Society for Sex Therapy and Research

SSTAR 2009: 34th Annual Meeting

Continuing Medical Education Credit is provided through joint sponsorship with The American College of Obstetricians and Gynecologists (ACOG).

The Ritz-Carlton Pentagon City
Arlington, VA
April 2 – 5, 2009

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PRESIDENT'S WELCOME

Welcome to the 34th Annual Meeting of the Society for Sex Therapy and Research! Whether you are a devoted SSTAR member who returns yearly or a newcomer to SSTAR, we hope you will share a special feeling of warmth, excitement and inclusion at this meeting. You will find welcoming, enthusiastic, knowledgeable and gracious sex therapists and researchers versed in multiple specialties, enjoying intellectual stimulation from different perspectives in the relaxed, intimate atmosphere of a SSTAR gathering. We appreciate quality state-of-the-art presentations, good humor, fine food, interesting excursions, and warm friendships.

Thursday, you may be attending one of the fascinating workshops by the masters, intended for clinicians new to the field (Management of Sexual Disorders or Becoming a Sex Therapist) as well as those interested in the nuances and new theories in the areas of Transgender issues or Cybersex. Thursday evening, the Consumer Book Award will be presented to internationally-known author and SSTAR member, Esther Perel. You shall enjoy our inviting and generous welcoming reception followed by the Movie, Transgender Stories, moderated and discussed by Richard Carroll and Walter Bockting.

The program is impressive! Drs. Eli Coleman and Brian Zamboni, our scientific chairs, have capitalized (so to speak) on the Political excitement and location, bringing in the DSM-V workgroup, research funding and ethical concerns. The meeting should have relevance and should appeal to the mental health practitioner, medical clinician, and university researcher. I want to thank Eli and Brian for their indefatigable efforts and selection of presenters. I am excited to hear the expert speakers and provocative, cutting edge lectures, posters and papers.

Dorothy Van Dam, as our local program chairperson, has taken us to the Ritz Carlton, a stunning location at one of the most significant times in history, as well as the most beautiful season with cherry blossoms in bloom. The Metro is only steps from the hotel entrance, a short ride to the cultural, historic and artistic riches of DC. Dorothy has arranged a tour of the Smithsonian American Art Museum (focused on Sexuality) with talented docents. Don't forget to sign up for the tour and for Fellowship Dinners hosted by our Washington members at their favorite restaurants!

For students, SSTAR will host a Pizza Party on Friday evening.

If you enjoy the clinical part of the meeting, plan on joining us at our Fall Clinical Meeting on Friday, September 25, 2009 at the Penn Club in New York, or come to our meeting next year at the Hyatt Regency Cambridge across the Charles River from Boston. If you are moved to become a part of SSTAR, pick up a membership application at the registration desk, from our beloved administrator, Ms. Yvonnada McNeil.

I look forward to meeting you personally and welcoming you to my favorite conference of the year.

Bonnie Saks, MD
President of the Society for Sex Therapy and Research
Clinical Professor of Psychiatry
University of South Florida

SAVE THE DATES!

SSTAR 2010: 35th Annual Meeting – Boston, Massachusetts, USA

BOSTON 2010

For the third time, I am delighted to welcome SSTAR to Boston for our 35th Annual Meeting next April. We will again be at the Hyatt Regency Cambridge which is close to Boston, Harvard Square in Cambridge, shopping, great restaurants and of course our museums. For those who know Boston, I want to welcome you back; for those who have never visited, you are in for a treat. The American Revolution, after all began here, and the history buffs will be able to visit Paul Revere's house, the Old North Church and Faneuil Hall. Spring will be in the air, and the joggers and cyclists (that means Richard Carroll) are in for a treat.

I look forward to being your host!

Derek

Plan to attend the
SSTAR 2009 Fall Clinical Meeting

Friday, September 25, 2009
The Penn Club of New York
30 West 44th Street
New York, New York 10036

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ACKNOWLEDGEMENTS

SSTAR extends appreciation to the following valued friends from industry for their generous support of the educational and scientific objectives of the SSTAR 2009 Annual Meeting.

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Lilly USA

Lilly USA is a leading, innovation-driven corporation committed to developing a growing portfolio of best-in-class and first-in-class pharmaceutical products that help people live longer, healthier and more active lives. We are committed to providing answers that matter.

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EXHIBITOR:

American Institute of Bisexuality

The American Institute of Bisexuality (AIB) is a nonprofit organization. We encourage support and assist research and education about bisexuality through programs likely to make a difference and enhance public knowledge and awareness.

CONTINUING EDUCATION ACCREDITATIONS & APPROVALS

NOTE: The SSTAR 2009 Annual Meeting is fully accredited or approved to award continuing education credits to psychologists, sexologists, physicians, social workers, and marriage and family therapists. For questions or concerns about continuing education credits, please contact:

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1. ACCME Accreditation

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint sponsorship of The American College of Obstetricians and Gynecologists (ACOG) and the Society for Sex Therapy and Research (SSTAR).

AMA PRA Category 1 Credit(s) ™ or ACOG Cognate Credit(s)

The American College of Obstetricians and Gynecologists (ACOG) designates this educational activity for a maximum of 23 AMA PRA Category 1 Credits™ or up to a maximum of 23 Category 1 ACOG Cognate Credits. Physicians should only claim credit commensurate with the extent of their participation in the activity.

Disclosure of Faculty and Industry Relationships

In accordance with ACOG policy, all faculty members have signed a conflict of interest statement in which they have disclosed any significant financial interests or other relationships with the industry relative to topics they will discuss at this program. At the beginning of the program, faculty members are expected to disclose any such information to participants. Such disclosure allows you to evaluate better the objectivity of the information presented in lectures. Please report on your evaluation form any undisclosed conflict of interest you perceive. Thank you!

2. American Association of Sex Educators, Counselors and Therapists (AASECT)

This program meets the requirements of AASECT and is approved for up to 23 hours. These CEs may be applied toward AASECT certification and renewal of certification.

3. American Psychological Association (APA)

SSTAR is approved by the American Psychological Association (APA) to sponsor continuing education for psychologists. SSTAR maintains responsibility for this program and its content. This program qualifies for up to 23 hours.

4. California Board of Behavioral Sciences (CBBS)

The California Board of Behavioral Sciences approved SSTAR as a "Provider of Continuing Education" (PCE #1719) for Licensed Marriage and Family Therapists (LMFT) and Licensed Clinical Social Workers (LCSW). This program qualifies for up to 23 hours.

2009 Award Recipients

Consumer Book Award

Esther Perel, MA, LMFT
Mating in Captivity: Reconciling the Erotic and the Domestic
HarperCollins, 2007

Masters & Johnson Award

Eli Coleman, PhD
Program in Human Sexuality
Department of Family Medicine and Community Health
University of Minnesota Medical School

SSTAR Student Research Award

Tuuli M. Kukkonen, PhD Candidate
Department of Psychology
McGill University
Montreal, Quebec

PROGRAM SCHEDULE: SSTAR 2009
Politics and Research in Sexuality:
Toward Greater Understanding of Cutting Edge Issues in Sex Therapy

THURSDAY, APRIL 2, 2009

Pre-conference workshops
FULL-DAY WORKSHOP (8:30 AM – 4:15 PM)
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8:30 - 9:30 AM
Assessment and Treatment of Couples with Sexual Dysfunction
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9:30 - 10:30 AM
Sexual Dysfunction in Women Associated with Medical Illness, Psychiatric Conditions, and Medication Therapy
Presented by: Anita H. Clayton, MD 17
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1:00 - 2:00 PM
Assessment and Treatment of Women's Low Sexual Desire and Arousal: An Update
Presented by: Lori A. Brotto, PhD 21
2:00 - 3:00 PM
Vulvar Pain and Sexual Pain Disorders
Presented by: Andrew T. Goldstein, MD 23
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3:15 - 4:15 PM Question and Answer Period

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Moderator: Bonnie R. Saks, MD
Presented by: Walter Bockting, PhD 24

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Moderator: Blanche Freund, PhD, FAACS, RN
Presented by: David L. Delmonico, PhD.....26

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So You Want to be a Sex Therapist?
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6:00 - 7:00 PM Welcome Reception

6:30 PM Consumer Book Award Presentation
Book title: Mating in Captivity: Reconciling the Erotic and the Domestic
Recipient: Esther Perel, MA, LMFT
Presented by: Shirley R. Baron, PhD

SSTAR Meeting Begins

7:15 - 9:00 PM Movie Screening
Movie title: Transgender Stories
Moderator: Richard A. Carroll, PhD
Discussant: Walter Bockting, PhD 29

FRIDAY, APRIL 3, 2009

7:30 AM - 5:00 PM Meeting Registration

7:30 - 8:45 AM Continental Breakfast

8:45 - 9:00 AM Welcome
SSTAR President: Bonnie R. Saks, MD
Scientific Program Chairs:
Eli Coleman, PhD and Brian D. Zamboni, PhD
Local Program Chair: Dorothy Van Dam, LICSW
Continuing Education Officer: Eric W. Corty, PhD

9:00 AM - NOON SYMPOSIUM: Provisional Report by the DSM-V Workgroup on Sexual and Gender Identity Disorders
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Richard Krueger, MD 36
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R. Taylor Segraves, MD, PhD 38
Lori A. Brotto, PhD 40
Irv Binik, PhD 42

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1:15 - 2:15 PM

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Presented by: Barry McCarthy, PhD 51

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4:30 - 6:00 PM SPECIAL EXCURSION:
Smithsonian American Art Museum Private Tour

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(Sign-up at the registration desk.)

7:00 - 9:00 PM Fellowship Dinners at Local Restaurants
(Sign-up at the registration desk.)

SATURDAY, APRIL 4, 2009

7:30 AM - 5:00 PM Meeting Registration

7:30 - 8:30 AM Breakfast Roundtables with Speakers

8:30 - 10:00 AM

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Presented by: Maria Cecilia Zea, PhD 57

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Sexuality and Training Professionals

SATURDAY, APRIL 4, 2009 continued

Cultures and Sexuality

NOON - 1:15 PM Business Meeting and Lunch ***(SSTAR Members Only)***

1:15 - 2:00 PM Masters and Johnson Award
Recipient: Eli Coleman, PhD
Presented by: Beverly Whipple, PhD

2:00 - 3:00 PM

PAPER SESSION II: Hot Topics in Student Research
Moderator: Stephanie W. Kuffel, PhD

SATURDAY, APRIL 4, 2009 continued

3:00 - 3:15 PM Break

3:15 - 4:15 PM

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Moderator: Dorothy Van Dam, LICSW

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Presented by: Hani Miletski, PhD, MSW.....109

4:15 - 4:30 PM Break

4:30 - 5:45 PM CASE PRESENTATION AND DISCUSSION
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Moderator: Hani Miletski, MSW
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Discussant: Fred S. Berlin, MD.....111

5:45 – SSTAR meeting ends

7:00 - 9:00 PM Fellowship Dinners at Local Restaurants:
(Sign-up at the registration desk.)

SUNDAY, APRIL 5, 2009

POST CONFERENCE WORKSHOP (9:00 AM - NOON)
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Politics, Research and Attempts to Change Human Sexuality
Presented by Daniel N. Watter, EdD and Peggy J. Kleinplatz, PhD 113

ASSESSMENT AND TREATMENT OF COUPLES WITH SEXUAL DYSFUNCTION
Michael E. Metz, PhD

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Sex dysfunction (SD) is best conceptualized, assessed, and treated using an interpersonal model, and focusing treatment on the couple working together as an "intimate team." From an integrative, biopsychosocial approach to comprehensive sex therapy, sexual problems are inevitably relationship problems with multiple causes and multiple effects on the man, woman, and their intimate relationship.

This workshop component considers the distinct advantage, and crucial importance, of couple assessment and treatment – even in the individual medical or psychological modality -- and the value and use of several clinical couple tools for effective sex therapy. Individual and couple assessment is aided by tools such as the Diagnostic Decision Tree process to efficiently explore 10 broad types (causes & effects) of SD in the couple system → five physical/medical (physiologic systems, acute physical illness, physical injury, pharmacologic side-effect, lifestyle issues), four psychological/relational (psychological system, acute psychological distress, psychosexual skills deficit, relationship dynamics and distress) and one mixed type (multiple sexual dysfunctions). Appreciating the severity and interactive impact of all factors on the partners is crucial for comprehensive treatment effectiveness → and has as its ultimate goal, couple satisfaction.

Emphasis underscores: (1) that SD is essentially a relationship difficulty with multiple dimensions in terms of both individual and relational causes and effects; (2) appreciating the value of focusing on the couple, the risks to not, and the possible harm that may unintentionally result from neglecting the relationship dimension ("If we misdiagnose, we will mistreat"); and (3) providing efficient clinical tools for assessing and treating couples in sexual medicine & sex therapy.

Typically, effective treatment is not "simple cause, simple cure" but rather involves a number of interventions tailored to the physical, psychological, and relationship factors. There are medical, individual, and couple interventions. Medical, physiological, and pharmacological techniques are not used, and may be limited in effectiveness, as "stand alone" interventions. Medical, pharmacologic and individual therapies inevitably need to be integrated into the relationship. Straight-forward features of the "Good-Enough Sex Model" for couple satisfaction summarize important elements of satisfying, healthy individual and couple sexual intimacy over the life-cycle – features such as: couple communication for sexual comfort, realistic sexual expectations, the counter-intuitive importance of sexual relaxation, the basic "purposes" for sex, 3 styles of sexual arousal, developing flexible sexual arousal scenarios, relaxed and "playful" intercourse, and humanistic and spiritual dimensions.

The workshop presentation will emphasize: (1) the importance of, and how to do, an efficient couple assessment and couple-sensitive treatment → adaptable to the usual 7-8 minute "express lane" patient visit that most U.S. physicians have, or the extended sessions of psychologists, MFTs, and other mental health professionals; (2) the features of the "Good-Enough Sex" couple satisfaction

approach; and (3) the requirement for specialized relapse prevention program and clinical follow-up to ensure couple satisfaction. Features are illustrated with clinical case examples including several typical cognitive, behavioral and emotional patterns common among couples with sex dysfunction.

Special attention is given to recognizing and ameliorating detrimental interpersonal / relationship dimensions using the straightforward I-C-A schema focusing on: (1) the couple's "identity" -- involving detailed cognitions about their relationship and sexual cohesion; (2) the couple's behavioral cooperation -- using the 5 features of couple conflict (known to be a crucial dimension of couple sexual problems); and (3) the strength of the couple's emotional empathy as underpinning for sexual intimacy. How to efficiently use several clinical tools will be briefly demonstrated.

Behavioral Learning Objectives:

After attending this presentation, the participants will be able to:

1. Consider and identify the features of the Integrative, biopsychosocial, multidimensional couple approach to assess and treat sex dysfunctions within the "express lane" of primary medical practice as well as extended psychotherapy.
2. Learn the 10 features of the "Good-Enough Sex" model for couple satisfaction.
3. Appreciate the essential need for medical and psychotherapy follow-up visit(s) to ensure compliance, provide relapse prevention, and facilitate individual and couple satisfaction.

References:

Epstein, N., & Baucom, D., (2002). *Enhanced cognitive-behavioral therapy for couples:* A contextual approach. Washington, DC, US: American Psychological Association.

McCarthy, B. (2001). Relapse prevention strategies and techniques with erectile dysfunction. *Journal of Sex & Marital Therapy, 27*; 1-8;

McCarthy, B. W. & Metz, M. E. (2008). *Men's Sexual Health: Fitness for Satisfying Sex*. NY Routledge/Taylor Francis.

Metz, M. E., & Epstein, N. (2002). The Role of Relationship Conflict in Sexual Dysfunction. *Journal of Sex & Marital Therapy*, 28: 139-164.

Metz, M. E., PhD and B. W. McCarthy, PhD (2007). "The Good-Enough Sex Model for Couple Sexual Satisfaction*." Sexual and Relationship Therapy*, Vol. 22 (3), 351-362.

Metz, M. E. & B. W. McCarthy, (2008). "Eros & Aging: Is Good-Enough Sex Right for You?" *Psychotherapy Networker*, July/August 2008; 55-61.

Metz, M. E. & McCarthy, B.W. (2004). *Coping with Erectile Dysfunction: How to Regain Confidence and Enjoy Great Sex.* Oakland: New Harbinger Publications.

Metz, M. E. & McCarthy, B.W., (2003). *Coping with Premature Ejaculation: Overcome PE, Please Your Partner, and Have Great Sex.* Oakland: New Harbinger Publications.

Biography:

Michael E. Metz, PhD is a psychologist and marital & family therapist in private practice in St. Paul, MN. He earned his PhD with distinction from the University of Pennsylvania, Philadelphia, Pennsylvania, and for 12 years, served on the faculty of the University of Minnesota Medical School, Department of Family Practice. He is the author of the couple conflict assessment measure, the *Styles of Conflict Inventory* (1993), and with Barry McCarthy, *Men's Sexual Health: Fitness for Sexual Satisfaction (2008); Coping with Premature Ejaculation (*2003); and *Coping with Erectile Dysfunction* (2004) which received the 2007 SSTAR best consumer sexual health book award.

SEXUAL DYSFUNCTION IN WOMEN ASSOCIATED WITH MEDICAL ILLNESS, PSYCHIATRIC CONDITIONS, AND MEDICATION THERAPY

Anita H. Clayton, MD

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Sexual complaints are common in the general population, but are significantly higher among patients with a psychiatric or medical diagnosis, likely due to changes in sex steroids and neurotransmitters mediating illness and sexual functioning via effects in the central nervous system and the genitalia. Mood and anxiety disorders, and medical conditions such as endocrine disorders, neurological illness, cardiovascular disease, and genitourinary conditions, as well as the associated treatments may negatively impact all aspects of sexual function. Co-morbidity of conditions further increases the likelihood of sexual problems, and use of multiple medications may further contribute to reduced function. Potential offending medications include antidepressants, benzodiazepines, narcotic analgesics, antihypertensives, antipsychotic medications, immunosuppressants, H2 blockers, anticonvulsants, and steroids (including hormonal contraceptives). Risk factors for sexual dysfunction associated with antidepressant therapy include genetic predisposition, age > 50 years, lower education and work performance, and poor prior sexual functioning, and are likely generalizable to other conditions affecting sex steroids and neurotransmitters. Gender differences have been identified in drug effects on specific phases of the sexual response cycle. Monitoring and treatment recommendations include a watch-and-wait strategy, dose adjustment, change of medication, adding a potential antidote, psychological interventions, and patient education.

Behavioral Learning Objectives:

At the conclusion of this presentation the participants will be able to:

1. Explain the impact of medications, medical illness, and psychiatric illness on sexuality
2. Describe strategies in the management of illness- and medication-associated sexual dysfunction

References:

Clayton AH, Pradko JF, Croft HA, et al. Prevalence of sexual dysfunction among newer antidepressants. *J Clin Psychiatry* 2002; 63:357-366.

Clayton AH, Keller A, McGarvey EL. Burden of phase-specific sexual dysfunction with SSRIs. *J Affective Disorders* 2006; 91:27-32.

Clayton, AH, Ramamurthy S. The Impact of Physical Illness on Sexual Dysfunction. In Balon, R (ed.): Sexual Dysfunction. The Brain-Body Connection. Adv Psychosom Med. Basel, Karger, 2008, vol 29, pp 70 – 88.

Biography:

Dr. Clayton's research interests include the effects of illness and medications on sexuality, the neurobiology of sexual function, development of tools to assess sexual desire and functioning, and trials of treatments for sexual dysfunction. She has served as the president of the International Society for the Study of Women's Sexual Health (2005-2007), and is a contributing editor for *the Journal of Sexual Medicine* and the *Journal of Sex & Marital Therapy*. Her book *Satisfaction: Women, Sex, and the Quest for Intimacy* was published in 2007.

ETIOLOGY, DIAGNOSIS AND TREATMENT OF MALE SEXUAL DYSFUNCTION
Michael A. Perelman, PhD

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This workshop presentation will describe the application of the Sexual Tipping Point® model (a biopsychosocial-cultural framework) to the etiology, diagnosis and treatment of Male Sexual Dysfunction (MSD). Both Combination Treatment (CT) and Integrated Sex Therapy (IST) approaches will be taught. These approaches are an extension of sex therapy's early professional history and teachings. Over a generation ago, Annon's PLISSIT model presciently anticipated the need to fuse counseling with the appropriate use of sexual pharmaceuticals (CT). Primary Care Physicians (PCP) will want to improve the guidance and counseling they provide, but other professionals must also be ready and trained to provide counseling which will optimize respsonse to appropriately prescribed sexual pharmaceuticals. All healthcare professionals (HCP) can learn to provide permission (P), limited information (LI) and specific suggestions (SS) which can be combined judiciously with sexual pharmaceuticals to improve risk/benefit ratios for patients suffering from sexual concerns.

It is clear that both organic and psychosocial factors play a role in the etiology of MSD. However, the mind and body both inhibit and excite sexual response, as described by the Sexual Tipping Point® model. The STP model postulates a set-point or threshold for the expression of any sexual response for any individual. This is a dynamic and not a static process. Therefore, that response may vary within and between any given sexual experience(s) and refers to any combination of desire, arousal, orgasm or resolution. The specific threshold for the sexual response is determined by multiple factors for any given moment or circumstance, with one factor or another dominating, while others recede in importance. Being turned on is mental and physical and so is being turned off. Positive mental and physical factors increase the likelihood of a response, while negative mental and physical factors inhibit the sexual response. All these factors combine to determine a unique threshold or Sexual Tipping Point®. For instance, each man will have a variably expressed erectile threshold or Erectile Tipping Point (ETP), which may be inhibited and/or facilitated. Furthermore, every man, whether he experiences a "normal" ejaculatory latency, PE, or RE, has an "Ejaculatory Tipping Point" (EjTP) determined by similar multidimensional factors. Importantly, this model is a useful heuristic device to describe the variety of vectors impacting both normal and dysfunctional sexual response in <u>both women and men</u>.

HCPs can easily apply the STP model to conceptualize a CT model where sex coaching and sexual pharmaceuticals are integrated into diagnosis and a more satisfactory efficacious treatment; where physiology, psychology, and culture are addressed. At any moment in the intervention process, the HCP determines, the most elegant solution, which focuses the majority of effort on fixing the predominant factor while not ignoring the others. HCP using the STP model, can fully conceptualize MSD by understanding the predisposing, precipitating and maintaining psychosocial aspects of their patient's diagnosis and management, as well as organic causes and risk factors. Sex coaching helps

integrate sex counseling and other psychological techniques into office practices, optimizing treatment for MSD. Sex coaching is useful as a monotherapy, but used adjunctively with sexual pharmaceuticals, it becomes the "oral therapy" of choice for MSD.

The workshop will incorporate diagnostic and case management examples of male sexual dysfunction from the perspective of a CT, including: 1) etiology; 2) a focused sex history; 3) partner issues; 4) pharmaceutical selection, patient preference and expectations; 5) follow-up highlighting the use of sexual pharmaceuticals as a "therapeutic probe" illuminating causes of failure or non-response; 6) "weaning" and relapse prevention; 7) referral.

Furthermore, Annon's model, when combined with the teachings of Masters, Johnson, Kaplan and others results in a multi-dimensional bio-psychosocial-cultural approach which can also be integrated with discerningly prescribed sexual pharmaceuticals (IST). In more complicated cases, adding education and specific suggestions while necessary, will not be sufficient to obtain a successful outcome. Sex therapists must embrace their unique ability to process complex matrices of variables, which dynamically shift the sexual equilibrium. Sex therapists will enhance their skills to treat those who suffer from more complex psychosocial obstacles to success by also managing the psychological forces of patient and partner resistance, which impact patient compliance and sex lives beyond organic illness and mere performance anxiety.

Sex counseling and therapy usually require more time than the typical prescribers of sexual pharmaceuticals have available during an office visit, and a different set of skills than those commonly employed by many generalist mental health colleagues. However, capacity for thoughtful examination of sexual issues and dynamics within a brief time frame, is also part the sex therapy legacy which will be shared.

Behavioral Learning Objectives:

After attending this presentation, will enable participants to:

1. Identify and describe the Sexual Tipping Point™ model.
2. Describe the use of STP as a model for conceptualizing CT where sexual pharmaceuticals and counseling are combined to restore sexual function and satisfaction for men suffering from a variety of male sexual dysfunctions.
3. Describe the difference between a CT and IST model for the treatment of sexual dysfunction.

References:

Annon, JS (1974) *The Behavioral Treatment of Sexual Problems, Volume 1 Brief Therapy,* Kapiolani Health Services, Honolulu

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Perelman, MA (2005). Combination therapy for sexual dysfunction: integrating sex therapy and pharmacotherapy. In R. Balon, & R. T. Segraves (Eds.), *Handbook of Sexual Dysfunction* (pp. 13-41). Taylor & Francis.

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Bella AJ, Perelman MA, Brant WO, Lue TF. "Peyronie's Disease." *Journal of Sexual Medicine*, 2007; 4(6):1527-1538.

Perelman MA. "Letter to the Editor: Post-prostatectomy Orgasmic Response." *Journal of Sexual Medicine*, 2008; 5(1):248-249.

Perelman MA. "Integrated Sex Therapy: Interplay of Behavioral, Cognitive, and Medical Approaches." In Textbook of Erectile Dysfunction, 2nd Edition, [Eds: C Carson, I Goldstein, & R Kirby], Informa Healthcare, London, UK, In Press.

Biography:

Dr. Michael A. Perelman is a Clinical Associate Professor of Psychiatry, Reproductive Medicine, and Urology at Weill Medical College of Cornell University. He is the Co-Director of the Human Sexuality Program, Payne Whitney Clinic of the N Y Presbyterian Hospital in New York City, founded by his late mentor Dr. Helen S. Kaplan. Additionally, he is the Senior Consulting Sex Therapist to the Department of Urology at Greenwich Hospital.

A National Institute of Health Fellow, he received his MS, M.Phil. and PhD degrees in clinical psychology from Columbia University, writing the first sex therapy dissertation in Columbia's history. Dr. Perelman was Chief Intern in Medical Psychology at Duke University Medical Center and was next a 1974 Postdoctoral Fellow at NY Weill Cornell Medical Center.

Dr. Perelman has served on several professional society boards of directors and is currently the President-Elect of The Society for Sex Therapy and Research (SSTAR). He was elected a Fellow of the Sexual Medicine Society of North America (SMSNA) and is a member of over twenty-five other professional associations (serving on or chairing numerous committees), including the American Psychological Association, the American Urological Association (AUA), the Society for the Scientific Study of Sex (SSSS), the International Academy of Sex Researchers (IASR), the International Society for Sexual Medicine (ISSM), and the International Society for Study of Women's Sexual Health (ISSWSH). Dr. Perelman was appointed to the Sexual Function Advisory Council of the American Urological Association Foundation.

Dr. Perelman maintains an independent practice in Manhattan, specializing in sex and marital therapy, and is certified by New York State and listed in the National Register of Health Service Providers in Psychology. The American Association of Sex Educators, Counselors, and Therapists (AASECT) certify him as a sex therapy diplomate, supervisor, sex educator, and sex counselor.

Dr. Perelman is on the Board of Directors for the *Journal of Sexual Medicine,* and is a consulting editor and/or reviewer for numerous journals, including: *British Journal of Urology International, Journal of Sex and Marital Therapy, Journal of Urology, Urology, International J. of Impotence Research* and *Current Sexual Health Reports.* In 1985, he co-authored *Late Bloomers.* He has published countless peer reviewed journal articles, abstracts, posters, chapters in sexual medicine texts and delivered over 250 invited presentations. Dr. Perelman consults to industry, conducting clinical trials, serving on advisory boards and speakers' bureaus. Additionally, his work in sex and marital therapy is often featured in the media.

ASSESSMENT AND TREATMENT OF WOMEN'S LOW SEXUAL DESIRE AND AROUSAL: AN UPDATE

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The goal of this talk is to provide an overview of the diagnostic categories of women's sexual desire/interest and arousal disorders, comparing and contrasting different diagnostic criteria and their implications for making a sexual desire or arousal diagnosis. Despite much recent attention aimed at discovering an effective pharmacologic treatment for desire and arousal disorders in women, there are currently no such approved treatments for these complaints in North America. Psychological therapy has a long history in the treatment of sexual dysfunction, however, only recently have there been randomized controlled trials of Cognitive Behavioural Therapy for women's low desire, and no published controlled trials on psychological therapy for arousal difficulties. In part, this is due to the high degree of comorbidity of arousal complaints with desire, orgasmic, and genital pain difficulties. This talk will use a model of responsive sexual desire (Basson, 2005) to discuss how one might conduct a comprehensive biopsychosocial assessment of sexual response in women. The major evidence-based treatments from both a psychological and biological perspective for women's loss of desire and arousal will also be discussed.

Behavioral Learning Objectives:

After attending this presentation, the participants will be able to:

1. Discuss recent reconceptualizations in the diagnosis of sexual desire/interest and arousal disorders in women
2. Formulate a comprehensive "case conceptualization" that takes into account aspects of personal, interpersonal, sociocultural, and medical factors that may be contributing to the low desire or arousal
3. List the major evidence-based treatments, and their degree of efficacy, in treating sexual desire and arousal difficulties in women.

References:

Basson R. (2005). Female Hypoactive Sexual Desire Disorder. In: R. Balon & R. T. Segraves (Eds.), *Handbook of Sexual Dysfunction* (pp. 43-66). Boca Raton, Florida:Taylor & Francis Group

Basson, R., Leiblum, S., Brotto, L., Derogatis, L., Fourcroy, J., Fugl-Meyer, K., Graziottin, A., Heiman, J.R., Laan, E., Meston, C., Schover, L., van Lankveld, J., Schultz, W.W. (2003). Definitions of women's sexual dysfunction reconsidered: advocating expansion and revision. *J Psychosom Obstet Gynaecol*, 24, 221-229.

Leiblum, S.R., Wiegel, M. (2002). Psychotherapeutic interventions for treating female sexual dysfunction. *World J Urol,* 20, 127-136.

Biography:

Lori Brotto has a PhD in clinical psychology from the University of British Columbia (2002) and completed a Fellowship in Reproductive and Sexual Medicine from the University of Washington (2004). She is an Assistant Professor in the UBC Department of Obstetrics and Gynaecology as well as a registered psychologist in Vancouver, Canada. She is the director of the UBC Sexual Health Laboratory where research primarily focuses on developing and testing psychological/psychoeducational interventions for women with sexual desire and arousal difficulties – many secondary to gynaecologic cancers. Her clinical work includes individuals and couples with sexual dysfunction. Dr Brotto trains gynaecology residents and medical students at UBC and teaches an undergraduate course in Human Sexuality. She is Associate Editor for Sexual and Relationship Therapy, and on the Editorial Boards of the Archives of Sexual Behavior, the Journal of Sex and Marital Therapy, and the International Journal of Sexual Health. Dr Brotto is the recipient of a Scholar Career Award from the Michael Smith Foundation for Health Research as well as a New Investigator Award from the Canadian Institutes of Health Research. She is also on the DSM-V Task Force for the Sexual Dysfunctions Subcommittee.

VULVAR PAIN AND SEXUAL PAIN DISORDERS
Andrew T. Goldstein, MD

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The workshop will provide an introduction to the vulvar pain disorders. In particular, we will focus on provoked vestibulodynia (vulvar vestibulitis syndrome, VVS.) The prevalence, typical clinical presentation, and diagnostic strategies will be discussed. We will discuss the diagnosis and treatments of the many causes of provoked vestibulodynia including pelvic floor dysfunction (AKA levator ani syndrome, vaginismus), atrophy, neuronal proliferation, vulvar dermatoses (lichen sclerosus, lichen planus, plasma cell vulvitus, and mucous membrane pemphigoid,) and vaginitis (candidiasis, desquamative inflammatory vaginitis, and trichomonas.) We will discuss local non-surgical therapies (e.g., injections, creams), systemic treatment options (e.g., oral medications), and surgery (i.e., vestibulectomy.) Lastly, we will provide a brief overview of psychological and other non-medical treatments for sexual pain, focusing on cognitive behavior therapy (CBT), physical therapy (PT), hypnosis, and acupuncture. Finally, a multimodal, multidisciplinary approach to vulvar pain and dyspareunia will be addressed.

Behavioral Learning Objectives:
After attending this presentation, the participants will be able to:
1. Diagnose the common causes of provoked vestibulodynia.
2. Offer patients a treatment plan based on the specific cause of their dyspareunia.
3. Discuss non-medical methods of treatment.

References:
AT Goldstein, SC Marinoff, HK Haefner. Vulvodynia: Strategies for Treatment. *Clin Obstet Gynecol*. 2005 Dec;48(4):769-85.
Burrows LJ, Shaw HA, Goldstein AT. The Vulvar Dermatoses. *J Sex Med*. 2008 Feb;5(2):276-83.
Burrows LJ, Goldstein AT. Vulvodynia. *J Sex Med 2008;5:5-15.*
AT Goldstein. Surgery for Vulvar Vestibulitis. *J Sex Med*. 2006;3:559-562.

Biography:
Dr. Andrew T. Goldstein graduated from the University of Virginia and the University of Virginia School of Medicine. After completing his residency in Obstetrics and Gynecology at the Beth Israel Medical Center, Dr. Goldstein joined the faculty of the Division of Gynecologic Specialties at the Johns Hopkins School of Medicine. In 2002 he became the Director of the Centers for Vulvovaginal Disorders in Washington, D.C. and New York City. Dr. Goldstein is board certified by the American Board of Obstetrics and Gynecology and he has been elected to the International Society for the Study of Vulvovaginal Disease and to the American Society for Colposcopy and Cervical Pathology. He is the Treasurer of the International Society for the Study of Women's Sexual Health and has been a grant recipient of the National Vulvodynia Association. He recently edited a textbook *Female Sexual Pain Disorders* that will be published by Blackwell-Wiley in 2009. Dr. Goldstein is actively involved in research and has recently published peer-reviewed articles on lichen sclerosus, lichen planus, lichen simplex chronicus, and vulvar vestibulitis syndrome.

TRANS-POSITIVE PSYCHOTHERAPY WITH CHILDREN, ADOLESCENTS, AND ADULTS
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Introduction: Therapy with children, adolescents, and adults presenting with gender identity issues continues to be controversial, in part due to some grave misunderstandings. Areas of controversy for children include pathologizing of gender variant behavior; the potential for misdiagnosis; who should be the focus of therapy (i.e., child or family); and concerns about a "reparative therapy" approach to treatment (Bockting & Ehrbar, 2005; Ehrbar et al., 2008). Areas of controversy for adolescents include the appropriateness of early medical intervention and gender role transition. Areas of controversy for adults include the gatekeeping role of the mental health professional and the value of the "Real Life Experience" (i.e., living one year full-time in the preferred gender role; Bockting, in press). This workshop will review the existing evidence-base informing these areas of controversy, and train participants in a trans-positive approach to therapy grounded in 20 years of clinical experience with this population.

Method: The American Psychological Association's Task Force on Gender Identity and Gender Variance conducted an extensive review of the scientific literature on transgender health (APA, 2008). Drawing on this review, the evidence informing current clinical practice will be discussed. A trans-positive model of care will be outlined, and illustrated with original research and case vignettes (Bockting et al., 2004). Participants are encouraged to bring their own case examples of clinical challenges and solutions.

Results: Central to a trans-positive approach is the affirmation of a transgender identity that transcends binary conceptualizations of gender (Bockting & Goldberg, 2006). Rather than guiding a transition from male-to-female or female-to-male, the task of the therapist is to facilitate a transgender coming out process for the client and his or her family (Bockting & Coleman, 2007; Lev, 2004). Children need sufficient space and time to explore their gender identity; care should be taken not to foreclose this process with premature medical intervention. Whereas some will show variance only in gender role, others will have a variant gender identity. The gatekeeping role, if managed responsibly, can aid in confronting such clinical issues as depression and internalized transphobia.

Discussion: Because gender variance continues to be stigmatized, and coming out is first and foremost a psychosocial issues, psychotherapy can be invaluable in improving the quality of life of any transgender person and their family.

Behavioral Learning Objectives:
After participating in this workshop, participants will be able to:
1. Discuss the available evidence informing clinical practice with transgender youth and adults
2. Explain the difference between traditional and contemporary approaches to the clinical management of gender dysphoria

3. Identify at least three therapeutic challenges and solutions in working with transgender clients and their families.

References:

APA Task Force on Gender Identity and Gender Variance (2008). *Report of the Task Force on Gender Identity and Gender Variance.* Washington, DC: American Psychological Association. Available online at www.apa.org/pi/lgbc/transgender/2008TaskForceReport.pdf

Bockting, W. (in press). From gender dichotomy to gender diversity: Implications for psychotherapy and the Real Life Experience. *Sexologies.*

Bockting, W., & Coleman, E. (2007). Developmental stages of the transgender coming out process: Toward an integrated identity. In Ettner, R., Monstrey, S., & Eyler, E. (Eds.), *Principles of transgender medicine and surgery* (pp. 185-208). New York: The Haworth Press.

Bockting, W.O., & Ehrbar, R. (2005). Commentary: Gender variance, dissonance, or identity disorder. *Journal of Psychology and Human Sexuality, 17*(3/4), 125-134.

Bockting, W.O., & Goldberg, J.M. (2006). *Guidelines for transgender care*. Double special issue of the International Journal of Transgenderism, 9(3/4), simultaneously published as a volume by the Haworth Press.

Bockting, W.O., Robinson, B.E., Benner, A., & Scheltema, K. (2004). Patient satisfaction with transgender health services. *Journal of Sex and Marital Therapy, 30*(4), 277-294.

Ehrbar, R.D., Witty, M.C., Ehrbar, H.G. & Bockting, W.O. (2008). Clinician judgment in the diagnosis of Gender Identity Disorder in Children. *Journal of Sex & Marital Therapy, 34*, 385-412.

Lev, A. (2004). *Transgender emergence*. Binghamton, NY: The Haworth Clinical Practice Press.

Biography:

Walter Bockting, PhD is a Licensed Psychologist, Associate Professor, and Coordinator of Transgender Health Services at the University of Minnesota Medical School. A native from the Netherlands, Dr. Bockting has over 20 years of experience in providing direct clinical services to transgender clients and their families. His research interests include transgender health, disorders of sex development, sexuality and the Internet, and the promotion of sexual health. He is Principal Investigator of an NIH-funded study of the sexual health of transgender people and the men with whom they have sex. Dr. Bockting is President-Elect of the World Professional Association for Transgender Health.

CYBERSEX UNHOOKED: UNDERSTANDING, ASSESSING, & TREATING COMPULSIVE ONLINE SEXUAL BEHAVIOR
David L. Delmonico, PhD & Elizabeth J. Griffin, MA, LMFT

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The purpose of this workshop is to introduce participants to various aspects of the Internet and other technologies where individuals are engaging in sexual activities. Although an estimated 80% of individuals report few problems with their online sexual behavior (Cooper, Delmonico, & Burg, 2000), there is a group who experience problems with compulsive online sexual behavior. Current literature and research related to online problematic sexual behavior will be presented. A model for understanding cybersex user typologies and methods for screening/assessing cybersex users will be discussed. Participants will learn techniques for managing and treating those individuals whose sexual behavior has been identified as problematic or compulsive.

Behavioral Learning Objectives:
After attending this presentation, the participants will be able to:
1. Explain ways sexual behavior online can become compulsive
2. Differentiate healthy online sexual behavior from compulsive online sexual behavior
3. Discuss methods for assessment and treatment of cybersex compulsivity

References:
Carnes, P. J., Delmonico, D. L., Griffin, E. J. (2007). In the shadows of the net: Breaking free of compulsive online sexual behavior (2nd ed.). Center City, MN: Hazelden Publishing.

Cooper, A., Delmonico, D. L., & Burg, R. (2000). Cybersex users, abusers, and compulsives: New findings and implications. Sexual Addiction & Compulsivity: The Journal of Treatment and Prevention, 7(1-2), 5-30.

Delmonico, D. L., & Miller, J. A. (2003). The internet sex screening test: A comparison of sexual compulsives versus non-sexual compulsives. Sexual and Relationship Therapy, 18(3), 261-276.

Delmonico, D. L., & Griffin, E. J. (2005). Sex offenders online: What clinicians need to know. In B. Schwartz (ed.). The Sex Offender: Issues in Assessment, Treatment, and Supervision of Adult and Juvenile Populations (Volume 5). Kingston, NJ: Civic Research Institute, 1 – 25.

Biographies:
Dr. David Delmonico is a graduate of Kent State University with degrees in psychology and counseling and human development. Currently, he is an Associate Professor at Duquesne University where he is director of the Online Behavior, Research, and Education Center (OBREC), and is editor

of the Sexual Addiction & Compulsivity journal. He has co-authored two books: *In the Shadows of the Net* and *Cybersex Unhooked.*

Elizabeth J. Griffin is a Licensed Marriage and Family Therapist with over 25 years of clinical experience working with sexual offense and sexually compulsive behaviors. She has worked in agency, prison, and military settings, and currently serves as director of Internet Behavior Consulting. Her knowledge, expertise, and reputation have resulted in hundreds of presentations on understanding and working with online problematic behaviors. She has co-authored two books: *In the Shadows of the Net* and *Cybersex Unhooked.*

SO YOU WANT TO BE A SEX THERAPIST?
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Introduction: In most college, graduate and medical schools, sexuality is a topic that often gets short shrift. Given the importance of sex in most peoples' lives, the value for a counseling therapist to provide sex therapy and guidance is enormous. In order to understand how to be helpful, therapists need to have a solid foundation in both individual and couple dynamics.

The therapist needs to be familiar with sexual physiology and the current theories of what can go wrong. This includes normal sexual responses; medical factors that have an impact on function, and the psychological issues that are either a cause of or a response to dysfunction.

Talking about sex directly and openly with a patient or client is usually uncomfortable initially. The discomfort of the therapist may mirror the anxiety of his/her patient. Becoming comfortable with discussing intimate details of a person's sexual life is a process from which both the therapist and client benefit.

Workshop Format:
This workshop is designed primary for Student Members of SSTAR. Using case illustrations and personal anecdotes, the route to becoming fluent and comfortable with sex therapy will be presented. Role play will be used to illustrate techniques of history taking and therapy. A brief overview of sexual dysfunction will be presented as a way to highlight the questions that need to be incorporated into the therapy sessions. The format of the workshop will be informal, and participants are encouraged to bring up their own observations and questions related to the field of sexual therapy.

Behavioral Learning Objectives:
1. Understand the history of the field of sex therapy.
2. Review the need to be versed in individual and couples therapy to understand sexual dynamics.
3. Discuss taking a sexual history and through clinical illustrations, participate in an understanding of the approach to several sexual dysfunctions.
4. Describe several sexual dysfunctions, through clinical illustrations.

Biography:
Dr. Polonsky graduated from Harvard Medical School in 1970. He completed an internship in medicine at Mount Sinai Hospital, New York City and was trained in psychiatry at the Beth Israel Hospital in Boston. He is on the faculty of the Departments of Psychiatry at Harvard Medical School and Tufts Medical School where he teaches medical students and residents. He has served on the executive committee of SSTAR and is the local events chair for the 2010 annual meeting in Boston. He is currently in private practice.

TRANSGENDER STORIES: A FILM
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Introduction: Transgender stories presents the narratives of a variety of transgender individuals. In this film, they discuss the struggles of growing up and coming out. They discuss how they have successfully integrated their gender identity into their overall identity. Also, these stories show how they have achieved their own unique identity. This documentary film is quite illuminating as it explores the process of identity formation among a diverse group of transgender men and women.

The film was produced by Walter Bockting at the Program in Human Sexuality at the University of Minnesota Medical School. A short version of the film will be shown (23 minutes). Dr. Bockting will discuss the film with the audience, answer questions, and invite commentary or discussion.

Behavioral Learning Objectives:
After attending this presentation, the participants will be able to:
1. Discuss the variety of transgender identities and the various options for identity management and integration.
2. Describe the process of coming out for transgender individuals.

References:
APA Task Force on Gender Identity and Gender Variance (2008). *Report of the Task Force on Gender Identity and Gender Variance.* Washington, DC: American Psychological Association. Available online at www.apa.org/pi/lgbc/transgender/2008TaskForceReport.pdf

Bockting, W. (in press). From gender dichotomy to gender diversity: Implications for psychotherapy and the Real Life Experience. *Sexologies.*

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Bockting, W.O., & Goldberg, J.M. (2006). *Guidelines for transgender care*. Double special issue of the International Journal of Transgenderism, 9(3/4), simultaneously published as a volume by the Haworth Press.

Lev, A. (2004). *Transgender emergence*. Binghamton, NY: The Haworth Clinical Practice Press.

Biography:
Walter Bockting is a Licensed Psychologist, Associate Professor, and Coordinator of Transgender Health Services at the University of Minnesota Medical School. A native from the Netherlands, Dr. Bockting has over 20 years of experience in providing direct clinical services to transgender clients and their families. His research interests include transgender health, disorders of sex development, sexuality and the Internet, and the promotion of sexual health. He is Principal Investigator of an NIH-funded study of the sexual health of transgender people and the men with whom they have sex. Dr. Bockting is President-Elect of the World Professional Association for Transgender Health.

THE DSM DIAGNOSTIC CRITERIA FOR GENDER IDENTITY DISORDER IN CHILDREN

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Introduction: The DSM-V Work Group for Sexual and Gender Identity Disorders includes a Subworkgroup focusing on gender identity disorders.

Objective: This talk will review the diagnostic criteria for gender identity disorder (GID) in children from DSM-III through DSM-IV. It will focus specifically on criticisms of the DSM-IV criteria and then discuss proposed options for revision of the criteria set.

Methods: Following a literature review, the hypothesis will be tested that the verbalized wish to be of the opposite sex (measured dimensionally) will be associated with maternal report of degree of surface cross-gender behaviors on the Gender Identity Questionnaire for Children (Johnson et al., 2004) and child report of degree of gender identity confusion on the Gender Identity Interview for Children (Wallien et al., 2008; Zucker et al., 1993).

Results: The results supported the two hypotheses.

Conclusion: Options for reform of the diagnostic criteria for GID in children will be discussed. It will include examples of a revised criteria set that will raise the threshold for the diagnosis and better separate children with gender non-conforming behavior without co-occurring gender dysphoria from children with a GID, at least how this construct is currently conceptualized.

Behavioral Learning Objectives:

After attending this presentation, the participants will be able to:

1. Discuss the contemporary criticisms of the GID diagnosis in children that can be addressed by empirical data.
2. Discuss the options for revision of the diagnostic criteria proposed by the author.
3. Discuss the options for revising the diagnostic criteria in a manner that might reduce the rates of false-positive diagnoses.

References:

Johnson, L. L., Bradley, S. J., Birkenfeld-Adams, A. S., Radzins Kuksis, M. A., Maing, D. M., & Zucker, K. J. (2004). A parent-report Gender Identity Questionnaire for Children. *Archives of Sexual Behavior, 33,* 105-116.

Wallien, M. S. C., Quilty, L. C., Steensma, T. D., Singh, D., Lambert, S. L., Leroux, A., et al. (2008). *Cross-national replication of the Gender Identity Interview for Children*. Manuscript submitted for publication.

Zucker, K. J., Bradley, S. J., Lowry Sullivan, C. B., Kuksis, M., Birkenfeld-Adams, A., & Mitchell, J. N. (1993). A gender identity interview for children. *Journal of Personality Assessment, 61,* 443-456.

Biography:

Dr. Zucker received his PhD in developmental psychology from the University of Toronto in 1982. He is Head of the Gender Identity Service in the Child, Youth, and Family Program at the Centre for Addiction and Mental Health (CAMH) in Toronto, Ontario. He is the Psychologist-in-Chief at CAMH and a Professor of Psychiatry and Psychology at the University of Toronto.

PARAPHILIAS VS. PARAPHILIC DISORDERS, PEDOPHILIA VS. PEDO- AND HEBEPHILIA, AND AUTOGYNEPHILIC VS. FETISHISTIC TRANSVESTISM

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Introduction: The DSM-V Work Group for Sexual and Gender Identity Disorders includes a Subworkgroup focusing on potential changes to the various Paraphilia diagnoses. This brief talk describes four of the options to be considered by that Subworkgroup.

Distinguishing between Paraphilias and Paraphilic Disorders: The Subworkgroup will consider distinguishing between paraphilias and paraphilic disorders along the following lines. A *paraphilia* is any powerful and persistent sexual interest other than that in copulatory or precopulatory behavior with phenotypically normal, consenting adult human partners. A *paraphilic disorder* is a paraphilia that causes distress or impairment to the individual or harm to others. One would *ascertain* a paraphilia (according to actions and self-report, e.g., sexual attraction to amputees or inanimate objects) but *diagnose* a paraphilic disorder (on the basis of distress and impairment). In this conception, having a paraphilia would be a necessary but not a sufficient condition for having a paraphilic disorder. This approach leaves intact the distinction between normative and non-normative sexual behavior, which could be important to researchers, but without automatically labeling non-normative sexual behavior as psychopathological.

Absolute vs. Relative Criteria in Ascertainment: Another issue concerns the quasi-quantitative criteria for ascertaining paraphilias. In DSM-IV-TR, Criterion A for every single paraphilia contains the phrase, "recurrent, intense sexually arousing fantasies, sexual urges, or behaviors." An alternative approach to quantification is based on the notion of paraphilias (like sexual orientations) representing erotic preferences. This approach to quantification was used in the DSM-III diagnostic criteria for pedophilia, for example. Criterion A of DSM-III reads, "The act or fantasy of engaging in sexual activity with prepubertal children is a repeatedly preferred or exclusive method of achieving sexual excitement." Both approaches make implicit comparisons, but with different points of reference. The first approach relates a patient's degree of variant sexual interest to the absence of that interest; the second approach relates a patient's degree of variant interest to his or her degree of normative sexual interest. It is possible that different approaches to quantification would work better for different paraphilias.

Adding a Separate Diagnosis of Hebephilia or Replacing Pedophilia with Pedohebephilia: The DSM-IV-TR defines pedophilia as sexual attraction to prepubescent children. A substantial body of evidence indicates that this definition excludes from diagnosis a sizable proportion of those men whose strongest sexual feelings are for physically immature persons. These are the *hebephiles*, that is, men whose strongest sexual feelings are for pubescent children (roughly, ages 11–14). One possible solution is to add a diagnosis of Hebephilia; another is to replace the diagnosis of Pedophilia with Pedohebephilia and offer three subtypes: Pedophilic, Hebephilic, and Pedohebephilic.

Re-Naming and Re-Specifying Transvestic Fetishism: One option here is to replace the current term Transvestic Fetishism with the DSM-III label—Transvestism—and replace the current specifier, *With Gender Dysphoria*, with two others: *With Fetishism* and *With Autogynephilia*. There is evidence that within the transvestitic population, autogynephilia is associated with a higher risk of gender dysphoria and fetishism is associated with a lower risk of gender dysphoria.

Behavioral Learning Objectives:

After attending this presentation, the participants will be able to:

1. Compare quantification strategies for ascertaining a paraphilia.
2. Define the term *hebephilia*.
3. Discuss the relations of gender dysphoria to autogynephilia and fetishism.

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Biography:

Dr. Blanchard (http://individual.utoronto.ca/ray_blanchard/) received his PhD in psychology from the University of Illinois in 1973. He is Head of Clinical Sexology Services in the Law and Mental Health Program at the Centre for Addiction and Mental Health in Toronto, Ontario and a Professor of Psychiatry at the University of Toronto.

1. FETISHISM: IS THERE SUFFICIENT DATA TO RETURN FETISHISM TO ITS HISTORICALLY BASED DEFINITION?

2. NONPARAPHILIC HYPERSEXUAL DISORDERS: CRITERIA FOR A NEW SEXUAL DISORDERS DIAGNOSIS

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Introduction: As a member of the DSM-V Sexual Disorders Working Group, Paraphilias Subcommittee, I will discuss two independent Sexual Disorders, Fetishism and Nonparaphilic Hypersexual Disorders.

Method: The Medline and PsychInfo databases were searched for empirically-based peer reviewed articles including data on Fetishism and sexual addiction, sexual compulsivity, compulsive sexual behavior, hypersexual, excessive sexual and related search terms. Primary sources, including 19th Century sexology texts, secondary peer-reviewed referenced articles as well as contemporary texts were reviewed for both conditions.

Results and Discussion: 1. Fetishism: For the 100 years prior to DSM-III (1980), the predominant clinically descriptive criteria for Fetishism included preferential sexual arousal to nonliving objects (eg. female undergarments, shoes) and/or body parts (hands, feet) not typically associated with sexual arousal. After DSM-III-R (1987), a new paraphilic diagnosis, Partialism was proposed as "an exclusive focus on part of the body" and placed as a Paraphilia NOS. Recent data since 1990 suggests that fetishistic sexual arousal and behavior in clinical and community samples typically includes significant overlap between fetishism and partialism (especially foot partialists). Based on these more recent publications, a revised definition for Fetishism that includes (for criterion A) both non-living objects and/or body parts is recommended.

2. Nonparaphilic Hypersexual Disorder is a new nosological category offered to subsume and integrate differing putative etiological models (eg. sexual addiction, compulsive sexual behaviors, paraphilia-related disorders, hypersexuality) characterizing nonparaphilic excessive sexual behavior disorders. The scientific justification for this new category and it's a-theortical appellation will be discussed. There will be a brief review of the varying descriptive models that have preceded and contributed to this new diagnostic category. A variety of possible ascertainment scales and measures to assess dimensional severity associated with these conditions will be reviewed. Last, the specific classes of nonparaphilic sexual behaviors subsumed by this diagnostic category will be described.

Limitations/Risks: Making any changes in existing diagnostic criteria or proposing a new diagnostic category for the DSM V must include a thorough and reasoned review of the available scientific literature and then a discussion of such proposals in public/professional settings to obtain feedback.

Behavioral Learning Objectives:

1. Discuss the differing historical definitions and changes in diagnostic criteria associated with the paraphilic diagnosis, Fetishism.
2. Compare various putative etiological assumptions regarding the nature of problematic nonparaphilic hypersexual behaviors and to be familiarized with diagnostic criteria proposed for these clinically significant sexual disorders.

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Biography:

Martin P. Kafka MD is a Distinguished Fellow of the American Psychiatric Association and an Associate Professor of Clinical Psychiatry at Harvard Medical School, Boston MA. He has authored over 30 scientific articles and book chapters describing Axis I comorbidity and pharmacological treatment modalities for paraphilias and nonparaphilic hypersexual disorders.

SEXUAL SADISM AND MASOCHISM
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Introduction: The DSM-V Work Group for Sexual and Gender Identity Disorders includes a Subworkgroup on potential changes to the various Paraphilia diagnoses. This brief talk describes evidence and suggestions for criteria for sexual sadism and sexual masochism in the DSM-V

Reviewing the Criteria for Sexual Sadism and Sexual Masochism: Sexual Sadism has been included in some form in the DSM since its inception, and Sexual Masochism since the second edition of the DSM, yet recent data suggest that these are not being used as diagnoses for billing purposes by psychiatrists or primary care practitioners. Additionally, there is a sentiment that inclusion of these diagnoses in the DSM-V amounts to medicalizing unconventional sexual behavior and, by, including such diagnoses in a manual of mental disorders, pathologizing and stigmatizing those who engage in such behavior. On the other hand, sexual sadism has enjoyed broad usage in forensic contexts and some feel that this, as well as the other paraphilias, are useful diagnoses. Studies reviewing the reliability of these diagnoses will be reviewed and the usefulness or lack thereof of these diagnoses will be discussed, along with a presentation of current recommendations and recommended changes.

Behavioral Learning Objectives:
After attending this presentation, the participants will be able to:
1. Discuss the evolution of the definitions and DSM criteria for sexual sadism and masochism.
2. List the situations where these diagnoses are used.
3. Discuss the pros and cons of inclusion of these diagnoses in the DSM.

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Krueger RB: (2003) A Positive View of Spitzer's Research and an Argument for Further Research. *Archives of Sexual Behavior*. 32:443-444.

Biography:
Richard Krueger, MD is a psychiatrist and Medical Director of the Sexual Behavior Clinic at New York State Psychiatric Institute. He is Vice-President of the New York State Chapter of ATSA. He is an Associate Clinical Professor in the Department of Psychiatry, Columbia University. He received his MD degree from Harvard Medical School and is board certified in forensic and addiction psychiatry. He consults on sex offenders for the New York State Office of Mental Health and his research interests and publications have focused on the psychopharmacological treatment of compulsive and aggressive sexual behavior.

GENDER IDENTITY VARIANTS AND THE DSM
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Introduction: The preparation of the revision of the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association has led to heated debates of the conceptualization of gender identity variants (GIVs) as psychiatric disorders ("gender identity disorders" [GIDs]). Here, we will review the history of the concept, describe the DSM-revision process, outline key issues in the current debate of GID, and point out the pros and cons of some of the options for DSM-V.

Methods: We will draw on recent publications in the scientific literature and materials from scientific societies and activist websites in documenting the history of the GID category, the DSM-revision process, the key issues of the current debate, and the options for the future.

Results: Individuals with GIVs have been documented for a great variety of cultures, and the social response is highly variable, ranging from extreme stigmatization and persecution to acceptance and attribution of special privileges. Western cultures have moved from condemnation on religious grounds to medicalization (as psychopathology), and most recently to increasing acceptance in the general public, leading to the rise of a demand for psychiatric depathologization.

Discussion: The empirical evidence of GIV as a mental disorder per DSM (implying impairment and/or distress) appears insufficient for a clear consensus, and additional studies would be desirable.

Utility/Limitations/Risks: Apart from the need to resolve the question of GIVs as mental disorders in a systematic fashion congruent with the DSM rationale, the possible (albeit largely undocumented) risk of added stigmatization as a side effect of the psychiatric categorization must be balanced against the risk of losing insurance coverage and other benefits, if GIVs are removed from the DSM. Several compromise options will be considered.

Behavioral Learning Objectives:
After attending this presentation, the participants will be able to:
1. Discuss the history of the GID concept in the DSM and the debate of GIVs as mental disorders.
2. Compare the various options for the categorization of GIVs in DSM-V.

References:
American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

American Psychological Association (2008). *Report of the Task Force on Gender Identity and Gender Variance.* Washington, DC: Author.

Biography:
Dr. Meyer-Bahlburg received his Dr. rer. nat. from the University of Düsseldorf, Germany, in 1970 and has been on the faculty in the Department of Psychiatry at Columbia University since 1978. He has been conducting research on the developmental psychobiology of gender and sexuality since the 1970s and has been a member of SSTAR since 1978.

DSM V AND SEXUAL DYSFUNCTION
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Introduction: Since the adoption of DSM IV TR in 2000, there has been an increase in knowledge concerning the sexual dysfunctions. The DSM V Committee on Sexual and Gender Identity Disorders has been charged with reviewing evidence concerning diagnostic criteria for threes disorders. The goal of this presentation is to solicit input from specialists in the area of human sexuality concerning the acceptability of current diagnostic criteria and possible modifications of these criteria.

Method: A subcommittee of the sexual disorders workgroup has been assigned the task of reviewing diagnostic criteria for the sexual dysfunctions. The various diagnostic entities were assigned to each of the four committee members for initial review. This presenter was assigned premature ejaculation and male orgasmic disorder. Medline searches from 1990 to the present were conducted concerning each of these diagnostic entities.

Results: A review of the diagnostic criteria for premature indicates that the current criteria have been criticized for their lack of precision and large reliance on clinician A literature review found that there is a paucity of research concerning diagnostic criteria for male orgasmic disorder. Most of the available literature uses the term ejaculatory delay instead of the term male orgasmic disorder. The literature review of the use of subtypes indicates that the distinction between lifelong and acquires has been commonly adopted by clinicians and clinical investigators .The subtype of global vs. acquired has been less commonly employed. The use of sub typing by etiology (due to psychological factors, due to combined factors) has been criticized as presupposing knowledge about etiology which simply does not exist.

Discussion: Clearly, we need criteria specifying severity and duration for the diagnosis of premature ejaculation. The International Society Sexual Medicine (ISSM) recently proposed that premature ejaculation be defined as ejaculation occurring within or less than one minute of penetration and before the man wishes it. This definition has the advantage of precisely defining homogenous groups for clinical research. It also limits the number of men who would have the stigma of a psychiatric diagnosis. This presenter would appreciate feedback concerning the advantages and disadvantages of adoption of this definition of premature ejaculation. Another issue is whether the name male orgasmic disorder should be changed to ejaculatory delay to reflect current usage. This presenter would also appreciate feedback concerning a proposal to delete subtyping by etiology or to add a subtype labeled idiopathic.

Utility/Limitations/Risks: Any modification of diagnostic criteria may influence reimbursement for clinical services. Also, modification of criteria may limit the usefulness of research using previous criteria.

Behavioral Learning objectives:

After attending this presentation, the participants will be able to:

1. Explain limitations of current diagnostic criteria for premature ejaculation and male orgasmic disorder
2. Discuss the advantages of disadvantages of alternative criteria sets

References:

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Waldinger, M., Hengeveld, M., Zwinderman, A., Oliver, S. (1998). An empirical observational study of DSM –V criteria for premature ejaculation*, International Journal Psychiatry Clinical Practice*, 2, 287-293.

Biography:

Dr Segraves obtained his PhD from the University of London, his MD from Vanderbilt University, and completed his psychiatry residency at the University of Chicago. He is currently professor of psychiatry at Case School of Medicine. He is a past treasurer and president of SSTAR.

RECONSIDERING THE DIAGNOSTIC CRITERIA FOR HYPOACTIVE SEXUAL DESIRE DISORDER IN WOMEN
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Introduction: The DSM-V Work Group for Sexual and Gender Identity Disorders includes a Subworkgroup focusing on sexual dysfunctions. This talk will review the current diagnostic criteria for Hypoactive Sexual Desire Disorder (HSDD) in women as outlined in the DSM-IV-TR, and discuss options for improving the diagnostic criteria that are currently being considered by the sexual dysfunction subworkgroup for DSM-V.

There have been several attempts to improve the existing diagnostic criteria for HSDD in women in recent years. However, some of the proposed changes are not based fully in empirical data and instead, stem from clinical opinion. Moreover, different theoretical models of women's sexual response exist with variable amounts of empirical support for each of them. Some of the issues to be considered in revising the criteria for HSDD include: (1) whether or not absence of sexual fantasies should be included as a diagnostic criterion; (2) whether absence of responsive desire should be a necessary criterion; (3) a discussion of implications for removing the distress criterion; and (4) how relationship factors precipitating and resulting from low desire might be captured. The talk will also provide a review of the literature on subjective sexual arousal, and sexual arousability, and whether or not it is distinct from sexual desire. The implications for incorporating subjective sexual arousal into the diagnostic criteria for low sexual desire will also be considered.

A secondary goal of this talk is to solicit feedback from sex therapists and researchers on the proposed criteria.

Behavioral Learning Objectives:
After attending this presentation, the participants will be able to:
1. Discuss existing concerns over the criteria for HSDD in women and formal attempts to revise the DSM-IV-TR criteria.
2. Discuss some of the options for improving criteria for HSDD currently being considered by the DSM-V subworkgroup committee.
3. Discuss the implications of removing distress from the HSDD criteria.

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Sand, M., & Fisher, W. A. (2007). Women's endorsement of models of female sexual response: The nurses' sexuality study. J*ournal of Sexual Medicine, 4,* 708-719.

Biography:

Lori Brotto has a PhD in clinical psychology from the University of British Columbia (2002) and completed a Fellowship in Reproductive and Sexual Medicine from the University of Washington (2004). She is an Assistant Professor in the UBC Department of Obstetrics and Gynaecology as well as a registered psychologist in Vancouver, Canada. She is the director of the UBC Sexual Health Laboratory where research primarily focuses on developing and testing psychological/psychoeducational interventions for women with sexual desire and arousal difficulties – many secondary to gynaecologic cancers. Dr Brotto trains gynaecology residents and medical students at UBC and teaches an undergraduate course in Human Sexuality. She is Associate Editor for Sexual and Relationship Therapy, and on the Editorial Boards of the Archives of Sexual Behavior, the Journal of Sex and Marital Therapy, and the International Journal of Sexual Health. Dr Brotto is the recipient of a Scholar Career Award from the Michael Smith Foundation for Health Research as well as a New Investigator Award from the Canadian Institutes of Health Research. She is also on the DSM-V Task Force for the Sexual Dysfunctions Subcommittee.

ARE DYSPAREUNIA AND VAGINISMUS DISTINCT DISORDERS?
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Introduction: Dyspareunia and vaginismus are classified as separate "sexual pain" disorders in the DSM IV.

Objective and Method: The literatures and recent data concerning the diagnosis and classification of dyspareunia and vaginismus are reviewed with a view to determining whether these diagnoses can be distinguished from each other and made reliably.

Results: Based on available data, there is no convincing evidence to suggest that the current DSM diagnoses can be made reliably. There is, however, data to suggest significant symptomatic overlap between vagnismus and dyspareunia.

Discussion: Vaginal spasm/tension does not reliably distinguish vaginismus from dyspareunia. Furthermore, a large number of women suffering from vaginismus experience dyspareunia when they achieve vaginal penetration. Alternative categorical and dimensional proposals for the characterization of women complaining of pain during intercourse or the inability to experience vaginal penetration will be discussed. The relative advantages or disadvantages of classifying these women as suffering from a pain disorder or a sexual dysfunction will also be discussed.

Behavioral Learning Objectives:
After attending this presentation, the participants will be able to:
1. Discuss the background to the DSM IV category of sexual pain.
2. Discuss the current difficulties with these diagnoses.
3. Evaluate alternatives to the current classification system.

References:
Binik, Y. M. (2005). Should dyspareunia be retained as a sexual dysfunction in DSM-V? A painful classification decision. *Archives of Sexual Behavior, 34*, 11-21.

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Biography:
Dr. Binik received his PhD in clinical psychology from the University of Pennsylvania in 1975. He is professor of psychology at McGill University and the Director of the Sex and Couple Therapy Service at the McGill University Health Center (RVH).

VESTIBULODYNIA VS. COMPLEX VULVAR PAIN: ARE VARIED FORMS OF VULVODYNIA ASSOCIATED WITH DIFFERENT PSYCHOSEXUAL EFFECTS?

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Introduction: Vulvodynia refers to chronic genital pain in women and is experienced by 15-21% of women in the general population. Provoked Vestibulodynia (PVD) is the most common subtype of vulvodynia, and involves pain that is localized to the vulvar vestibule (i.e., vaginal opening) and triggered by activities such as sexual intercourse. While research has established that PVD is associated with decreased sexual functioning and reduced quality of life, less research has focused on other forms of vulvodynia. The purposes of the current study were: 1) to describe the various pain locations and types of symptoms (i.e., unprovoked, provoked, or mixed) reported by women with vulvodynia; and 2) to examine sexual functioning, sexual satisfaction, relationship quality, and sexual communication among women with vulvodynia in comparison to non-affected women.

Method: This study is part of an ongoing project. To date, 46 women with self-reported PVD (*M* age = 31.13 years; *M* pain duration = 88.17 months) and 46 control women (*M* age = 29.93 years) have participated. In addition, 26 women reported experiencing vulvar pain that was not strictly localized and provoked (*M* age = 35.77 years; *M* pain duration = 96.50 months); we labeled these women as having 'complex vulvar pain'. All women were in current relationships and underwent a telephone screening interview to assess eligibility. If eligible, each participant was provided with a unique login id number for a secure online survey and was asked to complete the following standardized questionnaires: 1) the *Female Sexual Function Index* (FSFI) (Rosen et al., 2000) to assess sexual functioning; 2) the *Golombok-Rust Inventory of Sexual Satisfaction* (GRISS) (Rust & Golombok, 1985) to measure sexual satisfaction and functioning; 3) the *Dyadic Adjustment Scale* (DAS) (Spanier, 1976) to assess relationship quality; and 4) the *Dyadic Sexual Communication Scale* (DSCS) (Catania, 1986) to examine communication with one's partner regarding sexual matters. In addition, women were asked how many times they had engaged in sexual intercourse over the past six months, and, using a Numeric Rating Scale, were asked to rate how important sex was to them.

Results: Of the 26 women with complex vulvar pain, the majority reported experiencing mixed (i.e., both provoked and unprovoked) pain that was both generalized and localized (n = 10), followed by women who experienced mixed and generalized pain (n = 5), mixed and localized pain (n = 5), provoked pain that was both generalized and localized (n = 4), provoked and generalized pain (n = 1), and unprovoked and localized pain (n = 1). In comparison to control women, both women with PVD and those with complex vulvar pain reported significantly reduced sexual functioning and satisfaction, as measured by the FSFI and GRISS, respectively. In addition, women with complex vulvar pain reported significantly lower sexual functioning on the FSFI as compared to women with PVD; specifically, women with complex pain reported significantly more pain and significantly reduced orgasm, lubrication, arousal, and desire. Furthermore, while no significant differences were found between the three groups with respect to overall relationship quality on the DAS or sexual communication on the DSCS, women with pain (regardless of group) reported significantly less

affection with their partners in comparison to control women. Finally, the three groups did not differ significantly in terms of self-reported importance of sex; however, women with PVD and those with more complex pain engaged in significantly less frequent sexual intercourse as compared to control women.

Discussion: This study indicates that women with vulvodynia report various symptoms in terms of pain location and characteristics, and that such pain is associated with reductions in sexual functioning, sexual satisfaction, and affection in one's relationship. This study also suggests that women with more complex pain presentations experience greater decreases in sexual functioning as compared to women with PVD. These results are preliminary, yet support previous research that has established that vulvar pain has a negative impact on sexual functioning. More research is needed to examine the various subtypes of vulvodynia and the role that the various forms of vulvodynia have on women's intimate relationships.

Utility/Limitations/Risks: The results of this study will help clinicians and researchers recognize the various pain presentations that are associated with vulvodynia and the effects that such pain may have on women's functioning. However, the results are limited by the small sample size and self-report nature of the study.

Behavioral Learning Objectives:

After attending this presentation, the participants will be able to:

1. Discuss the different types of pain symptoms that women with vulvodynia may experience.
2. Discuss the impact that PVD and other forms of vulvodynia have on women's sexual and relationship functioning.
3. Discuss the need for further research in this area.

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Spanier, G.B. (1976). Measuring dyadic adjustment: New scales for assessing the quality of marriage and similar dyads. *Journal of Marriage and the Family, 38, 15-28.*

Biography:

Kelly Smith received her B.A. in Honours Psychology from the University of British Columbia (2002) and her M.A. in Clinical Psychology from Queen's University. She is currently completing her PhD in Clinical Psychology at Queen's University under the supervision of Dr. Caroline Pukall. Her research focuses on sexual, relationship, and psychological adjustment among individuals with chronic genital pain conditions. Kelly has been a student member of SSTAR since 2005 and won the SSTAR Student Research Award in 2006.

SELF-REPORTED SEXUAL PROBLEMS IN AMERICAN SEX THERAPISTS
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Introduction: The National Health and Social Life Survey (NHSLS) provided information about the prevalence of self-reported sexual problems that lasted several months or longer in a representative sample of 18-59 year olds in the United States (Laumann et al., 1994). Lindau et al. (2007) presented data on sexual problems in a representative sample of older (57-85 year old) Americans and collected data on how bothered respondents were by their sexual problems. The present study was undertaken in order to determine the prevalence of sexual problems in American sex therapists.

Method: A random sample of 100 members of the Society for Sex Therapy and Research (SSTAR) were targeted. They received mailed notification of the survey and then received an e-mail request to complete the survey on-line. They were assured of confidentiality (no names were collected, minimal demographic information was collected) and, as approved by the institutional review board at the Pennsylvania State University, provided implied consent by completing the survey. The survey asked whether the same seven sexual problems that were assessed by the NHSLS [(1) lack of interest in sex, (2) unable to come to a climax, (3) come to a climax too quickly, (4) experience physical pain during intercourse, (5) not find sex pleasurable, (6) feel anxious about the ability to perform sexually, and (7) erection or lubrication problem] had lasted for several months or more in two different time periods (ever in the respondent's lifetime or in the past 12 months). Thus, the survey provided information about lifetime and current (12-month) prevalence for seven self-reported sexual problems.

Results: Fifty-nine SSTAR members (42 women and17 men; 59% of the target sample) completed the survey. The women ranged in age from 20-29 years to 70 or higher with a modal age in the 50-69 year range. About half had masters degrees and half doctoral (MD, PhD, or EdD) level degrees. The women reported being in clinical practice from 1-9 years to 50 or more years, with a mode in the 20-29 year range. The men ranged in age from 30-39 years to 60-69, with a mode in the 50-59 year range. Almost 95% of the men reported doctoral level degrees. The men reported being in clinical practice from 0 to 30-39 years, with a mode of 20-29 years.

Regarding sexual activity in the past year, 7% of the female therapists and 6% of the male therapists reported no partnered sexual activity, 33% and 31%, respectively, reported some partnered sexual activity once a month or less frequently, and 60% and 62%, respectively, reported partnered sexual activity more often than once a month. With regard to overall satisfaction with one's sexual life in the past year, 33% of the female respondents reported it "not at all" or "slightly" satisfactory, 21% reported it "moderately" satisfactory, and 45% reported it "considerably" or "extremely" satisfactory; the respective percentages for the male respondents were 12%, 50%, and 38%.

Turning to self-report of the seven sexual problems, the female therapists had a median of two lifetime sexual problems and one current problem. For the male therapists the median number of

lifetime problems was one, with a median of zero for current problems. 12% of the female therapists and 41% of the male therapists reported never having experienced any of the seven sexual problems; 21% of the women and 29% of the men reported one lifetime sexual problem; 67% of the women and 30% of the men reported two or more lifetime problems. For sexual problems in the past year, the percentages reporting zero, one, or two or more for the female therapists were 36%, 31%, and 33%; the percentages for the male therapists were 76%, 12%, and 12%.

With regard to specific problems reported, Tables 1 and 2 show the lifetime and 12-month prevalence of self-reported sexual problems for the female (Table 1) and male (Table 2) therapists. Tables 3 (female) and 4 (male) compare the lifetime prevalence of self-reported sexual problems for the sample of therapists to the data from the NHSLS. Table 5 compares the lifetime prevalence of self-reported sexual problems for the female and male therapists.

Table 1: Lifetime vs. 12-month prevalence of self-reported sexual problems for female therapists

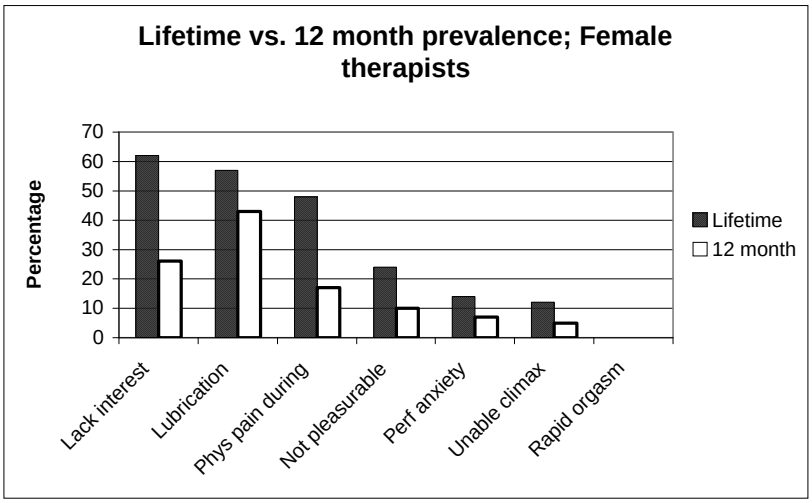


Table 2: Lifetime vs. 12-month prevalence of self-reported sexual problems for male therapists

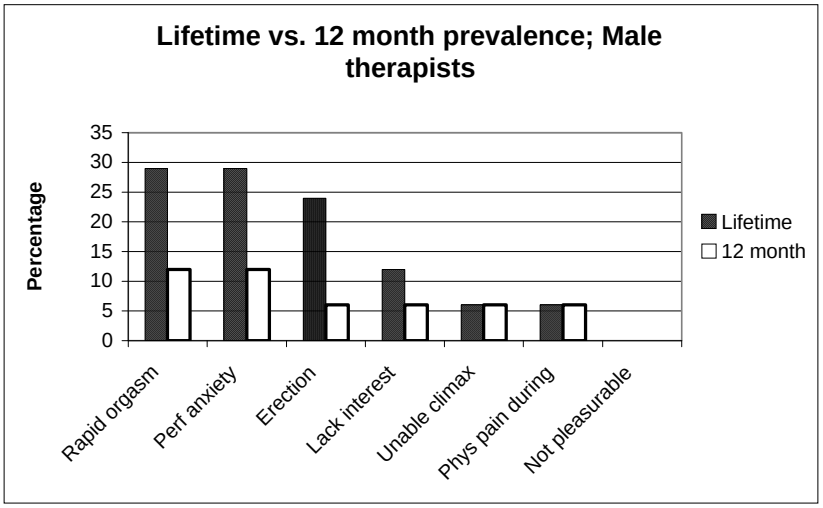


Table 3: Lifetime prevalence rates of self-reported sexual problems in women, sex therapists vs. U.S. population

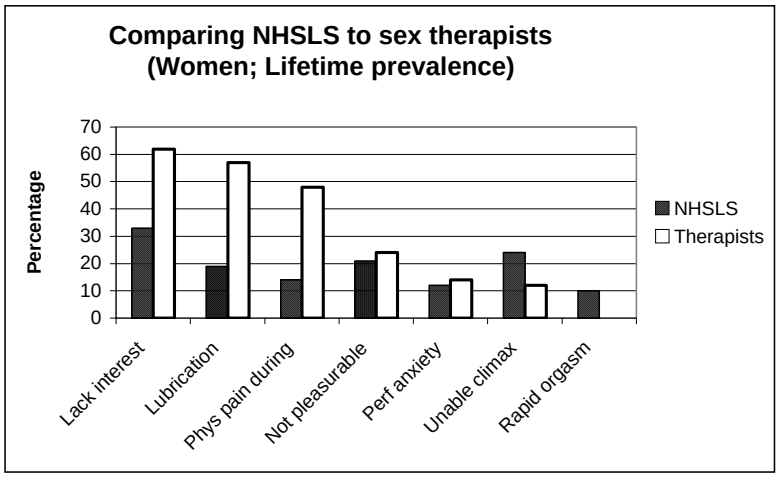


Table 4: Lifetime prevalence rates of self-reported sexual problems in men, sex therapists vs. U.S. population

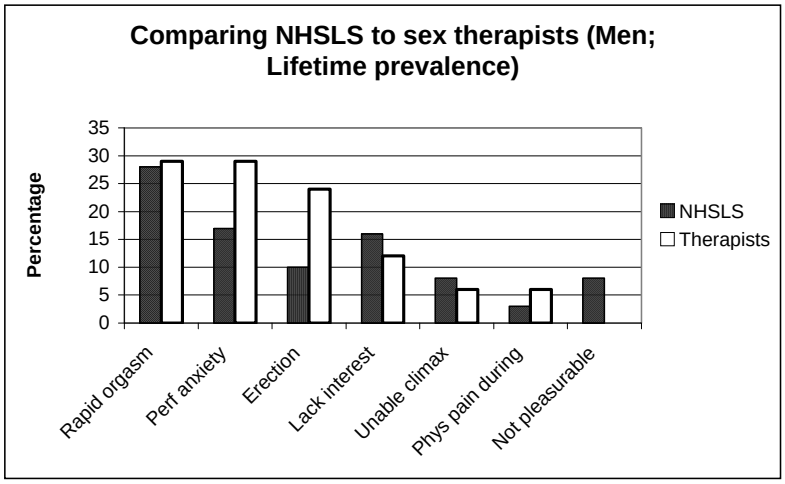
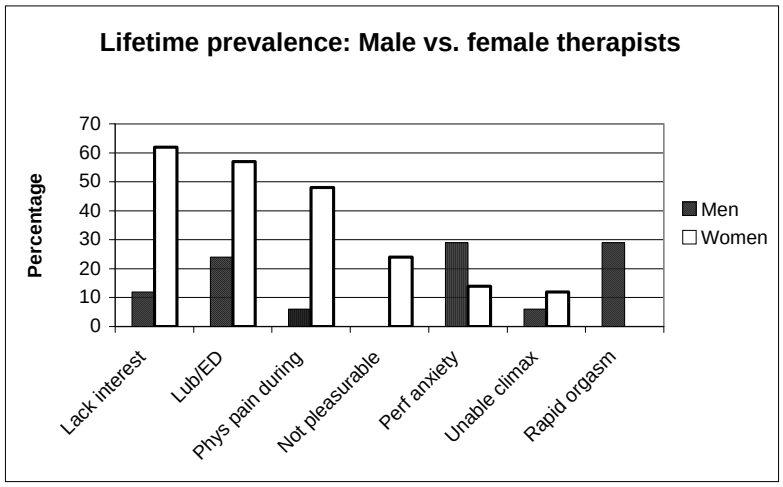


Table 5: Lifetime prevalence rates of self-reported sexual problems: male vs. female sex therapists



Discussion: Being a sex therapist does not buffer one from having sexual problems or being dissatisfied with one's sexual life. The rates of self-reported sexual problems are higher in female therapists than male therapists and are higher in therapists than in the general population. Whether the higher rates of sexual problems in therapists represents a real difference or a difference in threshold and/or expectations will be discussed. Analyses examining demographic correlates with the presence of self-reported sexual problems and of the degree to which sexual problems were bothersome will be presented.

Utility/Limitations/Risks: Less than 70% of the target sample completed the survey, so the sample may not be representative of the target population. Further, the target population −SSTAR members− may not be representative of the larger population of sex therapists in the United States. The sample is only from the United States and thus the results may not be generalizable to other countries. Finally, the sample of male therapists was small ($N = 17$), so the results for them may not be robust. Given all these limitations, the results should be taken as preliminary, awaiting replication by other researchers. At the same time, it is worth noting that these are the first data that examine the prevalence of self-reported sexual problems in sex therapists.

Behavioral Learning Objectives:

After attending this presentation, the participants will be able to:

1. Compare the lifetime and 12-month prevalence of self-reported sexual problems, for male and female sex therapists
2. Compare the lifetime prevalence of self-reported sexual problems between a sample of sex therapists and the general U.S. population
3. Discuss the limitations to generalizing from this sample of sex therapists

References:

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Lindau, S. T., Schumm, L. P., Laumann, E. O., Levinson, W., O'Muircheartaigh, C. A. & Waite, L. J. (2007). A study of sexuality and health among older adults in the United States. *The New England Journal of Medicine, 357*, 762-774.

Biography:

Eric Corty received his PhD in clinical psychology from Indiana University and completed a post-doctoral fellowship in human sexuality at Case Western Reserve University. He is on faculty at Penn State Erie, The Behrend College. He has been a member of SSTAR since the early 1990s.

CONTEMPORARY SEXUAL MEDICINE FOR SEX DYSFUNCTION:
WHAT WOULD HIPPOCRATES DO?
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Ethics as sexual health professionals considers what is principled, right, humane and just. In addressing male and female sexual problems for the 21st century, is the traditional Hippocratic Oath -- "Do no harm" -- sufficient guidance for physicians, psychologists and other healthcare providers? When does "do no harm" impede "helping this person"? How might "do no harm" endorse myopic, limited approaches to care? How do clinicians balance "evidence-based" treatment with personalized treatment?

This presentation (1) examines core traditional principles of ethical medical practice -- beneficence, non-maleficence, autonomy, justice, dignity, truthfulness; (2) describes how contemporary ethical practice of sexual medicine requires an integrative, biopsychosocial approach that integrates medical, psychological, and relational treatments to address the concerns of individuals and couples with sexual problems. While the Hippocratic imperative to "do no harm" is time-honored ethical guidance, integrative, biopsychosocial approaches offer comprehensive, principled and humane guidance.

Ethics as sexual health professionals considers what is principled, right, humane, decent and just. In addressing couple sexual problems for the 21st century, is the Hippocratic Oath -- "Do no harm" -- sufficient guidance for physicians, sex therapists and other healthcare providers?

When does "do no harm" impede "helping this person"? How might "do no harm" endorse myopic, limited approaches to care? How do clinicians balance "evidence-based" treatment with personalized treatment?

This presentation:
(1) offers a simple description of the Greek physician, Hippocrates, often called the "father of medicine" and some relevant features o his approach for today;
(2) reviews several traditional principles at the core of ethical medical practice ("bioethics") and their relevance to sexual medicine:
    a. "beneficence" – the best interest of the patient(s);
    b. "non-maleficence" – balancing risk and benefit and incremental treatment;
    c. "autonomy" – fully informing amidst complexity, and the patient's right to choose or refuse treatment ("informed choice");
    d. "justice" – fairness and equality concerning treatment;
    e. "dignity" – the patient and professional's right to personal respect;
    f. "truthfulness" – freedom from conflict of interest, dual relationships.
(3) discusses how contemporary ethical practice of sexual medicine warrants a comprehensive, integrative, biopsychosocial approach and to effectively integrate medical, psychological, and

relational "tools" currently available to address the comprehensive concerns of couples with sexual problems.

Few medical or psychological problems so clearly offer the clinician not only the opportunity to relieve distress but also to promote personal and relationship health and satisfaction. The unifying, essential, and ultimate purpose of the multiple treatments now available to address SD should be the well-being of the individual and couple. The one-dimensional "medicalization" of some physicians, as well as the one-dimensional "psychopatholgizing" approach of some psychologists to sex problems, risks falling short of fully ethical practice.

What is the ultimate purpose of sexual therapy? Physiological function? Prevention of social detriment? Individual self-esteem? Relationship satisfaction? An integrative approach recognizes that SD is usually a complicated individual and relationship problem which commonly undermines personal and relationship happiness which has detrimental family distress and even negative social consequences. Comprehensive approaches to practice (such as the "good-enough couple sex") attempt to use all available resources – medical, pharmacological, psychological, relational, and psychosexual skills -- to increase function, pleasure, relationship intimacy, and satisfaction.

Behavioral Learning Objectives:

After attending this presentation, the participants will be able to:

1. Discuss the value of using core traditional principles of ethical professional practice to guide clinical and research efforts;
2. Describe basic features of the integrative, biopsychosocial approach to comprehensive sexual care which help incorporate basic features of ethical practice --- such as beneficence, non-maleficence, autonomy, justice, dignity, and truthfulness.

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Biography:

Michael E. Metz, PhD is a psychologist and marital & family therapist in private practice in the Twin Cities of Minneapolis and St. Paul, MN. He earned his PhD with distinction from the University of Pennsylvania, Philadelphia, Pennsylvania, and for 12 years, served on the faculty of the University of Minnesota Medical School, Department of Family Practice. He is the author of more than 50 professional articles, the *Styles of Conflict Inventory* (1993), and three books with Barry McCarthy, *Men's Sexual Health* (2007); *Coping with Premature Ejaculation (*2003), and *Coping with Erectile Dysfunction*, (2004) which received the SSTAR 2007 Best Consumer Sexual Health Book award.

STRATEGIES FOR DEVELOPING A COMFORTABLE, FUNCTIONAL COUPLE SEXUAL STYLE

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As Perel (2006) noted the challenge for serious couples, married or unmarried, straight or gay, is to integrate intimacy and eroticism into their couple relationship. Gottman and Gottman (2008) observed that there is not "one right marital style". There are several functional couple styles, the focus on how partners resolve differences and conflicts. McCarthy and McCarthy (2009) explore strategies to discover a comfortable, functional sexual style with a focus on intimacy and eroticism. Most couples begin as a romantic love/passionate/idealized couple, but this relational phase dissipates within six months to two years. The challenge for serious couples is to develop a sexual style which uniquely integrates each person's "sexual voice" with being an "intimate team". The most common sexual styles by frequency are: 1) Complementary 2) Traditional 3) Soul Mate 4) Emotionally Expressive

The clinician's role is not to decide for the couple, but to help the couple make a "wise" choice based on their preferences, feelings, and values. The clinician urges them to acknowledge and reinforce the strengths of their couple sexual style. In addition, the clinician makes them aware of vulnerabilities ("traps") of their style so they can prevent these or deal with them as acute problems. When couples do change their sexual style as a result of therapy, the most common choice is complementary, in part because it is congruent with the sex therapy model of individual responsibility for sexual desire, arousal, and orgasm which then is integrated into an intimate team approach to desire, pleasure, and satisfaction (McCarthy and Thestrup, 2008).

Behavioral Learning Objectives:

1. Describe each type of sexual style that a couple may exhibit.
2. List at least 3 ways to help a couple adjust their sexual style.
3. List the advantages to a complementary sexual style.

References:

Gottman, J.& Gottman, J (2008). Gottman method couple therapy. In A. Gurman (ed.) Clinical handbook of couple therapy. (4th edition), pp.138-164. New York: Guilford

McCarthy, B & McCarthy, E. (2009). Discovering your couple sexual style. New York: Routledge.

McCarthy, B. & Thestrup, M (2008). Integrating sex therapy interventions with couple therapy. Journal of Contemporary Psychotherapy,38,139-149.

Perel, S. (2006). Mating in captivity. New York: Harper-Collins.

Biography:

Barry W. McCarthy, PhD is a professor of psychology at American University and practices individual, couple, and sex therapy at the Washington Psychological Center. He is co-author of 9 books, including *Rekindling Desire*, 2003; *Coping with Premature Ejaculation*, 2003; *Getting It Right the First Time*, 2004; *Coping with Erectile Dysfunction*, 2004.

IN THE SHADOWS OF THE NET:
ADDRESSING CYBERSEX COMPULSIVITY IN THE CLINICAL SETTING
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This plenary session will provide an overview of basic assessment, management, and treatment planning skills to assist clinicians in working with cybersex compulsive clients more effectively. Audience members will be introduced to techniques for differentiating cybersex users into a theoretical typology, including the separation of healthy cybersex users from problematic users. Basic management techniques and implications for treatment direction will be discussed.

Behavioral Learning Objectives:
After attending this presentation, the participants will be able to:
1. Identify common characteristics of cybersex compulsivity.
2. Describe how to assess and screen for problematic online sexual behavior.
3. Design a program to manage a client's out of control online sexual behavior.

References:
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Delmonico, D. L., & Griffin, E. J. (2005). Sex offenders online: What clinicians need to know. In B. Schwartz (ed.). *The Sex Offender: Issues in Assessment, Treatment, and Supervision of Adult and Juvenile Populations (Volume 5).* Kingston, NJ: Civic Research Institute, 1 – 25.

Biographies:
Dr. David Delmonico is an Associate Professor at Duquesne University where he is director of the Online Behavior, Research, and Education Center (OBREC), and is editor of the Sexual Addiction & Compulsivity journal. He has co-authored *In the Shadows of the Net* and *Cybersex Unhooked.*

Elizabeth Griffin has over 25 years of clinical experience working with sexual offense and sexually compulsive behaviors. She currently serves as director of Internet Behavior Consulting. She has co-authored *In the Shadows of the Net* and *Cybersex Unhooked.*

THE ROLE OF PHYSICAL AND MENTAL HEALTH AND MEDICATION-USE IN SEXUAL FUNCTION AT OLDER AGES

Linda J. Waite, PhD, Aniruddha Das, PhD and Edward O. Laumann, PhD

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Introduction: Little is known about sexual function and sexual problems at older ages. The contributions of mental health problems and of medications prescribed to treat these and other problems have generally been ignored.

Method: We present data from the *National Health and Social Life Project,* a nationally-representative sample of more than 3000 people between the ages of 57 and 85 in 2005-2006. Respondents were interviewed in their homes, with detailed information collected on sexual function, sexual problems, and characteristics of intimate relationships. *NSHAP* obtained a complete log of medications taken. Respondents also completed measures of physical health and function, depressive symptoms, anxiety, stress, happiness, relationship satisfaction, and self-rated mental health. *NSHAP* obtained a weighted response rate of 75.5%.

Results: Poor mental health is consistently and negatively related to sexual function for older men and, more consistently, for older women, increasing the odds of reporting problems such as lack of pleasure from sex, pain during sex, lack of interest in sex, and inability to achieve orgasm. For both men and women, dissatisfaction with one's marriage or intimate relationship strongly predicts reports of sexual problems. Compromised functional capacity lowers both women's and men's reports of sex in the preceding year. We find similar negative associations—with both sexual behaviors and sexual function—for a broad range of medications. These associations are consistent among both genders with antidepressants (especially SSRIs), cardiovascular, respiratory, and gastrointestinal agents, broader among men with CNS agents, antineoplastics, and coagulation modifiers, and among women with topical agents. In contrast, endogenous sex hormones and hormone supplements have a generally positive effect on both genders' sexual outcomes.

Discussion: Sexual behaviors and sexual problems among older men and women seem to respond to the presence of stressors in emotional well-being, physical capacity, and relationship quality. Our results suggest that women are more sensitive than men to these challenges to sexual health. A broad array of medications also have negative associations with both genders' sexual outcomes—a worrying finding given extensive and growing medication use among the elderly.

Utility/Limitations/Risks: The results of this study will help therapists and researchers working with older men and women.

Behavioral Learning Objectives:
After attending this presentation, the participants will be able to:
1. Discuss the sexual function of older men and women and changes in function with age.
2. Discuss the prevalence of sexual problems in older men and women.
3. Explain how to evaluate the role of mental and physical health as well as medication use as causal agents in sexual problems of older patients.

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Lindau, S.T., Schumm, P., Laumann, E.O., Levinson, W., O'Muircheartaigh, C.A., and Waite, L.J. 2007. "A National Study of Sexuality and Health Among Older Adults in the U.S." *New England Journal of Medicine* 357:762-774.

Lue, T., Basson, R., Rosen, R., Guiliano, F., Khoury, S.J., & Montorsi, F.. 2004. *Sexual Medicine: Sexual Dysfunction in Men and Women*. Paris: Health Publications.

Biography:

Aniruddha Das received his PhD from the University of Chicago, and is currently at the National Opinion Research Center (NORC), University of Chicago. His research interests center in the social structuration of the life process, with current projects focused on sexuality and gender, physical and mental health, and biosocial processes. He was associated with the 1999-2000 Chinese Health and Family Life Survey, and is currently affiliated with the National Social Life, Health, and Aging Project (NSHAP). He has published on various aspects of sexuality, including masturbation, sexual harassment, and sexual practices and problems among the elderly.

SEXUAL PLEASURE AND PSYCHOLOGICAL WELL-BEING IN EMERGING ADULTHOOD
Freya Sonenstein, PhD and Adena Galinsky

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Introduction: Sexual health policy documents, the positive psychology literature, youth development theory and sexual script theory all suggest that emerging adults in established heterosexual relationships who experience greater sexual pleasure also experience greater psychological well-being (Eccles, Gootman, IOM & NAS, 2002; Fredrickson & Roberts, 1997; Kan & Cares, 2006; PAHO/WAS, 2001; Peterson & Seligman, 2004; Roth & Brooks-Gunn, 2000; Ryff & Singer, 1996, 1998; Ryff, Singer & Love, 2004; US-DHHS, 2001; WHO 2002). In this study we test the empirical validity of this association using a national population sample

Method: Our sample consists of the (N=3,289) 19 to 25 year old respondents with complete data in the third wave of the National Longitudinal Study of Adolescent Health who were still in a relationship of 3+ month duration with their most recent other-sex sexual partner. Using regression analysis, we examine the associations between sexual pleasure (enjoyment of receiving and performing oral sex, and regularity of orgasm) and four aspects of well-being (empathy, autonomy, self-esteem, and relationship quality) and one measure of the absence of well-being (depressive symptoms), controlling for individual and relationship characteristics.

Results: We find some evidence of covariance, although the associations differ according to the measures examined and along gender lines.

Discussion: We compare these results to those reported in other national studies, as well as those from studies with smaller samples (e.g. Laumann, Gagnon, Michael and Michaels, 1994; Nosek et al, 1993; Tolman 2002). There are many more similarities than discrepancies, and the differences in the samples examined and the measures used largely explain the limited divergent results. We also comment on the relationship between these results and the claim that sexual pleasure is an aspect of positive sexual health.

Utility/Limitations/Risks: The results of this study will help therapists and researchers working with this population, but the results are limited by the measures available in the survey.

Behavioral Learning Objectives:
After attending this presentation, the participants will be able to:
1. Explain the hypothesized links between experiencing sexual pleasure and psychological well-being
2. Discuss the associations between three aspects of sexual pleasure and five aspects of well-being among young adults in established heterosexual relationships
3. Describe how measurement and sample selection impact the reliability and validity of results from studies of sexual enjoyment

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World Health Organization. (2002). *Definition of sexuality, sexual health and sexual rights*. Retrieved 12/12, 2006, from http://www.who.int/reproductive-health/gender/sexual_health.html

Biographies:

Dr. Sonenstein is a professor at the Johns Hopkins Bloomberg School of Public Health and is the Director of the school's Center for Adolescent Health Promotion and Disease Prevention. Previously, she was the Director of the Population Research Center at The Urban Institute in Washington, D.C. Dr. Sonenstein's primary interests include sexual and reproductive health with special emphases on adolescents and males.

Adena Galinsky is a doctoral candidate at the Johns Hopkins Bloomberg School of Public Health and has been working at the Center for Adolescent Health since 2005. Her interests include positive sexual health, the intersections of sexual and psychological health, and the effects of adolescent experiences on sexual health in adulthood.

CIRCUMCISION, UNPROTECTED INSERTIVE AND RECEPTIVE ANAL INTERCOURSE, AND SEXUAL PLEASURE AMONG LATINO MSM

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Introduction: The decreased pleasure experienced by MSM during anal intercourse with a condom in contrast to without a condom remains an important issue in HIV prevention. In a sample of Latino MSM, we examined the impact of biological characteristics of circumcision status and age, and cultural beliefs about male passion, on pleasure of unprotected anal intercourse beyond the pleasure experienced with a condom. Because circumcision status is relevant for a man in the insertive but not receptive role, we hypothesized that this variable would be associated with pleasure only in the prediction of pleasure during insertive sex. In addition, we hypothesized that cultural beliefs emphasizing the force of passion would be related to pleasure of unprotected sex.

Method: Participants were 482 immigrant Brazilian, Colombian, and Dominican MSM in the New York metropolitan area. A quantitative survey was administered using A-CASI with touch-screen responding in the participant's language of choice (Spanish, Portuguese, or English).

Results: The sample for these analyses included those men who reported having had unprotected insertive (N=334) or receptive (N=314) anal intercourse. Regression analysis was performed predicting the pleasure of unprotected insertive anal intercourse from circumcision status, a scale capturing cultural beliefs about male passion, and age. The pleasure of insertive anal intercourse with a condom was included as a control variable. Uncircumcised men and those who endorsed cultural beliefs about male passion reported greater pleasure from unprotected intercourse, after controlling for pleasure of insertive intercourse with a condom.

A parallel analysis was performed for receptive anal intercourse. As predicted, circumcision status was not related to the pleasure of unprotected receptive anal intercourse. Greater endorsement of cultural beliefs was associated with reports of greater pleasure.

Discussion: Uncircumcised men report a greater differential between the sexual pleasure experienced from insertive anal intercourse with and without a condom, suggesting a biological factor that could contribute to decisions about condom use. In addition, cultural scripts concerning sexual passion can shape an individual's experience, and in this study, influenced perceived pleasure of unprotected sex. In understanding motivations for unprotected anal intercourse, it is important to take into account both biological and cultural factors.

Utility/Limitations/Risks: The cross-sectional nature of the study does not allow for causal inferences. Findings can be useful to develop HIV prevention interventions.

Behavioral Learning Objective:
After attending this presentation, the participants will be able to:
1. Discuss the importance of biological factors (i.e., circumcision) and of cultural factors on unprotected anal intercourse among Latino MSM.

References:

Reisen, C. A., Zea, M. C., Poppen, P. J., & Bianchi, F. T. (2007). Male Circumcision and HIV status among Latino immigrant MSM in New York City. *Journal of LGBT Health Research, 3,* 29-36.

Weiss, H.A., Quigley, M.A., & Hayes, R.J. (2000). Male circumcision and risk of HIV infection in sub-Saharan Africa: A systematic review and meta-analysis. *AIDS, 14,* 2361-2370.

Williams, B.G., Lloyd-Smith, J.O., Gouws, E., Hankins, C., Getz, W.M., Hargrove, J., et al. (2006). The potential impact of male circumcision on HIV in sub-Saharan Africa. PLoS Medicine, 3, e262, 1032-1040.

Biography:

Dr. Zea received her PhD from the University of Maryland in College Park in 1990 and has been in the faculty in the Department of Psychology at George Washington University since 1990. She has been conducting research on sexual risk and HIV among Latino gay and bisexual men for the past 10 years. She has been funded by NIMH and NICHD.

THE THEORY OF GENDER AND STIGMA: TRANSGENDER-AFFIRMATIVE TYPOLOGY, TREATMENT, AND RESEARCH

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Introduction: Transgender people are a diverse group of individuals who cross or transcend culturally defined categories of gender. A number of typologies have been proposed to distinguish among the various developmental pathways leading to a request for access to feminizing or masculinizing hormone therapy and/or chest/breast or genital reconstructive surgery. A typology that more recently has gained prominence, yet remains highly controversial, is the typology of homosexual versus nonhomosexual or autogynephilic transsexuals (Blanchard, 1987, 1989). This particular typology will be challenged by an alternative typology grounded in a new theory-in-development proposed by the presenter: *The Theory of Gender and Stigma*.

Method: After critical review of the scientific literature, the Theory of Gender and Stigma will be outlined. Data from qualitative and quantitative research as well as clinical practice will illustrate the influence of gender-related stigma on the development of gender identity, gender role, attachment, sexuality, autonomy, personality, and mental health.

Results: Rather than sexual orientation, childhood gender role nonconformity is postulated as the critical factor in transgender identity development (Bockting & Coleman, 2007). Children who are able to conform outwardly are more likely to express their gender variance in (sexual) fantasy. They present a "false self" to the world and keep their transgender feelings secret, suffering from internal or felt stigma. Children who are outwardly gender role nonconforming (i.e., visibly feminine boys or masculine girls) cannot hide their "true selves," typically come out at an early age, and experience actual rejection, ridicule, and sometimes abuse. Both paths are challenging and can affect overall development and health, yet in very different ways. Instead of an "erotic target location error" (Lawrence, 2007), autogynephilia is viewed as an adaptation to social stigma associated with gender variance.

Discussion: In light of the Theory of Gender and Stigma, the old distinction between transvestites and transsexuals makes room for a transgender identity which development is affected by the social stigma attached to gender variance (Bockting, in press). Contemporary clinical approaches, with children as well as adults, are in line with this theory. Theory-driven hypotheses will be outlined for future research.

Behavioral Learning Objectives:
After attending this presentation, participants will be able to:
1. Discuss several typologies of transsexualism
2. Outline the Theory of Gender and Stigma
3. Explain how the changing paradigm translates into a transgender-affirmative approach to treatment

4. Give an example of a hypothesis for research derived from this new theory.

References:

Blanchard, R., Clemmensen, L., & Steiner, B. (1987). Heterosexual and homosexual gender dysphoria. *Archives of Sexual Behavior, 16*, 139-152.

Blanchard, R. (1989). The concept of autogynephilia and the typology of male gender dysphoria. *Journal of Nervous and Mental Disease, 177*, 616-623.

Bockting, W. (in press). From gender dichotomy to gender diversity: Implications for psychotherapy and the Real Life Experience. *Sexologies.*

Bockting, W., & Coleman, E. (2007). Developmental stages of the transgender coming out process: Toward an integrated identity. In Ettner, R., Monstrey, S., & Eyler, E. (Eds.), *Principles of transgender medicine and surgery* (pp. 185-208). New York: The Haworth Press.

Lawrence, A. A. (2007a). Becoming what we love: Autogynephilic transsexualism conceptualized as an expression of romantic love. *Perspectives in Biology and Medicine, 50*, 506-520.

Biography:

Walter Bockting, PhD is a Licensed Psychologist, Associate Professor, and Coordinator of Transgender Health Services at the University of Minnesota Medical School. A native from the Netherlands, Dr. Bockting has over 20 years of experience in providing direct clinical services to transgender clients and their families. His research interests include transgender health, disorders of sex development, sexuality and the Internet, and the promotion of sexual health. He is Principal Investigator of an NIH-funded study of the sexual health of transgender people and the men with whom they have sex. Dr. Bockting is President-Elect of the World Professional Association for Transgender Health.

'WHAT IS THE WORST THAT COULD HAPPEN?' HETEROSEXUAL & SEXUAL MINORITY WOMEN'S CONCERNS ABOUT PHYSICAL EXAMINATIONS

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Introduction: A great deal of resources are devoted on an annual basis to informing women that it is important for them to take care of their health, and that part of this includes visiting the doctor annually for a physical exam, including a pap smear and cervical examination. Despite the importance of these exams in the early detection of cancer and other serious illnesses, many women are still very reluctant to visit their doctor, dreading the exam as the best case scenario and avoiding it completely as the worst. Sexual minority women report visiting the doctor for a physical examination less frequently than heterosexual women, despite the fact that they are still at risk for cancer and STIs. The current study asked a sample of women to answer the question "What is your greatest concern about visiting a doctor of gynecologist for a sexual health physical?" Quantitative narrative analysis was used to analyze the responses to this question.

Method: Data was collected as part of a larger online survey concerning social support, relationship well-being and health. As part of the study, participants completed the Health & Behaviour Survey, which contains a section on their sexual health habits, such as visiting the doctor for a yearly physical and knowledge of conducting self-breast examinations. In addition, participants were asked to describe their primary concern related to visiting the doctor or gynecologist for a yearly pelvic exam/pap smear. Narrative data was analyzed using thematic coding. Each response was blindly coded for 20 different themes. Reliability coding was also performed.

Results: Of the 514 women who completed the Health & Behaviour Survey, 312 provided information about their primary concern related to visiting the doctor for their annual exam. 64% of these women were heterosexual and 36% were lesbian, bisexual or queer. The main concerns listed included physical discomfort with the examination, confidentiality, the discovery of something wrong (i.e. cancer, sti), body image issues, embarrassment, and concerns about their sexuality (having to come out, having an anti-gay doctor). Sexual minority women were significantly more likely to report their sexuality as the primary concern that would prevent them from having a yearly physical examination and were also more likely than heterosexual women to mention issues related to weight and body image. Heterosexual women were more often concerned with the discovery of something wrong, such as cancer. For the overall sample, reporting a concern related to the physical discomfort of the exam was negatively correlated with overall relationship satisfaction. Results of the Health & Behaviour Survey will also be presented.

Discussion: Implications of the differences based on sexuality, and the overall level of concern related to the yearly physical exam will be discussed with an emphasis on presenting solutions to address the most common concerns of heterosexual and sexual minority women. Directions for future research will also be discussed.

Utility/Limitations/Risks: Sexual health is an important part of all women's lives. Concerns about visiting the doctor of gynecologist for a yearly physical exam appear to be quite common. Therapists and sexual health providers may be able to play a vital role in providing education both to women concerning the importance of the exam and methods of increasing their comfort with the exam, as well as provide information to practitioners on how to properly address the concerns of women, especially sexual minority women.

Behavioral Learning Objectives:

After attending this presentation, the participants will be able to:

1. Describe the different concerns women have with respect to their physical pelvic exam.
2. Discuss the unique concerns of sexual minority women.
3. List advice for practitioners about how to address the concerns of women related to their physical exam.

Biography:

Karen Blair is a PhD Student at Queen's University working in the Sexual Health Research Lab with Dr. Caroline Pukall studying the psychosocial and psychosexual aspects of contemporary couples. Karen completed her master's degree at Acadia University, working with Dr. Diane Holmberg studying the impact of social support for relationships on relationship well-being and health in same-sex and mixed-sex couples.

CO-CREATION OF SEXUAL MEANING OF VULVAR VESTIBULITIS SYNDROME
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Introduction: This qualitative explorative study addressed the sexual and relational issues involved for heterosexual couples dealing with the sexual pain caused by a diagnosis of vulvar vestibulitis syndrome in the female partner.

Method: Participants included 16 couples, 1 married woman, and 2 single women, recruited through the National Vulvar Association in the Northeast and Midwestern United States. Transcendental phenomenology method was utilized (Moustakas, 1994) including semi-structured interviews, phenomenological reduction, and group synthesis.

Results: Couples described 3 strategies for coping with painful vaginal intercourse: (1) becoming non-sexual, (2) using alternative forms of physical intimacy, and (3) altering or enduring painful intercourse. Many women described their sexual lives being affected so that they either no longer had any desire to be sexual or distanced themselves from sexual feelings and behaviors. Alternative forms of physical intimacy included oral sex, cuddling, and outer course. Couples varied in their willingness to experiment and with their satisfaction with these methods.

Discussion: Clinical implications, such as encouraging multiple perspectives on sexual intimacy beyond vaginal intercourse are suggested. Couples' difficulties in broadening their acceptance of various forms of sexual intimacy will be presented, and hypotheses will be discussed.

Utility/Limitations/Risks: Exploring the meaning behind sexuality and vulvar vestibulitis from a systemic perspective will provide clinicians with new insights. A small convenience sample was utilized, therefore limiting the generalizability of the results.

Behavioral Learning Objectives:
After attending this presentation, participants will be able to:
1. Discuss the difficulties couples report when trying to broaden their sexual experiences beyond a focus on vaginal intercourse.

References:
Moustakas, C. (1994). *Phenomenological research methods.* Thousand Oaks: Sage Publications.
Tiefer, L. (2002). Beyond the medical model of women's sexual problems: A campaign to resist the promotion of 'female sexual dysfunction'. *Sexual and Relationship Therapy, 17(2),* 127-135.

Biography:
Dr. Connor completed her PhD in Family Social Science at the University of Minnesota, and is currently on the faculty in the Marriage and Family Therapy Program at St. Cloud State University. She has been practicing marriage and family therapy for over ten years, currently licensed in the state of Minnesota.

MISREMEMBERING THE PAIN: MEMORY BIAS FOR PAIN WORDS IN WOMEN REPORTING SEXUAL PAIN

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Introduction: A debate exists in the literature over whether dyspareunia should be classified as a sexual dysfunction or as a pain disorder. We do not know the extent to which women with this disorder experience it as more of a pain problem, or more of a sexual problem, or both. This study aimed to elucidate whether there was a differential saliency between the pain and sex aspects of dyspareunia by examining memory for pain- and sex-related words in an experimental paradigm.

Method: Twenty women reporting pain during sexual intercourse and 20 women reporting no sexual dysfunction (controls) participated in a memory protocol designed to detect differences as a function of group membership and type of stimulus.

Results: All women had better recall for sex-related words; however, women reporting pain during sex evidenced more false memories for pain words than did control women, and pain words elicited more false memories than any other type of word for women with sexual pain.

Discussion: Results are interpreted to suggest that repeated activation through experience in women with persistent sexual pain may have contributed to 1) the development of stronger semantic networks related to pain than those of no-pain controls, 2) the development of stronger semantic networks for pain than for sex, 3) and activation of pain networks more easily triggered by pain-related stimuli in comparison to no-pain controls.

Utility/Limitations/Risks: This study can help inform cognitive-behavioral treatment for dyspareunia but the results are limited by the experimental nature of the memory test employed.

Behavioral Learning Objectives:

After attending this presentation, the participants will be able to:

1. Explain how experiencing pain during sexual intercourse can affect memory for pain and sex-related words

References:

Binik, Y. M. (2005). Should dyspareunia be retained as a sexual dysfunction in DSM-V? A painful classification decision. *Archives of Sexual Behavior*, *34*, 11-21.

Payne, K.A., Binik, Y.M., Amsel, R. & Khalife, S. (2005). When sex hurts, anxiety and fear orient attention towards pain. *European Journal of Pain, 9*, 427–436.

Biography:

Lea Thaler is a pursuing her doctoral degree in clinical psychology at the University of Nevada, Las Vegas. She received her M.A. from UNLV in 2008. She has been conducting research on female dyspareunia since 2003 and has been a member of SSTAR since 2005.

PERSONALITY AND SEXUAL FUNCTIONING IN COLLEGE WOMEN
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Introduction: There is relatively little information on the relationship between personality disorders and women's sexual functioning. Research suggests that individuals with sexual difficulties are more likely to endorse personality disorder traits (Black, Goldstein, Blum, & Noyes, 1995). Compared with a control group, women with borderline personality disorder report more sexual dissatisfaction (Hurlbert, Apt, & White, 1992). These women also reported more orgasmic dysfunction, although they indicated their spouse had the latter sexual problem. Women with histrionic personality disorder reported less sexual desire and more orgasmic dysfunction compared with a control group (Apt & Hurlbert, 1994). The aim of this project is to investigate the relationships between all personality disorders and women's sexual functioning.

Method: Participants included 262 women from undergraduate Psychology courses at a large southwestern university. Data were included from 121 participants who were younger than 30 years, heterosexual, engaged in sexual intercourse over the past four weeks, had valid Personality Diagnostic Questionnaire profiles, reported subjective health status was fair to excellent, and had not been diagnosed with herpes or endometriosis in the past year. Participants completed a demographic questionnaire, the Female Sexual Function Index (FSFI; Rosen et al., 2000), and Personality Diagnostic Questionnaire (PDQ-4; Hyler, 1994). The average age of the sample was 19.42 (SD = 1.58). Most of the participants were White (80.3%) and had been in a relationship in the past year (91.8%).

Results: With respect to arousal, Avoidant Personality features were related to arousal, r = -.21, p = .02, such that higher scores on the Avoidant scale were associated with more subjective arousal difficulties. More lubrication difficulties were associated with higher scores on the Borderline, r = -.25, p = .007, Histrionic, r = -.28, p = .003, Narcissistic, r = -.23, p = .01, Obsessive Compulsive, r = -.20, p = .03, Avoidant, r = -.21, p = .02, and Negativistic, r = -.24, p = .009 personality scales. More orgasm difficulties were related to higher scores on the Borderline, r = -.19, p = .04, Avoidant, r = -.28, p = .002, and Depressive, r = -.26, p = .004, personality scales. Less sexual satisfaction was associated with higher scores on the Borderline, r = -.26, p = .006, Narcissistic, r = -.18, p = .04, and Avoidant, r = -.21, p = .02, personality scales. Finally, pain was associated with higher scores on the Paranoid, r = -.22, p = .02, Schizotypal, r = -.20, p = .03, Schizoid, r = -.18, p = .04, Borderline, r = -.30, p = .0009, Histrionic, r = -.24, p = .009, Narcissistic, r = -.19, p = .04, Avoidant, r = -.23, p = .01, Dependent, r = -.22, p = .02, and Negativistic, r = -.22, p = .01, personality scales.

Stepwise multiple regression analyses were conducted on personality variables significantly related to areas of sexual functioning. With respect to lubrication, Histrionic Personality, entered in Step 1, accounted for a significant amount of variance, p = .002, R^2 = .09. Avoidant Personality was entered in Step 2 but did not significantly account for variance in lubrication, p = .14, model R^2 = .11. With regard to orgasm, Avoidant Personality was entered in Step 1 and significantly accounted for the variance p = .0008, R^2 = .10. Depressive Personality was entered in Step 2 but did not significantly account for variance in orgasm, p = .09, model R^2 = .12. With respect to sexual satisfaction,

Borderline Personality was entered in Step 1 and significantly accounted for the variance, $p = .007$, $R^2 = .06$. Avoidant Personality was entered in Step 2 but did not significantly account for the variance in sexual satisfaction, $p = .12$, model $R^2 = .08$. With regard to pain, Borderline Personality was entered in Step 1 and significantly accounted for the variance, $p = .002$, $R^2 = .09$.

Discussion: Personality features are associated with many sexual problems experienced by women. Avoidant and Borderline Personality were significantly related to most of the sexual problems. This is consistent with the research of Black et al. (1995), who noted that participants in their study reported personality disorder traits suggestive of "social uneasiness and difficulty in getting close to others… lack of confidence, hypersensitivity to rejection, and boredom" (p. 282). It was interesting that Antisocial Personality was the only personality disorder not associated with any sexual problems. Also, desire was not significantly associated with personality features. In addition to other psychological variables associated with sexual difficulties (e.g., depression, anxiety), researchers and clinicians should also take into account personality variables in their study and treatment of sexual dysfunction. Although the directionality of the relationships cannot be determined, perhaps improvement in interpersonal interactions and relationships will improve sexual functioning.

Utility/Limitations/Risks: The results of this study will contribute to the understanding of how psychological factors relate to women's sexual functioning. The results of this study may not generalize to an older, clinical population.

Behavioral Learning Objectives:

After attending this presentation, the participants will be able to:

1. Describe the relationships between personality and women's sexual functioning.
2. Compare and contrast the relationships different personality features have with areas of sexual functioning.
3. Discuss the implications of personality for sexual functioning.

References:

Apt, C., & Hurlbert, D. F. (1994). The sexual attitudes, behavior, and relationships of women with histrionic personality disorder. *Journal of Sex & Marital Therapy, 20*, 125-131.

Black, D. W., Goldstein, R. B., Blum, N., & Noyes, R. (1995). Personality characteristics in 60 subjects with psychosexual dysfunction: A nonpatient sample.

Hurlbert, D. F., Apt, C., & White, L. C. (1992). An empirical examination into the sexuality of women with borderline personality disorder. *Journal of Sex & Marital Therapy, 18*, 231-242.

Hyler, S. E. (1994). *Personality Diagnostic Questionnaire (PDQ-4)*. New York, NY: New York State Psychiatric Institute.

Rosen, R., Brown, C., Heiman, J., Leiblum, S., Meston, C., Shabsigh, R., et al. (2000). The Female Sexual Function Index (FSFI): A multidimensional self-report instrument for the assessment of female sexual function. *Journal of Sex & Marital Therapy, 26*, 191-208.

Biography:

Dr. Fennell earned her PhD in Counseling Psychology from Texas Tech University in 2008 and is currently a postdoctoral resident specializing in Primary Care Psychology at the Louis Stokes Cleveland VA Medical Center. Her research interests include sexual behavior in partner-violent relationships, women's sexual health, and psychosocial factors associated with physical health and disability.

REFRAMING MENSTRUAL ATTITUDES, BODY CONSCIOUSNESS, AND LOCUS OF CONTROL

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Introduction: Despite the fact that menstruation is a universal experience for women and girls, much of what is taught about menstruation is framed negatively, contributing to the conflicting cultural messages girls receive about their bodies, and maintaining the general societal avoidance of the subject (Costos, Ackerman, & Paradis, 2002; Daniluk, 1998; Diorio & Munro, 2000; Gilllooly, 2004; Kissling, 1996; Stubbs, 2008). Not surprisingly, a significant relationship has been demonstrated between negative menstrual attitudes and body shame for women (Johnston-Robledo, Sheffield, Voigt & Wilcox-Constantine, 2007; Schooler, Ward, Merriwether, & Caruthers, 2005; Stubbs 2008). Relationships have also been found between high levels of premenstrual symptomatology, perceived lack of control, anxiety and depression (Lane & Francis, 2003), and between body image dissatisfaction and external attributions (Furnham & Greaves, 1994). This study was designed to explore the relationships between negative attitudes about menstruation, body shame, locus of control, and multiple sources of menstrual education for women in young adulthood.

Method: Participants included a convenience sample of 50 female students, ranging in age from 18 to 29 years old. The women were enrolled in an introductory psychology course at a large Midwestern University. The women completed the Locus of Control Scale (Levenson, 1981), The Menstrual Attitude Questionnaire (Brooks-Gunn & Ruble, 1980), and the Objectified Body Consciousness Scale (McKinley & Hyde, 1996). Participants also completed a demographic form with an item measuring religious commitment, and significance ratings for a variety of sources of education regarding reproductive health. The participants received academic credit as compensation for their participation.

Results: The women in the study ranked their primary female caregivers, school programs, and friends, as the more important sources of menstrual information. Using stepwise multiple regression, significant relationships emerged between menstruation as a bothersome event and the combination of high body shame, low internality, and low levels of primary caregiver education ($R^2 = 0.397$; adjusted $R^2 = 0.349$). Another stepwise regression with embarrassment about menstruation as a dependent variable, determined that it was significantly related to a combination of high levels of religious commitment, 'other female caregivers' as less significant educators and 'medical professionals' as a more significant source of education about menstruation ($R^2 = 0.394$ and adjusted $R^2 = 0.348$.)

Discussion: The results of this study provide evidence of possible relationships between sources of education about menstruation, negative menstrual attitudes, body shame and locus of control. The means for important sources of education support previous findings that primary female caregivers and school programs are significant sources of menstrual education for girls (Kieren, 1992; Koff & Rierdan, 1995). The combined effects of lower levels of internal control, less parental education, and higher levels of body shame seem to contribute to increased endorsement of menstruation as a

bothersome event. The correlation of these variables is potentially indicative of a sense of frustration these young women experience with menstruation in general. An orientation of low internal control, when combined with a consistently recurring event like menstruation, may place more salience on external sources of information in girls' attitude development, and may create a sense of helplessness (Levenson, 1981). These findings provide further support for the relationship between menstrual attitudes, locus of control, and more pervasive negative body perceptions (Brooks-Gunn & Ruble, 1980; Furnham & Greaves, 1994; Schooler et al., 2005).

Utility/Limitations/Risks: This study highlights important relationships among a breadth of variables in the development of attitudes about menstruation. The implications of these findings for education, clinical practice and research will be addressed during my presentation. It is important to note that this study used convenience sampling in which participants signed themselves up based on course credit for their introductory psychology classes. The number of participants and convenience sampling limit the generalizability of the findings.

Behavioral Learning Objectives:

This presentation will allow participants to:

1. Distinguish the various factors related to negative attitudes about menstruation, and describe the interrelated nature of multiple social influences on adolescent girls' psychological and sexual development
2. Identify the potential impact of salient combinations of factors affecting negative attitudes about menstruation
3. Evaluate the efficacy of different possible programs of prevention and intervention in girls' reproductive health education, and discuss useful methods of building on these research findings

References:

Brooks-Gunn, J., & Ruble, D.N. (1980). The Menstrual Attitude Questionnaire. *Psychosomatic Medicine, 42(5),* 503-512.

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

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Gillooly, J.B. (2004). Making menarche positive and powerful for both mother and daughter. *Women & Therapy*, *27(3/4),* 23-35.

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Kissling, E.A, (1996). Bleeding out loud: Communication about menstruation. *Feminism and Psychology*, *6(4*), 481-504.

Kieren, D.K. (1992.) Redesigning menstrual education programs using attitudes toward menstruation. *Canadian Home Economics Journal,* 42(2), 57-63.

Koff, E. & Rierdan, J. (1995). Preparing girls for menstruation: Recommendations from adolescent girls. *Adolescence*, *30*, 795-811.

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Schooler, D.,Ward, M.L., Merriwether, A., & Caruthers, A.S. (2005). Cycles of Shame: Menstrual shame, body shame, and sexual decision-making. *The Journal of Sex Research*, *42(4),* 324-334.

Stubbs, M.L. (2008). Cultural perceptions and practices around menarche and adolescent menstruation in the United States. *Annals of the New York Academy of Sciences 1135,* 58-66.

Biography:

Emily Polak is a graduate student in her first year of the Counselling Psychology doctoral program at the University of British Columbia. Originally from the Chicago area, she received her M.A. from the University of Minnesota's Counseling and Student Personnel Psychology program, where she conducted the above study under the supervision of Caroline Burke, PhD Currently, working with Judith Daniluk, PhD, she is further examining various topics related to women's reproductive health. Emily is a graduate student affiliate of the American Psychological Association, Division 35: Society for the Psychology of Women, the Canadian Psychological Association, and the Society for Menstrual Cycle Research.

PERSISTENT GENITAL AND PELVIC PAIN AFTER CHILDBIRTH
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Introduction: Although genital and pelvic pain are common and well-documented problems in the early postpartum period (e.g., Declercq, Cunningham, Johnson, & Sakala, 2008), little is known about their course. The few published studies of such pain beyond one year postpartum have focused primarily on the perineum and have not assessed pain onset (Johanson et al., 1993; Schytt, Lindmark, & Waldenström, 2005; Williams, Herron-Marx, & Knibb, 2007). The aim of this study was therefore to investigate the prevalence and characteristics of all types of genital and pelvic pain in the second year postpartum, and to explore risk factors for their persistence.

Method: Over a six-month period, a questionnaire on genital/pelvic pain, sociodemographic and childbirth variables, breastfeeding, and chronic pain history was mailed to patients of the collaborating obstetrician at 12 months postpartum.

Results: Almost half of the 114 participants (82% response rate; M = 14 months postpartum) reported a current (18%) or resolved (26%) episode of genital or pelvic pain lasting 3 or more months. Just under one in ten (9%) mothers continued to experience pain that had begun after they last gave birth. This pain was described at various locations (e.g., vaginal opening and pelvic area), as moderate in intensity and unpleasantness, and most often as burning, cutting, or radiating. Although it was triggered by both sexual and non-sexual activities, none of the mothers affected were receiving treatment. Univariate analyses revealed that only past diagnosis with a non-genital chronic pain condition (e.g., migraine headache) was significantly correlated with i) any history of chronic genital/pelvic pain or ii) the persistence of pregnancy- or postpartum-onset genital or pelvic pain.

Discussion: Postpartum genital and pelvic pain persisted for longer than a year for a significant percentage of mothers in our sample. Contrary to traditional assumptions, pain persistence was not significantly related to childbirth variables or breastfeeding. However, women with a history of other chronic pain appear to be particularly vulnerable to developing persistent genital or pelvic pain, both in general and specifically during pregnancy and after childbirth.

Utility/Limitations/Risk: This preliminary study points to a need for prospective examination of this problem in a larger, more representative study that incorporates gynecological examination, as its results are limited by the non-representative sample and use of a self-report measure. In the meantime, physicians should continue to ask mothers about any genital or pelvic pain beyond the first year postpartum and to make appropriate referrals for pain management and treatment of sexual dysfunction.

Behavioral Learning Objectives:

After attending this presentation, the participants will be able to:

1. Describe the characteristics and correlates of persistent genital and pelvic pain experienced by the mothers in this study.

References:

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Biography:

Laurel Paterson is a PhD student in clinical psychology at McGill University and an intern at the Sex and Couple Therapy Service of the McGill University Health Centre in Montreal, Canada.

AGREEMENT OF SELF-REPORTED AND GENITAL MEASURES OF SEXUAL AROUSAL AMONG MEN AND WOMEN: A META-ANALYIS
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Introduction: The assessment of sexual arousal in men and women informs theoretical studies of human sexuality, and provides a method to assess and evaluate the treatment of sexual dysfunctions and paraphilias (Chivers, 2005). In this meta-analysis, we reviewed research to quantify the extent of agreement between self-reported and genital measures of sexual arousal, to determine if there is a gender difference in this agreement, and to identify moderators of subjective-genital agreement.

Method: We identified 134 laboratory studies reporting a correlation between self-reported and genital measures of sexual arousal, with total sample sizes of 2,530 women and 1,930 men. Studies were coded for the presence of the following moderators; stimulus characteristics (modality, content, length, and variation in sexual stimuli); assessment of self-reported sexual arousal (method of reporting, timing, operationalization); assessment of genital sexual arousal (male methods, female methods, meaningful comparisons between sexes); statistical methods (type of correlation, number of data points); and participant characteristics (e.g., age, use of exogenous hormones).

Results: There was a statistically significant gender difference in the agreement between self-reported and genital measures, with men (r = .659) showing a larger degree of agreement than women (r = .264). Two moderators of the gender difference in subjective-genital agreement were identified: stimulus variability and timing of the assessment of self-reported sexual arousal.

Discussion: The results have implications for research on assessment of sexual arousal, the nature of gender differences in sexual arousal, and models of sexual response: These will be reviewed.

Utility/Limitations/Risks: The results of this study will help therapists and researchers treating and research sexual arousal problems. Results are limited by data collected from laboratory assessment.

Behavioral Learning Objectives:
After attending this presentation, participants will be able to:
1. Explain assessment of genital and subjective sexual response in women and men, the phenomenon of concordance between these measures, and the moderatoring variables

Reference:
Chivers, M. L. (2005). Leading comment: A brief review and discussion of sex differences in the specificity of sexual arousal. *Sexual and Relationship Therapy*, *4*, 377–390.

Biography:
Dr. Meredith Chivers received her PhD in clinical psychology from Northwestern University. She joined the Psychology faculty at Queen's University as a Queen's National Scholar in 2009.

EXAMINING THE RELATIONSHIP BETWEEN THOUGHT CONTENT OF COGNITIVE DISTRACTION, RELATIONSHIP SATISFACTION AND SEXUAL DESIRE

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Introduction: Researchers have established the inhibiting effect of neutral cognitive distraction on the sexual response (e.g., Dove & Wiederman, 2000). Research has also shown the importance of body image (e.g., Seal & Meston, 2007) and relationship satisfaction in regard to sexual desire. The purpose of this study was to further examine the relationship between thought content of cognitive distraction, relationship satisfaction, and sexual desire.

Method: Women viewed 3-minute clips of erotica during which either none, body-image, or neutral distracting sentences are played (counterbalanced). Individuals also viewed 15-minutes excerpts of nature/animal videos to reset emotional and physiological responses. During the erotic video conditions, participants were asked to record their subjective arousal via a potentiometer (lever). Physiological data was collected via labial thermistor during the entire viewing time of the videos.

Results: It was hypothesized that 1) relationship satisfaction moderates the relationship between cognitive distraction and objective and subjective levels of sexual desire and 2) body image related distracting thoughts will lead to lower levels of subjective and objective levels of arousal/desire as compared to nonsexual/neutral distracting thoughts.

Discussion: Implications for understanding the moderating role of relationship satisfaction in regard to body-image and neutral distractive thoughts and sexual desire as well as content of distracting cognitions will be discussed

Utility/Limitations/Risks: The results of this study will help therapists and researchers working with individuals presenting with decreased sexual desire. However, the results are limited by the fact that findings may be specific to the sample used in this study.

Behavioral Learning Objectives:

After attending this presentation, the participants will be able to:

1. Discuss the detrimental effects of distracting thoughts on sexual arousal/desire.
2. Explain the importance of relationship satisfaction on the relationship between cognitive distraction and sexual arousal/desire.

References:

Dove, N. L. & Wiederman, M. W. (2000). Cognitive distraction and women's sexual functioning. *Journal of Sex and Marital Theory, 26*, 67-78.

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Biography:

Verena Roberts is currently a doctoral candidate in the Clinical Psychology Program at Idaho State University. She is interested in furthering knowledge about models of sexual arousal and desire.

UNDERSTANDING SEXUAL DESIRE IN ESTABLISHED RELATIONSHIPS
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Introduction: In recent years, our understanding of the factors that motivate women to engage in sexual activity has been challenged. Previously, it was thought that women engaged in sexual activity because of "spontaneous" sexual desire, as suggested in the linear Human Sexual Response Cycle of Masters and Johnson and Kaplan. However, an accumulation of clinical evidence has instead suggested that women often do not begin a sexual encounter for reasons of sexual desire. Rather, they have "reasons" or "incentives" to either respond to a sexual invitation from their partner or to initiate sexual activity themselves. In the clinical literature these reasons/incentives have been suggested to include: wanting to enhance intimacy with a partner, wanting to please a partner, wanting to feel normal, etc. This has led to the formulation of a new intimacy-based sexual response cycle (Basson, 2002; 2003; 2004) which suggests that women, especially those in long-term relationships, experience "responsive desire" only after they have experienced sexual arousal in a sexual situation. This sexual response cycle has been used over the past decade in the clinical setting and influenced the formulation of new definitions of women's sexual desire and arousal disorders (Basson et al., 2003). However, this sexual response cycle remains to be empirically tested.

Method: 149 women (108 from the community, and 31 clinical patients at the British Columbia Centre for Sexual Medicine) were recruited to complete a questionnaire package comprised of the Golombok & Rust Inventory of Sexual Satisfaction (GRISS; 1986) as well as a four-item measure of responsive desire and a questionnaire measuring reasons for initiating and accepting sexual activity, both of which were developed and piloted by our research team on women seeking treatment for sexual concerns. Participants were required to have been in a committed cohabitating relationship for a minimum of 5 years.

Results: Women from the clinical sample were significantly ($p = 0.001$) more likely than community participants to indicate that their partner was “usually” or “always” the one to initiate sexual activity, and reported less responsive desire ($p = 0.05$). No significant differences were found between groups in the frequency of initiating or accepting requests for sexual activity when the woman had no sexual desire before proceeding to sex. Items most frequently endorsed as reasons for initiating sexual activity were those that related to spontaneous desire (i.e.: “because I felt desire”, because I had sexual fantasies”, “because I was in the mood for sex”), followed by reasons relating to relationship enhancement (i.e.: “to feel emotionally close to my partner”, “to show love”, “to be one with my partner”). There was a significant difference ($p < 0.001$) between the clinical and community group mean scores on items measuring desire to initiate sexual activity. Items most frequently endorsed as reasons for accepting sexual activity were, firstly, those that related to relationship enhancement followed by those related to spontaneous desire.

There was a significant correlation between responsive desire and the GRISS subscales of Dissatisfaction ($p = 0.012$), Avoidance ($p < 0.001$), Non-sensuality ($p < 0.001$) and Anorgasmia ($p < 0.001$).

Discussion: Frequency of accepting and initiating sexual activity without desire was the same for women in both samples, with the clinical sample reporting lower levels of responsive desire and higher rates of partner initiation. Women with higher scores on the Anorgasmia, Dissatisfaction and Non-Sensuality subscales report higher responsive desire, while women with lower Avoidance scores had more responsive desire.

Utility/Limitations/Risks: The clinical sample for this study is relatively small and may not acutely represent this population. Questionnaires were completed retrospectively, asking participants to report their motivations for sexual activity over the past 6 months, which may have caused some inaccurate reflections. Some of the reasons provided on the measure of motivators could be perceived as having low social (i.e.; "to prevent my partner for leaving the relationship", "because I felt an obligation", "because my partner did things without being asked"), which may have caused these items to be endorsed less frequently. Conversely, items that could be perceived as having high social desireability (i.e.; "to show love", "to show affection", "to communicate on a deeper level") may have been endorsed more often.

Behavioral Learning Objectives:

After attending this presentation, the participants will be able to:

1. Discuss the differences between the clinical and community groups in relation to responsive desire
2. Describe the most commonly cited reasons accepting or initiating sexual activity with a partner.

References:

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Golombok, S., & Rust, J (1986). The GRISS Questionnaire. In *Assessment: A Mental Health Portfolio*. D. Milne (Ed). Windsor, England: NFER-Nelson.

Biography:

Yvonne Erskine received her Masters of Education in Counseling Psychology from the University of British Columbia in 2006. She has worked with Dr. Lori Brotto since 2005 as a research coordinator and as a co-facilitator of psychoeducational groups for women with low arousal and desire.

TOWARD A THEORY OF SEXUAL DYSFUNCTION AND INFORMATION DEFICITS AS FACTORS CONTRIBUTING TO SOME PROBLEM SEXUAL BEHAVIORS
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Introduction: Little attention has been paid in the field of sexual offender therapy to the potentially significant contribution of sexual dysfunctions and limited sexuality knowledge to initiation and continuation of harmful sexual behavior. Additionally, few working in sexual dysfunction, motivation, and education fields have addressed how problems in these areas might lead some to consider alternate behaviors that are problematic in contemporary society. Recent theory and research in all these areas provide the material to knit together a theory linking sexual performance and motivation problems to some acts of nonconsensual sex.

Method: Drawing primarily from Ward and Beech's Integrated Theory of Sexual Offending, Wiegel, Scepkowski and Barlow's model of sexual dysfunction, Pfaus and Spiering and Everaerd's sexual motivation theories, and Bandura's self-efficacy theories, as well as case examples from clinical practice, I propose that negative affect associated with prior experiences or mental simulations of perceived sexual inadequacy lead some individuals to seek out satisfaction in ways that avoid the negative mood states, but impinge on the rights of others.

Results: The resulting theory explains some important proximal and ultimate factors in some sexually abusive behaviors, and implies that medical and psychological treatment of dysfunctions, along with education to improve sexual skills, coping, and decision making, can reduce recidivism in some offenders.

Discussion: The theory provides specificity to certain aspects of Ward and Hudson's Integrated Theory, as well as the groundwork for gathering evidence for sexual motivation theories.

Utility/Limitations/Risks: As a theory, this paper has good explanatory power for certain individuals' behavior, and is supported by evidence from several related fields, but difficulties in proving its components (and therefore the whole), and definitional problems of its numerous constructs, limit its immediate utility. Treatment implications include assessing and targeting education, medical, and social/sexual efficacy needs specific to individuals as part of their treatment for abusive sexual behavior.

Behavioral Learning Objectives:
After attending this presentation, the participants will be able to:
1. Discuss pathways from sexual function and knowledge problems to some sexual offenses.
2. Describe the theory linking sexual function and educational deficits, motivation, self-efficacy, and some harmful sexual behaviors.
3. Design more effectively treatment programs for persons with problem sexual behaviors by incorporating the treatment recommendations provided.

References:

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Willis, G., & Grace, R. (2008). The quality of community reintegration planning for child molesters: Effects on sexual recidivism. *Sexual Abuse: A Journal of Research and Treatment, 20*(2), 218-240.

Biography:

Thomas Graves received his M.S. in clinical psychology from Millersville University, and his M.Ed. in human sexuality education from Widener University. He is currently dissertating, studying the interaction of sexuality education deficits and sexual dysfunctions on sexual self-efficacy on sexual offenders. He currently works as a psychotherapist with persons with sexuality problems, including sexual offenders. He also presents sexuality related information to agencies and professionals locally and nationally.

CLASSIFICATION AND REGRESSION TREE ANALYSIS OF VIOLENT OFFENDERS
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Actuarial instruments are now used extensively in violence risk assessment. Nonetheless, most actuarial instruments have shown only modest correlations with violence and only moderate predictive accuracy. Recent advances in the field of risk assessment have enabled researchers to employ statistical methods with higher predictive accuracies.

The present work employs a Classification and Regression Tree (CART) approach to assess risk of violence in male sex offenders. It is demonstrated that CART outperforms two widely-used actuarial instruments (i.e. the Violence Risk Appraisal Guide, VRAG and the Sex Offender Risk Appraisal Guide, SORAG). Specifically, Receiver Operating Characteristic (ROC) and Pearson's r analyses indicate predictive abilities of CART significantly higher than those of VRAG and SORAG. Furthermore, a novel method is proposed to forecast the lowest and highest recidivism risks of each individual. Therefore, an interval of future recidivism risk can be assigned to each individual. Finally, employing the SPSS software, significance of each predictor, analysis of misclassification error and representations of subgroups of individuals are provided.

Behavioral Learning Objectives:
1. Describe how decision tree methods are straightforward to apply and generate high levels of predictive accuracies.
2. Explain how the Classification and Regression Tree (CART) approach can outperform two widely-used actuarial instruments (i.e. VRAG and SORAG).

References:
R.A. Berk, B. Kregler, J.-H. Baek, (2006) Forecasting dangerous inmate misconduct: An application of ensemble statistical procedures. *Journal of Quantitative Criminology, 22*, 131-145.
E.P. Mulvey et al. (2000) A classification tree approach to the development of actuarial violence risk assessment tools. *Law and Human Behavior, 24*, 83-100.

Biography:
Dr. Fedoroff is Vice Chair of the Royal Ottawa Research Ethics Committee, Director of the Integrated Forensic Program Sexual Behaviors Clinic, and Director of Forensic Research Unit at the University of Ottawa Institute of Mental Health Research. He is also Associate Professor of Psychiatry in the Department of Medicine at the University of Ottawa in Canada.

Dr. Fedoroff's primary clinical and research interests are in the assessment and treatment of men and women with problematic sexual behaviors, especially those with intellectual disabilities. He has published extensively in these areas and provided consultation internationally. His publications support the proposition that with modern methods, many criminal sexual problems can not only be treated but also prevented.

SEXUAL PROBLEMS IN BREAST CANCER SURVIVORS: THE RELATIONSHIP BETWEEN MENTAL HEALTH SYMPTOMS AND SEXUAL PROBLEMS

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Introduction: One in eight women in the United States will develop breast cancer in her lifetime. Research shows that approximately 40% of breast cancer survivors experience negative sexual impacts for up to seven years post-treatment. This study examined sexual difficulties in women following cancer treatment to determine if mental health symptoms can predict sexual problems.

Method: We assessed 54 breast cancer survivors' mental health symptoms (SCL-90-R) and sexual problems (Sexual Problem Scale) at two time points, six months apart.

Results: The survivors' mental health remained constant over time, whereas their sexual problems significantly increased 12 to 18 months post-treatment, and then decreased 18 to 30 months post-treatment. Mental health symptoms predicted the presence and severity of sexual difficulties six months later. Specifically, Interpersonal Difficulties and Depression were correlated with most sexual problems. Conversely, lack of sexual pleasure was correlated with almost all mental health symptoms, whereas orgasm difficulties were not correlated with any mental health symptoms.

Discussion: Sexual problems post-treatment do not follow a linear pattern. Our finding that sexual problems peak approximately twelve months post-breast cancer treatment suggests that a woman may not realize the psychological and sexual impact until after treatment finishes. Mental health predicted sexual functioning six months later, which may be due to reduced partner communication and impaired relationships from other mental health problems.

Utility/Limitations/Risks: This study will help professionals to understand the risk factors for sexual difficulties among women with breast cancer. These results are limited by the homogeneous sample.

Behavioral Learning Objectives:

After attending this presentation, the participants will be able to:

1. Describe the pattern between time since breast cancer treatment ended and sexual difficulties.
2. Associate specific mental health symptoms with future sexual difficulties in this population.

References:

Carroll, R.A. & O'Mahoney, J. (1997) Breast cancer and intimate relationships. Journal of the Robert H. Lurie Cancer Center Vol. 6 (2).

Knobf, M. T. (2007). Psychosocial Responses in Breast Cancer Survivors. *Seminars in Oncology Nursing*, *23*(1), 71-83.

Biography:

Beth Fischgrund is a doctoral candidate at Northwestern University Feinberg School of Medicine. She received her BA from New York University in 2002. Her research interests include sexual dysfunctions, paraphilias, HIV and other STIs, and health psychology.

EFFECTIVE SEXUAL RESPONSE AFTER TREATMENT FOR PROSTATE CANCER: THE ROLE OF GRIEF AND MOURNING

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Introduction: One in six men in the United States is diagnosed with prostate cancer each year. While many recover from the illness, up to 80% of men cope with erectile dysfunction as a side effect of the treatment. Research indicates that men find consequent sexual difficulties upsetting and damaging to their self image as men. Men cope by being strong and silent as is dictated by cultural expectations. Partners experience distress and couples do not communicate effectively about their concerns. Only approximately 50% of men seek help for erectile dysfunction and discontinue the use of erectile aids within a year. Reasons for this lack of interest in and withdrawal from sexual recovery is poorly understood. The authors propose that grief and mourning of familiar sexuality are a process that facilitates coping with erectile and sexual dysfunction and promotes help-seeking and sexual recovery.

Method: The authors searched the PubMed database to review the literature on sexual recovery from prostate cancer, and reviewed clinical data of 50 patients who participated in the University of Michigan Prostate Cancer Survivorship Program.

Results: The PubMed review pointed to a men's substantial distress regarding erectile and sexual dysfunction, to parallel distress in partners and disturbances in couples' sexual functioning. Twenty four (48%) of the 50 Prostate Cancer Survivorship Program patients reported some aspects of a grief reaction during their initial, post-prostatectomy psycho-sexual assessment.

Discussion: The literature review indicates that men and partners experience distress about sexual losses, and the clinical data indicate that both men and partners experience a grief reaction in response to their sexual difficulties. The authors suggest that when men and partners are unable to process grief and mourn the losses, they are unable to problem solve sexual difficulties and develop a new sexuality together. They withdraw from the sexual recovery process and do not use available help. Grief and mourning are significant aspects of sexual recovery from prostate cancer. Interventions by sex therapists should include exploration of grief related to loss of familiar sexual functioning and sexual identity. The grief process and the development of new sexual functioning and sexual identity are entwined and forward moving.

Utility/Limitations/Risks: This is a practical model that can easily be adapted by sex therapists in a variety of settings. It is currently a theoretical model based on literature review and clinical data. It would benefit from empirical validation in the future.

Behavioral Learning Objectives:

After attending this presentation, the participants will be able to:

1. Explain the importance of a psychosexual evaluation of men and partners after prostate cancer treatment.

2. List reasons for including partners in the assessment and treatment of men's sexual dysfunction after prostate cancer treatment.
3. Discuss and integrate into sex therapy treatment the role of grief and mourning in sexual recovery after prostate cancer treatment.

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Biography:

Sallie Foley, MSW has been a sex therapist and educator since 1985. She is an adjunct professor in the School of Social Work at the University of Michigan and Director of the *center for sexual health*, University of Michigan Health Systems. She has authored and co-authored books, chapters, and articles on the subject of the treatment of sexual dysfunction. She has been a member of SSTAR since 1998.

PSYCHOEDUCATION AS A BRIEF INTERVENTION FOR SEXUAL SIDE EFFECTS OF SELECTIVE SEROTONIN REUPTAKE INHIBITORS: THE ROLE OF MEDICATION ATTRIBUTION

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Introduction: While education about sexual side effects (SSE) of medications is an important part of doctor-patient communication, some doctors do not present SSE for fear that it may increase the patient's expectation of experiencing those SSE (Ong, deHaes, Hoos, & Lammes, 1995) or change a patient's interpretation of previously existing symptoms as resultant from their medication (Morris & Kanouse, 1982). This study tested the efficacy of an online psychoeducational intervention on SSE of selective serotonin reuptake inhibitors (SSRIs), investigated the effect of presentation style of information on medication attribution and patient experience of SSE.

Methods: 92 SSRI users experiencing sexual dysfunction (14 % male, 86% female) were recruited online to fill out a 2 session survey. In the first session, participants completed a questionnaire on SSRI use, sexual functioning and satisfaction, and attribution of sexual symptoms to SSRIs. Participants then received one of three online psychoeducational interventions: the High Attribution intervention, which emphasized the role of SSRIs in causing SSE; Low Attribution, which de-emphasized the likelihood of an SSRI directly causing SSE; or the Neutral condition, which made no explicit links between SSRI use and sexual symptoms. Participants filled out a follow-up survey two weeks later.

Results: There was a significant correlation between change in sexual dysfunction scores and change in medication attribution (r = 0.238, p <0.05), indicating that those who changed in attribution towards attributing sexual problems to their SSRI medication were less likely to report sexual dysfunction. This was not due to a change in satisfaction, as there was not a significant relationship between change in sexual satisfaction scores and change in medication attribution scores (r = 0. 083, p = *ns*). However, there was no significant difference in medication attribution change between the three conditions, indicating that the framing condition had no effect on shifting attributions.

Discussion: It was shown that medication attribution is an important factor in patient education about side effects. Namely, shifting a patient's focus from external (medication) factors to internal (personal) factors changes their experience of those side effects. Moreover, the method of presentation of educational information was not as important as the patient's interpretation of that information.

Utility/Limitations/Risks: While these findings have important implications for education about the potential sexual side effects of antidepressant medications, it is unknown if they will extend to communication doctor-patient relationships.

Behavioral Learning Objectives:

After attending this presentation, the participants will be able to:

1. Define *medication attribution* and discuss the ongoing debates about this concept
2. Identify potential benefits of psychoeducation about sexual side effects of medications
3. Discuss the impact that medication attribution plays in sexual side effect psychoeducation

References:

Ong, L. M. L., de Haes, J., Hoos, A. M., & Lammes, F. B. (1995). Doctor-patient communication: A review of the literature. *Social Science & Medicine*, *40*, 903-918.

Morris, L. A., & Kanouse, D. E. (1982). Informing patients about drug side effects. *Journal of Behavioral Medicine*, *5*, 363-373.

Biography:

Ms. Ahrold is a doctoral graduate student in the Clinical Psychology department at the University of Texas at Austin since 2006. Her work in SSRI-related sexual dysfunction began upon entering graduate school and is currently ongoing, so please feel free to contact her regarding collaboration or for suggestions on future directions.

TRAINING AND EXPERTISE AMONG SEXUAL HEALTH PROFESSIONALS: AREAS FOR FUTURE DEVELOPMENT

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Introduction: As noted by Apt, Hurlbert, and Clark (1994), there is little research on professionals who do research, education, or therapy in human sexuality. Professional work in sexual health remains a marginalized specialty, which might make it challenging to receive proper training. Poor training can lead to substandard professional work and make it difficult to find employment. Moreover, if training in sexual health is too difficult to obtain, fewer individuals will be able to enter the field. These educational issues prompt two questions: How do sexual health professionals gain their training in sexual health? Is there evidence that fewer individuals are entering the field? In addition to these issues, given the esoteric field of sexual health and the broad nature of human sexuality, it seems likely that there are topics in sexuality that may be neglected in sex research, education, and therapy. Thus, what aspects of human sexuality do sex researchers, educators, and therapists address the most? Are there neglected topics in human sexuality? To nurture the life of sexual health as a professional field and contribute to well-being of individuals, relationships, families, and communities, it is important to understand the training and expertise of sexual health professionals.

Method: Participants were recruited if they were a member of at least one sexual health organization. With the permission of each sexual health organization, members of the organization were contacted individually via e-mail and invited to participate in an internet-based survey via SurveyMonkey.com.

A representative sample of individuals belonging to SSSS (257 of 597, 43%) and SSTAR (71 of 177, 40%) were obtained, but not HBIGDA (71 of 400, 17.8%) or ISSWSH (77 of 710, 10.8%). A final sample of 500 participants was obtained. Participants ranged in age from 21 to 84 with a mean age of 49.76 (SD = 12.59). The majority of the participants were female and professionals (non-students). Most professionals had a PhD or an MA, with fewer reporting an MD or another degree. Although over half of the sample reported that they have a license, less than half reported having certification in some area.

Results: Of the 500 individuals who completed the survey (mean age = 50 years), most were non-students (84%) and female (56%). A representative sample was garnered from only two of these organizations, both of which have a reputation for valuing sex research.

About 36% definitely planned to do work in sexuality, but another 35% denied having made such plans. Planning to do work in sexuality was associated with satisfaction in training. Most respondents (67%) did not complete an internship that involved some type of sex-related work and even more (82%) denied completing a post-doctoral program that involved sex research, therapy, or education. A significant portion of training in sexuality occurs without a mentor as reported by these participants and most report varying degrees of difficulty in achieving their training. The most

common reason for working in a sex-related field was personal interest in the topic. Work experience was another influence, but fewer individuals noted a class or teacher as motivators. Participants reported doing more work in sex therapy than in sex education or sex research. Female and male sexual dysfunction receive more professional attention at the expense of specialized topics (Wylie, de Colomby, & Giami, 2004).

Discussion: The data suggest that a large percentage of sex professionals are engaged in therapy services. Male and female sexual dysfunctions were dominant areas of expertise for most professionals. There are several areas of sexuality that appear to be neglected by sex professionals, including prostitution, sex offenders, and infertility. Other neglected topics include sexuality as it relates to spirituality, legal issues, and persons with a disability. Overall, the data suggest that the field of sexuality is filled with active professionals and is not in danger of "drying up." Yet, there appear to be notable problems in the training of sexual health professionals. In addition, sexual health professionals may not be covering the breath of sexual issues faced by various segments of society. Suggestions for further developing the field are offered.

Utility/Limitations/Risks: The results of this study will help educators and therapists create better training programs for sexual health professionals and increase the diversity of work in sexuality. However, the results are limited by the non-representative sample size and self-report nature of the study.

Behavioral Learning Objective:

After attending this presentation, the participants will be able to:

1. Name three trends or problems in the current training and expertise of sexual health professionals.

References:

Apt, C., Hurlbert, D. F., & Clark, K. J. (1994). Neglected subjects in sex research: A survey of sexologists. *Journal of Sex and Marital Therapy, 20,* 237-243.

Wylie, K. R., de Colomby, P., & Giami, A. J. (2004). Sexology as a Profession in the United Kingdom. *International Journal of Clinical Practice, 58,* 764-768.

Biography:

Brian Zamboni, PhD is a certified sex therapist and certified sex educator via AASECT. He provides sex therapy as a faculty member at the Program in Human Sexuality, University of Minnesota. He teaches undergraduate and graduate courses in human sexuality, helps train medical students, and trains other health or helping professionals via workshops and seminars. In addition to conducting research, Brian reviews sex research for publication in several journals.

INCORPORATING SEXUALITY TRAINING INTO GRADUATE MEDICAL EDUCATION CURRICULUM: THE SUMMA HEALTH SYSTEM MODEL

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Introduction: Studies show that more than 90% of patients believe it is the physician's responsibility to address sexual issues. However, for a variety of reasons, many physicians rarely or never ask about sexual function or concerns. In a climate where many academic institutions are cutting sexuality training programs, or, more likely, have none at all, Summa Health Systems is committed to incorporating sexuality training into six medical residency programs. We have begun this process by developing a pilot program for the delivery of sexuality training in several of our hospital-based residency programs. The goal of this pilot program is to increase the comfort and knowledge base of resident physicians when addressing patients' sexual concerns, as well as increase rates of screening for sexual problems.

Method: Utilizing a multidisciplinary team approach we have developed and delivered a curriculum that contains both general theory, which is applicable across all programs, and customized content relevant to each individual specialty. Baseline attitude and knowledge of the residents are measured pre-delivery and post-delivery of curriculum by utilizing Rosen et al.'s *Sexual Communication Skills in Residency Training* questionnaire.

Results: The initial delivery of this curriculum is being taught in the Obstetrics/Gynecology, Psychiatry, and Geriatric Residency Programs. Family Practice, Internal Medicine, and Urology will also participate in the pilot program. Based on the current literature we expect the following results:

- Increased awareness and recognition of common sexual problems
- Increased comfort and skill in taking a sexual history
- Increased understanding of the role of specialist evaluation and consultation for sexual problems

Discussion: Sexual health education is an often neglected, yet important part of residency training. We are faced with an alarming increase of STDs in the elderly. Adolescents are engaging in risky sexual behaviors at disturbing rates. Nearly one third of men and nearly one half of women experience sexual problems. Most physicians feel unequipped to adequately address patients' sexual concerns. We must prepare physicians during residency to comfortably discuss sexual issues with patients as part of their standard protocol.

Utility: Other hospitals and training centers can incorporate similar programs into their curriculum with the expectation that it will:

- reduce barriers around discussing sexual issues with patients
- improve patient satisfaction
- increase detection of sexual and non-sexual conditions

Limitations: Time-consuming, requires cooperation on an institutional scale, existing institutional and faculty attitudes, as well as lack of knowledge, may hinder initial acceptance of the curriculum.

Behavioral Learning Objectives:

1. Identify current trends of sexual health curriculum in graduate medical education.
2. Discuss how Summa Health System incorporated sexuality curriculum into graduate medical education.
3. Explain preliminary results of the impact of the sexuality curriculum on resident physicians' knowledge base and clinical interviewing style.

References:

Laumann, E, Paik, A., Rosen, R. (1999). Sexual dysfunction in the United States: prevalence and predictors. *JAMA, 281,* 537-544.

Marwick, C. (1999). Survey says patients expect little physician help on sex. *JAMA, 281,* 2173-2174.

Nusbaum, M., Hamilton, C. (2002). The proactive sexual health history. *American Family Physician 66:9,* 1705-1712.

Parish, S., Clayton, A. (2007). Sexual Medicine Education: review and commentary. *J. Sex Med, 4*, 259-268.

Rosen, R., Kountz, D. Post-Zwicker, T. et al. (2005). Sexual communication skills in residency training: The Robert Wood Johnson Model. *J. Sex Med, 3,* 37-46.

Biography:

Kimberly Resnick Anderson, LISW is Director of the Summa Center for Sexual Health. She teaches in the Departments of Psychiatry and OB/GYN through Northeastern Ohio Universities College of Medicine. She is an adjunct instructor at Case Western Reserve University in Cleveland Ohio. She developed the sexual health curriculum for this study and provided all of the training. She speaks locally and nationally on a variety of sexual topics. She has been a member of SSTAR since 1993.

CULTURE-LINKED AFFECTIVE REACTIONS TO FIRST SEXUAL INTERCOURSE

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Introduction: Studies of ethnic differences in sexual behaviour have consistently found that individuals of East Asian (Chinese, Japanese, & Korean) descent experience their sexual debut at a later age and that among adolescents and university convenience samples, East Asian individuals are significantly less likely than their Caucasian counterparts to have engaged in sexual intercourse. In contrast to the large body of literature on sexual behaviour, to our knowledge there has been no research examining cultural differences in affective reactions to first intercourse. This paucity of research on the emotional aspects of sexuality has led to an inadequate understanding of cultural disparities in sexual health, of which emotional well-being comprises an integral part. The lack of empirical evidence also has clinical implications as the emotional and cognitive dimensions associated with first intercourse are often a target in assessment as they are thought to affect later sexual function.

In addition to examining ethnic differences in affective responses to first intercourse, this study will also investigate the potential effects of acculturation on affective reaction to the first intercourse experience. Acculturation is the process whereby values of the new culture (Mainstream, or Canadian, culture) are incorporated into one's self-identity and culture of origin (Heritage culture). With rapidly increasing ethnic diversity, and much of that diversity being due to immigration, it is essential to improve the understanding of how acculturation impacts sexuality.

The purpose of the current study was to examine the effects of culture on how women respond to their first intercourse experience, firstly by comparing reactions between East Asian and Euro-Canadian women, and secondly by studying the effects of acculturation on these reactions among the East Asian women.

Method: Euro-Canadian (n = 112) and East Asian (n = 155) female university students completed questionnaires online which included a measure of acculturation and a measure of affective reactions to first intercourse that was developed for this study. Of these women, 89 of the Euro-Canadian and 74 of the East Asian women had engaged in sexual intercourse at least once and thus only data from these women were included in statistical analysis.

Results: East Asian women reported significantly more negative affect in recalling their first intercourse experience, including feeling sad, guilty, exploited, nervous, tense, embarrassed and afraid. The East Asian women were also significantly less excited than the Euro-Canadian women after their sexual debut. In addition, the 2 groups significantly differed in the extent to which they regretted losing their virginity to their first intercourse partner, with the Euro-Canadian women expressing less regret. Among the East Asian women, higher Mainstream acculturation was significantly correlated with increased planning for the first intercourse experience. Heritage acculturation was significantly and positively correlated with sadness, embarrassment and regret following sexual debut.

Discussion: The current study sheds light on cultural differences in emotional reactions to the experience of first intercourse. Findings supported our hypothesis that the East Asian women would experience more negative affect than the Euro-Canadian women, and that continued affiliation with the Heritage culture among the East Asian women would be associated with more negative affect.

Utility/Limitations/Risks: The findings have clinical implications as first intercourse is a formative sexual experience that may affect later adult sexual functioning. Our results may be limited by our use of a university convenience sample, as well as by our use of a non-validated questionnaire to assess affective reactions to first intercourse.

Behavioral Learning Objectives:

After attending this presentation, the participants will be able to:

1. Discuss the impact of culture on emotional reactions to sexual debut.
2. Explain the importance of taking into account acculturation (not just ethnic differences) in studying cultural influences on sexuality.

References:

Abramson, P. R., & Imai-Marquez, J. (1982). The Japanese-American: A cross-cultural, cross-sectional study of sex guilt. *Journal of Research in Personality, 16,* 227-237.

Guggino, J. M., & Ponzetti, J. J., Jr. (1997). Gender differences in affective reactions to first coitus. *Journal of Adolescence, 20,* 189-200.

Ryder, A. G., Alden, L. E., & Paulhus, D. L. (2000). Is acculturation unidimensional or bidimensional? A head-to-head comparison in the prediction of personality, self-identity, and adjustment. *Journal of Personality and Social Psychology, 79*, 49-65.

Woo, J. S. T., & Brotto, L. A. (2008). Age of first sexual intercourse and acculturation: Effects on adult sexual responding. *The Journal of Sexual Medicine, 5,* 571-582.

Biography:

Jane Woo received her MA in Economics from the University of British Columbia in 2002. She decided early in her banking career that her true interest lay in how culture impacts sexuality and has been conducting research in this area since 2005. She is currently enrolled in the PhD program in Clinical Psychology at the University of British Columbia under the supervision of Dr Brotto. She has been a member of SSTAR since 2007.

THE ROLE OF SEX GUILT IN TESTICULAR CANCER SCREENING IN EAST ASIAN CANADIAN MEN

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Introduction: Although a number of studies have examined testicular cancer screening practices among various ethnic groups, little empiric attention has focused on these practices among East Asian (Chinese, Japanese, Korean) men. If diagnosed while the cancer remains localized to the testis, testicular cancer has a survival rate of approximately 95%. However, because the etiology of testicular cancer is currently not well understood, primary prevention is not possible and successful treatment outcomes appear to depend on early presentation. With the rapidly growing East Asian population in North America and the well-documented lower rates of preventive health practices among individuals of East Asian descent, there is growing urgency to better understand the prevalence of both testicular self-examination (TSE) and physician-conducted testicular examination (PTE) among East Asian men. In addition, although an early study by Abramson & Imai-Marquez (1982) found that sex guilt was significantly higher in Japanese Americans compared to Caucasian-Americans, the role of sex-related guilt has never been explored in the context of culture-linked influences on testicular cancer screening. The purpose of the current study was twofold: (1) to empirically explore the rates of testicular cancer screening in Euro-Canadian and East Asian-Canadian men, and (2) to examine the impact of sex guilt on TSE and PTE, practices that necessitate physically inspecting a sexual part of the body.

Method: Euro-Canadian (n = 35) and East Asian-Canadian (n = 30) male university students completed measures online which included: sexual function, sex guilt, reproductive health knowledge, and rates of self- and physician-conducted testicular examinations.

Results: Euro-Canadian men had significantly higher levels of sexual functioning, significantly lower levels of sex guilt and a broader repertoire of sexual activities. Euro-Canadian men were also significantly more likely to have conducted TSE and to have undergone PTE. Sex guilt mediated the relationship between ethnicity and PTE, in that East Asian men with higher levels of sex guilt were significantly less likely to perform PTE. However, sex guilt did not mediate the relationship between ethnicity and TSE.

Discussion: The finding that rates of TSE and PTE are significantly lower in the East Asian-Canadian group is consistent with a large body of literature showing that individuals of East Asian descent engage in fewer preventive health behaviours. The finding that the relationship between ethnicity and PTE is mediated by sex guilt whereas the relationship between ethnicity and TSE is not mediated by sex guilt suggests that sex guilt may prevent testicular cancer screening only when a third party such as a physician is conducting the examination. Thus, sex guilt is an important variable to consider when attempting to understand preventive reproductive health behaviours in cultures that hold conservative sexual norms.

Utility/Limitations/Risks: The results of this study will help physicians better understand barriers that patients may experience in seeking reproductive health care, but the results may be limited by our use of a university convenience sample.

Behavioral Learning Objectives:

After attending this presentation, the participants will be able to:

1. Describe the importance of taking culture into account when studying sexuality in different cultures.
2. Compare the impact of sex guilt on testicular cancer screening behaviour in East Asian-Canadian and Euro-Canadian men.

References:

Abramson, P. R., & Imai-Marquez, J. (1982). The Japanese-American: A cross-cultural, cross-sectional study of sex guilt. *Journal of Research in Personality, 16,* 227-237.

Brotto, L. A., Woo, J. S. T., & Ryder, A. G. (2007). Acculturation and sexual function in Canadian East Asian men. *Journal of Sexual Medicine, 4,* 72-82.

Courtenay, W. H., McCreary, D. R., & Merighi, J. R. (2002). Gender and ethnic differences in health beliefs and behaviours. *Journal of Health Psychology, 7,* 219-231.

Meston, C. M., Trapnell, P. D., & Gorzalka, B. B. (1998). Ethnic, gender, and length-of-residency influences on sexual knowledge and attitudes. *The Journal of Sex Research, 35*, 176-188.

Ryder, A. G., Alden, L. E., & Paulhus, D. L. (2000). Is acculturation unidimensional or bidimensional? A head-to-head comparison in the prediction of personality, self-identity, and adjustment. *Journal of Personality and Social Psychology, 79*, 49-65.

Biography:

Jane Woo received her MA in Economics from the University of British Columbia in 2002. She decided early in her banking career that her true interest lay in how culture impacts sexuality and has been conducting research in this area since 2005. She is currently enrolled in the PhD program in Clinical Psychology at the University of British Columbia under the supervision of Dr Brotto. She has been a member of SSTAR since 2007.

ACCULTURATION AND SEXUAL PSYCHOPHYSIOLOGY TESTING IN ASIAN CANADIAN WOMEN

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Introduction: There is a wealth of research showing that individuals of East Asian descent hold sexually conservative attitudes by Western norms. Recent studies have revealed the importance of exploring acculturation when investigating sexuality in East Asian individuals, and sexual attitudes have been shown to be a barrier to Pap testing in East Asian women. There were two aims of this study; To (1) explore the role of acculturation, sexual attitudes, and sexual behaviours among women who do and do not elect to participate in physiological sexual arousal testing using the vaginal photoplethysmograph, and (2) to examine the relationship between acculturation and vaginal pulse amplitude (VPA) in Euro-Canadian and East Asian women living in Canada. We hypothesized that there might be ethnic differences in women who chose to participate in the psychophysiological phase, and that level of acculturation might be related to this decision among the East Asian women. Specifically, we hypothesized that Euro-Canadian women, and East Asian women who were more acculturated to Western culture would be more likely to consent to the physiological sexual arousal testing. Further, based on prior research, we hypothesized that Euro-Canadian women would show higher ratings of self-reported sexual arousal, and that East Asian women would show lower VPA scores in response to audiovisual erotic stimuli.

Method: Euro-Canadian (n=50) and East Asian (n=58) women completed a battery of questionnaires, including measures of acculturation (Vancouver Index of Acculturation; VIA), sexual beliefs and knowledge (Sexual Beliefs & Information Questionnaire; SBIQ), and sexual function (Female Sexual Function Index; FSFI). They were then informed of the opportunity to participate in a second phase of the study (Phase 2), in which they would view neutral and erotic audiovisual films in private while their vaginal blood flow patterns were monitored using the vaginal photoplethysmograph (VPP). Thirty-six women agreed to participate in the physiological arousal testing (14 Euro-Canadian and 22 East Asian). Subjective measures of affect and self-reported sexual arousal were taken immediately before and after the films in addition to measuring vaginal pulse amplitude (VPA).

Results: Twenty-eight percent of Euro-Canadian and thirty-eight percent of East Asian women agreed to participate in the sexual psychophysiology testing. No differences were found between the two groups on the proportion who had engaged in a wide range of sexual activities--the one exception being that significantly more of the Euro-Canadian women reported being the recipient of oral sex by a current partner. Euro-Canadian women had significantly greater sexual knowledge than the East Asian women. No significant differences were found between the two groups on sexual response as measured by the FSFI. Increasing age, greater sexual knowledge and East Asian ancestry predicted a significantly higher likelihood of participation in Phase 2. Among the East Asian women, greater heritage acculturation was associated with lower likelihood of participating in Phase 2, whereas greater mainstream acculturation was associated with a greater likelihood of

participating in Phase 2. There were no significant film by ethnic category interactions on any self-report measure, and no significant film by ethnic group interaction on VPA. Among the East Asian women alone, there were no significant correlations between VPA and either Heritage or Mainstream Acculturation.

Discussion: Contrary to our hypothesis, we found that East Asian women were more likely to participate in sexual psychophysiology testing. Possible explanations for this unexpected finding are discussed, as are possible reasons for the influence of heritage and mainstream acculturation on VPP participation. The finding that there are no significant differences between Euro-Canadian and East Asian women on measures subjective or physiological sexual arousal does not lend support to speculations that there may be genetic differences in sexual response that underlie any self-reported differences between ethnic groups.

Utility/Limitations/Risks: The results of this study could have important ramifications for how healthcare providers bring up the topic of Pap testing with East Asian women. An important limitation of the study is the ethnicity of the experimenter. Faced with a Euro-Canadian experimenter, the East Asian women may have felt undue pressure to oblige by taking part in an experiment that they otherwise would have preferred to refuse and may not have felt the same sense of pressure had the experimenter been of their same ethnicity.

Behavioral Learning Objectives:

After attending this presentation, the participants will be able to:

1. Discuss the similarity between the ethnic groups in the proportion of women who elected to participate in the sexual psychophysiological arousal testing.
2. Describe the effect of acculturation and other predictors on participation in physiological arousal testing in East Asian women.
3. Discuss the lack of difference in subjective and physiological sexual arousal observed between Euro-Caucasian and East Asian women.

References:

Brotto, L. A., Chik, H. M., Ryder, A. G., Gorzalka, B. B., & Seal, B. N. (2005). Acculturation and Sexual Function in Asian Women. *Archives of Sexual Behavior, 34*, 613-626.

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Ng, M. L., & Lau, M. P. (1990). Sexual attitudes in the chinese. *Archives of Sexual Behavior, 19*(4), 373-388.

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Biography:

Morag Yule received her BSc in Molecular Biology from the University of Victoria in 2003. After taking two years off to work and travel in Scotland and Japan, she returned to Vancouver and completed a BA in Psychology in 2007. She has been conducting research in the area of culture and sexuality since 2006, and is looking forward to entering the Clinical Psychology program at the University of British Columbia under the supervision of Dr. Lori Brotto starting in 2009.

EASTERN APPROACHES TO TREATMENT OF SEXUAL PROBLEMS
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Introduction: The focus of this session will be a review of empirical research of Eastern medicine approaches to treating sexual problems. In recent decades, Western providers have increasingly turned to Eastern medicine techniques to assist their clients in managing pain symptoms (such as arthritis and headaches), as well as insomnia, hypertension, treatment-related symptoms of cancer, and other stress-related illnesses (Kabat-Zinn, 2002; Astin, Shapiro, Eisenberg & Forys, 2003). Sex therapists should also benefit from awareness of the wide range of techniques available to assist clients with treatment concerns. While non-Western treatment approaches have not often been studied in controlled research trials, literature appears to suggest that some techniques offer substantial promise as components of effective holistic treatment. In order to refer appropriately, scientist-practitioners require familiarity with the level of empirical support associated with such mind-body approaches, which include acupuncture, meditation and yoga, among others. This presentation will assist in filling this training gap, and will also offer recommendations for further assessment of the utility of Eastern treatment techniques in sex and reproductive therapy.

Method: Using multiple academic search engines, empirical studies were identified that examined the efficacy of Eastern medicine in treating sexual problems, including but not limited to non-organic male erectile dysfunction, premature ejaculation, sexual offending, male and female infertility, premenstrual syndrome, dysmenorrhoea, and climacteric symptoms. Treatment techniques included acupuncture and acupressure, meditation and yoga.

Results: This literature review identified a number of studies that report positive effects. For example, Dhikav, Karmarkar, Gupta and Anand (2007) found that yoga and fluoxetine were associated with comparable improvement rates (as measured via intravaginal ejaculatory latencies) for premature ejaculation. Wyon and colleagues (1995) report that acupuncture resulted in decreased hot flushes and sweating associated among postmenopausal women, as compared to non-therapeutic, superficial needle insertion. Likewise, Habek, Habek and Barbir (2002) reported significant reductions in premenstrual symptoms via acupuncture, as compared to placebo acupuncture. Other studies reported therapeutic effects clearly relevant to the treatment of sexual problems. For example, it appears that yoga can assist in reduction of anxiety (Gupta, Khera, Vempati, Sharma & Bijlani, 2006) as well as risk factors for cardiovascular disease and diabetes mellitus (Bijlani et al., 2005).

While multiple studies reported positive effects, others failed to demonstrate treatment effects superior to control groups (Gupta et al., 2006), and methodological problems were frequent. Many studies' findings are compromised by lack of control or comparison groups (Dong et al., 2001), and/or failure to use random group assignment (Dhikav et. al, 2007). Relatively few studies are double-blind, and comparison of Eastern and Western approaches to treatment seems rarely explored. Finally, the impact factor of journals that publish studies of Eastern medicine techniques tend to be low, and almost no studies are published in sex research journals.

Discussion: Examination of the literature on a number of Eastern approaches to treating sexual problems suggests that acupressure and acupuncture may be promising treatments for dysmennorhoea, as is acupuncture for female infertility (White, 2003). While yoga and meditation appear useful for managing a wide range of symptoms associated with stress, illness, and pain, more research is needed to confirm these effects, and extend them to specifically address sexual problems. Methodologically sound research on Eastern approaches to treating sexual problems is needed to keep sexology abreast of current trends in behavioral medicine.

Utility/Limitations/Risks: The results of this literature review are limited to the studies identified. Other research may be available that was not reviewed.

Behavioral Learning Objectives:

After attending this presentation, the participants will be able to:

1. Describe empirical data on the efficacy of Eastern medicine in the treatment of sexual problems.
2. Identify needs for future research surrounding the use of Eastern medicine in sex therapy.

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Biography:

Dr. Carpenter received her PhD in Clinical Science from Indiana University-Bloomington in 2002. She completed a year-long residency in Health Psychology at the University of Texas Medical Branch at Galveston, and a two-year clinical/research postdoctoral fellowship at the Program in Human Sexuality at the University of Minnesota-Twin Cities. She has been on the faculty of the Department of Psychology at Christopher Newport University since 2006.

ALMOST EVERYONE LIKES IT HOT! ASSESSING THE VALIDITY OF THERMOGRAPHY AS A PHYSIOLOGICAL MEASURE OF SEXUAL AROUSAL
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Introduction: Current physiological measures of sexual arousal do not correlate highly with subjective measures, are intrusive, hard to compare between genders and quantitatively problematic (Janssen, 2001). In addition, the required genital manipulation and output measures of available instruments make it difficult to establish diagnostic criteria for sexual arousal difficulties in a clinical setting. This study was designed to 1) generalize our previous college student thermography study findings to an older sample (mean age = 37.05 years); 2) add an anxiety control group to further examine the specificity of temperature change; and 3) examine the relationship between genital temperature and a continuous measure of subjective sexual arousal.

Method: Healthy men (n = 40) and women (n = 39) viewed a neutral film clip after which they were randomly assigned to view one of four other videos: 1) neutral (n = 20); 2) humor (n = 19); 3) anxiety provoking (n = 20); 4) sexually explicit (n = 20). Genital and thigh temperature were continuously recorded using a TSA ImagIR thermographic camera. Continuous and discrete reports of subjective sexual arousal were also obtained.

Results: Repeated measures ANOVAs followed by trend analyses, demonstrate that both men and women in the erotic condition had significantly greater genital temperature change over time than those in the humor, anxiety or neutral conditions (F (6, 142) = 15.01, p <.001). Furthermore, genital temperature was significantly correlated with continuous and discrete subjective ratings of sexual arousal (range r = .26-.46, p <.05). While there were no significant differences between men and women viewing the sexually arousing video for latency to maximal physiological arousal, trend analyses revealed that men and women differed in the magnitude of temperature change over time. There were no significant differences in thigh temperature between experimental conditions or within each condition, indicating that temperature increases during sexual arousal were specific to the genital region.

Discussion: Results support the validity of thermography as a measure of sexual arousal: temperature change was specific to the genitals during the sexual arousal condition and was significantly correlated with subjective continuous and discrete reports of sexual arousal. Further development is assessing the potential of thermography as a tool for the diagnosis and treatment evaluation of sexual arousal difficulties and for studying gender differences.

Utility/Limitations/Risks: The results of this study provide additional support for the use of thermography as a physiological measure of sexual arousal. Before being used as a clinical measure, however, research must determine the within-subject stability of baseline genital temperature as well as assess the utility of thermography for repeated measures designs.

Behavioral Learning Objectives:

After attending this presentation, the participants will be able to:

1. Identify the advantages of remote temperature recording during sexual arousal
2. Discuss the similarities in patterns of sexual arousal between men and women
3. Discuss the clinical and research implications of measuring sexual arousal via thermal imaging

References:

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Biography:

Ms. Kukkonen is currently completing her PhD in Clinical Psychology at McGill University under the supervision of Dr. Irv Binik. She has completed one half-time internship at the Sex and Couple Therapy Service of the McGill University Health Centre (MUHC) and is currently completing her second in the MUHC's Psychosocial Oncology Program.

A PROSPECTIVE EXAMINATION OF THE EFFECTIVENESS OF PELVIC FLOOR PHYSICAL THERAPY IN TREATING PHYSICAL AND PSYCHOSEXUAL COMPONENTS OF PROVOKED VESTIBULODYNIA

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Introduction: Provoked vestibulodynia (PVD) is the most common form of vulvodynia (i.e. chronic vulvar pain), and it has significant and negative impacts on sexual function, psychological well-being, and overall quality of life. Studies suggest that increased muscle tension in the pelvic floor of women with PVD may play an important role in maintaining and exacerbating their pain. However, no prospective studies of pelvic floor physical therapy (PFPT) for PVD have been carried out. The purpose of the current study was to prospectively examine the effectiveness of a comprehensive PFPT intervention in treating the physical, psychological, and sexual components of PVD. The study also aimed to determine predictors of successful treatment outcome.

Method: Thirteen women with PVD completed eight weekly sessions of PFPT. Women were assessed at pre-treatment and post-treatment via gynecological examinations, vestibular pain threshold testing, structured interviews and standardized questionnaires measuring pain variables (pain during intercourse and other sexual and non-sexual activities), psychological variables (Pain Catastrophizing Scale, Pain Anxiety Symptom Scale-20, Center for Epidemiological Studies Depression Scale, State Trait Anxiety Inventory Trait Version, Medical Outcome Survey 12-Item Short-Form Health Survey), and sexual function (frequency of intercourse, Female Sexual Function Index). A 3-month follow-up telephone interview was also conducted to assess any further changes in psychological and sexual functioning.

Results: As compared with pre-treatment, participants reported significant reductions in pain intensity ratings during the gynecological examination and during intercourse. Participants' vestibular pain thresholds significantly increased from pre- to post-treatment indicating reduced pain sensitivity. Participants were also able to engage in significantly more pain-free sexual and non-sexual activities. Participants' overall sexual function did significantly improve following treatment; however, a number of components of sexual function did not significantly improve. Additionally, frequency of sexual intercourse did not increase following treatment and avoidance was still the most frequently used coping technique. Participants did not change with respect to levels of depression, anxiety, or health-related quality of life; however, they did show significant reductions in both pain catastrophizing and pain-related anxiety following treatment. The treatment was considered to be successful for 10 (77%) of the 13 participants and satisfaction rates were very high. Predictors of more successful treatment outcome included greater reductions in helplessness over the course of treatment.

Discussion: Results provide preliminary support for the effectiveness of PFPT in treating the physical (i.e., pain), psychological, and sexual components of PVD. In particular, there appear to be improvements in terms of pain reduction during physical and psychophysical testing and during

sexual activity. The treatment also positively impacts a number of cognitive correlates of pain and improves overall sexual function.

Utility/Limitations/Risks: The results of this study will help a variety of health professional determine the usefulness of PFPT for their client with PVD. The results also indicate the need for large-scale, randomized studies of the effectiveness of PFPT in comparison and in conjunction with other treatment options. The study results are limited by the lack of control group, the small sample size, and the lack of long-term follow-up.

Behavioral Learning Objectives:

After attending this presentation, the participants will be able to:

1. Explain the role that pelvic floor muscles play in PVD and the rationale behind pelvic floor physical therapy
2. Discuss the areas of functioning affected by pelvic floor physiotherapy in women with PVD

References:

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Biography:

Corrie Goldfinger received her BA in Honours Psychology from York University. She then joined a research team at the Centre for Addiction and Mental Health studying perinatal mental health in lesbian women. She recently completed her Master's program in Clinical Psychology at Queen's University and has begun her Doctoral degree in the same program. She is supervised by Dr. Caroline Pukall, and her research focuses on non-medical treatment options for vulvar pain.

"JUST RELAX" - PHYSICIANS' EXPERIENCES WITH WOMEN WHO ARE DIFFICULT TO EXAMINE GYNECOLOGICALLY

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Introduction: The internal pelvic exam is a critical component of women's reproductive health care; however, it can be perceived as uncomfortable, embarrassing and painful (e.g., Millstein, Adler, & Irwin, 1984). As a result, some women experience difficulty during such exams, or altogether avoid the experience (Hilden, Sidenius, Langhoff-Roos, Wijma, & Schei, 2003), which may increase their risk for a variety of gynecological problems. The purpose of this study was to survey physicians with respect to their experiences with female patients who are difficult or impossible to examine gynecologically.

Method: Six-hundred and fifty-eight obstetrician-gynecologists and family physicians were sent a 15-item questionnaire by mail, made up of both closed and open-ended items, and 424 participants responded (64% response rate). The survey included questions concerning the frequency with which physicians encounter female patients who are difficult or impossible to examine, the behaviors exhibited by such patients, the strategies employed by physicians and their beliefs about such patients. Items pertaining to demographic variables, professional training and practice information were also included in the survey.

Results: The results indicate that, of the final sample (N = 401), the majority had experience with patients who were difficult or impossible to examine gynecologically on a monthly basis. Commonly reported strategies were to encourage the patient to relax (87%) and enquire about the patient's anxiety or pain (73%), with the majority of respondents indicating that their strategies were almost always (73%) or always successful (12%). Both verbal and non-verbal expressions of discomfort were reported to be observed with such patients. The majority of physicians believed that a previous negative experience with a pelvic exam was to blame for women being difficult or impossible to examine (87%). Other commonly cited explanations were anxiety/fear about the exam (79%), past emotional (69%) or genital (58%) trauma, and pain (52%).

Discussion: This study suggests that encountering patients who are difficult or impossible to examine is not uncommon, as virtually all respondents reported clinical experience performing difficult exams. Physician strategies (such as education, relaxation, referral, and inaction) and attributions will be discussed in the context of existing literature concerning women's perceptions and experiences with pelvic exams. The meaning of the results will also be addressed in terms of women with sexual pain disorders, and their gynecological presentation. This study reinforces the importance of being aware of patient discomfort during pelvic exams and of developing strategies that fit the individual patient and her needs. Further research is needed regarding women's perceptions of their reproductive care.

Utility/Limitations/Risks: While this study is the first to examine physicians' experiences with patients who are difficult or impossible to examine, it is limited by the descriptive and self-report

nature of the data. The results are relevant to health professionals who perform pelvic examinations, and may contribute to increased awareness of patient difficulties in such situations, as well as strategies that may reduce discomfort in this context.

Behavioral Learning Objectives:

After attending this presentation, the participants will be able to:

1. Discuss the importance of awareness of patient discomfort during pelvic exams, what it may be indicative of, and the differences in individual patient needs.
2. Discuss the utility of different strategies for dealing with patients who are difficult or impossible to examine.

References:

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Millstein, S. G., Adler, N. E., & Irwin, C. E., Jr. (1984). Sources of anxiety about pelvic examinations among adolescent females. *Journal of Adolescent Health Care, 5*, 105-111.

Biography:

Stéphanie Boyer receiver her B.Sc. from McGill University in 2004. She is completing her Master's degree in Clinical Psychology at Queen's University, under the supervision of Dr. Caroline Pukall. Her research examines the relationship between sexual arousal and pain sensitivity in women with provoked vestibulodynia, and she is completing other studies on the topic of women's reproductive care. She has been a student member of SSTAR since 2007.

HOW TEDIOUS IS A GUILTY CONSCIENCE: THE ROLE OF SEX GUILT IN FEMALE SEXUAL FUNCTION

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Introduction: A large body of literature demonstrates that individuals of East Asian (Chinese, Japanese, and Korean) descent have lower sexual function in comparison to those of European descent and this is true for both males and females. In contrast, there has been a paucity of research examining feelings of guilt surrounding sexuality. With the exception of Abramson and Imai-Marquez (1982) who explored cultural differences in sex guilt among Japanese Americans and Caucasian Americans, sex guilt in East Asian individuals has received no empirical attention. Furthermore, although numerous studies have shown that there are significant ethnic differences in sexual functioning, most have explained these differences by referring to general culture-linked differences in attitudes towards sexuality rather than examining the potential role of specific constructs such as sex guilt.

In addition to studying ethnic differences in sexuality, recent research is increasingly focusing on acculturating individuals in North America. With rapidly increasing ethnic diversity, there is an urgent need to understand how the process of acculturation influences sexuality. Acculturation is the process whereby values of the new culture (Mainstream, or Canadian, culture) are incorporated into one's self-identity and culture of origin (Heritage culture). Empirical evidence suggests that the 2 dimensions of acculturation are independent of each other and that studying acculturation provides more rich information about an acculturating individual than by studying how long the individual has lived in the Mainstream culture.

The purpose of the current study was twofold: (1) to examine the effect of culture on sex guilt by comparing levels of sex guilt in East Asian and Euro-Canadian women, as well as by studying the relationship between sex guilt and the 2 dimensions of acculturation among the East Asian women, and (2) to explore the role of sex guilt in the relationship between culture and sexual function.

Method: Euro-Canadian (n = 112) and East Asian (n = 155) female university students completed questionnaires online which included measures of sexual function, sex guilt and acculturation.

Results: Euro-Canadian women had significantly higher levels of sexual functioning, significantly lower levels of sex guilt and a broader repertoire of sexual activities. In analyses of the whole sample, sex guilt mediated the relationship between ethnicity and sexual function, in that women with higher levels of sex guilt had significantly lower sexual function. Among the East Asian women, sex guilt mediated the relationship between Mainstream acculturation and sexual function such that women with higher levels of sex guilt reported lower sexual functioning.

Discussion: The current study is novel in that no other study has to our knowledge examined the role of sex guilt in cultural differences in sexual function. As expected, levels of sex guilt are higher in East Asian women, as well as in East Asian women who are less westernized. In addition, the

finding that Euro-Canadian women had higher sexual function is consistent with a large body of literature on this topic.

Utility/Limitations/Risks: The finding that sex guilt mediates the relationship between ethnicity and sexual function is a fascinating finding that helps to narrow down the mechanisms underlying the well-documented ethnic differences in sexual function. Clarifying the role of a specific construct such as sex guilt in level of sexual functioning may be helpful to clinicians working to address sexual difficulties. However, our results may be limited by our use of a university convenience sample.

Behavioral Learning Objectives:

After attending this presentation, the participants will be able to:

1. Discuss the importance of taking culture into account when studying sexuality in different cultures.
2. Discuss the impact of sex guilt on sexual functioning in East Asian and Euro-Canadian women.

References:

Abramson, P. R., & Imai-Marquez, J. (1982). The Japanese-American: A cross-cultural, cross-sectional study of sex guilt. *Journal of Research in Personality, 16,* 227-237.

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Woo, J. S. T., & Brotto, L. A. (2008). Age of first sexual intercourse and acculturation: Effects on adult sexual responding. *The Journal of Sexual Medicine, 5,* 571-582.

Biography:

Jane Woo received her MA in Economics from the University of British Columbia in 2002. She decided early in her banking career that her true interest lay in how culture impacts sexuality and has been conducting research in this area since 2005. She is currently enrolled in the PhD program in Clinical Psychology at the University of British Columbia under the supervision of Dr Brotto. She has been a member of SSTAR since 2007.

POST ORGASM FATIGUE IN MEN -A SPECTRUM OF SYNDROMES?

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Introduction: Two cases of post orgasm fatigue (POF) have been previously described in the literature (Waldinger and Schweizer 2002) and 110 reported informally on an internet forum. (www.thenakedscientists.com/forum/index.php?topic=6576) In parallel to this The "Dhat syndrome" a collection of culture bound complaints causing POF (Sumathipala A et al 2004) has been recognised in the literature as a psychosomatic complaint (American Psychiatric Association 1994).

In this paper we present 2 cases of post orgasm fatigue of seemingly different aetiologies, and discuss a possible wider spectrum of causes for this apparently unusual syndrome.

Method: We have systematically investigated two of our patients in an attempt to elucidate an explanation for the syndrome we describe. We performed a full physical examination, biochemical, haematological and endocrine testing. The patients were screened for sexually transmitted infections. Magnetic Resonance Imaging of the brain was performed and neurological opinion sought. Standard investigations for autonomic dysfunction were undertaken at a dedicated unit. Neuropsychological testing was performed one and two days after orgasm whilst the patients was symptomatic, and repeated at a time remote form the episode of post orgasm fatigue syndrome. The patients were assessed using the Hospital Anxiety and Depression Scale (HADS) scores system. We here summarise the salient features of their complaints.

Results: Both our cases describe severe physical and mental tiredness and lethargy associated with myalgia and malaise following any orgasm. The symptoms were noted to have been present for some years. The symptoms occur consistently within an hour of orgasm and last up to 3 days after orgasm. In between episodes of post orgasm fatigue, the patients are fit and well, and are able to perform exercise without any similar symptoms or impediment. The symptoms are severe enough to cause the patients to seek medical advice and to avoid sexual activity involving orgasm.

Patient 1
Mr A is a 52 year old exclusively gay man, who is happy in his sexual expression and in a loving long term relationship. He has no physical or psychological complaints. His POF started suddenly 3 years ago and sounded organic in nature both to us and him. Mr A does not complain of a sexual dysfunction per se.
Physical examination normal. Blood pressure 136/82 (lying) 128/76 (standing). Normal range renal function, liver function, creatinine kinase, full blood count, thyroid function tests and prolactin. Testosterone = 323ng/dL, SHBG = 16 nmol/l, Cholesterol = 232mg/dL (all within normal limits)
MRI brain Normal, Autonomic testing - no evidence of sympathetic vasoconstrictor or cardiac parasympathetic failure. Neurological opinion – no neurological abnormality identified.
Neuropsychological testing – no evidence of anxiety/depression, no change in scores on day 1 day 2 post orgasm and remote date from orgasm.

No improvement was noted after taking sertraline or bromocryptine. However, he described a significant reduction in the malaise and muscle aches with some attenuation of the fatigue after taking a single dose of diclofenac an hour prior to intercourse and orgasm on a number of separate occasions.

Patient 2
Mr B is a 28 year old Pakistani law student of Muslim background. He describes very limited sex education in his early years both at home and school. Sexual debut involved anal sexual activity with male class mates aged 13 in Pakistan. For last 6 months has had a female partner, but has severe premature ejaculation (less than a minute and ejaculating prior to vaginal penetration) and mild situational psychogenic erectile dysfunction. He has also attempted penetrative sex with men in recent years, and suffers from premature ejaculation in this situation also. He is definite that his preferred sex is with women, suggesting sex with men is at times for him, facultative. POF occurred in all these scenarios. However, since being given tadalafil prior to sex he can penetrate his partner vaginally and orgasms after 3-10 minutes. To date he no longer has POF after vaginal sex. Physical examination normal. Blood pressure normal, no postural change. Normal renal function, normal liver function, normal prolactin, creatinine kinase, testosterone, thyroid function. EEG/MRI brain/neuropsychometric testing/autonomic testing outstanding.

Discussion: The first case, "Mr A", sounds remarkably organic in nature, with many features suggestive of cytokine release (Pollacher et al 2002) as do Waldinger and Schweizer's cases. This hypothesis is consistent with his good response to a non steroidal anti-inflammatory drug. Anecdotal reports on the internet website (mostly from patients but also some physician reports) have hypothesised this organic state could be caused by hypertension, autoimmune disease, milk allergy or dissociative states. Depression has been postulated as a cause in some cases who improve as their depression lifts (personal communication Steve Snyder) Single anecdotal case reports of treatments include buproprion, tramadol, naloxone, gabapentin SSRIs and vardenafil with variable outcomes.. Our second case complained of similar POF, but also was showing features consistent with the "Dhat syndrome". This is a belief held within some cultures that ejaculation outside of the vagina is pathological (Sumathipala A et al 2004). However, Dhat is not considered so culture bound (Indian or Chinese) by these authors. PDE5 inhibitors such as tadalafil are known to have antidepressant effects (Orr G et al 2008) and it is possible the improvement seen in our second case "Mr B" was a result of PDE5i anti-depressant action.

POF is thus a poorly understood and possibly often unrecognised condition that may have a wide range of aetiologies - organic, psychological and cultural.

Utility/limitations/risks: The description of this syndrome will hopefully lead to improved recognition by physicians' and therapists of POF, and allow better characterisation and understanding of this debilitating syndrome and its prevalence in practice

Behavioural Learning Objectives:
After attending this presentation, the participants will be able to:
1. Describe how to recognize and diagnose post orgasm fatigue syndrome in patients.
2. Discuss the need to ascertain prevalence and causes of this syndrome.
3. Discuss the need to gather information to contribute to further knowledge surrounding the aetiology and treatment of this condition.

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Biography:

Dr Ashby graduated from Imperial College School of Medicine with honours in 2000. She has been working with HIV and infectious diseases for the last 6 years and a trainee of sexual health and HIV at St Mary's Hospital Campus, Imperial College London for 2 years.

IMPLICATIONS OF "PSYCHOPATHOLOGY" IN A GENDER IDENTITY CLINIC: A REPORT OF TEN CASES

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Introduction: Our gender team has long noted the antipathy to the term psychopathology and its synonyms among the transgendered. We have repeatedly experienced its political and clinical consequences.

Methods: Data were gathered in 2007 by reviewing the presentations of the last ten patients interviewed by our Gender Committee. Patients are interviewed by our team after an initial evaluation, request for hormones, request for surgery, or follow-up.

Results: Nine of the ten patients bore both the burdens of their gender disorder and associated psychopathology. These included significant problems of mood and anxiety regulation and adapting in the world. Two of the ten have had persistent significant regrets about their previous transitions. When permission to publish their cases was requested, after reading their case vignettes three of the first six felt betrayed by the observations, refused, and used email to declare our clinic anti-transgendered. We then decided not to publish the vignettes of the remaining four except in a Table.

Discussion: Our findings seem to be in marked contrast to the public, forensic, and professional rhetoric of many who care for transgendered adults. Much of this rhetoric sounds remarkably certain about the value of gender transition, hormones, and sex reassignment surgery in improving the lives of those with gender identity disorder in a lasting manner. To establish such certainty in a scientifically acceptable style, carefully established prospective sophisticated follow up findings are required. In fact, follow up studies are limited in numbers and quality. Hormone administration, gender transition, and multiple surgical procedures have preceded data collection about long term results. Clinical decision making in this complex field balances interpretation of the Standards of Care, the civil right of alternative gender presentation, and conflicting ethical considerations.

Conclusion and Limitations: Compassion, thoughtfulness, and caution are particularly necessary when dealing with GID. Emphasis on civil rights is not a substitute for the recognition and treatment of associated psychopathology by mental health professionals. Gender identity specialists, unlike the media, need to be concerned about the majority of patients, not just the ones who are apparently functioning well. This study, while limited in sample size, is also limited by our clinicians' sensitivity to conspicuous forms of psychiatric co-morbidity. Perception of psychopathology can play either a primary or a secondary role depending on the ultimate importance of the clinician's value system concerning civil rights.

Behavioral Learning Objectives:

After this presentation, the clinician is likely to:

1. Discuss the profound influence of the controversial assumption that the suffering of men and women with GID can be cured by gender transition, hormone administration, and surgery.
2. Discuss the importance of defining and attempting to treat the associated psychiatric co-morbidity.
3. Discuss both the positive support the Internet has provided to transgendered people and its power to drive away most clinicians from caring from these individuals.

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Biography:

Stephen B. Levine is the author of *Demystifying Love: Plain Talk for the Mental Health Professional* and Senior editor of the *Handbook of Clinical Sexuality for Mental Health Professionals*. He is a long time member of SSTAR.

BESTIALITY AND ZOOPHILIA – AN EXPLORATORY STUDY
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Introduction: This presentation is based on an exploratory study resulting in abundant and rich information about the life and sexual behaviors of individuals who have had sexual relations with animals – a sexual behavior (bestiality) that has been under-studied and misunderstood. The presenter does not advocate this behavior, but wishes to demystify a topic which has long suffered ridicule and pdeudo-scientific rhetoric.

Method: The study is based on 350-item, 23 page, anonymous questionnaires, filled out by 82 men and 11 women volunteers between the ages of 19 and 78. The majority of the participants (73%) heard about the study through the internet. However, each subject had to make telephone or personal contact with me to ensure authenticity and to obtain the individuals' postal address. All the women and 87 percent of the men were from the United States.

Results: The study yielded some groundbreaking findings, some of which will be presented during the presentation, such as the frequency of sexual activities with animals, the kind of sexual activities with animals, the motivations for having sex with animals, and the difference between "bestiality" and "zoophilia."

Discussion: This is a descriptive study designed to gather as much data as possible about bestiality and zoophilia. Most of the data gathered from this study are new information that can begin to fill the void sexologists have been experiencing in the collective knowledge on bestiality and zoophilia.

Utility/Limitations/Risks: Although this study cannot be representative of the "zoo" community and it had its inherit flaws, such as small sample size, "snow-ball" effect recruitment of subjects, and my bias, the results of this study can still help sexologists to better understand and empathize with this population.

Behavioral Learning Objectives:
At the end of this presentation, participants will be able to:
1. Define and distinguish between "Bestiality" and "Zoophilia."
2. Discuss new data about bestiality and zoophilia.

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Biography:

Hani Miletski, PhD, MSW, is a psychotherapist in private practice in Bethesda, Maryland. She is a Licensed Clinical Social Worker with a Maser's degree in Social Work from the Catholic University of America, National School of Social Service, in Washington, DC, and with a Doctoral Degree in Human Sexuality from the Institute for Advanced Study of Human Sexuality, in San Francisco, California. Hani is a Certified Sex Therapist (Diplomate) and Supervisor by the American Association for Sexuality Educators, Counselors, and Therapists (AASECT), and she is currently the AASECT Membership Services Steering Committee Chair, which is a Board of Directors' position. Hani is the author of *Understanding Bestialtiy and Zoophilia, Mother-Son Incest: The Unthinkable Broken Taboo Persists*, and a variety of other professional articles and chapters in professional literature. Hani has been training and supervising other therapists and professionals in the field of human sexuality, and she has lectured in various national and international professional conferences.

A CASE OF AUTOMOBILE EROTICISM

Chris Kraft, PhD (Presenter)
Fred Berlin, MD (Discussant)

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This case will present the life of a man in his late thirties who has been sexually aroused by luxury automobiles since the age of eight. This man presented for evaluation and treatment at the Johns Hopkins Sexual Behaviors Consultation Unit after being charged with two misdemeanors for entering luxury cars at night in car dealerships where he would roll around the back seat of cars until he ejaculated in his pants. This man stated his arousal to cars began in elementary school when he became particularly excited by the luxury car that would pick up the girl he had a crush on after school. By adolescence he recalled rubbing himself on the outside of luxury cars until he ejaculated in his pants. By his late teens, he started entering unlocked parked luxury cars where he found both the smell and feel of the back seat sexually stimulating and began rubbing himself on the seats until he ejaculated in his pants.

Throughout his twenties he would enter unlocked luxury cars parked in the garage of his apartment complex on a weekly basis. When these cars were not available he would jog around his neighborhood and search for unlocked to enter. By his late twenties, he discovered he could find photographs of car interiors on the internet that he could use to masturbate with. In his early thirties, he was arrested two times for entering cars in two different car dealerships during off hours.

Throughout the course of treatment he continued to enter unlocked cars three or four times a year. This man is very shy and nervous around females. He has had considerable difficulty being sexually aroused by females he would attempt to date. Recently, he has purchased his own luxury car where he can participate in the arousing activities without entering cars and running the risk of being arrested.

Behavior Learning Objectives:
After attending the presentation, the participants will be able to:
1. Describe and trace the development of a unique paraphilic fetish.
2. Discuss the various theories of paraphilic etiology.
3. Discuss the various treatment options for paraphilias.

Biographies:

Chris Kraft, PhD is currently an Instructor in the Department of Psychiatry and Behavioral Sciences at the Johns Hopkins University School of Medicine and the Director of Clinical Services for the Sexual Behaviors Consultation Unit in the Department of Psychiatry at Johns Hopkins School of Medicine. He is also a part-time Lecturer in the Psychological and Brain Sciences Department at the Johns Hopkins University, Krieger School of Arts and Sciences where he teaches two courses on human sexuality. His clinical work focuses on treatment issues related to all aspects of gender and sexuality issues. Dr. Kraft also specializes in treating sexually addictive/compulsive behaviors along with marital/sex therapy for couples who are experiencing marital/sexual distress. Sexual challenges treated include low or mismatched sexual desire, erection/arousal difficulties, genital pain, and orgasmic problems. His research has focused on the relationship between body/genital image and sexual functioning.

Fred S. Berlin, MD, PhD is currently an Associate Professor in the Department of Psychiatry and Behavioral Sciences at The Johns Hopkins University School of Medicine and an Attending Physician at The Johns Hopkins Hospital. He is also the Founder of The Johns Hopkins Sexual Disorders Clinic and the Director of the National Institute for the Study, Prevention and Treatment of Sexual Trauma. Dr. Berlin has been the recipient of a contract from the National Institute of Mental Health to prepare an annotated bibliography on sex offender etiology and treatment, and of a grant from the Guggenheim Foundation to study the activity of brain neurotransmitters during sexual arousal. He was also a member of the subcommittee on the paraphilias (the sexual deviation disorders) for the 3rd revision of The Diagnostic and Statistical Manual of Mental Disorders.

ETHICAL DILEMMAS AND CLINICAL CONUNDRUMS IN SEX THERAPY: POLITICS, RESEARCH AND ATTEMPTS TO CHANGE HUMAN SEXUALITY

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All too often, ethics workshops focus on *compliance* as opposed to ethical *decision-making*. The presenters believe that this focus is far too narrow and misses the complexity and nuances central to ethical practice. This workshop will concentrate on the interplay between politics, morals, and values in an effort to better understand the construction of codes of ethics in the healthcare disciplines.

Through a combination of didactic presentation, case examples/vignettes, and spirited discussion, the presenters hope to guide the participants to a greater awareness of the complexities of ethical decision-making as it relates to attempts to change human sexual behavior. Participants will have an opportunity to examine, in depth, the multiple layers of consideration that must be given to the determination of what makes one's practice ethical and defensible.

The criteria that help us to evaluate codes of ethics, including whether they are coherent, defensible and comprehensive (Beauchamp and Childress, 2009) will be examined. More specifically, the principles of Autonomy, Beneficence, Nonmaleficence, and Justice will be applied to clinical policies in an effort to assess their usefulness and relevance for ethical decision–making.
In addition, this workshop will focus on the role of politics and research in dealing with ethical dilemmas in sex therapy. A template for evaluating such ethical dilemmas emerges by analyzing the American Psychological Association (APA) policy on reparative or conversion therapy for treatment of homosexuality. On August 14, 1997 the APA's Council of Representatives issued a policy statement that essentially banned the use of such treatment. The document entitled, *Appropriate Therapeutic Response to Sexual Orientation,* declared that treatments aimed at changing a homosexual orientation were both ineffective and harmful, and as such should not be part of ethical psychological practice (DeLeon, 1998).

However, there were several clinicians/researchers who took issue with this declaration (Spitzer, 2006). They claimed the policy might be more the product of a social or political agenda than reflective of a genuine concern for the best interests of patients and the ethical practice of psychotherapy (Svensson, 2003). While many were outraged that such an endeavor would be questioned, others maintained that all organizational policies should be routinely examined for their usefulness and relevance.

How are sex therapists to respond to public policy debates so as to best serve the needs of our clients/patients? The template for ethical decision-making that develops from discussion of the reparative therapy debate will then be extended to an examination of therapies that seek to change other sexual behaviors, such as the Paraphilias. Implications for psychotherapy, sex therapy, and sex offender-specific therapy will be discussed.

Behavioral Learning Objectives:

After attending this workshop, the participants will be able to:

1. Use the ethical constructs of Principlism as a means of understanding the creation and application of ethical principles to clinical decision-making.
2. Discuss several ethical dilemmas and their impact on the use of therapies that attempt to address of a variety of sexual behaviors and lifestyles.

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Biographies:

Dr. Watter is a clinical and forensic psychologist, as well as a certified sex therapist, in private practice. He is an adjunct professor of Psychology at Seton Hall, Fairleigh Dickinson, and Drew Universities, where he teaches graduate and undergraduate courses in Sex Therapy. In addition, he is a clinical instructor of OB/GYN and Women's Health at UMDNJ-NJ Medical School, and a clinical assistant professor of Psychiatry and Behavioral Medicine at the NY College of Osteopathic Medicine. He has recently completed Drew University's post-graduate program in Medical Humanities with a concentration in Biomedical Ethics. Dr. Watter has been a member of SSTAR since 1989, and currently serves as the organization's Secretary/Treasurer.

Peggy J. Kleinplatz, PhD is Associate Professor of Medicine and Clinical Professor of Psychology at the University of Ottawa. She is a clinical psychologist, Board Certified in Sex Education and as a Diplomate and Supervisor of Sex Therapy. Since 1983, she has been teaching Human Sexuality at the School of Psychology, University of Ottawa, where she received the Prix d'Excellence in 2000. She is Chair of Certifications for the American Association of Sex Educators, Counselors and Therapists. She is in clinical practice and deals with sexual issues in individual, couple and group therapy. Her work focuses on optimal sexuality, eroticism and transformation.

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