SEX AND ANXIETY

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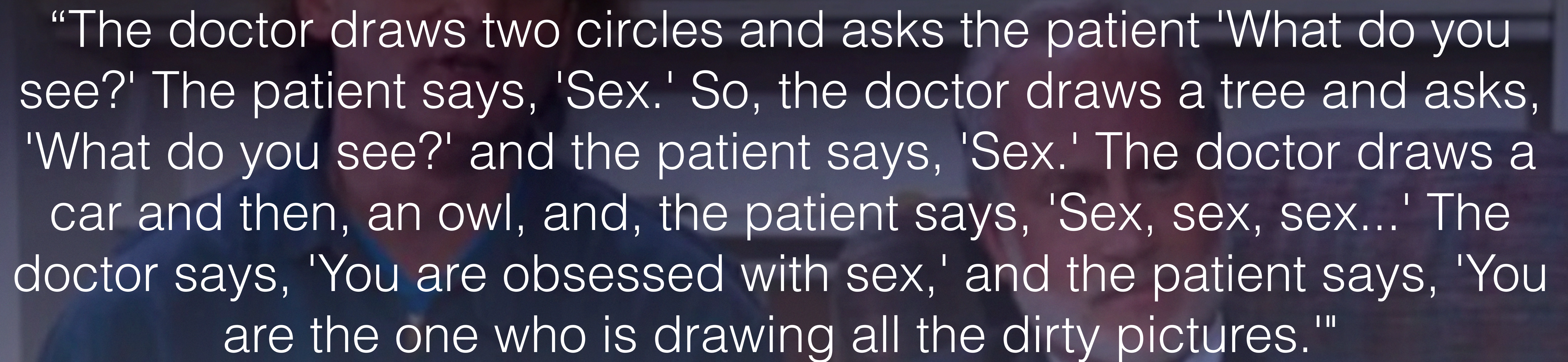

“The doctor draws two circles and asks the patient 'What do you see?' The patient says, 'Sex.' So, the doctor draws a tree and asks, 'What do you see?' and the patient says, 'Sex.' The doctor draws a car and then, an owl, and, the patient says, 'Sex, sex, sex...' The doctor says, 'You are obsessed with sex,' and the patient says, 'You are the one who is drawing all the dirty pictures.'"

– Bob Wiley in *What About Bob*

Sexuality is an essential part of being human. Love, affection, and sexual intimacy contribute to healthy relationships and individual happiness. However, along with the positive aspects of our human sexuality, there are physical illnesses, negative emotions, and unintended consequences that can affect our sexual health.

WHERE WE WERE!

History of Sexuality for Men

- **Greek and Roman:** Penetration proof of manhood. Plato believed that sexuality was an irrational frenzy and for procreation
- **18th C:** Philosophers offered various theories. Kant believed sexual desire is morally wrong
- **19th C:** Privacy culture found topic distasteful and that excess lead to loss of stamina. Morality prevailed
- **20th C:** Shift from moral to psychological (psychoanalysis and castration anxiety). Most mental illness caused by underlying sexual problems. Masters and Johnson and research on human sexual response. Lucy and Ricky Ricardo slept in separate beds
- **21st C**: Physiology and biochemistry and Viagra

History of Sexuality for Women

- **16th C:** Victorian era: Women were considered to be detached from sexuality. Demanded modesty and repression
- **17th C:** Women defined by their sexuality as a virgin or whore and by family status.
- **18th C:** Women more sexually assertive
- **19th C:** Freud postulated that most forms of mental illness in women caused by sexual frustration. Propounded two kinds of orgasms
- **20th C:** Sexual satisfaction over repression, limitation, or abstinence. Master and Johnson and research on the human sexual response. Ralph and Alice Kramden slept in separate beds
- **21st C:** Shift in cultural and scientific understanding of female sexuality. Considered more complex than men’s

WHERE WE ARE!

(Due to snoring and sleep apnea, nobody sleeps in the same room!)

Patients who need help are saying…

"Perhaps your performance anxiety wouldn't be so bad if you performed better."

"Believe me, you're just thinking about it too much."

Mental Health Treatment and Sexuality

- Mental health and medical professions have yet to fully recognize that sexual problems can contribute to depression, anxiety, eating disorders, trauma, and substance abuse
- Conversely, mental health and medical professionals rarely discuss the effect that these disorders have upon a patient's sexuality

“The moment you doubt whether you can fly, you cease forever to be able to do it.”

– Peter Pan

Fight/Flight

When involved with battle or threat of any kind, the survival instinct understands that this is not the time for passion, dining, reading, or pleasure.

Most Frequent Reasons for Marital Conflict

- Finances
- Sex Problems
- Careers
- Children
- Chores
- Yet, therapists rarely discuss sex or money with patients

Benefits Of Sex

- Improves immune system
- Lowers blood pressure
- Burns calories and lowers risk of heart disease
- Reduces stress and anxiety and improves depression and sleep
- Improves bladder control and may reduce incidence of prostate disease
- Improves self esteem
- Improves relationships

Benefits of Overcoming Phobias

- Flying
- Elevators
- Bridges
- Public Speaking
- Snakes, Spiders, Insects
- Driving
- White Coat Syndrome….MUCH LESS BENEFIT THAN HAVING SEX, YET WE DO NOT FOCUS ON IT

Why Do Therapists and Patients Not Mention Sex?

- Lack of training
- Lack of “skill self-efficacy” and “information self-efficacy”
- Religious background
- Fear of being wrongly judged
- Therapists own experience with sexual abuse or trauma
- Shame and embarrassment

Sexual Dysfunctions According to DSM 5

- Symptoms have persisted for at least six months
- Symptoms cause clinically significant distress
- Symptoms not better explained by other disorders, relationship distress, major stressors, effects of substances, or medications

(American Psychiatric Association [APA], 2013)

Defining Characteristics of Sexual Disorders

- **Delayed Ejaculation:** Delayed or absent 75% to 100% of encounters
- **Erectile Disorder:** Marked difficulty in obtaining or maintaining 75% to 100% of encounters
- **Female Orgasmic Disorder:** Marked delay or absence 75% to 100% of encounters
- **Female Sexual Interest/Arousal Disorder:** Lack or reduced interest, fantasies, initiation, or receptivity
- **Genito-Pelvic Pain/Penetration Disorder:** Persistent or recurrent difficulties with penetration
- **Male Hypoactive Sexual Desire Disorder:** Lack of or reduced desired to engage in sexual encounters
- **Premature Ejaculation:** Pattern of ejaculation within one minute of penetration
- **Substance/Medication-Induced Sexual Dysfunction:** Sexual dysfunction developed during or shortly after substance intoxication/withdrawal or medication use
- **Other Specified Sexual Dysfunction**
- **Unspecified Sexual Dysfunction**

Sexual Dysfunctions and Subtypes

- **Lifelong:** Present from first sexual experiences
- **Acquired:** Developed after period of normal functioning
- **Generalized:** Not limited to certain types of stimulation, partners of situations
- **Situational:** Difficulties only occur in certain types of stimulation, partners or situations

Prevalence of Sexual Disorders According to DSM 5

- **Erectile Disorder:** Strong age related increase, especially after age 50. 13% to 21% age 40 to 80
- **Female Orgasmic Disorder:** 10% to 42% depending on culture, severity and duration. 10% never have orgasm in lifetime
- **Female Sexual Interest/Arousal Disorder:** Unknown
- **Genito-Pelvic Pain/Penetration Disorder:** 15% of women
- **Male Hypoactive Sexual Disorder:** 6% (18-24) and 41% (66-74)
- **Premature Ejaculation Disorder:** International 20%-30%
- **Substance/Medication-Induced Sexual Dysfunction:** 25%-75%

(APA, 2013)

Effects of Anxiety on Sexual Dysfunction

- Anxiety plays important role in pathogenesis and maintenance of sexual dysfunction
- Anxiety is final common pathway by which social, psychological, biological, and moral factors converge to impair sexual response
- Anxiety linked to 2.6 times greater orgasmic dysfunction
- Anxiety linked to 2.1 greater risk of inhibited sexual dysfunction
- Anxiety linked to 3 times greater risk of decreased sexual desire

Effects of Sexual Dysfunction on Anxiety

- Negative sexual experiences can condition anxiety response
- Anxiety response can be cognitive or somatic or both
- Anxiety leads to negative overthinking
- Negative overthinking results in more sexual dysfunction
- Cycle leads to avoidance behavior

Specific Anxiety Disorders and Incidence of Sexual Dysfunction

- **Generalized Anxiety Disorder:** 64% report decreased desire or arousal
- **Panic Disorder:** 75% report sexual aversion or sexual arousal dysfunction
- **Social Anxiety Disorder:** In men 30% report arousal or orgasm-ejaculation dysfunction. In women 40% report desire dysfunction and 42% pain
- **PTSD:** 69% Report erectile or orgasm dysfunction
- **OCD:** Sexual dysfunction ranges from 54% to 73%

Prominent Aspects of Specific Anxiety Disorders and Sexual Dysfunction

- **Panic Disorder:** Fear of panic during sex or that sex can cause panic leads to avoidance or sympathetic interference
- **Social Anxiety Disorder:** Sexual performance anxiety prominent as well as general fear of negative appraisal
- **Generalized Anxiety Disorder:** Vulnerability to "what if thinking" and catastrophic thinking leads to more anxiety
- **OCD: I**ntrusive thoughts, sexual obsessions, perfectionism, guilt and shame, contamination obsessions and compulsive behaviors
- **PTSD:** Distressing thoughts or flashbacks during sex, fear of loss of control, mistrust issues

Standard Recommendation for Treatment of Sexual Disorders in Medical Office

- Evaluation of medical cause
- Prescription medications, such as vasodilators, antidepressants, hormone replacement, or devices
- Counseling

Treatments for Sexual Dysfunction

- **Delayed Ejaculation:** Evaluation of medical causes, resolution of guilt shame or anger issue, reduction in masturbation and pornography, behavioral methods, conjoint therapy
- **Erectile Disorder:** Evaluation of medical issues, devices, mindfulness, cognitive and behavioral methods, conjoint therapy
- **Female Orgasmic Disorder:** Behavioral techniques like sensate focus and mindfulness, conjoint therapy
- **Female Sexual Interest/Arousal Disorder:** Mindfulness, psychotherapy, medications, conjoint therapy

Treatment for Sexual Dysfunction

- **Genito-Pelvic Pain/Penetration Disorder:** Medications (estrogen), education about chronic pain, pelvic floor physical therapy, progressive desensitization and mindfulness, conjoint therapy
- **Male Hypoactive Sexual Disorder:** Hormone replacement , medication, cognitive techniques, conjoint therapy
- **Premature Ejaculation Disorder:** Cognitive-Behavior therapy, mindfulness , medications, conjoint therapy
- **Substance and Medication Induced Sexual Dysfunction:** Medication evaluation and education with cognitive therapy, conjoint therapy

Treatment of Sexual Disorders When Mixed with an Anxiety Disorder

- **Panic Disorder:** Education about panic attacks, correction of misbeliefs about sex panic connection, methods for panic control, gradual exposure to sexual activity, conjoint therapy
- **Social Anxiety Disorder:** Focus on the issues of performance anxiety, negative core beliefs related to sexual behavior, mindfulness and acceptance methods, exposure, conjoint therapy
- **Generalized Anxiety Disorder:** Focus on worry mechanism and how it applies to sexual behavior, reduction of “what if” thinking and mindfulness
- **OCD:** Focus on obsessions related to sexual behavior, develop techniques to reduce reactivity to intrusive thoughts during sex, identify and reduce compulsive behaviors that negatively effect sex, ERP
- **PTSD:** Education about effect of trauma on sexual behavior and avoidance of intimacy, techniques to reduce negative hyperarousal, help calm negative core beliefs related to sexual activity, EMDR

For the Future

- Medical and mental health teaching institutions must include education and training about sexual dysfunction and psychiatric problems
- Clinicians need to include sexual function questions in their evaluations of patients just like any other symptom
- Clinicians need to understand and address the bio-psycho-social dimensions of patient's symptoms in sexual and anxiety disorders and their interaction
- Clinicians need to be able to apply the appropriate empirically based treatments to the patient's problems rather than fit the patient to the treatment that is available

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