Women's Sexual Problems - A Guide to Integrating the "New View" Approach CME/CE

Author: Karen M. Hicks, PhD

Complete author affiliations and disclosures are at the end of this activity.

Release Date: October 7, 2004; **Valid for credit through October 7, 2005**

Target Audience

This activity is intended for physicians, nurse practitioners, RNs, and other clinicians in the specialties of Ob/Gyn, Family Practice, Primary Care, and Pediatrics.

Goal

The goal of this activity is to familiarize clinicians with the "New View" approach to treating women who present with sexual problems.

Learning Objectives for This Educational Activity

Upon completion of this activity, participants will be able to:

1. Recognize the value of an approach to women's sexual problems that considers relational and sociocultural factors.
2. Integrate detailed sexual history-taking skills into clinical practice.
3. Assess women's sexual problems using the "New View" nosology.
4. Discuss diagnostic and treatment strategies with a patient that take into account the relational and sociocultural factors that may contribute to her sexual problem as well as biologic or physiologic factors.

Credits Available

Physicians - up to 2.0 AMA PRA category 1 credit(s);
Registered Nurses - up to 2.4 Nursing Continuing Education contact hour(s)

All other healthcare professionals completing continuing education credit for this activity will be issued a certificate of participation.

Participants should claim only the number of hours actually spent in completing the educational activity.

Accreditation Statements

For Physicians

Medscape is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

Medscape designates this educational activity for a maximum of **2.0 category 1 credit(s)** toward the AMA Physician's Recognition Award. Each physician should claim only those credits that reflect the time he/she actually spent in the activity.

For questions regarding the content of this activity, contact the accredited provider for this CME/CE activity: CME@webmd.net. For technical assistance, contact CME@webmd.net.

For Nurses

Approved for 2.4 contact hour(s) of continuing education for RNs, LPNs, LVNs and NPs. This activity is cosponsored with Medical Education Collaborative, Inc. (MEC) and Medscape. MEC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

Provider approved by the California Board of Registered Nursing, Provider Number CEP 12990, for 2.4 contact hour(s).

Approved by the Florida Board of Nursing, Provider Number FBN 2773.

For questions regarding the content of this activity, contact the accredited provider for this CME/CE activity: info@meccme.org. For technical assistance, contact CME@webmd.net.

Instructions for Participation and Credit

This online activity is formatted to include text, graphics, and may include other multi-media features. There are no fees for participating and receiving credit for this activity.

Participation in this self-study activity should be completed in approximately 2.0 hour(s). To successfully complete this activity and receive credit, participants must follow these steps during the period from **October 7, 2004 through October 7, 2005**.

1. Make sure you have provided your professional degree in your profile. Your degree is required in order for you to be issued the appropriate credit. If you haven't, click here. For information on applicability and acceptance of continuing education credit for this activity, please consult your professional licensing board.
2. Read the target audience, learning objectives, and author disclosures.
3. Study the educational activity online or printed out.
4. Read, complete, and submit answers to the post test questions and evaluation questions online. Participants must receive a test score of at

least 70%, and respond to all evaluation questions to receive a certificate.
5. When finished, click "submit."
6. After submitting the activity evaluation, you may access your online certificate by selecting "View/Print Certificate" on the screen. You may print the certificate, but you cannot alter the certificate. Your credits will be tallied in the CME Tracker.

This activity is supported by funding from WebMD.

Legal Disclaimer
The materials presented here do not reflect the views of Medscape or the companies providing unrestricted educational grants. These materials may discuss uses and dosages for therapeutic products that have not been approved by the United States Food and Drug Administration. A qualified healthcare professional should be consulted before using any therapeutic product discussed. All readers or continuing education participants should verify all information and data before treating patients or employing any therapies described in this educational activity.

Copyright © 2004 Medscape.

Contents of This CME/CE Activity

1. Women's Sexual Problems - A Guide to Integrating the "New View" Approach
   Introduction
   Normative Sexual Functioning
   Sex Therapy From 1970-1998
   Issues of Diagnosis and Prevalence of Women's Sexual Problems
   A New View of Women's Sexual Problems
   The Role of the Clinician in Treating Women's Sexual Problems
   Specific Recommendations for Enhancing Clinicians' Ability to Attend to Women's Sexual Problems
   Taking a Sexual History Using Guidelines From a New View
   A New View Approach to Diagnostic and Treatment Strategies for Clinicians
   Case Presentations
   References

Women's Sexual Problems - A Guide to Integrating the "New View" Approach

Introduction

Physicians and other healthcare providers are increasingly being called on to play a new role in dealing with men and women's sexual problems. In the past 5 years, new biomedical and pharmaceutical approaches to sexuality problems have emerged and more are in development. There is a risk, however, that an overemphasis on such approaches will fail to address patients' fundamental problems with their sexuality and sexual relationships and perhaps medicalize our approach to problems in human sexuality to an extent that will prove unhelpful and possibly harmful. Indeed, when it comes to women's sexual health, it has been argued that female sexual dysfunction "is the freshest, clearest example we have" of a "corporate-sponsored creation of a disease."[1] It is thus imperative that clinicians who are called upon to treat women's sexual problems attempt to develop a sophisticated approach that brings to bear the relevance of the psychosocial, sociocultural, and socioeconomic contexts of human sexuality and sexual problems as well as an understanding of the physiologic and biological aspects. One such approach has

been developed by a group of clinicians, sex therapists, and social scientists in response to what they see as a growing medicalization of sexuality in clinical settings, particularly within urology. The purpose of this CME program is to familiarize doctors with their "New View" approach[2] to treating women who present with sexual problems. The foundation of the approach is the consideration of the relational and sociocultural factors that contribute to women's expressions about their sexual problems.

This CME/CE Clinical Update is organized around 5 major themes:

1. A review of the concept of normative sexual function and the classification of sexual dysfunction as developed by the sexologic community over the past 40 years;

2. The introduction of the New View approach to women's sexual problems;

3. A discussion of the role of the clinician in treating women's sexual problems and specific recommendations that aim to enhance a clinician's ability to attend to women's sexual problems, including a chart that highlights diagnostic and treatment strategies;

4. Presentation of interactive case studies; and

5. The provision of supplementary materials and information for further learning for the clinician and the patient.

Normative Sexual Functioning

Over the past 40 years, the clinical standard for normal sexual functioning has been the model of sexual response first described in 1966 by William Masters and Virginia Johnson.[3] Masters and Johnson studied sexual behavior through observing and measuring masturbation and sexual intercourse in the laboratory. Their now classic Human Sexual Response Model (HSRM) is the theoretical framework that has informed and guided the classification system in editions of the American Psychiatric Association's *Diagnostic and Statistical Manual* (DSM) and the International Classification of Diseases (ICD) from the World Health Organization (WHO), as well as the major therapeutic approaches to sexual dysfunction since the 1970s.

The HSRM defines the "natural and normal" human sexual response as consisting of a sequence of physical events that can be divided into 4 phases that are posited to be the same for men and women: excitement, plateau, orgasm, and resolution. The phases are characterized on the basis of changes in respiration, heart rate, muscle tension, and various sex organ changes. According to the model, a healthy normal sexual response entails a smooth passage through these 4 phases. However, there have been numerous critiques of the use of the HSRM to make universal claims about sexual normality in women.[4-7] Two major criticisms are worth noting here:

1. There were a number of subject selection biases in the original study. Masters and Johnson deliberately recruited "easily orgasmic" subjects, ie, those who could "perform" under bright lights and rolling cameras.[6] At first they studied prostitutes, and later individuals and couples who self-identified as easily orgasmic in masturbation and coitus. Also, the study subjects were not a sexually or socioeconomically representative sample. Masters and Johnson recruited a deliberately narrow population that was mostly white, middle- and upper-middle class.[6]

2. Experimenter bias and interference were present. Masters and Johnson gave their subjects extensive coaching on methods of effective sexual stimulation, which they termed and described in their book as a "controlled orientation program," before sending them into the laboratory for observation.[3] They also interrupted observation sessions and

provided further coaching. Thus, the HSRM results were influenced by the coaching of the investigators.

It is also worth noting, as Tiefer has,[8] that there have been no large-scale population studies to establish sexual function norms. Personal expectations concerning sexual frequency and the nature of sexual response come from cultural norms, and it seems that in the case of women's sexual response, "sexual scripts" have shifted; women are expected to respond similarly to men in terms of arousal and orgasm. Gagnon and Simon[9-11] coined the term "sexual scripts" to describe cultural messages that transmit information about a culture's sexual values to individuals. These scripts act as guidelines for sexual experience and behavior. Examples of such cultural values are virginity for women until marriage, the expectation of high sex drive for all men, and a double standard of sexual conduct. Values shift, however, and Kleinplatz[12] argues that American women today are encouraged by popular culture to look sexy but not to be sexual, in the sense of focusing on their own personal fulfillment and satisfaction. Contradictions in script elements or subtle negative messages can produce low desire, inability to initiate sex, problems with body image, ambivalence about using sex for pleasure, and ignorance about sexual anatomy and function. Clinicians do well never to underestimate the confusing and contradictory impact of the culture's sexual messages on women.

The Interpersonal Exchange Model of Sexual Satisfaction (IEMSS) provides empirical support for the importance of relational context for women's sexual satisfaction.[13] On the basis of survey results, Lawrance and Byers concluded that sexual satisfaction is based on 4 factors: the balance of sexual rewards and costs in the relationship, how actual rewards and costs compare to the expected level, the perceived quality of sexual rewards and costs between partners, and relationship satisfaction.[13] Relationship satisfaction emerged as the most important contributor to sexual satisfaction.

Sex Therapy From 1970-1998

Sex therapy blossomed in the late 1960s and 1970s after the acclaim given to the groundbreaking work of Masters and Johnson and the couples' therapy treatment model they developed.[14] This period coincided with important sociopolitical movements in the United States, including the modern sexual revolution. The introduction of the first oral contraceptive in the early 1960s and the social movements for civil rights and women's rights contributed to a sense of personal entitlement of sex for pleasure, not generally socially acceptable for women before this time.

The couples' treatment model entailed short-term therapy for both partners and included a few elements considered a radical departure from previous therapeutic strategies. The therapy included the elements of a dual therapy team, sensate focus exercises, and an emphasis on the primary cause of sexual dysfunction as being psychological rather than physical in most cases. They asserted that this sex therapy approach could be accomplished in a rapid manner through reeducation rather than through intensive individual psychotherapy.[15]

As sex therapy developed, it came to consist of typically an 8- to 10-week format that combined weekly psychotherapy sessions (cognitive, behavioral, and psychodynamic) with behavioral homework assignments to overcome gaps in sex education and ineffective technical practices. These included sensual exercises to develop skills and comfort with nondemand (ie, nonintercourse-oriented) pleasuring and improved sexual communication. Individuals and couples were given books and videos for supplementary education. In some settings, therapy for individual patients used sexual surrogates as partners, and some entailed group therapy for nonorgasmic women.[16]

It is important to note that during this time, sex therapy was situated in the psychological and psychiatric professional community.[15,17-19] Leading sex therapists joined medical school faculties and opened clinics within departments of Psychiatry and Behavioral Sciences. Psychiatrist Helen S. Kaplan (1974),[17] a master teacher and therapist, for example, founded the Human Sexuality Teaching Program at New York Hospital - Cornell Medical Center in New York City. She emphasized psychodynamics, emotion, and psychological factors during treatment sessions, and it was through her work and Harold Lief's that the stage of desire was added to the Masters and Johnson's HSRM in 1977.

During the 1970s and 1980s, several large outcome studies were published testing various elements of the Masters and Johnson model (For a review, see Bancroft's *Human Sexuality and Its Problems* [1989].)[20] The conclusions drawn were that many people with sexual dysfunction could benefit from a short, directive method of treatment. However, the noted sex therapist and researcher John Bancroft was critical of the work, believing that an "undue emphasis on physical factors and over-enthusiastic application of physical methods of treatment" fails to recognize or address "the considerable heterogeneity of problems that present for sex therapy." Yet, he also argued that it is difficult to define success when evaluating sex therapy: "This is an important issue because more often than not the specific dysfunction is only one aspect of the sexual relationship and therapy can achieve substantial improvement in the quality of the relationship whilst leaving the dysfunction largely unaltered."[20] Thus, the emerging clinical consensus emphasized a biopsychosocial model as the best, integrated approach to sexual problems.

The Medicalization of Male Sexual Problems and Beyond

The 1980s saw the beginning of published studies on medical treatment for male sexual problems -- specifically, intracavernosal injections with vasoactive drugs as a treatment for impotence,[21,22] which was renamed erectile dysfunction at a 1992 National Institutes of Health (NIH) consensus development conference.[23] Urologists became well known as sexuality specialists by the middle 1990s, and then the huge public reaction to the approval of sildenafil in 1998 redirected interest away from psychosexual therapies to pharmacologic solutions.[8] Tiefer has noted that many sex therapy clinics have closed, that there are few sex therapy training programs in medical schools, and new journals have started that focus almost exclusively on biology/physiology and pharmacotherapy (eg, *The International Journal of Impotence Research*).

Primary care physicians began to prescribe sildenafil to patients with sexual problems almost as soon as the drug was approved.[24,25] The extent of sildenafil (and vardenafil and tadalafil) use is so widespread that now even young men with no history of erectile dysfunction are requesting the drug from their physicians "in the hopes of enhancing performance and endurance".[26,27] "*Viagra* has left the realm of a medically prescribed drug," as Abraham Morgentaler (a Harvard Medical School urologist and researcher in sexual dysfunction) has stated. He also notes, "One thing that is remarkable is it has all happened without anybody paying much attention."[26] More attention may be paid now as the prescription drug-tracking firm Express Scripts recently found that, of > 5 million insured adults from 1998 to 2002, the fastest-growing segment of men using sildenafil were those between ages 18 and 55 years; the number of men younger than 45 using the drug tripled during this period. The company also states that their findings suggest that sildenafil is being used as an enhancement or recreational agent.[27] Of note is that Morgentaler felt compelled to write the book, *The Viagra Myth: The Surprising Impact on Love and Relationships*[28] because he had seen so many patients who believed the drug would solve problems in their relationships.

Female Sexual Dysfunction -- A Modified Medical Classification System

In October 1998, a consensus conference on female sexual dysfunction was organized by Irwin Goldstein (a Boston University School of Medicine urologist active in research on male erectile dysfunction) and sponsored by the American Foundation for Urologic Disease and 8 pharmaceutical companies.[29] Their purpose was to arrive at some consensus about the definition

of female sexual dysfunction. Participants modified the DSM/ICD language slightly to produce a definition for medical settings.[29,30] This group classified women's sexual problems into the DSM/ICD 4 general categories: sexual desire disorders, sexual arousal disorders, orgasmic disorders, and sexual pain disorders, but added a personal distress criterion, meaning that a condition would be considered a disorder only if it creates distress for the woman experiencing the condition.[29] This new classification was published in *The Journal of Urology*, the journal of the American Urology Association, further emphasizing the authority of urologists in the management of women's sexual problems. The difficulties in adapting female sexual dysfunction definitions to clinical trials, however, have produced continuing nomenclature evolution. Basson and colleagues[31] recently suggested that sexual desire is often experienced only after sexual stimuli have elicited subjective sexual arousal and that arousal is often poorly correlated with genital vasocongestion. Importantly, the authors recommend "that all diagnoses be accompanied by descriptors relating to associated contextual factors and to the degree of distress."[31]

Momentum to find drugs that could specifically treat sexual problems in women began in 1998, shortly after sildenafil received US Food and Drug Administration (FDA) approval. Goldstein had earlier predicted that treatment of female sexual dysfunction would create an "explosion" for the field of female urology.[32] The research has included studying sildenafil itself as a treatment for female sexual dysfunction.[33-38] Notably, Pfizer recently announced that several large-scale, placebo-controlled studies including about 3000 women with female sexual arousal disorder showed inconclusive results on the efficacy of sildenafil and that the company would not file for regulatory approval to use the drug for female sexual arousal disorder.[39]

Another industry-sponsored international consensus conference was held in 2001 on female androgen deficiency.[40,41] The consensus definition of " female androgen insufficiency" is that it consists of a pattern of clinical symptoms in the presence of decreased bioavailable testosterone and normal estrogen status. One of the symptoms seems to be decreased sexual desire. In an industry-supported conference report written for Medscape originally as a continuing medical education program, Lorraine Dennerstein stated that although "some small observational studies provide suggestions that there is a link between androgens and sexual functioning, there is no body of substantial evidence based on large samples and using validated questionnaires to confirm these findings."[40] Although no androgen therapies are currently approved by the FDA for the treatment of sexual problems in women, they are widely used in clinical practice to treat decreased sexual desire mostly in postmenopausal women.[42,43] A survey of 39 ob/gyns physicians in Tucson, Arizona, for example, revealed that an average of about 4 testosterone prescriptions per week were being written for women.[43]

In addition, a group of researchers are investigating a centrally acting drug -- a peptide analogue of alpha-melanocyte-stimulating hormone that binds to central melanocortin receptors -- that seems to selectively stimulate solicitational behaviors in the female rat. The investigators suggest this may be an agent that could be developed to selectively treat female sexual desire disorders.[44]

Issues of Diagnosis and Prevalence of Women's Sexual Problems

Sexual medicine centers, Web sites, continuing education symposia, and professional organizations focused on women's sexual problems have become increasingly prevalent. Diagnostic labels are becoming more common in the sexual medicine literature on female sexual dysfunction -- for example, "hypoactive sexual desire disorder," "sexual aversion disorder," "female orgasmic disorder," "female androgen deficiency syndrome,"[40,45] "psychotropic-induced sexual dysfunction,"[46] female sexual arousal disorder,"[45] and "persistent sexual arousal syndrome"[47] are terms being used today. However, the true prevalence of these disorders has not been established.

Results from a comprehensive and representative survey of American sexual behavior were published in 1994.[48] Although the survey focused on sociology, a single question related to sexual problems in women was reanalyzed in 1999.[49] About 1500 women were asked to answer yes or no as to whether they had experienced any of 7 problems, for 2 months or more, during the previous year. These problems included a lack of desire for sex, anxiety about sexual performance, and difficulties with lubrication. If the women answered yes to just 1 of the 7 questions, they were characterized as having sexual dysfunction.[1] As a result, the authors concluded that 43% of women report sexual problems. This figure is repeatedly cited in pharmaceutical industry public relations releases as well as in the sexual medicine literature as evidence that female sexual dysfunction is widespread (see footnote). However, serious concerns have been raised about the figure's misuse.[1,50,51]

In a 1993 nationwide survey of 2632 women by sex researchers Bernie Zilbergeld and Carol Ellison,[52] participants were given a list of 23 sexual circumstances dealing with sexual difficulties. The 3 most frequently marked items on the overview list were (in the following order): being too tired to have sex, being too busy, and lower sexual desire than wanted. About 28% (n = 457) of these had to do with physical responsiveness of the woman *or her partner*.[52] The major problems cited are: (1) if her partner, male or female, had difficulty getting aroused or seemed distracted during sex; (2) if her male partner had difficulty getting and/or maintaining an erection; (3) if she herself reached orgasm too quickly; (4) if she experienced pain during intercourse or other internal stimulation; or (5) if she experienced involuntary vaginal spasm so that vaginal entry and/or intercourse was impossible or difficult.[52] These kinds of function problems affected the atmosphere and conduct of sexual encounters, making them awkward, tense, and disappointing.

Laumann and colleagues[53,54] recently attempted to estimate the prevalence and correlates of sexual problems in 13,882 women and 13,618 men from 29 countries using data from the Pfizer Global Study of Sexual Attitudes and Behaviors, which is an industry-funded international survey of various aspects of sexuality and relationships among adults aged 40 to 80 years of age. Laumann and colleagues[53] found that lack of interest in sex and the inability to reach orgasm were the most common problems cited by women worldwide, with prevalence ranging from 26% to 43% and 18% to 41%, respectively. But as noted by the researchers -- in both the 1994 and 2004 studies -- sexual problems are associated with poor physical and emotional health and negative experiences in sexual relationships and overall well-being. The international study, for example, found that women's inability to reach orgasm was associated with poor health, financial problems, depression, and a low expectation about the future viability of their relationship. Notably, the only sexual problem associated with aging was lubrication difficulty.

Typing in the phrase "43% of women with sexual dysfunction" into the Google search engine highlights the extent to which this figure is cited See:
http://www.google.com/search?sourceid=navclient&ie=UTF-8&oe=UTF-8&q=43%25+of+women+with+sexual+dysfunction

A New View of Women's Sexual Problems

A New View of Women's Sexual Problems[2] was written to assist researchers, educators, and clinicians in response to the growing medicalization of sexuality in the media following the introduction of sildenafil in 1998. The goal of "New View" proponents is to offer a multidimensional model of sexual function that will assess women's experience as accurately as possible and lead clinicians toward more successful treatment outcomes, whether in psychosexual therapy or a medical context.

Briefly, New View proponents recommend considering women's sexuality within a broader, multidimensional framework of sociocultural, economic, and relational factors, as they play a large role both in the development of sexuality and sexual problems. Thus, clinicians learn to consider a woman's sexual problems and conflicts and ambiguities in her feelings about her

sexuality in the context of her particular experience in the society and social arena in which she lives. The New View therapeutic approach begins with a woman's own description of her sexual problem and attempts to place that description in her lived context, rather than looking immediately to diagnose her problem within a presumed universal functional picture of desire, arousal, and orgasm. The New View does not ignore the physiologic aspects of sexual experience, nor does it ignore or deny medical factors, but it holds that a comprehensive and appropriate understanding and diagnosis of sexual problems must include an investigation of social factors.

The New View Nomenclature

The New View nomenclature does not define normal sexual function per se. It rejects the definition of normal sexual response in terms of arousal, desire, orgasm, and then the identification of sexual problems as deviations from that norm. Rather, the New View nomenclature begins by acknowledging that women may be dissatisfied with *any emotional, physical, or relational aspect of sexual experience.* It then goes on to specify many different causes of such dissatisfaction, arising from social, relational, personal, or physical causes. The competent clinician will take a history with all of these sorts of etiologic issues in mind. (Taking a sex history using principles from the New View nosology is discussed in the next section.)

The New View nomenclature considers 4 categories of causes of sexual problems:

I. **Sexual Problems due to Sociocultural, Political, or Economic Factors**

   A. Ignorance and anxiety due to inadequate sex education, lack of access to health services, or other social constraints

      1. Lack of vocabulary to describe subjective or physical experience

      2. Lack of information about human sexual biology and life-stage changes

      3. Lack of information about how gender roles influence men's and women's sexual expectations, beliefs, and behaviors

      4. Inadequate access to information and services for contraception and abortion, STD prevention and treatment, sexual trauma, and domestic violence

   B. Sexual avoidance or distress due to perceived inability to meet cultural norms regarding correct or ideal sexuality, including:

      1. Anxiety or shame about one's body, sexual attractiveness, or sexual responses

      2. Confusion or shame about one's sexual orientation or identity, or about sexual fantasies and desires

   C. Inhibitions due to conflict between the sexual norms of one's subculture or culture of origin and those of the dominant culture

   D. Lack of interest, fatigue, or lack of time due to family and work obligations

II. **Sexual Problems Relating to Partner and Relationship**

A. Inhibition, avoidance, or distress arising from betrayal, dislike, or fear of partner, partner's abuse of couple's unequal power, or arising from partner's negative patterns of communication

B. Discrepancies in desire for sexual activity or in preferences for various sexual activities

C. Ignorance or inhibition about communicating preferences of initiating, pacing, or shaping sexual activities

D. Loss of sexual interest and reciprocity as a result of conflicts over commonplace issues such as money, schedules, or relatives, or resulting from traumatic experiences, eg, infertility or death of a child

E. Inhibitions in arousal or spontaneity due to partner's health status or sexual problems

III. **Sexual Problems due to Psychological Factors**

A. Sexual aversion, mistrust, or inhibition of sexual pleasure due to:

1. Past experiences of physical, sexual, or emotional abuse

2. General personality problems with attachment, rejection, cooperation, or entitlement

3. Depression or anxiety

IV. **Sexual Problems due to Medical Factors**

Pain or lack of physical response during sexual activity despite a supportive and safe interpersonal situation, adequate sexual knowledge, and positive sexual attitudes. Such problems can arise from:

A. Numerous local or systemic medical conditions affecting neurologic, neurovascular, circulatory, endocrine, or other systems of the body

B. Pregnancy, sexually transmitted diseases, or other sex-related conditions

C. Side effects of many drugs, medications, or medical treatments

D. Iatrogenic conditions

All the complex facets in the development and maintenance of the sexual persona over a woman's lifetime are interrelated and relevant to the present state of a woman's sexual functioning or problem condition. Issues implicit in this classification scheme also include the following:

5. Current developmental stage

6. Childhood and adolescent conditioning experiences

    a. religious and/or spiritual teachings and practices

b. gendered power relations

c. parental modeling of sexuality

d. sex education (formal and/or informal)

7. Previous experiences (positive and negative) with intimacy, love, attraction, and sexual activity

The Role of the Clinician in Treating Women's Sexual Problems

The daily schedule, routines, and demands of modern clinical practice make it difficult to take the time to develop an environment that allows the patient to bring up sensitive topics and have them addressed during the typical office visit. Clinicians without sufficient knowledge about sexuality or who have not had the opportunity to process and reflect on their own values, beliefs, and attitudes may react to patients with silence, embarrassment, imposition of his/her own personal values, signs of surprise or shock, personal discounting and/or belittling.[55] Yet publications from various medical specialties report that patients would like their doctors to initiate conversations about sexual sequelae to their other medical conditions.[56,57] A cardiologist reported that a considerable proportion of patients wanted their physicians to take a full sexual history and that they would be comfortable having such discussions with doctors.[58] Increasing comfort and developing interview skills are top priorities for healthcare professional school and postgraduate training generally, and developing the skills, confidence, and comfort to conduct sexual discussions with patients presents a substantial professional challenge that requires guidelines, training, and supervised practice. At the present time, there are little established data on the extent to which health professionals or medical students receive human sexuality training. In an October 2003 article that assessed physician training in human sexuality issues at medical schools, the majority of schools who responded to the survey reported providing 3 to 10 hours of sex education.[59]

A contributing challenge to the clinician's ability to be comfortable and capable in the quest to help patients with sexual problems is his or her own sexual belief system and personal life experience. Physicians and other healthcare professionals require introspection and reflection on the impact of their own sexual development, sex education, important cultural, spiritual, and familial messages, and personal expectations and behaviors. What is the level of tolerance for and acceptance of sexual difference from oneself?

The Role of the Clinician in Treating Women's Sexual Problems - Cont'd

Few people, let alone medical and nursing students, receive comprehensive sexuality education, which has a primary goal of promoting sexual health. Such education is age-appropriate, culturally sensitive, and geared toward the particular developmental level of the learner. It encompasses sexual development, reproductive health, interpersonal relationships, affection, intimacy, body image, and gender roles. Sexuality education seeks to assist people in understanding a positive view of sexuality.[60] Clinicians are encouraged to visit the Web site of the Sexuality Information and Education Council of the United States (www.siecus.org), which has a wealth of information on various aspects of sexuality. In addition, a beginning step for anyone working in the sexual health field is participation in a Sexual Attitude Reassessment (SAR) seminar. These seminars are offered frequently as preconference workshops at the annual conferences of the leading professional sexology organizations. See the Web site of the American Association of Sexuality Educators, Counselors and Therapists (AASECT) at www.aasect.org for more information.

The ideal approach to the treatment of sexual problems is an integrated sexual health team model, involving nurses, sex counselors, medical social workers, and sexuality educators. Familiarity with sexual abuse and domestic violence screening is essential,[61] and there are some useful paper-and-pencil inventories that can be used as an adjunct to interviewing. An excellent resource is William L Maurice's *Sexual Medicine in Primary Care*.[62] He includes a detailed list of questions to ask (and not ask) at an initial visit and offers examples of dialogue and suggestions for responding to certain questions. His main purpose is to assist in screening patients for sexual problems and undertaking appropriate treatments or clinical referrals. Another text full of practical suggestions is *Sexuality and Chronic Illness: a Comprehensive Approach,* by Leslie R. Schover and Soren Buus Jensen.[63] These authors emphasize an integrative approach from a biopsychosocial perspective. The text describes assessment and treatment of sexual problems in patients with specific illnesses, case studies, and an outline for training programs in sexuality for physicians. Charles Moser, an internist specializing in the sexual aspects of medical concerns, has written *Health Care Without Shame*,[64] a guide to communication between healthcare professionals and patients about sexual issues.

In the final analysis, the busy clinician ought to take a collaborative approach to the management of female patients' sexual problems. The very nature of sexuality's biopsychosocial complexity compels an interdisciplinary, collegial, and multimodal approach to the resolution of women's sexual problems.

Specific Recommendations for Enhancing Clinicians' Ability to Attend to Women's Sexual Problems

The healthcare clinician will be an asset to his or her patients by incorporating the appropriate recommendations from the following list:

1. Be or become knowledgeable about the fundamentals of sexual functioning; think about what you believe constitutes healthy, positive sexual functioning. Participation in a Sexual Attitude Reassessment (SAR) seminar (mentioned above) is an intensive learning opportunity. The exposure and structured discussions in the SAR experience constitute a useful process for increasing the practitioner's own level of comfort, which will lead to improved communications about sexual issues with patients. An alternative would be to organize and hold either a SAR or a sex education seminar for your office group and/or network. You can contact AASECT (www.aasect.org) for recommendations of certified leaders and instructors. Also, you may find useful the New View Classification of Positive Sexual Functioning (see Sidebar, New View Classification of Positive Sexual Functioning).

2. The patient is going to be helped optimally by being able to articulate her problem without being judged. Recognizing one's own values and attitudes is the first step in being able to suspend judgment in relation to someone else. Gaining knowledge about the negative impact of cultural scripts for sexual behavior is an important insight. The physician should be able to take a neutral and objective approach to the problems of all women, including those of varying sexual orientations, ethnicities, and cultural backgrounds.

3. Much attention in medicine over the past decade has been placed on improving the listening and communication skills of physicians and other healthcare providers. In the matter of sexual problems, listening to the story of the woman, from her perspective, in the fullness of her lived experience, is an essential starting point. Broaden the working definition of sexual satisfaction to include more than orgasm. What exactly do the words "pleasure" and "satisfaction" mean to each individual patient presenting with a sexual problem? What are the presenting patient's expectations for a more fulfilling sexuality? Think about how the categories of sexual problems as defined in the New View nomenclature may be relevant when planning a therapeutic strategy that responds to the

patient's stated problem. Print out the useful chart: A New View Approach to Diagnostic and Treatment Strategies for Clinicians (see below).

4. Engage in a scholarly exploration of women' s sexual and sociopolitical realities. What are the pressures of conformity to an ideal, cultural expectation for body image? What are the extent and patterns in abuse, violence, and harassment -- physical, emotional, and sexual? What are the current and varying experiences of women in terms of their financial burdens, employment patterns, and caretaking roles? A new report issued by the Institute of Medicine in April 2004 recognizes the urgency of incorporating behavioral and social science instruction into medical school curriculum.[65] In fact, it also urges aspiring physicians to have a good undergraduate foundation in these areas. The report acknowledges that this is not merely advisable, but no longer acceptable *not* to have such a foundation. If these strategies are successful, the report predicts measurable improvements in the health of Americans, brought about by clinicians who recognize, understand, and effectively respond to patients as individuals, not just their symptoms.

5. Affirm the expansive force of positive, healthy sexual energy (see Sidebar, New View Classification of Positive Sexual Functioning). Stock a lending library of books and multimedia which address a wide range of sexual behaviors and lifestyles, cultural sensitivities and lifespan issues (see Sidebar, Supplementary Resources). Insightful, holistic, and constructive solutions to sexual problems have been written about extensively and are recommended to clients by many sex therapists. Two classic books are *For Yourself: The Fulfillment of Female Sexuality*[66] and *Sex for One: The Joy of Self-Loving*.[67] Two new books, written by men describing women-centered sexual techniques, are: *She Comes First: The Thinking Man's Guide to Pleasuring a Woman*[68] and *Great Sex: A Man's Guide to the Secret Principles of Total-Body Sex*.[69]

6. Education about the structure and function of the clitoris is useful for both clinicians and their patients (see Figures 1 and 2). The structure of the clitoris is still poorly understood and not generally included in a genital examination. Most anatomy textbooks in clinical use still include only the clitoral glans and do not describe the entire internal clitoral structure. However, that omission has been remedied by books such as *The Clitoral Truth*[70] and "*A New View of a Woman's Body*."[71] Only the clitoral glans, which corresponds to the glans penis, is visible and palpable in the external genitalia. The internal nerve fibers in the crura of the clitoris divide into 2 branches that attach deep in the pelvis. Some of the fibers go to the vaginal vestibule, and it is likely that there is significant variation in the number and location of fibers, probably contributing to variations in response to vaginal stimulation (Bennett SE. Personal email communication; 2004).

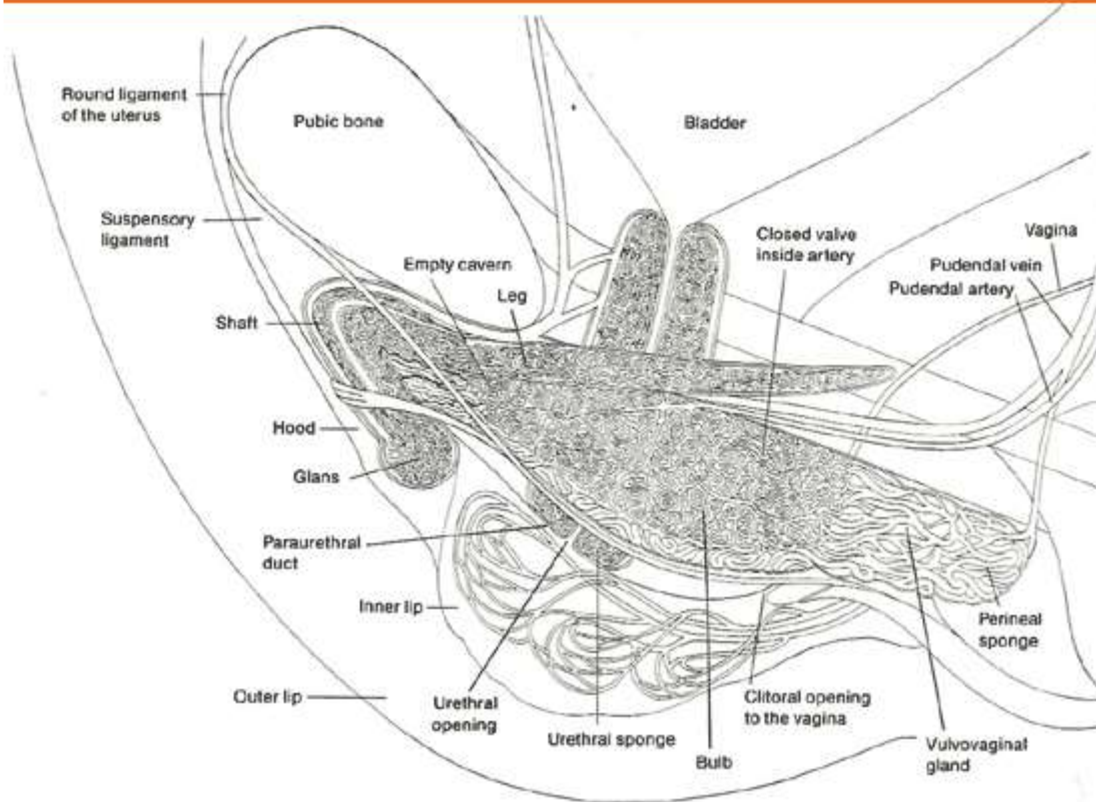

Figure 1. A cross section of the nonerect clitoris
Federation of Feminist Women's Health Centers. "A New View of a Woman's Body." Illustrator: Suzanne Gage. Publisher: Feminist Health Press, Los Angeles, CA. www.womenshealthspecialists.org.
Reprinted with permission.

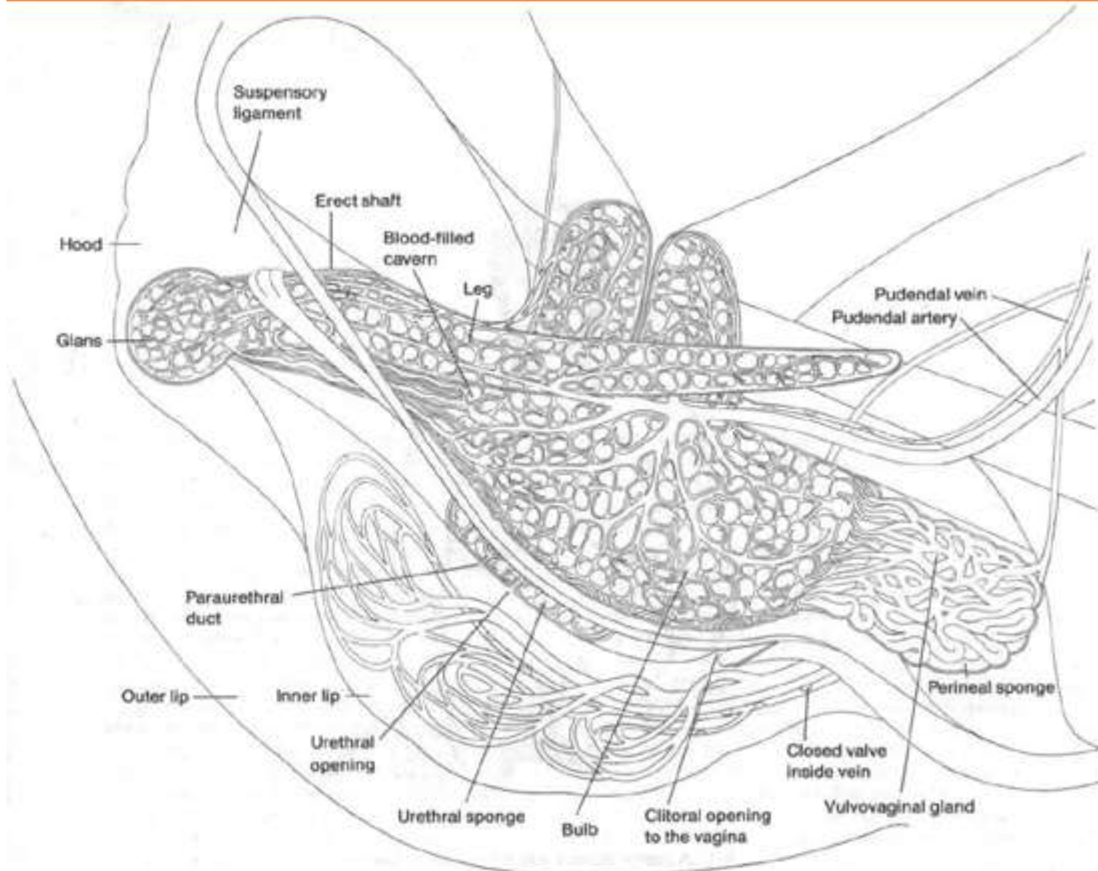

Figure 2. A cross section of the clitoris during sexual arousal
Federation of Feminist Women's Health Centers. "A New View of a Woman's Body." Illustrator: Suzanne Gage. Publisher: Feminist Health Press, Los Angeles, CA. www.womenshealthspecialists.org.
Reprinted with permission.

7. Sponsor or organize a human sexuality course for the public. To be sexually healthy adults, lifelong learning opportunities are warranted but not often available. AASECT can recommend and locate a trained and certified sexuality educator. It is possible that other professionals will greet this measure with mixed feelings, at best, either from a place of their own sexual frustrations, rigid religious or moral beliefs, and fear associated with public discussion of sexuality. This is reinforced by the well-known fact that in spite of overwhelming support for comprehensive sexuality education in the public schools, most school districts avoid the contentious and potentially disastrous bad press from opponents (see footnote). However, this is not public education, and these courses are offered to adults on a voluntary basis. Holding such programs also telegraphs the importance of taking this topic much more seriously than it has been in the past.

8. Consider the difference between women's choices vs their fundamental rights. Choices are central to women's health. Notions of choice can be misunderstood in a medical setting, making it a risk to women's health and well-being. Consider the following questions before prescribing one of the newer medical treatments for sexual problems:

    - Have you taken a detailed sexual history of the patient?

- Have you discussed with your patient the sociocultural and relational factors that could be at the root of her sexual problem and/or provided a referral to a therapist?

- Do you have books and other resources in your office to show or loan to patients (ie, other than patient education brochures and videotapes that have been developed with funding from pharmaceutical companies)?

- Are you convinced that the patient's sexual problem is mostly physiologic?

- Have you established a set of criteria that must be met before you prescribe a procedure or medication whose safety has not yet been clearly demonstrated as treatment for a sexual problem?

- Which laboratory tests and physical exams are necessary to conduct before prescribing any medical treatment for a sexual problem?

- What risks and benefits need to be disclosed fully before prescribing a treatment or a medication for a sexual problem?

- Do you believe that the patient can make a fully informed choice?

9. Become thoroughly informed and develop comprehensive office procedures for handling the confidentiality and ethical issues that surround this sensitive area of human experience. Case material cannot be shared freely, without special permission. The patient's medical record may be read by clerks, nurses, and other personnel. Reports of evaluations in the patients' medical chart should be limited to information fulfilling legal requirements and contributing to good, interdisciplinary care.[63]

10. Invite sex therapists, sex educators and sexologists to make presentations to your participating hospital networks, grand rounds, and the periodic programs sponsored by local hospitals for the public. Also, recommend such programs be added to the programs at the professional conferences that you attend. Pre-conference workshops would be a time-efficient manner to further the skills and knowledge base of busy clinicians. AASECT has a searchable database of experts on a large variety of sexuality topics.

11. Develop a network of professionals in your area who have sexuality expertise and skills. The level of comfort can be increased if the physician accepts his or her professional limitations in providing therapy and knows what other sources of care are available. Again, a searchable database of experts around the country is available through AASECT.

12. Post in your office the Declaration of Sexual Rights adopted by the World Association of Sexology at its 1999 international conference in Hong Kong. (See Sidebar, Declaration of Sexual Rights.) The implicit message your patients will receive when reading this display is that you are informed about sexuality issues and are approachable for communication about sexual concerns.

13. Support the efforts of the Sexuality Information and Education Council of the United States (SIECUS) and more than 20 prominent professional medical and health organizations to campaign for comprehensive sex education. An extensive bibliography of sexuality education materials is available from their Web site at www.siecus.org.

14. Many clinicians have learned to ask "Are you sexually active?" as part of their history, but this can be misleading. A "yes" answer will not tell you if the patient uses her vagina,

clitoris, anus, or other body parts in her sexual activities. Be prepared to ask detailed questions about sexual practices before forming opinions about the nature of sexual problems or appropriate interventions.

Note that the Texas Board of Education this year may approve 4 books for sex education for high school students, all of which extol the virtues of abstinence.[72] Moreover, 3 do not discuss contraceptives at all and only 1 makes passing reference to condoms. As stated in a Reuters news story, the approval of these texts has national implications because the state is the second largest market for textbooks in the United States, and books approved by the state's school board are usually marketed nationally.[72] The sexuality education programs in most of the United States, which receive federal funding, promote abstinence only until marriage (AOUM).

Taking a Sexual History Using Guidelines From a New View

Taking a detailed sexual history will be most helpful to the clinician and to the patient who is seeking help for sexual problems. The following questions highlight the New View approach to taking a sexual history. The clinician should make it clear to the patient that she should respond to the questions only if she feels comfortable doing so and to the extent that she feels comfortable.

1. Do you consider yourself proficient in having the right words, terms, and vocabulary to describe sexuality issues or matters?
    - What words, terms, and definitions would you like to learn?
2. Would you like to have more knowledge of human sexual biology? Would you like to know more about:
    - Contraception
    - STIs
    - Pregnancy
    - Childbirth
    - Menopause
    - Sexual desire, arousal, orgasm
    - "Sex"
    - Oral sex
    - Frequency of sexual activity
    - Other?
3. What type of sex education have you ever had?
    - Was your sex education satisfactory to you?
        - What topics would you like to have further education and information about? (Refer to the list under the previous question.)
4. Do you have information about how sexuality changes at different life stages (eg, pregnancy, childbirth, midlife, old age)?
5. Have you thought much about how men and women are socialized to think about sex ?
6. Do you experience any conflict or disagreement between the messages you have learned from the social/cultural group you grew up in and the social/cultural group you live in now?

- If so, please describe.

7. What kinds of ideas about sexuality did you receive from your past or present religion?

8. Do you feel comfortable with how your body looks and functions?

9. Do you enjoy sexual activities?

10. Are you sexually active?

11. Do you feel sexually satisfied?

12. Who is (are) your current partner(s)? (No names -- just description, eg, new or long-time lover, husband, friend, acquaintance.)

13. How do you feel about your sexual partner(s)?

    - Do you like each other?
    - Are you ever afraid?
    - How do you communicate about sex?

14. Please describe your sexual relationship with regard to:

    - Similar level of desire
    - Similar preferences for certain sexual activities
    - Ability to communicate preferences for initiating, pacing, or shaping your sexual activities

15. Do you experience any of the following?

    - A lack of sexual desire
    - A lack of sexual arousal
    - A lack of orgasm

16. Are you comfortable with nudity and physical touch?

17. Do you experience any anxiety about or difficulty with sex due to any of the following?

    - Past emotional abuse
    - Past physical abuse
    - Emotional intimacy issues
    - Rejection or fear of rejection

18. Do you or does your partner attribute a loss of sexual interest over any of the following issues?

    - Money
    - Schedules
    - Children/childcare
    - Parents/eldercare
    - Relatives
    - Traumatic experiences either has had
    - Health status of self or partner

19. Would you describe your sexual orientation/identity as:

- Heterosexual?
- Lesbian?
- Bisexual?
- Transgender?

20. Are you comfortable with your sexual fantasies? (Do not ask for the content.)

21. Do you masturbate?

    - If yes, how do you masturbate?
    - If yes, do you experience orgasm? Always? Sometimes? Never?
    - If no, would you like to learn more about self-pleasuring?

22. Do you experience pain with sexual activity?

    - If yes, please describe.

23. Do you experience lack of response with sexual activity?

24. Is your pain or lack of response associated with anxiety or tension?

25. Is your pain or lack of response associated with a physical problem or health condition?

26. Is the pain or lack of physical response associated with any of the following?

    - Pregnancy
    - Outcomes from childbirth
    - Sexually transmitted infection
    - Pelvic surgeries (eg, hysterectomy, cancers, prolapsed uterus)
    - Side effects of drugs, medications, or medical treatments

    (The physician or another healthcare provider may now wish to do a physical examination and explore possible conditions involving neurologic, neurovascular, circulatory, and/or endocrine systems.)

A New View Approach to Diagnostic and Treatment Strategies for Clinicians*

*This protocol was developed jointly by Karen M. Hicks, PhD, and Gina Ogden, PhD

Chart. Diagnostic and Treatment Strategies for Clinicians

Preliminary Observations, Patient Description of Her Sexual Problem, and Clinician Questions	**Bibliotherapy Recommendations:*** ***Book titles only. See full citations in Reading Room Resources (Sidebar)***	**Physician Action**
Preliminary Observations of Patient Assess the following: • Self confidence • Personal hygiene • Exhausted		Observations and notes Observe patient's response to touch during physical exam.

<table>
<tr><td>Stressed
Mood
Response to touch during physical exam
Comfort with sexual inquiry</td><td></td><td></td></tr>
<tr><td>Patient's Description of Sexual Problem

Ask patient to describe her sexual problem, in her own words.</td><td></td><td>Assess patient's ability to use sexuality vocabulary.

Record her description as close to verbatim as possible.</td></tr>
<tr><td>Sexual Knowledge
What type of sex education have you had?

Would you like to have more knowledge about human sexual biology eg, reproduction, sexual response, sexual behaviors)? Be specific.

Would you like to know more about:
Contraception
STIs
Pregnancy
Childbirth
Menopause
Sexual desire, arousal, orgasm
"Sex"
Oral sex
Frequency of sexual activity
Other?
Do you have information about sexuality at different life stages?</td><td>*Sexuality Information and Education Council of the United States (www.siecus.org)

*A New View of a Woman's Body (Federation)

*The Clitoral Truth (Chalker)

*Our Bodies, Ourselves (www.ourbodiesourselves.org)

*Women's Sexualities (Ellison)

*Dilemmas of Desire (Tolman) (about girls)

*Ourselves, Growing Older (Doress-Worters & Siegal)

*Women's Sexuality Across the Lifespan (Daniluk)

*The Wisdom of Menopause (Northrup)</td><td>Recommend a sexuality education course from local college, hospital, or women's health center.

Sponsor a sexuality education mini-course periodically from your practice. Certified sexuality educators in your local area can be found on www.aasect.org.</td></tr>
<tr><td>Sexual Self Image

Do you feel comfortable with how your body looks and functions?

Do you enjoy sexual activities?

Are you sexually satisfied?

Are you sexually active?

Who is or are your current partner(s)? (eg, new or long-time lover, husband, friend, acquaintance)

Would you describe your sexual</td><td>*The Beauty Myth (Wolfe)

*Women's Bodies, Women's Wisdom (Northrup)

*Women Who Love Sex (Ogden)

*The Lesbian Love Companion (Hall K)

*www.biresources.org

*Bi Any Other Name (Hutchins)

*Transgender Emergence: Therapeutic Guidelines for</td><td>Assess overall vitality.

Recommend:
Mirror affirmations
Assertiveness training
Support groups
Therapeutic massage
Physical exercise</td></tr>
</table>

orientation/identity as: • Heterosexual • Lesbian • Bisexual • Transgender	*Working With Gender-Variant People and Their Families* (Lev)	
Autoerotic Behavior Are you comfortable with your sexual fantasies? (Do not ask her for content.) Do you masturbate? If yes, how do you masturbate? If yes, do you experience orgasm? If no, can you explain more about that? Would you like to learn more about self-pleasure, sensuality, fantasy, or vibrators?	**My Secret Garden* (Friday) **In the Garden of Desire* (Maltz & Boss) **Pleasures: Women Write Erotica* (Barbach) **Sex for One* (Dodson) **The Big Book of Masturbation* (Cornog) **Women's Sexuality Boutiques** *www.goodvibes.com *www.mypleasure.com *www.evesgarden.com *www.royalle.com www.bettersex.com (Sinclair Institute videos)	Recommend • Masturbation education from sex therapist, sex toy store, book • Sex education course • Therapeutic massage • Kegel exercises • Sex counseling or therapy for guilt, anxiety, or disgust associated with autoerotic activities
Social and Cultural Messages Have you thought much about how men and women are socialized about sex? Do you experience any conflict or disagreement about sex between the social/cultural group you grew up in and the group you live in now? If yes, please describe. What kinds of ideas about sexuality did you receive from your past or present religion?	**Great Sex* (Castleman) **The New Male Sexuality* (Zilbergeld) **Women and Love* (Hite) **She Comes First* (Kerner) **Stolen Women* (Wyatt) **The Black Woman's Health Book* (White) **Latina Realities* (Espin) **The Vagina Monologues* (Ensler) **Women, Religion and Sexuality* (Becher) **Good Sex: Feminist Perspectives From World's Religions* (Jung, Hunt & Balakrishnan) **Transcendent Sex* (Wade)	Recommend • Courses in gender studies • Assertiveness training • Credible support group in community or online (eg, www.ourbodiesourselves.org) Recommend Center for Sexuality and Religion (www.ctrsr.org)

Relationships & Sexual Partner(s) Are you currently active with a sexual partner? How do you feel about your sexual partner: • Do you like each other? • Are you ever afraid? • How do you communicate about sex? Please describe your sexual relationship with regard to: • Similar level of desire? • Similar preferences for sexual activities? • Ability to communicate preferences for initiating, pacing, or shaping your sexual activities? Do you or your partner ever experience a loss of sexual interest over any of the following issues: • Money • Schedules • Health status • Children/childcare • Parents/eldercare • Relatives	**Women Who Love Sex* (Ogden) **The Essential Tantra* (Stubbs) **She Comes First* (Kerner) **Sex Matters for Women* (Foley, Kope & Sugrue) **Transcendent Sex* (Wade) **New Directions in Sex Therapy* (Kleinplatz) **Women's Bodies, Women's Wisdoms* (Northrup) **The Seven Principles for Making Marriage Work*(Gottman & Silver)	***For relationship problems listed in first column*:** Recommend relationship or marriage counseling. For referrals to professionals in your area: www.aamft.org ***For sexual problems listed in first column:*** Recommend sex therapist or counselor. For referrals to professionals in your area: www.aasect.org
History of Sexual Abuse or Trauma Do you experience any anxiety about or difficulty with sex due to any of the following: • Past emotional/physical abuse? • Emotional intimacy issues? • Rejection?	**The Courage to Heal* (Bass & Davis) **Allies in Healing* (Davis) **Sexual Healing Journey* (Maltz)	Recommend • Sexual abuse therapy • Support groups Take CME course on screening for domestic violence (eg, Improving Screening of Women for Violence - Basic Guidelines for Physicians. www.medscape.com/viewprogram/277)
Sexual Desire, Arousal,	**Orgasms for Two* (Dodson)	Recommend relationship or sexuality counseling

<table>
<tr>
<td>Orgasm

Do you experience a lack of sexual desire, arousal, or orgasm?

Are you comfortable with nudity and physical touch?</td>
<td>*Becoming Orgasmic (Heiman & LoPiccolo)

*A New View of Women's Sexual Problems (Kashak & Tiefer)

*Reclaiming Your Sexual Self (Hall.)

*Sex Matters for Women (Foley, Kope & Sugrue)

*The Complete Idiot's Guide to Sensual Massage (Britton & Hodgson)</td>
<td>or sex therapy. Referrals for professionals in your area can be found online at:
www.aamft.org
www.aasect.org</td>
</tr>
<tr>
<td>Pain and/or Physical Discomfort Associated With Sexual Activity

Do you experience pain with sexual activity? If yes, please describe.

Is your problem specific to sexual activity or associated with a health condition?

Is your pain associated with anxiety?

Is your pain or lack of response during sex associated with a physical problem?</td>
<td>*Our Bodies, Ourselves (Boston Women's)

*National Vulvodynia Association (www.nva.org) for qualified provider

www.sexualhealthnetwork.org

*Enabling Romance (Kroll & Klein)

*Bodies Besieged (McCormick)

*Women's Bodies, Women's Wisdom (Northrup)</td>
<td>During physical exam

Rule out:
Vaginismus
Vulvar vestibulitis
Vulvodynia
Dyspareunia
Urologic conditions
(eg, interstitial cystitis)
Other conditions
(eg, fibromyalgia, inflammatory bowel syndrome)
Rule out pain disorder.

Recommend assessment, counseling or therapy with pain specialist and/or sex therapist.

Refer to medical specialist and/or sex therapist.

For specialty workup, assess:
Fertility/infertility issues
STDs
Sequelae of:
Pregnancy
Childbirth
Hysterectomies
Pelvic prolapses
Cancers
Cancer treatments
Recreational drug use
Current or past medications
(eg, psychotropic, long-term antibiotic, vulvar treatments
Other</td>
</tr>
</table>

Case Presentations

The following case presentations highlight the New View approach to women's sexual problems.

Case 1 -- Using the New View Nosology

This case was originally published in Candib LM. "A New View of Sexual Problems - A Family Physician's Response." Kaschak E, Tiefer L (eds). A New View of Women's Sexual Problems. New York, NY: The Haworth Press; 2001:9-15. Reproduced with permission from Haworth Press.

A 32-year-old Salvadoran married woman, a documented immigrant, works 40 hours cleaning houses, looks after her 2 children and her husband's aging mother, cares for the house, and does all the housework and cooking. She presents to her family physician with an urgent concern about sex. She reports that for the last few months, she has not been interested in having sexual relations and worries that her husband will seek sex elsewhere. Family history reveals that her mother died when she was young. She was raised by an older brother in whose home she was a servant. She was never sexually abused but felt neglected and poorly treated by her brother and sister-in-law. Further inquiry reveals that communication between her and her husband about sex or the relationship is minimal and he is not affectionate. Nevertheless, she finds him to be a good provider and good father. She has no interest in other partners or in divorce. She reports that although she used to become sexually aroused, she has never had orgasm. She takes oral contraceptives and wonders if they are the cause of her lack of interest. She does not feel depressed although sometimes she is tired for days on end, but she wonders if her husband could be depressed.

Diagnosis

This patient is typical of the women from the multicultural population at the urban community health center where Dr. Lucy M. Candib practices. Under a DSM-IV classification of women's sexual dysfunctions, this patient can be viewed as suffering from disorders of sexual desire, arousal, and orgasmic dysfunction. Oral contraceptives or depression may be contributing factors. Under the New View nosology, her problems can be dissected in the following ways.

I. **Sociocultural, political or economic factors**

   A. The patient herself lacks information about sexual functioning.

   B. Culturally, she believes that she should make herself available to her husband whether or not she is interested.

   C. She has been raised with a strict division of labor in the home along gender lines.

   D. She works hard and is often overtired; economically, she cannot cut back her hours.

II. **Sexual problems relating to partner and relationship**

   A. She acknowledges her unhappiness with lack of communication and affection and lack of his help in the home.

   B. She does not recognize the link between these deficits to her lack of sexual interest.

   C. She does not recognize a power imbalance in their relationship.

D. She worries about the repercussions of not having sex.

E. Her partner may be depressed, exacerbating the problems.

III. **Sexual problems due to psychological factors**

A. A. She fears loss of partner's fidelity if she does not comply with his needs.

B. B. Her unrecognized resentment may interfere with her interest in sex.

C. C. She herself may have a masked depression. Perpetuation of the current dynamic may lead to clinical depression.

IV. **IV. Medical factors**

A. Oral contraceptives may contribute to lack of sexual interest and/or depression.

Treatment Strategy

This woman faces many challenges that would negatively affect her sexual function. Her financial status alone will constrain her access to some therapeutic options. For example, sexual therapy or psychotherapy may not be covered by her medical insurance plan if she has one; nearly 60% of Hispanic persons in the United States were without medical insurance for some time between 2001 and 2002.[73] She needs to be asked about her reading abilities, and hopefully she can obtain and read a copy of *Nuestros Cuerpos, Nuestras Vidas*[74] (the Spanish version of *Our Bodies, Ourselves*) to give her some basic sexuality education. In addition, if she can read English well enough, the clinician might also recommend *Latina Realities: Essays on Healing, Migration and Sexuality*.[75] Given what she has said about the long working hours that she cannot cut back on, she may not be able to regularly attend organized meetings or leave her employment to go to lengthy therapy appointments, but it could be recommended to her that she join a relevant community support group to work on personal issues as a vehicle for gaining more awareness of dynamics that constrain her life and have a negative impact on her relationship with her husband. She will probably not know of any, so it would be useful for her clinician to have on hand a list of active community groups in the area. If she attends an urban community health center, it is possible that the center has programs on adult sexuality, and if so she should be encouraged to participate in one. It would be ideal if she could be involved in culturally relevant couples relationship therapy. The clinician should also ask her whether she thinks that her husband would be amenable to participating in such therapy. At a minimum, a community organization with a support group environment is indicated. She should be evaluated for depression and, if present, a treatment plan is indicated. She should be asked whether she thinks it might be realistically feasible for her to consider changing her contraceptive to something other than the pill to see if that makes a difference in her sexual response and affect.

Case Presentations - Cont'd

Case 2 -- A Young Woman Unable to Achieve Orgasm During Intercourse

This case was provided by Dr. Lucy M. Candib, University of Massachusetts Medical School, Boston.

Melissa is a 21-year-old college senior from a liberal family who thinks she has a problem because she "can't come with penis-in-vagina sex" although she has no problem having orgasm with external stimulation, oral sex, or masturbation. She has been with the same partner for a

year and had hopes that he would be "the one," but her partner feels dissatisfied that he can't "satisfy" her. She is worried that this will jeopardize their long-term relationship.

The patient needs to learn that many women are unable to achieve orgasm with intercourse and that there is nothing wrong with her. Her partner needs to know that he is not failing her by not being able to bring her to orgasm with intercourse. The clinician should ask this young woman whether she feels pressure from her boyfriend. Does she feel that she is a reasonably assertive person? Can she assert herself in this situation? Does she feel shame? Does she believe that her inability to achieve orgasm through intercourse is a "defect"? These are important questions for her to explore, perhaps with a therapist, as simple education about the facts are insufficient to address pressure, assertiveness, and feelings of shame. The clinician can also recommend reading material, for example:

- *Our Bodies, Ourselves for the New Century*. Boston Women's Health Book Collective. (1998).
- *Orgasms for Two: The Joy of Partnersex*. Dodson B (2002).
- *A New View of a Woman's Body*. Federation of Feminist Women's Health Centers (1981).
- *She Comes First: The Thinking Man's Guide to Pleasuring a Woman*. Kerner I (2004).
- *Women's Experience of Sex. The Facts and Feelings of Female Sexuality at Every Stage of Life*. Kitzinger S (1983).
- *The New Male Sexuality: The Truth about Men, Sex and Pleasure*. Zilbergeld B (1992).

Case Presentations - Cont'd

Case 3 -- A Perimenopausal Woman Experiencing Pain With Intercourse

This case was provided by Dr. Lucy M. Candib, University of Massachusetts Medical School, Boston.

Alice is a 45-year-old woman who has recently been having pain during sex. Previously she had no pain but only enjoyed sex occasionally. She wonders if it is menopause, as she has been having hot flashes, although her periods are still regular. She denies problems with lubrication, but she does say that it hurts more if her husband enters her before she is ready. Further inquiry reveals that her husband has been laid off for a year and has been drinking excessively. They fight about his drinking, and sometimes when he comes back from the bar he makes her have sex when she does not want to. She denies "abuse" but admits that he calls her fat and ugly when he is drunk.

Case Presentations - Cont'd

Case 4 -- A Lesbian Couple With One Partner Who Has Experienced Incest

This case was provided by Dr. Lucy M. Candib, University of Massachusetts Medical School, Boston.

Robin is a 40-year-old woman in a committed lesbian relationship. In the past year, her partner, Terry, who has been in psychotherapy, has been working on problems around her experience as

an incest survivor. Terry does not want to be sexually active at all, as it stirs up all her feelings about the incest. Previously they had had an infrequent but satisfactory sexual relationship. In other areas they are very compatible. Terry and Robin go to the same ob/gyn clinician. Robin is frustrated around the sexual issues and wonders if there is anything that can help.

Case Presentations - Cont'd

Case 5 -- A Busy Executive With Low Desire

This case was adapted from one provided by Dr. Lucy M. Candib, University of Massachusetts Medical School, Boston.

Crystal is a 35-year-old married software engineer who is a team leader in a highly competitive company. She works 12-hour days and says she has no time for exercise or relaxation. Her husband is also an engineer. She has been trying to get pregnant for the past 8 months. They have been having scheduled intercourse on the 13th and 15th days of her regular cycle without success. She states that sex seems like work and she just wants to get it over with. When she married 5 years ago, her sex life was satisfying and she had no difficulty with interest or orgasm. She has heard that testosterone will increase her desire and asks for a prescription.

Acknowledgment

The author wishes to acknowledge the following people for the contributions to editing and strengthening this CME program: Susan E. Bennett, MD, Lucy Candib, MD, Gina Ogden, PhD, Ursula Snyder, PhD, Joan Z. Spade, PhD, and Leonore Tiefer, PhD.

References

1. Moynihan, R. The making of a disease: female sexual dysfunction. BMJ. 2003;326:45-47.
2. Kaschak E, Tiefer L (eds). *A New View of Women's Sexual Problems*. New York, NY: The Haworth Press; 2001.
3. Masters W, Johnson V. *Human Sexual Response*. Boston, Massachusetts: Little, Brown; 1966.
4. Apfelbaum B. Masters and Johnson revisited: a case of desire disparity. In: Rosen RC, Leiblum SR (eds). *Case Studies in Sex Therapy*. New York, NY: Guilford Press; 1995: 23-45.
5. Bullough V. *Science in the Bedroom: A History of Sex Research*. New York, NY: Basic Books; 1994: 204.
6. Irvine JM. *Disorders of Desire: Sex and Gender in Modern American Sexology*. Philadelphia, Pennsylvania: Temple University Press; 1990: 89-94.
7. Tiefer L. Historical, scientific, clinical and feminist criticism of 'The Human Sexual Response Cycle' model. Annual Review of Sex Research. 1991;II:1-24.
8. Tiefer L. Arriving at a "new view" of women's sexual problems: background, theory, and activism. In: Kaschak E, Tiefer L (eds). *A New View of Women's Sexual Problems*. Binghamton, New York: Haworth; 2001: 63-98.
9. Gagnon J, Simon W. The sexual scripting of oral genital contacts. Archives of Sexual Behavior. 1987;16:1-25.
10. Gagnon J, Simon W. Sexual scripts: Permanence and change. Archives of Sexual Behavior. 1986;15:97.
11. Gagnon J, Simon W. *Human Sexualities*. Glenview, Illinois: Scott, Foresman; 1977.
12. Kleinplatz PJ. On the outside looking in: In search of women's sexual experience. In: Kaschak E, Tiefer L (eds). *A New View of Women's Sexual Problems*. Binghamton, New York: Haworth; 2001:123-132.

13. Lawrance, K & Byers, ES. Sexual satisfaction in long-term heterosexual relationships: The interpersonal exchange model of sexual satisfaction. Personal Relationships. 1995;2:267-285.
14. Masters W, Johnson V. *Human Sexual Inadequacy*. Boston, Massachusetts: Little, Brown; 1970.
15. Leiblum SR, Pervin L. *Principles and Practice of Sex Therapy*. New York, NY: Guilford Press; 1980: 14.
16. Barbach L. Group treatment of anorgasmic women, In Leiblum SR, Pervin LA (eds). *Principles and Practice of Sex Therapy*. New York, NY: Guilford Press; 1980: 107-146.
17. Kaplan HS. *The New Sex Therapy*. New York, NY: Brunner/Mazel; 1974.
18. Kaplan HS. *Disorders of Sexual Desire and Other New Concepts and Techniques in Sex Therapy*. New York, NY: Brunner/Mazel; 1979.
19. Lief HI. Inhibited sexual desire. Medical Aspects of Human Sexuality. 1977;7:94-95.
20. Bancroft J. *Human Sexuality and Its Problems*, *2nd ed*. Edinburgh, UK, and New York, NY: Churchill Livingstone; 1989: 460-462, 494.
21. Zentgraf M, Baccouche M, Junemann KP. Diagnosis and therapy of erectile dysfunction using papaverine and phentolamine. Urol Int. 1988;43:65-75.
22. Kursh ED, Bodner DR, Resnick MI, et al. Injection therapy for impotence. Urol Clin North Am. 1988;15:625-629.
23. No listed authors. Impotence. NIH Consensus Statement. 1992;10:1-31. Available at: http://consensus.nih.gov/cons/091/091_statement.htm
24. Mobley DF, Baum N. When patients request the impotence pill. Postgrad Med. 1998;104:55-8, 61-62,65-66.
25. Harrold LR, Gurwitz JH, Field TS, et al. The diffusion of a novel therapy into clinical practice: the case of sildenafil. Arch Intern Med. 2000;160:3401-3405.
26. No listed authors. The new young face of *Viagra* abuse. Chicago Tribune, December 27, 2003. Available at: http://www.azcentral.com/health/men/articles/1226viagra-abuse-ON.html
27. No listed authors. More Recreational Use of Viagra Seen Among Younger Men. Reuters Health Information. August 5, 2004.
28. Morgentaler A. *The Viagra Myth: The Surprising Impact On Love And Relationships*. Hoboken, New Jersey: Wiley Publishing; 2003.
29. Basson R, Berman J, Burnett A, et al. Report of the international consensus development conference on female sexual dysfunction: definitions and classifications. Urology. 2000;163:888-893.
30. Fourcroy JL. Female sexual dysfunction: Potential for pharmacotherapy. Drugs. 2003;63:1445-1457.
31. Basson R, Leiblum S, Brotto L, et al. Definitions of women's sexual dysfunction reconsidered: advocating expansion and revision. J Psychosom Obstet Gynaecol. 2003;24:221-229.
32. Bankhead C. New field could open for urologists: Female sexual dysfunction. J Sex Marital Ther. 1997;25:39.
33. Dasgupta R, Wiseman OJ, Kanabar G, Fowler CJ, Mikol DD. Efficacy of sildenafil in the treatment of female sexual dysfunction due to multiple sclerosis. J Urol. 2004;171:1189-1193; discussion 1193.
34. Berman JR, Berman LA, Toler SM, Gill J, Haughie S; Sildenafil Study Group. Safety and efficacy of sildenafil citrate for the treatment of female sexual arousal disorder: a double-blind, placebo controlled study. J Urol. 2003;170(6 Pt 1):2333-2338.
35. Basson R, Brotto LA. Sexual psychophysiology and effects of sildenafil citrate in oestrogenised women with acquired genital arousal disorder and impaired orgasm: a randomized controlled trial. BJOG. 2003;110:1014-1024.
36. Caruso S, Intelisano G, Lupo L, Agnello C. Premenopausal women affected by sexual arousal disorder treated with sildenafil: a double-blind, cross-over, placebo-controlled study. BJOG. 2001;108:623-628.
37. Nurnberg HG, Lauriello J, Hensley PL, Parker LM, Keith SJ. Sildenafil for sexual dysfunction in women taking antidepressants. Am J Psychiatry. 1999;156:1664.

38. Ashton AK. Sildenafil treatment of paroxetine-induced anorgasmia in a woman. Am J Psychiatry. 1999;156(5):800.
39. Mayor S. Pfizer will not apply for a license for sildenafil for women. BMJ. 20046;328:542.
40. Dennerstein L. Female Androgen Deficiency Syndrome: Definition, Diagnosis, and Classification. An International Consensus Conference. Medscape. August 14, 2001. Available at: http://www.medscape.com/viewprogram/302.
41. Bachmann G, Bancroft J, Braunstein G, et al. Female androgen insufficiency: the Princeton consensus statement on definition, classification, and assessment. Fertil Steril. 2002;77:660-665.
42. Shifren JL. The role of androgens in female sexual dysfunction. Mayo Clin Proc. 2004;79(4 Suppl):S19-S24.
43. Freeman MP. Testosterone supplementation in women: prescribing practices in one community. J Womens Health (Larchmt). 2004;13:239-240.
44. Pfaus JG, Shadiack A, VanSoest T, Tse M, Molinoff P. Selective facilitation of sexual solicitation in the female rat by a melanocortin receptor agonist. Proc Natl Acad Sci U S A. 2004;101:10201-10204.
45. Walsh KE, Berman JR. Sexual dysfunction in the older woman : an overview of the current understanding and management. Drugs Aging. 2004;21:655-675.
46. Gitlin M. Sexual dysfunction with psychotropic drugs. Expert Opin Pharmacother. 2003;4:2259-2269.
47. Leiblum SR, Nathan SG. Persistent sexual arousal syndrome: a newly discovered pattern of female sexuality. J Sex Marital Ther. 2001;27:365-380.
48. Laumann EO, Gagnon JH, Michael RT, Michaels S. *The Social Organization of Sexuality: Sexual Practices in the United States*. Chicago, Illinois: University of Chicago Press; 1994.
49. Laumann EO, Paik A, Rosen R. Sexual dysfunction in the United States: Prevalence and predictors. JAMA. 1999;281:537-544.
50. Bancroft J. The medicalization of female sexual dysfunction: the need for caution. Arch Sex Behav. 2002;31:451-455.
51. Segraves RT (ed). Historical and international context of nosology of female sexual disorders. J Sex Marital Ther. 2001;27:205-207.
52. Ellison CR. *Women's Sexualities: Generations of Women Share Intimate Secrets of Sexual Self-Acceptance*. Oakland, California: New Harbinger Press; 2000.
53. Laumann EO, Nicolosi A, Glasser DB, et al. Sexual problems among women and men aged 40-80 y: prevalence and correlates identified in the Global Study of Sexual Attitudes and Behaviors. Int J Impot Res. 2004 Jun 24 [Epub ahead of print]
54. Pfizer. The Pfizer Global Study of Sexual Attitudes and Behaviors. Available at: http://www.pfizerglobalstudy.com/. Last accessed August 20, 2004.
55. Reamy K. Sexual counseling for the non-therapist. Clin Obstet Gynecol. 1984;27:781-788.
56. Dominguez L. Mature Sexuality. Program and abstracts of the 5th Annual Meeting of The National Association of Nurse Practitioners in Women's Health; September 25-28, 2002; Scottsdale, Arizona.
57. Fallowfield L. Medscape Interview: Clinicians Reluctant to Discuss Sex with Cancer Patients, 2002, Oct. 24. Available at: http://www.medscape.com/viewarticle/443553. Last accessed August 20, 2004.
58. Bedell SE, Duperval M, Goldberg R. Cardiologists' discussions about sexuality with patients with chronic coronary artery disease. Am Heart J. 2002;144:239-242.
59. Solursh DS, Ernst JL, Lewis RW, et al. The human sexuality education of physicians in north American medical schools. International Journal of Impotence Research. 2003;15(Suppl 5):S41-S45.
60. SIECUS. *Guidelines for Comprehensive Sexuality Education, 2nd ed.* 1996: 6.

61. Stevens L. Improving Screening of Women for Violence - Basic Guidelines for Physicians. November 20, 2003. Medscape. Available at: http://www.medscape.com/viewprogram/2777. Last accessed August 20, 2004.
62. Maurice WL. *Sexual Medicine in Primary Care*. St. Louis, Mo: Mosby; 1999.
63. Schover LR, Jensen SB. *Sexuality and Chronic Illness.* Binghamton, New York: Guilford Press; 1988.
64. Moser C. *Health Care without Shame: A Handbook for the Sexually Diverse and Their Caregivers*. San Francisco, California: Greenery Press; 1999.
65. Institute of Medicine. Improving Medical Education: Enhancing the Behavioral and Social Science Content of Medical School Curricula. Special Report. Washington, DC: Institute of Medicine; March 2004.
66. Barbach L. *For Yourself: The Fulfillment of Female Sexuality*. New York, NY: Anchor Books; 1975.
67. Dodson B. *Sex for One: The Joy of Self-Loving*. New York, NY: Crown Books; 1987.
68. Kerner I. *She Comes First: The Thinking Man's Guide to Pleasuring a Woman*. New York, NY: Regan Books; 2004.
69. Castleman M. *Great Sex: A Man's Guide to the Secret Principles of Total Body Sex*. New York, NY: St. Martins Press; 2004.
70. Chalker R. *The Clitoral Truth: The Secret World at Your Fingertips*. New York, NY: Seven Stories Press; 2000.
71. Federation of Feminist Women's Health Center*. A New View of a Woman's Body*. New York, NY: Feminist Press; 1991.
72. Herskovitz J. New Sex-Education Textbooks in Texas Likely to Ignore Contraception. Reuters Health Information. August 5, 2004.
73. Families USA. One in Three: Non-Elderly Americans without Health Insurance, 2002-2003. A report by Families USA. June 2004. Families USA Publication No. 04-104 © 2004 by Families USA Foundation. Available at: http://www.familiesusa.org/site/DocServer/82million_uninsured_report.pdf?docID=3641. Last accessed August 20, 2004.
74. Boston Women's Health Book Collective. *Nuestros Cuerpos, Nuestras Vidas*. New York, NY: Seven Stories Press; 2000.
75. Espin OM. *Latina Realities: Essays on Healing, Migration and Sexuality*. Boulder, Colo: Westview Press; 1997.

Sidebar: A Prescription for a New View of Women's Positive Sexual Health*

I. **Socio-Cultural, Political, or Economic Factors**

   A. Adequate and comprehensive sex education, access to health services, and other social services

      - Precise vocabulary to describe subjective or physical experience
      - Full information about human sexual biology and life-stage changes
      - Knowledge of how gender roles influence men's and women's sexual expectations, beliefs, and behaviors
      - Full access to information and services for contraception and abortion, STD prevention and treatment, sexual trauma, and domestic violence

   B. Woman-centered definition regarding correct or ideal sexuality, including:

      - Acceptance and self-esteem about one's body, sexual attractiveness, or sexual responses

- Positive acceptance of one's sexual orientation or identity, or about sexual fantasies and desires

C. Confidence in one's own divergences between the sexual norms of one's subculture or culture of origin and those of the dominant culture

D. Equitable distribution of family and work obligations with partner and network

II. Sexual Partners and Relationships

A. Equality in relationship power, and skills of both partners to engage in positive patterns of communication to resolve conflicts or dissatisfaction, coupled with absence of betrayal, dislike, or fear of partner

B. Acceptance of peaks and valleys in sexual desire for sexual activity and negotiated agreement about preferences and tolerable limits for various sexual activities

C. Communicating preferences of initiating, pacing, or shaping sexual activities

D. Acceptance of various traumas and challenges that affect sexual activity and interest over commonplace issues such as money, schedules, or relatives, or resulting from traumatic experiences, eg, infertility or death of a child

E. Acknowledgment of difficulty with arousal or spontaneity due to partner's health status or sexual problems

III. Psychosexual Factors

A. Conscious recognition and attempt to resolve sexual aversion, mistrust, or inhibition of sexual pleasure due to:

1. Past experiences of physical, sexual, or emotional abuse
2. General personality problems with attachment, rejection, cooperation, or entitlement
3. Depression or anxiety.

IV. When to Seek Medical Attention

Pain or lack of physical response during sexual activity despite a supportive and safe interpersonal situation, adequate sexual knowledge, and positive sexual attitudes. Such problems can arise from:

A. Numerous local or systemic medical conditions affecting neurologic, neurovascular, circulatory, endocrine, or other systems of the body

B. Pregnancy, sexually transmitted diseases, or other sex-related conditions

C. Side effects of many drugs, medications, or medical treatments

D. Iatrogenic conditions

*This prescription for positive, healthy sexual development was developed by Karen Hicks, PhD, using the New View approach to women's sexual problems.

Sidebar: Supplementary Resources - Reading Room List, Sexuality Supply Vendors, Sexuality Information and Education Web Sites

Reading Room List

Barbach L (1993). *The Pause: The Positive Approach to Menopause*. New York, NY: Dutton.

Barbach L, ed. (1984). *Pleasures: Women Write Erotica*. New York, NY: Doubleday.

Barbach L (1975). *For Yourself: The Fulfillment of Female Sexuality*. New York, NY: Anchor Books.

Barbach L (1980). *Shared Intimacies: Women's Sexual Experiences*. New York, NY: Bantam Doubleday Dell/Bantam Books.

Bass E, Davis L (1988). *The Courage to Heal: A Guide for Women Survivors of Child Sexual Abuse.* New York, NY: Harper & Row.

Becher Jeanne, ed. (1990). *Women Religion and Sexuality: Studies on the Impact of Religious Teachings on Women*. Philadelphia, Pa: Trinity Press International.

Bornstein K (1995). *Gender Outlaw: On Men, Women and the Rest of Us*. New York, NY: Routledge.

Boston Women's Health Book Collective (1998). *Our Bodies, Ourselves for the New Century*. New York, NY: Touchstone.

Boston Women's Health Book Collective. *Nuestros Cuerpos, Nuestras Vidas*. New York, NY: Seven Stories Press, 2000.

Britton P, Hodgson H (2003). *The Complete Idiot's Guide to Sensual Massage*. New York, NY: Alpha Books.

Brown RM (1977). *Rubyfruit Jungle*. New York, NY: Bantam.

Buxton AP (1991). *The Other Side of the Closet: The Coming-Out Crisis for Straight Spouses*. Santa Monica, Calif: IBS Press.

Castleman M (2004). *Great Sex: A Man's Guide to the Secret Principles of Total-Body Sex*. New York, NY: St. Martins Press.

Chalker R (2000). *The Clitoral Truth: The Secret World at Your Fingertips*. New York, NY: Seven Stories Press.

Cornog M (2003). *The Big Book of Masturbation*. San Francisco, Calif: Down There Press

Daniluk J (1998). *Women's Sexuality Across the Life Span*. Binghamton, NY: Guilford Press.

Davis L (1991). *Allies in Healing: When the Person You Love Was Sexually Abused as a Child*. New York, NY: Harper-Perennial.

Dodson B (1987). *Sex for One: The Joy of Self-Loving*. New York, NY: Crown Books.

Dodson B (2002). *Orgasms for Two: The Joy of Partnersex*. New York, NY: Harmony Books.

Doress-Worters PB, Siegal DL (1994). Ourselves, Growing Older: Women Aging with Knowledge and Power. New York, NY: Touchstone.

Ellison CE (2000). *Women's Sexualities: Generations of Women Speak About Sexual Self-Acceptance*. San Francisco, Calif: Jossey Bass.

Ensler E (2000). *The Vagina Monologues: The V-Day Edition*. New York, NY: Villard.

Espin OM (1997). *Latina Realities: Essays on Healing, Migration and Sexuality*. Boulder, Colo: Westview Press.

Federation of Feminist Women's Health Centers (1981). *A New View of a Woman's Body*. New York, NY: Touchstone.

Fisher HE (1992). *The Anatomy of Love: The Natural History of Monogamy, Adultery and Divorce*. New York, NY: W.W. Norton.

Foley S, Kope S, Sugrue D (2002). *Sex Matters for Women: A Complete Guide to Taking Care of Your Sexual Self*. Binghamton, NY: Guilford Press.

Francoeur RT, ed. (1997). *The International Encyclopedia of Sexuality*. New York, NY: Continuum.

Friday N (1973). *My Secret Garden*. New York, NY: Pocket Books.

Gottman JM, Silver N (2000). *The Seven Principles for Making Marriage Work*: *A Practical Guide from the Country's Foremost Relationship Expert.* New York, NY: Three Rivers Press.

Hall K (2004). *Reclaiming Your Sexual Self: How You Can Bring Desire Back Into Your Life*. New York, NY: Wiley.

Hall M (1998). *The Lesbian Love Companion*. San Francisco, Calif: Harper San Francisco.

Heiman J, LoPiccolo L (1988). *Becoming Orgasmic: A Sexual Growth Program for Women*. New York, NY: Prentice-Hall.

Herman JL (1991). *Trauma and Recovery*. New York, NY: Basic Books.

Hite S (1987). *Women and Love*. New York, NY: St. Martin's Press.

Hutchins L, Kaahumanu L, eds. *Bi Any Other Name: Bisexual People Speak Out*. Los Angeles, Calif: Alyson Publications.

Jung PB, Hunt ME, Balakrishnan R, eds. (2001). *Good Sex: Feminist Perspectives from the World's Religions*. Princeton, NJ: Rutgers University Press.

Kaplan HS (1974). *The New Sex Therapy*. New York, NY: Brunner Mazel.

Kashak E, Tiefer L, eds. (2001). *A New View of Women's Sexual Problems*. Binghamton, NY: Haworth Press.

Kerner I (2004). *She Comes First: The Thinking Man's Guide to Pleasuring a Woman*. New York, NY: Regan Books.

Kitzinger S (1983). *Women's Experience of Sex. The Facts and Feelings of Female Sexuality at Every Stage of Life*. New York, NY: Penguin Books.

Kleinplatz K, ed. (2001) *New Directions in Sex Therapy: Innovations and Alternatives*. Philadelphia, Pa: Brunner-Routledge.

Kroll K, Klein ER (1992). *Enabling Romance: A Guide to Love, Sex and Relationships for the Disabled*. New York, NY: Crown Publishers, Harmony Books. Lev AI. *Transgender Emergence: Therapeutic Guidelines for Working With Gender-Variant People and Their Families (Haworth Marriage and the Family)*

Loulan J (1988). *Lesbian Passion*. San Francisco, Calif: Spinsters Ink.

Maltz W, Boss S (1997). *In the Garden of Desire: The Intimate World of Women's Sexual Fantasies*. New York, NY: Broadway Books.

Maltz W (1992). *The Sexual Healing Journey: A Guide for Survivors of Sexual Abuse*. New York, NY: Harper Collins.

McCormick N (1996). Bodies Besieged: The Impact of Chronic and Serious Physical Illness on Sexuality, Passion and Desire. In: *Journal of Sex Research* Special Issue. Vol. 33, No. 3, pp 175-270.

Northrup C (1995). *Women's Bodies, Women's Wisdom: Creating Physical and Emotional Health and Healing*. New York, NY: Bantam.

Northrup C (2001). *The Wisdom of Menopause: Creating Physical and Emotional Health and Healing During the Change*. New York, NY: Bantam.

Ogden G, rev ed. (1999). *Women Who Love Sex: An Inquiry Into the Expanding Spirit of Women's Erotic Experience*. Cambridge, Mass: Womanspirit Press.

Pipher M (1994). Reviving *Ophelia: Saving the Lives of Adolescent Girls*. New York, NY: Ballantine.

Savage L (1999). *Reclaiming Goddess Sexuality*. Carlsbad, Colo: Hay House.

Sexuality Information and Education Council of the United States (SIECUS) Extensive materials on sex education. Many are free for downloading at www.siecus.org.

Stubbs KR (1999). *The Essential Tantra: A Modern Guide to Sacred Sexuality*. New York, NY: Penguin/Putnam. Timmerman JH (1992). *Sexuality and Spiritual Growth*. New York, NY: Crossroad.

Tolman DL (2003). *Dilemmas of Desire: Teenage Girls Talk About Sexuality*. Cambridge, Mass: Harvard University Press.

Wade J (2004). *Transcendent Sex: When Lovemaking Opens the Veil*. New York, NY: Paraview Pocket Books.

White E, ed. (1994). *The Black Women's Health Book: Speaking For Ourselves*. Seattle, Wash: Seal Press.

Winks C, Semans A (1997). *The New Good Vibrations Guide to Sex*. 2nd ed. San Francisco, Calif: Cleis Press.

Wolfe N (1991). *The Beauty Myth: How Images of Beauty Are Used Against Women*. New York, NY: William Morrow.

Wyatt G (1997). Stolen Women: Reclaiming Our Sexuality, Taking Back Our Lives. New York, NY: John Wiley & Sons.

Zilbergeld B (1992). *The New Male Sexuality: The Truth about Men, Sex and Pleasure*. New York, NY: Bantam.

Sexuality Supply Vendors

www.mypleasure.com

This company was founded by a group of sex therapists.

www.goodvibes.com

This company is called Good Vibrations and is located in San Francisco.

www.omyonline.com (O'My products)

This company provides many lubricating gels and sex toys.

www.royalle.com (Femme Productions)

This woman-owned company produces woman-centered erotic films and sex aids.

www.bettersex.com (Sinclair Intimacy Institute)

This company provides quality videos demonstrating various sexual techniques.

Sexuality Information and Education Websites

www.sexualhealth.com

Sexual Health Network is devoted to sexuality issues for people with disabilities.

www.aasect.org

American Assn. of Sexuality Educators, Counselors & Therapists:

- Searchable databases of sexuality educators, counselors and therapists
- Certification standards and procedures for sexuality professionals

www.siecus.org (Sexuality Information and Education Council of the U.S.)

- Exemplary comprehensive sexuality education books, pamphlets
- Downloadable and free information sheets by various topics
- Prolific bibliographies of articles arranged by various topics

www.biresources.org

This Web site is devoted to the subject of bisexuality.

www.ourbodiesourselves.org

This Web site is offered by the Boston Women's Health Book Collective. Spanish language translations for most information are available.

Sidebar: Declaration of Sexual Rights*

Sexuality is an integral part of the personality of every human being. Its full development depends upon the satisfaction of basic human needs such as the desire for contact, intimacy, emotional expression, pleasure, tenderness and love. Since health is a fundamental human right, so must sexual health be a basic human right. In order to assure that human beings and societies develop healthy sexuality, the following sexual rights must be recognized, promoted, respected and defended by all societies through all means.

1. The right to sexual freedom. Sexual freedom encompasses the possibility for individuals to express their full potential. This excludes all forms of sexual coercion, exploitation and abuse.

2. The right to sexual autonomy, sexual integrity and the safety of the sexual body, including the ability to make autonomous decisions about one's sexual life within a context of one's own personal and social ethics.

3. The right to sexual privacy as long as they do not intrude on the sexual rights of others.

4. The right to sexual equity, which includes freedom from all forms of discrimination regardless of sex, gender, sexual orientation, age, race, social class, religion or physical and emotional disability.

5. The right to sexual pleasure as a source of physical, psychological, intellectual and spiritual well being.

6. The right to emotional sexual expression, which is more than erotic pleasure of sexual acts. Individuals have a right to express their sexuality through communication, touch, emotional expression and love.

7. The right to sexually associate freely, which means the possibility to marry or not, to divorce and establish other types of responsible sexual associations.

8. The right to make free and responsible reproductive choices, including whether or not to have children, the number and spacing of children and full access to the means of fertility regulation.

9. The right to sexual information based upon scientific inquiry, generated through unencumbered and yet scientifically ethical inquiry, disseminated appropriately at all societal levels.

10. The right to comprehensive sexuality education -- a lifelong process from birth throughout the life cycle, that should involve all social institutions.

11. The right to sexual healthcare, available for prevention and treatment of all sexual concerns, problems and disorders.

*Adopted in Hong Kong at the 14th World Congress of Sexology, August 26, 1999. Full text available at: http://www.tc.umn.edu/~colem001/was/wdeclara.htm.

Authors and Disclosures

As an organization accredited by the ACCME, Medscape requires authors and editors to disclose any significant financial relationship during the past 12 months with the manufacturer of any product that may relate to the subject matter of the educational activity, whether or not the activity is commercially supported. Authors are also asked to disclose any mention of investigational products or unapproved uses of products regulated by the U.S. Food and Drug Administration.

Authors

Karen M. Hicks, PhD

AASECT certified Sexuality Educator, Lehigh University, Bethlehem, Pennsylvania

Disclosure: Dr. Hicks has no significant financial interests or relationships to disclose.The author discusses unlabeled uses of testosterone, sildenafil, vardenafil, and tadalafil in this activity.

Clinical Editors

Ursula Snyder, PhD

Editor/Program Director, Medscape Ob/Gyn & Women's Health

Disclosure: Ursula K. Snyder has no significant financial interests or relationships to disclose.

Registration for CME credit, the post test and the evaluation must be completed online.
To access the activity Post Test and Evaluation link, please go to:
http://www.medscape.com/viewprogram/3437_index