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Strides in Sexuality in Western Culture

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If we look historically at the science and treatment of sexual dysfunction we see that it has been influenced by a heteronormative aging population, and can be termed "The Graying of America" which is a contemporary term used to describe the baby boomer generation. The baby boomers generation added to the sexual revolution and witnessed the rise of oral contraceptives, the cultural shift in sex from procreation to a form of recreation and the trend for more permissive sexual attitudes and behaviors (Twenge, Sherman, & Wells, 2015). Today the focus with regard to sexual functioning is on quality of life, moving away from life expectancy to health expectancy, living life longer with the least amount of health issues and enjoying sex throughout their lives (Elders, 2010; Herbenick et al., 2010).

Male sexual dysfunctions began earning prominent media focus in the late '80s with the introduction of Viagra-like agents. This began the era of sexual pharmacology. A number of "Viagra failures" made it clear that a pill alone does not create an adequate sexual relationship. The complexity of sexual functioning was recognized and gave birth to the field of sexual medicine. Over the last several years there has been a growing collection of clinical research and treatment focusing on sexual functioning and dysfunction from a biopsychosocial perspective. This model can be applied to any sexual orientation and across gender. Since the millennium, science and treatment have advanced and is best viewed through the lens of the biopsychosocial model. This model assists us in with classification strategies of disorders. It is based on advances in research in brain neuroscience, and neurotransmitter balance, reproductive endocrinology, and ovarian hormones, psychological impact of traumatic events, mood and cognition body image, performance anxiety, stressors, the interpersonal domain related to relationship duration and satisfaction and sociocultural and religious factors (Kingsberg & Janata, 2007).

Sex is openly discussed by many and is generally seen in a positive light unless one is suffering from a sexual dysfunction or a disruption in sexual identity and gender identity. Disruptions impede one's development of sexual interaction and sexual practices and may be experienced by an awakening of gender identification. Integrating one's gender and sense of self occurs throughout development and will influence sexuality and its development (Nikkelen & Kreukels, 2018). People tend to suffer silently with sexual dysfunctions.

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 and overcome difficulties with sex and intimacy and achieve inner balance and overall well-being.

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Mood and Sex Can Work Together

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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 the 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.

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), mindfulness training and many others to enhance mood, cognition, sexual responses and produce a sense of inner balance.

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Contributors to Sexual Functioning

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If we examine the contributors to sexual functioning more closely we turn to the Biopsychosocial Model which include neurotransmitter, hormonal changes, medical and psychological conditions, including attachment and intimacy, mood, cognition, body image, performance anxiety, sociocultural and religious values and varying stressors (Rosen et al., 2009; Kingsberg & Janata, 2017). In general, we find that disease conditions; ovarian age as it relates to perimenopause and menopause (surgical or natural); sexual victimization and history of sexual trauma, health and length of the relationship; any sexual dysfunction experienced by the partner; type and severity of stressors can influence sexual functioning and dysfunction (Shindel et al., 2012; Flynn, Lin, & Weinfurt, 2017).

It would seem that these contributors also exist across sexual orientations and gender. However, the sexual minorities which include lesbian, bisexual, transgender, non-binary, and intersex individuals bring a set of social stressors that are idiosyncratic to them (Frost, Lehavot, & Meyer, 2015; Graham et al., 2011). These influences may affect sexual functioning and generate various types of sexual dysfunctions (Kuyper & Vanwesenbeeck, 2011). Researchers face the challenge of meeting the highest standards of evidence-based medicine while demonstrating the complexity of sexual life.

As we see in the literature, there is a significant interaction between communication and sexual satisfaction among heterosexual samples, perhaps this would also be the case with other sexual orientations and gender status's (Jones, Robinson, & Seedall, 2018). The idiosyncratic nature of sexual functioning, the frequency of activity and pleasure with regard to Transgender and non-binary individuals needs to be considered (Nikkelen & Kreukels, 2018). If sexual functioning and gender identity were addressed openly it would seem that this may result in more satisfaction with regard to sexual behaviors sexual relations.

Psychotherapeutic Treatments

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Psychotherapeutic Treatments are commonly utilized to assist in bringing balance into one's life. Whatever is affecting the physical aspects of the self also affect the psychological aspects of self and vice versa.

Treatments may occur individually, with Couples and Families. Some commonly utilized approaches are psychodynamic, cognitive-behavioral (CBT), clinical hypnosis and eye movement desensitization reprocessing (EMDR), mindfulness training and many others. Two techniques that are often used in short-term psychotherapy and are empirically-based are clinical hypnosis and EMDR. These approaches can be integrated with mindfulness as well as cognitive-behavioral strategies in working with difficult situations.

Clinical Hypnosis works with the assumption that the unconscious mind drives our motivation, beliefs, and behaviors (Lynn, Rhue, Kirsch, 2010). It is mostly used in addition to other forms of psychotherapy (Kirsch, Montgomery, & Sapirstein, 1995).

The way clinical hypnosis works is that it uses specific mental skills and techniques such as visualization, imagery and mental rehearsal. It releases unproductive and unhealthy emotions and transforms negative beliefs, habits, and behaviors through the use of positive suggestions. Changes result in sensation, perception, thought, and behavior (Kirsch et al., 1995).

Eye Movement Desensitization Reprocessing (EMDR) allows healing from psychological and physiological and symptoms which have resulted from trauma (Shapiro, 2002). EMDR is considered an effective psychotherapeutic method for treatment of post-traumatic stress disorder (PTSD) and trauma-based symptoms (Van Etten & Taylor, 1998; Schubert & Lee, 2009; Lee & Cuijers, 2013). It is also effective in the treatment of anxiety and depressive disorders. and stress-related symptoms (Maxfield, 2007).

The way EMDR works is that it facilitates the accessing and processing of traumatic memories in order to release emotional distress. It enhances information processing related to the maladaptive memory of an event and it can create new adaptive associations so that positive emotional connections and cognitive insights can develop. It releases unproductive and unhealthy emotions and transforms negative beliefs, habits and behaviors through the use of positive suggestions. Changes result in sensation, perception, thought, and behavior (Kirsch et al., 1995).

Is Pain Impacting Your Sex Life?

Dr. Rose Schlaff, PT, DPT, WHC, IF

If you are experiencing pain with sex, you are NOT alone. Nearly 75% of women will at some point in their life experience pelvic pain that impacts sexual functioning, quality of life and psychological well-being (The American College of Obstetricians and Gynecologists, 2017).

How can pelvic floor muscles contribute to pain with sex? Your pelvic floor muscles are one of the first muscles to contract in response to threat (Van der velde, Laan, Everaerd 2001). This means that your pelvic floor will be more contracted during stressful times, even if you aren't in physical danger. This can cause soreness and tenderness due to lack of oxygen and blood flow to the tissue.

What can I do to help my pelvic floor muscles relax and decrease my pain? Diaphragm breathing is one of my favorite tools to decrease pelvic pain. It calms your nervous system, sends a safety signal to the brain and it taps into the relationship between your diaphragm and pelvic floor to relax these muscles and increase blood flow. As you breathe in, your pelvic floor relaxes and lengthens and as you breathe out your pelvic floor contracts and lifts.

The easiest way to check if you're doing this properly is if you place your hands on your lower ribs. You should feel your ribs expand outwards as you breathe in and come back in when you breathe out. Do this 15 min/day and before and during sexual activity, it can make a world of difference!

For more tips on how to decrease your pain with sex, check out my FREE e-book "Relaxation Tips for an Overachieving Pelvic Floor" at www.bewellwithrose.com

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