Mood and Sex Can 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, 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 underestimate 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; Corrupt & 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.