The Relationship Between Anxiety Disorders and Sexual Dysfunction

August 01, 2007 | Anxiety [1], Comorbidity In Psychiatry [2], Generalized Anxiety [3], Panic Attacks [4], Physiological Sexual Dysfunction [5], Sexual Disorders [6]
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In this article, we examine the relationship between anxiety disorders and SDs, using DSM-IV-TR categories, although we are conscious of the limits of this approach. In doing so, we will consider not only the dichotomy between normal and pathological functioning but also the issue of sexual satisfaction as part of wellness.

Anxiety can be defined as a feeling of apprehension and fear characterized by physical, psychological, and cognitive symptoms. In the context of stress or danger, these reactions are normal. However, some people feel extremely anxious with everyday activities, which may result in distress and significant impairment of normal activity.

Anxiety disorders are a group of clinical entities in which an abnormal level of anxiety is the prominent symptom. This group includes panic disorder, specific and social phobia, obsessive-compulsive disorder (OCD), posttraumatic stress disorder (PTSD), acute stress disorder, and generalized anxiety disorder. Sexual dysfunctions (SDs) are defined in DSM as disturbances of the 3 phases of the sexual response cycle: desire, arousal, and orgasm, in addition to sexual pain disorder.

Anxiety plays an important role in the pathogenesis and maintenance of SDs. This co-presence is very common in clinical practice: patients with SDs will often present with an anxiety disorder, and in many cases it is unclear which is the primary disorder. On the other hand, for many patients with a psychiatric disorder an SD may be a persistent disturbance.

Anxiety represents the final common pathway by which social, psychological, biological, and moral factors converge to impair sexual response. The neurobiological expression of anxiety is complex, but it mainly involves a release of adrenergic substances (epinephrine and norepinephrine). Sympathetic dominance is also negatively involved in the arousal and orgasm phases and may interfere with sexual desire.1,2 Psychological elements are generally considered important in the pathogenesis of SD, but it is difficult to explore these factors with standardized instruments. There are few studies that explore this hypothesis using diagnostic tools, and in some cases these studies have considered anxiety as a feeling and not as a clinical entity.

In this article, we examine the relationship between anxiety disorders and SDs, using DSM-IV-TR categories, although we are conscious of the limits of this approach. In doing so, we will consider not only the dichotomy between normal and pathological functioning but also the issue of sexual satisfaction as part of wellness. We review studies that report on sexuality in anxiety disorders and on those that report on anxiety in patients who have SDs.

Anxiety disorders in patients with sexual dysfunction

The complex relationship between anxiety disorders and desire disorders is rarely clarified in the medical literature. Kaplan1 underlines a strong prevalence of panic disorder (25%) in patients affected by sexual aversion disorder. Anxiety is also relevant in sexual arousal. Induced by different stressors, anxiety can distract from erotic stimuli and impair sexual arousal, principally through an increased sympathetic tone.3,4 This may result in poor erection in males and a reduction in lubrication and clitoral tumescence in females.

Various aspects of anxiety are historically considered in arousal disorders, particularly the vicious circle of anxiety/dysfunction/performance anxiety.5 Honeymoon impotence is a specific example of this, as suggested by Shamloul,6 who studied 100 patients with this problem.

Several studies have found that the prevalence of anxiety disorders varies from 2.5% to 37% in males affected with erectile dysfunction (ED).7-9 However, these studies failed to point out a significant correlation between a sin-gular type of anxiety disorder and ED. Recently, however, a link between free-floating anxiety and ED has been suggested.10 Others report that the association...
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One study found that the presence of anxiety symptoms in patients with arousal disorders was associated with poor treatment outcomes. Hyperarousal syndromes, such as persistent sexual arousal, are not found in DSM-IV-TR. The specific role of anxiety in these cases is unknown. Leiblum and colleagues described 103 women with involuntary genital and clitoral arousal. An anxious experience represented the trigger in one third of these women. Anxiety-related symptoms such as worry, panic attacks, and obsessive thoughts or behaviors were also seen in significant numbers of these patients, as were secondary anxiety symptoms (worry and embarrassment).

In addition to desire and arousal, orgasm may also be impaired by anxiety. While it is widely accepted that anxious thoughts or feelings disrupt female orgasm, few studies have examined this relationship or tried to identify specific aspects of anxiety related to impaired orgasm. Negative emotions, including anxiety or fear of failing to meet a partner's expectations, represent one of the most common causes of premature ejaculation (PE). This has been explained by investigators as being caused by a sympathetic hyperactivity that reduces ejaculation control.

Others have pointed to the role of attention, suggesting that men who are anxious during sexual intercourse are worried about sexual performance or sexual adequacy, and that these thoughts may distract attention from the sexual sensations that precede orgasm and ejaculation. Hyperattention to performance and fear of inadequacy in meeting others' expectations are typical of social phobia, in which concern about performance and judgment reflect a high sympathetic tone. This has been confirmed by Tignol and colleagues and Corretti and colleagues, who report that the prevalence of social phobia is 47% and 25.5%, respectively, in patients with PE. This link between social phobia and PE was also substantiated by reports of 2 cases in which worry about social performance led to uncontrolled ejaculation.

Other investigators propose a significant role of free-floating anxiety in PE. The relationship between anxiety and retarded ejaculation is unclear, although some investigators suggest that sexual performance anxiety can contribute to retarded ejaculation.

### Anxiety disorders and pain disorders

High levels of anxiety have been found in women with dyspareunia, who seem to experience severe pain during sexual intercourse. The pathophysiological factors that regulate this phenomenon are unknown. An interesting hypothesis suggests that a strong relationship exists between anxiety and hypervigilance in patients with anxiety and SD, with attention being allocated to threatening stimuli during sexual intercourse.

Recent studies have significantly increased the understanding of pain perception and have demonstrated that a complex series of spinal, midbrain, and cortical structures are involved in pain perception. Pain perception can be roughly divided into a lateral, somatosensory system involved in discrimination of pain location and intensity, and a medial system that mediates the anticipatory, fearful, affective quality of pain through limbic structures. Dysfunctions of these limbic structures, including the hippocampal cortex, may be involved in SDs in which pain represents the prevalent symptom. Patients with chronic pelvic pain have often been found to have a history of sexual trauma or abuse. Moreover, similar alterations in limbic structure have been demonstrated both in patients with chronic pelvic pain and in survivors of trauma. This may suggest that pain represents not only a symptom of SD but also a symptom of a more specific anxiety disorder such as PTSD.

### Sexual dysfunction in patients with anxiety disorders

Looking at the other side of the picture, sexual difficulties are common in patients affected by anxiety disorders. Often, in fact, a sexual symptom is the first reason for consulting a physician. Kaplan suggested a prevalence of SD of 75% in patients with panic disorder. These data were confirmed by Figueira and colleagues, who retrospectively evaluated the sexual function and the sexual history of 30 patients with panic disorder and social phobia. They found that sexual aversion disorder is the most common SD in patients with panic disorder, and that its prevalence in this population is greater than in the general population. Furthermore, they found that in their series, sexual aversion was secondary to panic disorder: patients said that they avoided sex because they feared having a panic attack during intercourse. These results were found in both men and women and suggest that sexual aversion may be part of the agoraphobic spectrum.

Sexual avoidance may also be caused by ED in males affected with panic disorder. An analysis of 60,949 patients with ED showed that men with panic disorder have an increased risk (odds ratio) of ED in the range of 1.33 to 2.29. Studies on sexuality in patients with social phobia show a comorbidity of about 30%. Arousal disorders (loss of desire during sexual intercourse) and orgasm-ejaculation disorders are most
common in males with social phobia. Some studies that have analyzed social phobia in male populations found a high prevalence of PE (47%), while others found a link with retarded ejaculation (33%). The correlation between PE and social phobia is accepted, but there is also a relationship between retarded ejaculation and social phobia, which underlines that the specific role of anxiety is still unclear.

Pleasure and sexual satisfaction are impaired in persons with social phobia. Women with social phobia are more likely to have concomitant desire disorders (46%), pain during sex (42%), and less frequency of sexual thoughts and sexual intercourse. SDs have a prevalence of 39% in females with OCD. Patients may report sexual disgust, the absence of sexual desire, very low sexual arousal, anorgasmia, and high avoidance of sexual intercourse. Patients with OCD show severe impairment in both interpersonal and sexual relationships and they tend to perceive themselves as less sensual in comparison to patients with other anxiety disorders. The results are a poor level of sexual pleasure and a strong dissatisfaction with their sexuality (73%).

PTSD affects emotional, social, professional, and sexual life. It is still unclear whether populations with PTSD have normal levels of sexual desire. Certainly, these patients have ED (prevalence of about 69% in combat veterans with PTSD) and problems with orgasm, and thus report a poor level of sexual satisfaction.

Unresolved problems and future targets

The relationship between anxiety and sexual function is complex because it has been considered in 2 symmetrical directions: the primary symptom and the secondary consequence. Understanding the cause-effect link in clinical practice necessitates experience and an expanded point of view. The relationship between anxiety and sexuality can be theoretically described as one of the following:

- Anxiety may cause sexual failure.
- SDs may cause anxiety.
- SDs and anxiety are not causally related.
- Anxiety and SDs may be different expressions of the same processes.

The analogies in neurobiology and the good response to similar treatments (psychotherapy and/or SSRIs) seem to confirm the last hypothesis, suggesting a common root of these 2 manifestations. Obtaining a complete psychopathological and sexual history represents an important step in diagnosis that can influence prognosis with either pathology.

When investigating anxiety disorders, it is important to consider the patient's sexual life, and vice versa. When we evaluate SD, anxiety disorder should always be considered. In our practice, failure to investigate the patient's psychological background negatively influences the treatment goal of a patient with an SD.

The clinical evaluation should not be restricted to the patient but should extend to the partner. In particular, partners of men with SDs frequently have not only an unsatisfactory sexual life but an anxiety disorder as well.

References:

9. Lee IC, Surridge D, Morales A, Heaton JP. The prevalence and influence of significant psychiatric


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