adults the situation can be not only confusing, but unbearable should these be in any type of sexual intimacy relationship. Read on.

This new(er) problem, now being openly researched and finally talked about, is termed "Post-SSRI Sexual Dysfunction" or PSSD. (I did not make up the acronym, but it fits just fine.)

Here's the truth: While psychiatrists and physicians have known about the effects of SSRIs on sexual functions and feelings (I describe the issues below), *none of it has come to the forefront as a recurrent, real issue until very recently*. It wasn't until 2019 and through the National Health Service (UK) that the symptoms and effects were categorized as a *syndrome* and given a name by the European Medicines Agency. The American Psychiatric Association, who manages the "bible" of mental health diagnostics, the DSM (Diagnostic and Statistical Manual) has still to bring a formal classification to PSSD.[6] To

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[3] Chua, Kao-Ping, et al. "Antidepressant Dispensing to US Adolescents and Young Adults: 2016-2022." *Pediatrics.* 2024, Mar 1,153(3):e2023064245. doi: 10.1542/peds.2023-064245.

[4] Harmony Healthcare IT. "State of Gen Z Mental Health (Report), 2022." https://www.harmonyhit.com/state-of-gen-z-mental-health.

[5] Peleg, Lirian C. et al . "Post-SSRI Sexual Dysfunction (PSSD) : Biological Plausibility, Symptoms, Diagnosis, and Presumed Risk Factors." *Sexual Medicine*, 2022. Jan 10 (1), 91–98.

[6] The only section of the DSM 5TR that potentially addresses this issue—still without a formal dysfunction number or separate inclusion in the DSM, is the section on "Sexual Dysfunctions" which lists "Substance/Medication-Induced Sexual Dysfunction"; but quickly refers to the ICD 10/11 (International Classification of Diseases codes) in order to "classify" any etiology and symptoms. ICD classification is for insurance purposes and to catalogue a disease, not necessarily to establish principles for diagnosis and

date, many who prescribe SSRIs *do not adequately tell their patients of the probable sexual effects of the drugs*. The prestigious Mayo Clinic (Rochester MN) continues to state on their website,

> *Selective serotonin reuptake inhibitors, also called SSRIs, are the type of antidepressant prescribed most often. They can ease symptoms of moderate to severe depression. They are relatively safe,* ***and they typically cause fewer side effects than other types of antidepressants.***

What more, data shows that a growing majority of those that are treated with SSRIs are *not* the most severe cases of depression. Instead, they tend to be those with milder symptoms, and again, often teenagers and young adults. David Healy, MD and founder of the organization *Data Based Medicine,* is quoted saying, *"…the average family doctor is [now] handing SSRIs out to people who are anxious or mildly depressed. They need to realize that if you cause PSSD, you're going to lead to potential suicides, because people feel they can't live this way."*[7]

What Happens?

For close to one hundred percent of those who take SSRIs, and within 30 minutes of taking a dose, there is a degree of *genital sensory change*—meaning a reduced sensitivity to what would otherwise be interpreted as "arousing." Most people won't notice this at first, unless of course they are in an arousing situation when dosing (not probable.) What more, there is often a 'numbing' of the genitalia that follows—more in men than women (I'll note differences below)—which again, means persons who should be getting aroused and 'feeling' their arousal, don't.

This reduced sensitivity is accompanied by an immediate delay of ejaculation in men (if these *do* get aroused to the point of orgasm), and a 'muting' or lack of orgasmic pleasure in *both* men and women if orgasms do occur. The 'numbing' effect produced by SSRIs has been described by patients "as if having rubbed Lidocaine" (an anesthetic) on the genital area. After a period of SSRI use, orgasms may stop altogether, and there may be a consistent loss of libido (sexual arousal and feeling sexual). And, while there is no precise consensus on "how long" the effects can last, most individuals who have been on SSRI's longer-term (2+ years or more) and *do* develop PSSD, report the effects have been

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treatment per se. Regardless, the "diagnostic features" that are listed here suggest the dysfunctions are in "a temporal relationship" with the medication being used or discontinued. In other words, the ICD and DSM criteria suggests the substance used has *temporal and not long lasting effects*. This is clearly not the case with SSRIs.

[7] Cox, David. "It Feels Like We've Been Lobotomized: The Possible Sexual Consequences of SSRI's." The Guardian, March 2, 2024. https://www.theguardian.com/society/2024/mar/02/ssri-antidepressants-sexual-dysfunction-side-effects-consequences-libido.

permanent. The point to underscore here is that when these dysfunctions happen, *they often do not resolve when the SSRI medication is stopped*.[8]

Male-Female Differences in PSSD

For males, the numbness delays or altogether *truncates erections*. When there *are* erections, these are stated to "feel like dead wood,"[8] or have significantly reduced sensorial effects. What follows is, of course, *delayed or no ejaculations*. When these do occur, they seem "hollow," "have no pleasure," "no orgasmic high that takes your breath away."[9] There is a persistent shut-down of erotic affect that disables arousals. Men report being "robbed of their humanity," "no more love, no more sex, no more feelings," and "losing your libido is equivalent to going blind, or deaf; it's that level of sensory impairment."[10]

For females, the numbness is often equally present, as is the inability to feel sexual sensations. Orgasms often disappear. *"Now, nearly four years on…I am riddled with psychological grief and anguish. I can't experience any physiological sexual response. No arousal, even when physically touched. It's as if my electrical hardwiring of the sexual system has been short-circuited."*[8]

Let's keep in mind that women—of any age group—are prescribed more antidepressants, and more often, than men. And this has held true over decades, but especially during and after COVID in younger cohorts of females. As of 2023, 24% of women in the U.S. were being treated for depression.[11] Based on pharmacy claims of those who filled at least one prescription for mental health medication 2019-2023, *nearly twice as many teenage girls take antidepressants* today compared to teenage boys.[12]

Ultimately and regarding differences, not everyone develops all the drastic symptoms, and a lot depends on how an individual's body responds to SSRIs. That said, we can accurately report given present data, that some people are especially vulnerable; and most who do develop PSSD have a range of symptoms which these described as sexually disabling. Estimates of percentiles of those who develop PSSD after SSRI

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[8] Healy, David. "Post-SSRI Sexual Dysfunction and Other Enduring Dysfunctions." *Epidemiology and Psychiatric Sciences*, 29 e55, 1–2. https://doi.org/10.1017/S2045796019000519. **To note**, these genital effects do not occur with antidepressants that do not inhibit serotonin reuptake. While other antidepressants may cause some erectile dysfunction in men, and a lower desire in women, these do not cause the *syndrome* of numbness, pleasureless orgasms, loss of libido, or absent arousals that SSRIs are noted for.

[9] Cox, David. "It Feels Like We've Been Lobotomized," op.cit.

[10] ExCEL Male Forum. Posted quotes on PSSD website forum: https://www.excelmale.com/threads/post-ssri-sexual-dysfunction-pssd.28703.

[11] *Statista, Inc.* "Percentage of Adults in the United States Who Currently Had or Were Being Treated for Depression in 2017 and 2023, by Gender." https://www.statista.com/statistics/1391260/us-adults-currently-have-or-being-treated-for-depression-by-gender/.

[12] Vankar, Preeti. "Antidepressant Use among Teenagers in the U.S. from 2015-2019, By Gender." *Statista,* November 29, 2023. https://www.statista.com/statistics/1133612/antidepressant-use-teenagers-by-gender-us/.

treatment ranges between 5–15%. Let's keep in mind, however, that PSSD has *not* been clinically studied much, nor diagnosed accurately, so figures are more than likely higher.[13]

Where in the Brain is the Issue?

Antonei Csoka, MD, of Howard University has been studying PSSD since the early 2000s and believes that when SSRIs target serotonin receptors in the brain, the medication drives "epigenetic changes,"[14] particular modifications to DNA material which then affects the activity of genes that relate to sexual function. Dr. Roberto Melcangi's research at the University of Milan (IT) suggests SSRIs also alter certain steroid hormones in the brain, which in turn act as regulators of brain functions that include the sexual. [15] Why the permanency in some patients during, and after treatment is discontinued, is an unknown. Also unknown are the actual mechanisms and neurochemical reactions that bring on these epigenetic and/or hormonal changes. Obviously, more research is needed—a fact that the now well-populated (+10,000 member) *PSSD Network* is pushing (https://www.pssdnetwork.org/). Challenges are many, and PSSD is most likely to be found to have varied underlying mechanisms, and these may also vary between individuals and the sexes.

What Can be Done?

Most researchers who are now actively pursuing treatments agree that it will be difficult to find a therapeutic approach that addresses all the effects of PSSD. But at least some of the consistently large effects are already being addressed.

For the enduring problem of PSSD, two drugs that attempt to readjust the chemical imbalances in the brain are *vortioxetine,* and to a lesser degree, *bupropion*. These, in combination with nutraceuticals that specifically target the imbalances seem to work for some to re-engage *some* sensations and feelings, as well as the physical capacity to orgasm.[16] But this is not an open ticket. There is still no definitive treatment for PSSD. Switching out from SSRIs is an immediate, important part of any approach, as could be expected. Emotional and physical therapies are also a necessary part of the treatment, and such offer some successes with coping, self-esteem, and with physical performance.

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[13] Cox, David, op.cit.

[14] "Epigenetic changes" are modifications to the DNA which can be brough about by influences outside the body, such as through environment, medications, sometimes historical foods and diets. https://medlineplus.gov/genetics/understanding/howgeneswork/epigenome.

[15] Silvia Giatti, Silvia Diviccaro, Lucia Cioffi, Roberto Cosimo Melcangi. "Post-Finasteride Syndrome and Post-SSRI Sexual Dysfunction: Two Clinical Conditions Apparently Distant, But Very Similar." *Frontiers in Neuroendocrinology,* 72, January 2024. https://www.sciencedirect.com/science/article/pii/S0091302223000626

[16] De Luca, Rosaria, et al. "Cutting the First Turf to Heal Post-SSRI Sexual Dysfunction: A Male Retrospective Cohort Study." *Medicines 2022*, 9, 45, https://doi.org/10-3390/medicines9090045.

The Bottom Line

Realizations are often hard to stomach. To discover that one's libido is waning, one's sexual prowess evaporating, certainly begins to redefine one's sexuality and even future. PSSD sufferers feel they should have been given greater warnings on the potential "side-effects" of SSRIs before commencing these drugs. Some reported psychiatrists as refusing to acknowledge this source of drug-induced harm. Other physicians concluded the symptomatology presaged other emotional issues, and thus relegated them to affective issues manifest as sexual dysfunctions.

Both the psychiatric community as well as pharmaceutical companies need to be made to realize these have a moral, ethical, and professional responsibility to not only disclose potential harm, but most significantly, *also fund research* into treatments for drug-induced conditions. Leading SSRI manufacturers such as Eli Lilly and GSK ought not hide under the "all drugs have potential risks" banner.

For those that are being prescribed antidepressants, the message here is clear: educate yourself and become your own advocate when it comes to both being given information on what drug(s) you are prescribed, as well as in asking the significant questions about them. Also, "do your homework." Don't settle for what you are being told as complete information.

From my sightline, it is especially impossible to ignore that young people, with lives to still live but with a current episode of depression, trauma, or anxiety, would be frequently placed on SSRIs as a "cure-all" regimen! We now know the possible ensuing problematics of sexual dysfunction that may befall them. We owe them, and everyone else better information; and one can start by liberally spreading the news given *here*.

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