Performance anxiety in sexual intimacy rarely starts in the body. The body is usually following a story the brain learned somewhere along the way: a moment of embarrassment, a shaming comment from a past partner, a strict upbringing where desire was policed, or a medical scare that turned sex into a test. When those memories sit unresolved, arousal cues can collide with threat cues. Heart rate climbs, mind races, muscles tighten, and the very systems required for pleasure shift to self-protection.

EMDR therapy was designed for trauma, but the mechanism underneath it applies anywhere the nervous system gets stuck in a loop. In my practice, I see EMDR help individuals and couples loosen the grip of sexual performance anxiety by targeting the specific memories, images, and body sensations that highjack the moment. Paired with sex therapy, couples therapy, and sometimes parts work or family therapy, it can change not just what happens in bed, but the entire meaning of intimacy.

What performance anxiety actually looks like

People often picture performance anxiety as not being able to maintain an erection or reach orgasm. Those are common outcomes, but the anxiety itself shows up earlier and more subtly. I hear descriptions like, "I get a flash of a past comment and I'm done," or, "Right as things start, my chest tightens and my thoughts start sprinting." For some, it is a fear of premature ejaculation, a sense of going numb, or a sudden drop in lubrication. For others, it is an intrusive inner critic that treats sex like a performance review. Sometimes it is tied to specific contexts, like new partners or certain positions. Sometimes it shows up after childbirth, illness, or relationship betrayal.

Biology plays a role. If the brain assigns intimacy to the threat column, the sympathetic nervous system prepares you to run, not to open. Blood flow, muscle tone, and attention all shift. But you cannot breathe your way out of a story that keeps triggering the alarm. You have to update the story in memory so the body stops bracing.

Why EMDR belongs in the bedroom conversation

EMDR therapy, or Eye Movement Desensitization and Reprocessing, is built on a straightforward idea: the brain has a natural way of digesting experience, but high stress can block that process and trap sensory fragments, beliefs, and emotions in a raw state. Bilateral stimulation, usually through guided eye movements or taps, helps re-engage adaptive processing while you hold in mind the target memory and what it evokes now. Over sessions, the distress drops, the image loses its charge, and new beliefs become available.

The strongest research base for EMDR sits in PTSD, with dozens of randomized trials and guidelines from multiple countries endorsing it. Sexual performance anxiety is a more specific application with a smaller evidence base, made up of case reports, small trials, and clinical experience. The logic is consistent though. If a humiliating event, a shaming family rule, or a medical scare is driving the current shutdown, then reprocessing that material should reduce the alarm paired with sexual cues. I have watched men regain reliable erections because the image of a jeer from a college girlfriend no longer felt like a live wire. I have seen women who dissociated during sex begin to stay present after reprocessing a single invasive gynecological exam that had never been named as traumatic.

EMDR also fits because it respects the body. Sex therapy often focuses on behavior, communication, and education, which help, but if a client's body flips to survival mode at the first touch, no amount of sensate focus exercises will land. EMDR invites the body to update.

Not every anxiety is the same

Before moving to EMDR, I map the terrain. Is the anxiety situational or generalized? Did it begin after a specific event? Are there medical contributors like hormonal changes, pelvic floor dysfunction, SSRI side effects, sleep apnea, or vascular disease? How does porn use fit in, if at all? What relationship patterns exist around pressure, avoidance, criticism, or caretaking? I also screen for trauma history, attachment injuries, OCD features, and mood disorders. When needed, I coordinate with primary care, urology, gynecology, or pelvic PT. EMDR is powerful, but it is not a replacement for medical care.

If the anxiety is primarily linked to a few clear memories or carves itself along a familiar body sensation, EMDR tends to move quickly. If there is longstanding developmental trauma, insecure attachment, or betrayal trauma in the partnership, we can still use EMDR, but with a broader plan that includes couples therapy and pacing.

How EMDR unfolds in sexual anxiety work

Preparation matters. Clients often expect to jump to the most painful sexual scene in session one. That approach usually backfires. I spend our early work building stabilization skills and setting a tight frame of consent and control so that you know you can stop, slow, or titrate at any point. Sexual content often carries shame, and shame thrives in secrecy. We are going to name it, normalize the nervous system's logic, and make a plan.

When we begin targeting, we do not have to start with the worst moment. We can start with the first time it happened, the most recent time, or a feeder memory that seems minor but keeps showing up. For performance anxiety, feeder memories often include a parent's comment about bodies or purity, locker room humiliation, a teenage sexual encounter where consent was murky, a traumatic pregnancy or birth, a medical procedure, or a breakup laced with ridicule. Sometimes the target is not sexual at all, for example a teacher who shamed you for not getting something right the first time.

As we reprocess, three things shift. The first shift is in the image itself, which becomes duller and less sticky. The second is in *internal parts work* the emotions and body sensations, which settle and change tone. The third is in the belief you hold about yourself, like moving from "I am broken" to "I am capable" or from "I have to perform" to "I can connect." Those beliefs are not affirmations we force. They emerge naturally as the brain links old material with current resources.

The role of sex therapy, couples therapy, and parts work

I do not treat sexual performance anxiety with EMDR in isolation if a live relationship is part of it. Sex therapy gives us the language and experiences needed to translate internal change into the bedroom. Couples therapy helps recalibrate pressure, pacing, and meaning when two nervous systems keep triggering each other.

In couples work, I pay close attention to repetitive cycles. One partner's fear of failure leads to avoidance, which the other reads as rejection, which brings protest or withdrawal, which adds pressure, which increases fear. We slow those moves, help both partners speak from softer places, and create agreements that protect practice time from judgment. We use exercises like sensate focus, graduated exposure to triggers, and clear stop signals that reduce performance demands.

Parts work is a natural companion. Many clients feel like they have conflicting parts during sex. A young part wants closeness and fun. A protector part says, "Don't you dare let go." A critical part keeps score. Rather than crushing those voices, we get to know them, earn their trust, and invite them to step back at the right moments. Sometimes I use parts language explicitly with EMDR, asking a protector to sit on the bench while we reprocess a feeder memory that created its job in the first place.

Family therapy concepts can also help, even if we do not bring relatives into the room. Family rules about sex, success, gender, and vulnerability shape bodies. A client raised in a family that equated emotional exposure with weakness will have a nervous system that spikes when they make eye contact during sex. We map those rules and update them. If a couple is still entangled with family-of-origin expectations or carries religious trauma, brief family therapy sessions or clergy consultation may reduce the background noise enough to let intimacy grow.

What a course of EMDR can look like

There is no single timetable. In a contained case with a specific sexual embarrassment and a supportive partner, I have seen marked improvements within 4 to 8 EMDR sessions layered into broader sex therapy. With complex trauma or attachment injuries, we often need months of integrated work, paced to avoid flooding. Many clients feel some relief early, like being able to stay present longer or noticing less catastrophic thinking before intimacy.

Sessions have a rhythm. We identify the target image and the negative belief, measure distress, and choose a positive belief we want available. We notice what the body is doing. Then comes the bilateral stimulation. During sets of eye movements or taps, I ask you to just notice what arises. Between sets, I check in briefly. The mind and body do the heavy lifting. Across sessions, we re-measure distress, install the positive belief, and do a body scan to catch any leftover activation. If new material pops up, we follow it. The process is structured, but we leave room for the brain to lead.

Grounding and pacing during sexual practice

Clients often ask, "What do I do at home while we work?" Homework is strategic, not heroic. I want short, predictable practices that build trust with the body. That might mean non-demand touch, semi-structured time with explicit pause rights, or education about arousal cycles. It also means nervous system skills that translate directly to the bedroom.

Here is a compact at-home grounding sequence I teach to support reprocessing and reduce pre-performance spikes:

- Orient: look around and name five non-sexual details in the room to anchor in the present.
- Breathe low and slow: inhale through the nose for about four seconds, exhale for six, for two minutes.
- Vagal swing: seated, gently turn your head left until you feel a yawn or swallow, then right, without strain.
- Temperature shift: hold a cool compress on the cheeks or splash cold water to cue a parasympathetic rebound.
- Micro-allowing: notice one square inch of pleasant or neutral sensation and let it expand for 15 to 30 seconds.

This is not a cure. It is a way to keep the body within a workable range so that intimacy experiments feel safe enough to try.

Common targets and how they shift

I think in patterns. Some targets appear so often in this work that I can almost predict the belief they carry.

- The smirk: a past partner rolled their eyes or made a cutting joke. Belief: "I am laughable." After reprocessing, clients stop replaying the face. During sex, they stop scanning for signs of disgust.
- The test: a medical encounter where a body part became a problem to fix. Belief: "My body fails under scrutiny." After reprocessing, clinical settings feel less loaded, and sexual touch no longer feels evaluative.

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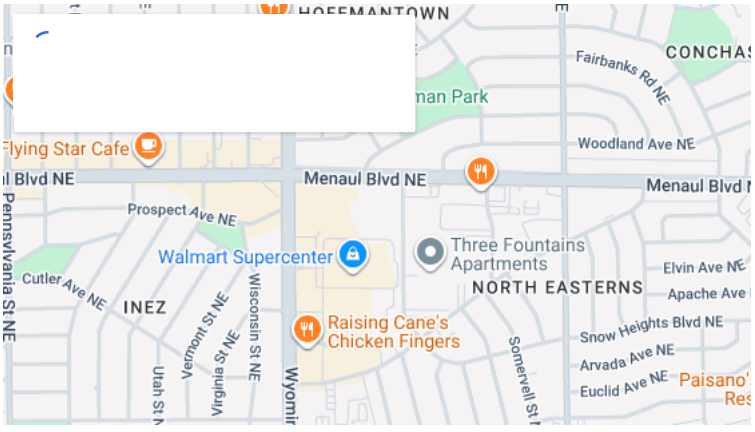
4F52+7R Albuquerque, New Mexico, USA

- The rule: messages like “Good girls do not initiate,” “Real men are always ready,” or “Sex is dirty.” Belief: “Desire is dangerous.” After reprocessing, desire feels safer, and initiation patterns shift.
- The rupture: discovery of porn, emotional affair, or betrayal. Belief: “I am not enough,” or “Intimacy is unsafe.” EMDR can reduce the visceral shock while couples therapy repairs trust and meaning.
- The freeze: early life experiences where a body boundary was crossed. Belief: “I have no say.” Reprocessing can restore a sense of choice. Sex therapy then rebuilds touch with explicit consent and micro-choices.

I do not promise erasing memories. The point is to let them take their proper place, as something that happened, not something that is happening now.

When to slow down or choose a different route

EMDR is not a fit for every moment. If someone is actively using substances to self-medicate or has unstable medical issues, we stabilize first. If dissociation is strong, we spend more time on parts work and present-time anchoring before touching sexual targets. If a relationship is unsafe due to coercion or violence, couples sessions are not appropriate, and the goal of sexual function takes a back seat to safety and autonomy.



I am wary of rushing EMDR for someone whose only motivation is to pass a perceived partner test. That pressure often recreates the performance dynamic we are trying to soften. The better frame is, “We are building a sexual life that works for both of us,” not, “We are fixing you so you stop messing this up.”

Measuring progress without reintroducing performance pressure

We do track change. I use subjective distress ratings tied to specific triggers. I also ask for concrete markers: frequency of intrusive images, time able to stay present before anxiety spikes, ease of initiating or responding, changes in lubrication or erection reliability, and how quickly you rebound when things do not go as planned. In couples therapy, we watch the interactional cycle. Are repairs quicker? Do you try again sooner? Do you laugh together more?

What we do not do is turn sex into a lab experiment with daily scorecards. A rough monthly check is often enough. Numbers are to guide us, not to grade you.

Telehealth, privacy, and practicalities

Plenty of EMDR for sexual anxiety happens via telehealth now. Bilateral stimulation can be delivered on screen, by tapping your own shoulders, or with audio. Privacy is the variable. If you share a home, we problem-solve white noise, car sessions, or scheduling. Many clients prefer the privacy of an office for sexual material, at least for early sessions.

Typical fees vary widely by region and training. Many clinicians offer 50 to 60 minute sessions; some use 75 to 90 minute intensives for faster momentum. Insurance coverage for EMDR is inconsistent, often requiring a diagnosable condition like PTSD or an anxiety disorder. Ask directly. Good therapy is an investment, and it is fair to discuss costs and expected length up front.

Choosing the right therapist for this work

Credentials matter, but fit matters more. You are trusting someone with highly personal material. Interview two or three therapists if you can. Notice your body's reaction during the consult. Do you feel respected, not rushed? Do they have a plan beyond generic reassurance?

Here is a brief checklist to guide the search:

- Training: EMDRIA-approved basic training at minimum, plus advanced training or consultation in sexual issues.
- Scope: experience with sex therapy or collaboration with a sex therapist when needed.
- Approach: comfort integrating parts work and couples therapy if relevant.
- Ethics: clear consent practices, boundaries, and discussion of confidentiality limits.
- Collaboration: willingness to coordinate with medical providers or pelvic PT where appropriate.

If you are a couple, ask whether the clinician treats partners together and individually, and how they manage confidentiality. Some EMDR targets land better in individual sessions, followed by couple sessions to integrate changes.

What your partner can do that actually helps

A supportive partner can shift outcomes dramatically. Here is what makes a difference in real homes. Reduce pressure, which includes subtle body language. Set up explicit off-ramps, like a "yellow light" phrase meaning pause and cuddle. Praise process, not outcome, as in "I loved being close with you," rather than "You lasted longer." Separate practice time from spontaneous intimacy so both have a place. Own your triggers in couples therapy, rather than outsourcing them to the anxious partner's body.

Often a partner carries their own injuries. If you grew up with rejection or contempt, your nervous system may read a no as a global verdict and escalate. That is your work to do. Couples therapy helps both people carry their share.

A short vignette from practice

Names and details changed. James, 34, came in after a second relationship ended with the feedback that he checked out during sex and could not maintain erections half the time. He had no significant medical issues and reported strong desire, especially early in relationships. Things went sideways around month three to four, right when sex felt more intimate. He could recall a specific recollection that intruded during sex: a high school girlfriend laughing after he lost his erection the first time they tried. He also carried a home rule that men initiate and lead.

We started with stabilization and a few sessions of sex therapy to take intercourse off the table for two weeks, add structured touch, and agree on a pause phrase. His new partner joined one session to learn the plan and reduce pressure. We then did EMDR on the high school moment, the sound of the laugh, the phrase "you can't keep it up," and the belief "I am weak." During reprocessing, a second memory surfaced of his father mocking him for quitting baseball. We followed that link.

By session six of EMDR, the original laugh felt dull and distant. His belief shifted to "I am steady." His body scan no longer lit up in the chest. He and his partner reported more playfulness and less planning. Erections became more reliable, but more importantly, he stayed connected when they were not. They built in humor and tried again. Three months later, they still had variability, as every couple does, but no meltdowns. He described sex as "available again."

Not every case looks this linear. Plenty take longer, especially with betrayal trauma or longstanding avoidance. But the direction is common: reduce threat, update meaning, let the body rejoin.

Special considerations for women and non-binary clients

Performance anxiety gets masculinized in culture, but I see plenty of women and non-binary clients whose bodies go on alert at the first sign of arousal. For some, dryness or pain becomes a feedback loop. For others, the moment of orgasm feels like losing control, which clashes with a protector part. Pelvic pain, endometriosis, birth trauma, and challenging experiences with providers can further sensitize the system.

The plan changes slightly. Collaboration with a gynecologist or pelvic floor physical therapist can address tissue and muscle contributors. We adapt EMDR targets to include body-based triggers, like the speculum sound or the smell of a clinic. Sex therapy *EMDR therapy* may include dilator work with a consent frame and micro-choices. Parts work often plays a larger role, with explicit work to earn the protector's trust. The outcome we shoot for is not just the presence of orgasm or penetration, but a felt sense of agency and ease.

Cultural and religious context

Beliefs shape bodies. Clients from conservative religious contexts often carry beautiful values around commitment and care, along with rules that frame desire as sinful or women's pleasure as secondary. We treat those beliefs with respect while also checking how they land in the body. EMDR can target moments where shame was installed, like a youth group talk or a confession that led to humiliation. Therapy can also include values clarification, often with the support of culturally competent clergy or mentors, to integrate faith and sexuality without panic.

For clients of color, queer clients, or those navigating disability, performance anxiety can be complicated by societal narratives that oversexualize, desexualize, or scrutinize bodies. Therapy should name those contexts. A nervous system is not an island.

What success looks like

Success is not perfect sex. It is a nervous system that recognizes intimacy as safe most of the time. It is a couple that can adjust on the fly, laugh, and return to connection after a moment of disconnection. It is a set of body memories that no longer leap into present time. It is voice and choice during touch. It is less rumination and more curiosity.

Many clients describe a quiet they had not felt in years. Not a boring quiet, but the kind where arousal can build without a courtroom in the background.

Final thoughts for the hesitant client

If your sexual life has become a gauntlet, you are not broken. Your body learned fast and well in an environment that made sense at the time. EMDR therapy offers a way to unlearn what no longer serves you, to file old scenes where they belong, and to give your current relationship a chance to breathe. When paired with sex therapy, couples therapy, and the occasional dose of family therapy or parts work, it becomes less about fixing a symptom and more about recovering a birthright: pleasure with presence.

If you decide to try, take your time choosing a guide. Ask blunt questions. Expect a plan. Keep your partner in the loop if you are in a relationship, and make room for their experience as well. Most of all, give your nervous system permission to change at the pace of safety. It knows how.

Albuquerque Family Counseling

Name: Albuquerque Family Counseling

Address: 8500 Menaul Blvd NE, Suite B460, Albuquerque, NM 87112

Phone: (505) 974-0104

Website: https://www.albuquerquefamilycounseling.com/

Hours:
Sunday: Closed
Monday: 9:00 AM – 7:00 PM
Tuesday: 9:00 AM – 7:00 PM
Wednesday: 9:00 AM – 7:00 PM
Thursday: 9:00 AM – 7:00 PM
Friday: 9:00 AM – 7:00 PM
Saturday: 9:00 AM – 2:00 PM

Open-location code / plus code: 4F52+7R Albuquerque, New Mexico, USA

Coordinates: 35.1081799, -106.5479938

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Albuquerque Family Counseling provides therapy for adults, couples, and families from its office in Albuquerque, New Mexico.

The practice is located at 8500 Menaul Blvd NE, Suite B460, near the Northeast Heights and Uptown areas of Albuquerque.

Listed specialties include trauma therapy, anxiety therapy, depression therapy, PTSD therapy, sex therapy, lack of intimacy counseling, couples therapy, and family therapy.

Listed therapeutic approaches include Cognitive Behavioral Therapy, EMDR therapy, Parts Work, Discernment Counseling, Solution-Focused Therapy, couples therapy, and family therapy.

The practice offers both in-person appointments at the Albuquerque office and virtual therapy options for clients who need more flexible access to care.

Albuquerque Family Counseling is locally positioned for clients in Albuquerque, Santa Fe, Bernalillo County, and other New Mexico communities where telehealth is appropriate.

The practice's FAQ notes that openings can change day to day, so prospective clients should confirm current availability and appointment format before scheduling.

To contact the practice, call (505) 974-0104 or visit https://www.albuquerquefamilycounseling.com/.

The public map listing for Albuquerque Family Counseling can help clients verify the Menaul Boulevard office location before an in-person appointment.

Popular Questions About Albuquerque Family Counseling

What is Albuquerque Family Counseling?

Albuquerque Family Counseling is a psychotherapy and counseling practice in Albuquerque, New Mexico, offering therapy for adults, couples, and families.

Where is Albuquerque Family Counseling located?

The main office is listed at 8500 Menaul Blvd NE, Suite B460, Albuquerque, NM 87112. The FAQ page also lists a second office in Santa Fe, New Mexico.

Does Albuquerque Family Counseling offer virtual therapy?

Yes. The official site says the practice offers both in-person and virtual therapy options. The FAQ notes that telehealth appointments are often more abundant than in-person appointments.

What types of therapy does Albuquerque Family Counseling provide?

The practice lists couples therapy, individual therapy, family therapy, trauma therapy, anxiety therapy, depression therapy, PTSD therapy, sex therapy, EMDR therapy, Cognitive Behavioral Therapy, Parts Work, Discernment Counseling, and Solution-Focused Therapy.

Does Albuquerque Family Counseling specialize in couples therapy?

Yes. The official FAQ describes couples therapy as a specialty and explains that the couples therapy process may begin with structured sessions to gather background, understand each partner's perspective, and define goals.

Does Albuquerque Family Counseling work with children?

The FAQ states that only a few therapists work with adolescents on a case-by-case basis and that the practice may provide referrals for services such as play therapy or sand tray therapy when needed.

What insurance does Albuquerque Family Counseling accept?

The official FAQ lists Presbyterian, Blue Cross Blue Shield, Aetna, Centennial Care/Medicaid, Molina, and GEHA. Clients should confirm current coverage, benefits, and billing details directly before scheduling.

What are Albuquerque Family Counseling's listed hours?

The matching public listing shows Monday through Friday from 9:00 AM to 7:00 PM, Saturday from 9:00 AM to 2:00 PM, and Sunday closed. Appointment availability may vary by therapist.

Is Albuquerque Family Counseling an emergency mental health provider?

No crisis or emergency service was verified for this dataset. Anyone in immediate danger or experiencing a mental health crisis should call 911, contact 988, or go to the nearest emergency room.

How can I contact Albuquerque Family Counseling?

Call (505) 974-0104, visit https://www.albuquerquefamilycounseling.com/, or use the listed social profiles: https://www.facebook.com/p/Albuquerque-Family-Counseling-61563062486796/, https://www.instagram.com/albuquerquefamilycounseling/, https://www.linkedin.com/company/albuquerque-family-counseling, and https://www.youtube.com/@AlbuquerqueFamilyCounseling.

Landmarks Near Albuquerque, NM

Albuquerque Family Counseling is located on Menaul Blvd NE in Albuquerque, with in-person therapy available at the office and virtual therapy options listed by the practice. Clients near these landmarks can call (505) 974-0104 or visit https://www.albuquerquefamilycounseling.com/ to ask about availability and fit.

- 8500 Menaul Blvd NE — The listed office address area for Albuquerque Family Counseling; clients can use the map listing to verify the location.
- Menaul Boulevard NE — The main corridor connected with the practice's listed address and a practical reference point for local clients.
- Wyoming Boulevard NE — A major north-south road near the office area; nearby clients can call to ask about in-person or virtual appointments.
- Northeast Heights — A large Albuquerque area near the Menaul and Wyoming corridor; local clients can contact the practice for therapy options.
- Coronado Center — A major shopping landmark in the Uptown area and a useful point of orientation near the practice's service area.
- Winrock Town Center — A well-known Uptown Albuquerque destination close to the Menaul Boulevard corridor.
- ABQ Uptown — A recognizable shopping and dining district near the office area; clients nearby can verify directions through the map listing.
- Uptown Transit Center — A transit reference point for clients navigating Albuquerque's Uptown and Northeast Heights areas.
- Jerry Cline Park — A nearby recreation landmark that helps orient clients around the Menaul and Louisiana area.
- Expo New Mexico — A major event venue in Albuquerque and a useful landmark west of the practice's local office area.
- Arroyo del Oso Park — A Northeast Albuquerque park and neighborhood landmark for clients in the surrounding area.
- Sandia Foothills Open Space — A major Albuquerque outdoor landmark east of the office area; clients throughout the city can ask about telehealth availability.