# Summer 2022 Newsletter

## Lori A. Futterman RN, Ph.D.

## Health Disparities and Inequities in Minoritized Populations: Maintaining a Clear Mind in the Face of Uncertainty

*Lori A. Futterman RN, Ph.D.*

COVID has created a cultural shift and a new health care environment to navigate. The impact of this pandemic has uncovered healthcare discrepancies among minoritized groups and provided an impetus for providers to become aware of the influence of their unconscious attitudes. The discriminations that exist for minority populations e.g., racial/ethnic minorities, sexual and gender minorities, disability status and poor economic backgrounds, have become heightened (Kantamneni, 2020). Health disparities and inequities within these domains may result in increased rates of disease, increase in mortality and mobility and poor health outcomes (Alvidrez, Castille, Laude-Sharp, Rosario, Tanbor, 2019; Brown, Ma, Miranda, Eng, Castille, Brockie, Patricia-Jones,Airhihenbuwa, Farhat,Zhu,Trinh-Shevrin 2019)). The pandemic has generated an epidemiological transition about how health, disease and mortality are viewed and responded to.

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The Supreme Court's ruling overturning Roe vs Wade has disturbed the reproductive rights we worked 50 years ago to obtain. This generated another collective shift within the USA and its implications can extend globally. The American Psychological Association (APA) (March 2022) supports the reproductive rights of women as well as legalized abortions. APA suggest that restrictive policies on women's reproductive health care rights are related to an increase in risk for mental health difficulties and negatively affect wellbeing (APA, 2020). This is another major jolt on minority populations in seeking reproductive justice. The implications of this Supreme Court decision on the rights of reproductive freedom and its probable effects on mental health, sexual health and sexual functioning are considerations that we as clinicians need to be aware of. The impact on our health care system of this new policy is enormous, creating an influx of reproductive rights cases across state lines and highlighting the existing health inequities and disparities among racial/ethnic minorities and sexual/gender minorities.

How are these sociocultural changes affecting you and your work? As clinicians we bring our own implicit biases (unconscious bias) to our workplace which ultimately intersect with the social identities of others. The intersection of social identities may incorporate race, gender status, sexual orientation, body size, social class, nationality, religion, age all of which can impact patient care, co-workers, and the healthcare system both (Ogungbe, Mitra, Roberts, 2019). Ogungbe et al, 2019 suggest that these intersectionality's of biases can affect clinical judgment and contribute to health disparities. They suggest that research is needed to study the effect of the intersectionality of implicit bias (Ogungbe et al,2019).

We can increase our awareness of culturally responsive care, improve patient/provider communication and create a learning environment in healthcare settings while maintaining a clear mind by:

- Engaging in mediation practice with emphasis on developing a clear mind and encouraging patients to do the same
- Developing a psychotherapeutic alliance with a clinician who can assist you in enhancing internal balance and create positive ways to work with stress
- Becoming alert to own implicit biases
- Seeking out training opportunities that include self-reflection, perspective taking, empathy training and skill development to work with specific biases that can generate calmness
- Advocating for education and curriculum development that reduce macroaggressions and implicit bias
- Generating research on the implications of implicit bias within the healthcare delivery systems to reduce negative healthcare outcomes and create policy changes

# Mood and Intimacy Work Together: Can We Enhance Both?

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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 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;). 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 (Palace & Gorszalka, 1990; van Minnen & Kampman, 2000; Aksaray, Yelken, Kaptanoglu, Oflu, & Ozaltin, 2001; Marques, & Hayes, 2001; Bonierbale, Lançon & Tignol, 2003; Bradford & Meston, 2006; Corretti & Baldi, 2007; Figueira, Possicente, McCabe et al., 2010). 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).

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We can enhance mood and sexual functioning using a variety of methods. 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. Research using Yoga to treat mood and indirectly enhance sexual functioning concluded that practicing Yoga had significantly raised S. DHEAS levels in medical students and improved their immunological status as well as enhanced mood and behavior (Kumar, Kumar, Singh, Pooja, Pandey, Divya, 2018).

***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.*

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