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Mood and Intimacy Work Together

Lori A. Futterman RN, Ph.D.

What role does mood play in sexual functioning? A distinction needs to be made between a mood state and a mood disorder. Consideration of the type and severity of the mood state or mood disorder is essential in evaluating its impact on sexual functioning. The result may be one of inhibition or activation of the psychoneuroendocrine system and will have an effect on the sexual response cycle (Wierman, et al., 2010). The result will likely be a change in desire, arousal and/or orgasmic functioning (Wierman, et al., 2010). It is not uncommon to feel some excitement and notice inner tension which acts to enhance our sexual responses. This would be an example of a mood state. Mood disorders, on the other hand, are persistent and tend to interfere with everyday life, including one's sexual responses.

Evidence exists that Major Depressive Disorder is associated with a higher incidence of sexual dysfunction (Sobecki-Rausch, 2018; Angst, 1998; Kennedy, Dickens, Eisfeld, & Bagby, 1999; Laumann et al., 2005). There is a high correlation between the severity of the depression and the severity of sexual dysfunction (Fabre & Smith, 2012). Brotto, Petkau, Labrie, and Basson, (2011) found that mood was the strongest predictor of sexual dysfunction and sexual distress. This research supported the idea that psychiatric history is the sole variable over demographics and hormonal variables. Anxiety disorders, depressive disorders, bipolar disorder, psychotic disorders and personality disorders strongly predicted severity of sexual dysfunction (Brotto et al., 2011).

The relationship between sexual dysfunction and depression is complicated by the use of antidepressant therapy as part of a treatment regimen (Basson & Gilks, 2018; Ferguson, 2001). These psychotropic medications carry sexual liability with them (Clayton, 2002; Derogatis, 2009; Kanaly & Berman, 2008; Kennedy, Eisfeld, Dickens, Bacchiochi, & Bagby, 2000). Selective Serotonin Reuptake Inhibitors (SSRIs) are the most common medications associated with sexual dysfunction. Sexual dysfunction commonly occurs during antidepressant treatment. Seventy percent of patients who classify themselves as female, on antidepressants experience loss or delay of orgasm with reduced sexual desire and arousal (Basson & Gilks, 2018; Clayton, 2002; Derogatis, 2009; Kanaly & Berman, 2008). The reported rates of sexual dysfunction vary across antidepressants (Clayton et al., 2002). In the overall population of men and women of newer antidepressants it was seen that bupropion IR (22%) and SR (25%) and nefazodone (28%) were associated with the lowest rates for sexual dysfunction, whereas selective serotonin reuptake inhibitor (SSRI) antidepressants, mirtazapine, and venlafaxine XR were associated with higher rates (36%-43%) (Clayton et al., 2002). Clinicians tend to be underestimated the prevalence of antidepressant-associated sexual dysfunction (Clayton et al., 2002).

If depression is untreated, there is a 50% reduction in sexual desire and arousal and a 15-23% delay in orgasmic functioning (Kennedy et al., 1999; Ekselius & von Knorring, 2001). Longer periods of untreated depression may predispose women to increased rates of FSD (Kennedy et al., 1999; Ekselius & von Knorring, 2001). There is no empirical evidence on untreated anxiety and FSD. It is possible that any form of mental disorder would negatively impact sexual functioning.

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Psychotherapeutic Techniques Can Be Used On Various Formats

Lori A. Futterman RN,Ph.D.

Telehealth is an innovative way of delivering psychotherapy using videoconferencing or telephone devices. There has been interest in providing evidenced-based psychotherapies through using the platform of telehealth. The advantages of this type of treatment include increasing coverage for all individuals across all areas of the globe. The COVID-19 pandemic created the environment for wide use of telehealth services. Research is focusing on the effectiveness of evidenced-based psychotherapies using telehealth venues and show that telehealth could represent an important component of future psychotherapy and clinical practice (Gros, Morland, Greene, Acierno, Strachan, Egede, Tuerk, Myrick, Fruech 2013). Face-to-face therapy and consultation has always been considered the best way to develop and maintain a therapeutic alliance. However, this may be changing in light of present demands and changing circumstances. Data is needed on specific types of psychotherapies, such as eye movement desensitization reprocessing (EMDR) , clinical hypnosis, psychodynamic approaches using videoconferencing or telephone devices.

Sexual Health and Dysfunctions Extend Across Sexual and Gender Minorities: Need for Professional Training

Lori A. Futterman RN, Ph.D.

Sexual dysfunction, a disruption in sexual health, describes a constellation of sexual complaints and disorders affecting all ages throughout the life span. Etiologies and contributing factors involve the psychological, physiological and socio-cultural aspects of the individual and cuts across sexual and gender minorities. Female sexual dysfunction has expanded from the general population of 43% (Laumann & Rosen,1999) to sexual minority women (SMW) of 48% with the modification of the Female Sexual Function Ind ex (FSFI) (Boehmer, Timm, Ozonoff & Potter,2012). However, examining sexual dysfunctions to include gender minorities i.e. transgender, non-binar y and intersex populations (LGBTQI) has been limited to date.

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The attention to the interaction between gender and sexuality have encouraged a number of people to come forth seeking help from clinicians to assist with sexual concerns. Gender, sex and sexuality are intertwined in that they intersect but remain separate aspects of the individual (Barker & Richards, 2015, pg 79). Sociological and anthropological shifts have resulted in significant changes in cultural values and education on sexual practices for all sexual and gender minorities (i.e., lesbian, gay, bisexual, transgender, non-binary and intersex (LGBTQ).

There continues to be a need to educate clinicians and broaden professional curriculum aimed at recognizing, evaluating and addressing sexuality and sexual practices across sexual orientation and gender status. The emerging field of sexual medicine is an evidenced-based practice which includes both medical and psychological specialties. It incorporates culture competence specifically with sexual and gender minorities and is being integrated into the curriculum of professional training institutes (Mayfield, Ball, Tillery, Crendall & Dexter, 2017). Training in comprehensive assessment and treatment of sexual and gender minorities need to include sexual dysfunction (Borough,Bedoya, O'Cleirigh, & Safren, 2015; Mayfield et al., 2017) as well as overall health status. The training needs to be part of the core curriculum in medical and psychological training institutions. The aim of this review is to expand the current knowledge in sexual health as well as sexual dysfunction and become more inclusive across LBGTQ populations.

Barriers in Delivering Best Practices in Sexual Health: Sexual Orientation and Gender Status

Lori A. Futterman RN, Ph.D.

There are a number of other obstacles that occur for clinicians in assessing and treating intimacy, sexual function and dysfunction lending itself to barriers in health care access and in providing comprehensive and culturally competent care (Boroughs, Bedoya, O'cleirigh, & Safren, 2015; Eubanks-Carter et al., 2005; McNair & Hegarty, 2010; Rubin, 2015). Clinicians hesitate to address the topic of sexual health and are aware of their own limitations which include cultural and language barriers (Althof, Rosen, Perelman, & Rubio-Aurioles, 2013; Fallin-Bennett, 2015). Not only has cultural incompetence refrained physicians from adequate inquires, discomfort with sexual terminology and articulate concerns that their own personal bias about sex and gender status only serve to reinforce insensitive and discriminatory attitudes towards care given (Althof et al., 2013; Safer et al., 2016). It is common practice to assume that somatic complaints are unrelated to sexual problems, yet difficulties with intimate relationship to self and other can generate medical complaints (Althof et al., 2013),

The 2010 Gay and Lesbian Medical Association Collaborative Survey on Physicians Experiences Caring for LGBTQ patients found that 40% of physicians received no formal training on LGBTQ health in medical school or residency and those who had received training found the preparation inadequate for caring for LGBTQ patients (Fallin-Bennett, 2015). Twenty percent of the respondents reported receiving no training at all in eliciting sexual histories in LGBTQ patients (Fallin-Bennett, 2015). The majority of medical school programs do not include clinical training on sexual problems and dysfunctions, and sexual history scripts provided to students rarely include discussion of sexual problems" (Rubin et al., 2018). Standards need to include sexual and gender minorities and cultural competency within graduate training programs to prepare clinicians to work effectively with lesbian, gay, bisexual, transgender and gender non-binary patients (Boroughs et al., 2015). Access to evidence-based sexual and reproductive healthcare allows for each individual to attain a healthy self-concept of sexuality and gender identity (McCool-Myers, Theurich, Zuelke, Knuettel, & Apfelbacher, 2018). Knowledge of the significant risk factors of female sexual dysfunction which include poor physical health, poor mental health, stress, genitourinary problems, female genital mutilation, relationship dissatisfaction, and sexual abuse is essential.

"The majority of medical school programs do not include clinical training on sexual problems and dysfunctions, and sexual history scripts provided to students rarely include discussion of sexual problems"

Transgender and non-binary gender individuals tend to be marginalized and pathologized within our society (Avera, Zholu, Speedlin, Ingram, & Prado, 2015). Substantial evidence exists that LBTQ patients perceive discrimination in health care environments (Grant et al., 2010; Saulnier, 2002; Sinding, Barnoff, & Grassau, 2004). Meanwhile, minority stressors, such as internalized homo and trans phobia, experienced by LBTQ women translate into negative effects on sexual health, mental health, and physical health (Baptiste-Roberts, Oranuba, Werts, & Edwards, 2017; Frost et al., 2015; Baptiste-Roberts et al. 2017; Carrotte et al., 2016; Kuyper & Vanwesenbeeck, 2011). These stressors act to curtail their discussion of their sexual, psychological and physical difficulties.

Research indicate that 43.4% of bisexual women as compared to 26.5% of heterosexual women reported a need for professional sexual health care in the last year (Kuyper and Vanwesenbeeck (2011). The poorer mental and physical health reported by LBTQ populations is a reflection of less access, health disparities. (Baptiste-Roberts et al., 2017; Carrotte et al., 2016; Kuyper & Vanwesenbeeck, 2011; Safer et al., 2016). Cultural sensitive educational training for health care providers in women's sexual health would serve to reduce heterosexism and homo- and trans-phobia and to reduce the disparities in LBTQ women's sexual health and empower women (Althof, Rosen, Perelman, & Rubio-Aurioles, 2013; Fallin-Bennett, 2015; Kitts, 2010; Parameshwaran et al., 2017; McCool-Meyers et al., 2018).

ONLINE ARTICLES

Dr. Futterman has published extensively on topics related to women's health and sexual medicine. She has made several of her articles available online. View or download articles at www.drlorifutterman.com.

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State-anxiety has been shown to be arousing for most women, independent of sexual orientation and gender status, unless they suffer from a sexual dysfunction or mood disorder (Levin et al., 2016; Sobecki-Rausch, 2018). There is a high comorbidity of Anxiety Disorders and Sexual Disorders (Aksaray, Yelken, Kaptanoglu, Oflu, & Ozaltin, 2001; Bonierbale, Lançon & Tignol, 2003; Bradford & Meston, 2006; Corretti & Baldi, 2007; Figueira, Possicente, Marques, & Hayes, 2001; McCabe et al., 2010; Palace & Gorszalka, 1990; van Minnen & Kampman, 2000). Lack of subjective arousal and orgasmic functioning can be linked to trait anxiety (Basson & Gilks, 2018). If one is suffering from a traumatic event, the sympathetic response generated by sexual arousal can be associated with fear, similar to the traumatic response, rather than sexual pleasure. The most common type of sexual pain is 10 times more common in women with previous diagnoses of anxiety disorder (Basson & Gilks, 2018). .

Psychotherapeutic treatments that work to enhance well-being are psychodynamic and cognitive-behavioral (CBT) approaches. These may include clinical hypnosis and eye movement desensitization reprocessing (EMDR), mindful-

Dr. Lori Futterman, *Psy8636, is a clinical psychologist in private practice who specializes in sexual medicine and women's health. She is dedicated to helping both men and women achieve their highest potential, overcome difficulties and achieve inner balance and overall wellbeing.*

Dr. Futterman applies current research to customize care. She uses cognitive/behavioral and psychodynamic techniques, clinical hypnosis, eye-movement desensitization reprocessing (EMDR), energy psychotherapy, and educational strategies.

Dr. Futterman believes in close coordination with entire health teams to facilitate a comprehensive approach to care. Pychotherapy appointments are available virtually or in-office.

More Articles on Emotional Wellness, Women's Health and Sexual Health

EMOTIONAL WELLNESS

- Mood Influencers
- What are Mood Disorders?
- Depression
- Major Depressive Disorder
- Dysthymic Disorder
- Bipolar Disorder
- Generalized Anxiety Disorder
- Specific or Social Phobia
- Panic Disorder
- Managing Stress and Life Events
- Managing Burnout and Life Events
- Happiness
- Emotional Well-Being
- Maintaining Your Well-Being
- Effect of Stress and Our Perception of Self on Mood
- Exhaustion, Burnout, Fatigue or Depression?
- Ways to Work with Your Emotions
- Contributors to Sexual Functioning
- Strides in Sexuality in Western Culture
- Mood & Sex Can Work Together

WOMEN'S HEALTH

- Living Through the Middle Years
- Coping with Endometriosis
- Female Sexual Dysfunction
- The PMS Experience
- Breast Cancer Support
- Contributors to Sexual Functioning
- Ovarian Changes and Effect on Mood
- Strides in Sexuality in Western Culture
- Mood & Sex Can Work Together

SEXUAL HEALTH

- Sex And Zest
- Coping with Endometriosis
- Female Sexual Dysfunction
- Contributors to Sexual Functioning
- Strides in Sexuality in Western Culture
- Mood & Sex Can Work Together

TREATMENTS & APPROCHES

- Breast Cancer Support
- Pychotherapeutic Treatments