# Society for Sex Therapy and Research

# *SSTAR 2011: 36th Annual Meeting*

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

**March 31- April 3, 2011**
**Four Seasons Resort**
**Palm Beach, Florida**

# TABLE OF CONTENTS

# PRESIDENT'S WELCOME LETTER

Welcome to our 36th Annual SSTAR Meeting in Palm Beach, Florida. Thanks to the hard work of our Scientific Program Chair, **Len Derogatis** and our entire Executive Council, the 2011 program continues to reflect our tradition of presenting the most comprehensive and cutting edge work in sex therapy practice and research, Those new to SSTAR will experience discussions reflecting extraordinary clinical sophistication; and we hope you will share the feeling of warmth and inclusion, typical of our meetings. Welcome back to so many of you, who like myself consider SSTAR your favorite meeting! The sex therapists and researchers whose articles you read and lectures you most want to hear, will engage you in fascinating conversations throughout the meeting. In addition, you will experience good humor and fine food, all taking place in a beautiful environment thanks to our enthusiastic Local Arrangements Chair, **Blanche Freund**.

Thursday features a one-day pre-conference workshop overview of assessment and treatment with presentations by: **Lori Brotto, Don Strassberg, Sheryl Kingsberg, Andrew Goldstein, Michael Krychman,** and myself. There are also specialized half-day workshops by **Eli Coleman** and **Barry McCarthy.** At Thursday evening's "Welcome Reception", we present the SSTAR Consumer Book Award to **Christopher Ryan** and **Cacilda Jethá** authors of *Sex at Dawn: The Prehistoric Origins of Modern Sexuality*. We will also view and discuss submitted posters with their authors.

Our formal Friday and Saturday program will incorporate symposiums, paper presentations, roundtables, an in-depth case presentation and debates! These various formats will allow for lively discussion around this year's theme: "Innovations and Controversies in Sex Therapy and Research." Throughout Friday and Saturday, elements of theory, diagnosis, treatment and research will all be presented and fully discussed with the audience by leading experts in the field, including: **Althof, Berlin, Broderick, Brotto, Burnett, Clayton, Meana, Morehouse, and Segraves.** We conclude Saturday evening with our "Fellowship Dinners." Sunday morning **Daniel Watter and Peggy Kleinplatz** offer a post-conference half-day **Ethics Workshop**.

We hope you will join us at our Fall Clinical Meeting on Friday, September 16, 2011 at the Penn Club in New York. Our next Annual Meeting will be held in Chicago, Illinois on March 29-April 1, 2012. In order to join SSTAR, obtain a membership application at the registration desk from our administrator, Ms. Cassandra Larkins.

I look forward to seeing you in Palm Beach and welcoming you to our annual meeting.

Michael A. Perelman, Ph.D.
President, Society for Sex Therapy and Research
Clinical Associate Professor of Psychiatry,
Reproductive Medicine and Urology
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New York, NY USA

# SAVE THE DATES!

## SSTAR 2012 Annual Meeting in Chicago at the Intercontinental Hotel
## March 29-April 1, 2012

**Come experience SSTAR in the center of Chicago's Magnificent Mile. Meeting attendees will participate in a cutting edge scientific and clinical program, while enjoying the best that an American metropolis has to offer. The historic Intercontinental is within easy reach of Chicago's panoply of museums, shops, restaurants, and theaters. Surrounded by stunning architecture, historical landmarks, national treasures, and a hip and vibrant urban ambiance, the SSTAR 2012 Annual Meeting will bring together science, clinical practice, and culture. Don't miss it!**

ALSO...

**Plan to attend the STAR 2011 Fall Clinical Meeting**
Friday, September 16, 2011
The Penn Club of New York
30 West 44th Street
New York, New York 10036

Where the best clinical minds in sex therapy
present and discuss cases to the illumination of all!

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**EXECUTIVE COUNCIL & ADMINISTRATIVE STAFF**
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# CONTINUING EDUCATION
# ACCREDITATIONS & APPROVALS

NOTE: The SSTAR 2011 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 and The Society for Sex Therapy and Research.

***AMA PRA Category 1 Credit(s)™***

The American College of Obstetricians and Gynecologists designates this educational activity for a maximum of *20.25 AMA PRA Category 1 Credits.*™ Physicians should only claim credit commensurate with the extent of their participation in the activity.

**College Cognate Credit(s)**

The American College of Obstetricians and Gynecologists designates this educational activity for a maximum of 20.25 Category 1 College Cognate Credits. The College has a reciprocity agreement with the AMA that allows *AMA PRA Category 1 Credits*™ to be equivalent to College Cognate Credits.

**Disclosure of Faculty and Industry Relationships**

In accordance with College policy, all faculty and planning committee members have signed a conflict of interest statement in which they have disclosed any significant financial interests or other relationships with industry relative to topics they will discuss at this program. At the beginning of the program, faculty members are required 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 the AASECT and is approved for up to 22.5 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 22.5 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 22.5 hours.

# 2011 Award Recipients

## Consumer Book Award

Christopher Ryan, Ph.D. and Cacilda Jetha, M.D.
*Sex at Dawn: The Prehistoric Origins of Modern Sexuality*

## Sandra R. Leiblum Student Paper Award

Julia Elizabeth Mackaronis, B.A.
Department of Psychology
University of Utah

# Program Schedule: SSTAR 2011
# Innovations and Controversies in Sex Therapy and Research

**THURSDAY, MARCH 31, 2011**

7:00 AM – 5:00 PM Conference Registration

**PRECONFERENCE WORKSHOPS**

**FULL-DAY WORKSHOP (8:30 AM – 4:15 PM)**
Moderator: Lori Brotto, Ph.D.

8:30 – 9:30 AM Assessment and Treatment of Male Sexual Dysfunctions
*Presented by Don Strassberg, Ph.D.*

9:30-10:30 AM Assessment and Treatment of Female Sexual Dysfunctions
*Presented by Sheryl Kingsberg, Ph.D.*

10:30-10:45 AM Break

10:45-11:45 AM Genital Pain in Women
*Presented by Andrew Goldstein, M.D.*

11:45 AM- 1:00 PM Lunch (on your own)

1:00-2:00 PM Cancer, Cardiac Disease, and Sexual Dysfunction
*Presented by Michael Krychman, M.D.*

2:00-3:00 PM Combination Therapies in the Treatment of Sexual Dysfunction
*Presented by Michael A. Perelman, Ph.D.*

3:00-4:00 PM Question and Answer Period

**HALF-DAY WORKSHOP #1 (2:00-5:00 PM)**
Assessment and Treatment of Sexual Compulsivity/Impulsivity
*Presented by Eli Coleman, Ph.D.*

**HALF-DAY WORKSHOP #3 (2:00-5:00 PM)**
Enduring Desire: Building a Strong, Resilient Couple Sexuality
*Presented by Barry McCarthy, Ph.D.*

6:00-7:00 PM Welcome Reception

6:30 PM Presentation of Consumer Book Award
*Sex at Dawn: The Prehistoric Origins of Modern Sexuality*
Christopher Ryan, Ph.D. and Cacilda Jetha, M.D.

6:00-8:00 PM Posters Session

**FRIDAY, APRIL 1, 2011**

7:30 AM–5:00 PM Conference Registration

7:30-8:30 AM Continental Breakfast

8:30-8:45 AM Welcome
*SSTAR President: Michael A. Perelman, Ph.D.*
*Scientific Program Chair, Len Derogatis, Ph.D.*
*Local Program Chair, Blanche Freund, Ph.D.*
*Continuing Education Officer, Brian Zamboni, Ph.D.*

8:45-10:45 AM Symposium I: Innovations in the Psychological Treatment of Sexual Dysfunctions
Moderator: Kathryn Hall, Ph.D.

Applications of Mindfulness in the Treatment of Women's Sexual Dysfunctions
*Presented by Lori Brotto, Ph.D.*

New Developments in CBT Treatment for Sexual Pain: Targeting Partner and Pain-Related Factors
*Presented by Sophie Bergeron, Ph.D.*

A Model for Combined Psychotherapy/Pharmacotherapy
*Presented by Alessandra Rellini, Ph.D.*

Women's Sexual Health and Sensorimotor Approaches to Therapy
*Presented by Sara Mize, Ph.D. and Alex Iantaffi, Ph.D., LAMFT*

10:45-11:00 AM Break

11:00-12:00 PM Paper Session I: New Developments in the Diagnosis and Treatment of Sexual Dysfunctions/ New Agents in the Pipeline *(CME is not available for this session)* Moderator: Mark Ackerman, Ph.D.

New ISSM Guidelines for Premature Ejaculation
*Presented by Stanley E. Althof, Ph.D.*

Low Cardiovascular Event Rate in Post-Menopausal Women With Increased Cardiovascular Risk: Two Year Blinded Summary from the Libigel Cardiovascular Safety Study
*Presented by Michael Snabes, M.D., Ph.D. and Joanne Zborowski, BSN*

Treatment of Hypoactive Sexual Desire Disorder often Requires Concomitant Treatment of Mood Disorders—A Role for Gepirone ER
*Presented by Louis Fabre, M.D., Ph.D. and Louis C. Smith , Ph.D.*

**FRIDAY, APRIL 1, 2011 (continued)**

| | |
|---|---|
| 12:00–1:15 PM | Lunch (on your own) |
| 1:15-2:15 PM | Invited Lecture I: Sexual Adjustment to Cancer [Supported by the Sexual Medicine Society of North America (SMSNA)]<br>*Presented by Greg Broderick, M.D.*<br>Moderator: Michael A. Perelman, Ph.D. |
| 2:15-3:15PM | Paper Session II: Predictive Value of Certain Aspects of Sexual Dysfunctions<br>Moderator: Daniel N. Watter, Ed.D. |
| | Erectile Dysfunction: The Canary in the Coal Mine<br>*Presented by Anne Katz, RN, Ph.D.* |
| | Anxiety, Catastrophizing and Self-Efficacy Predict Pain Intensity among Women with Provoked Vestibulodynia: A Prospective Study<br>*Presented by Katy Bois, B.Sc., Sophie Bergeron, Ph.D., Natalie Rosen, Ph.D., Serena Corsini-Mundt, M.A.* |
| | Physical Therapy Interventions for Lifelong Vaginismus<br>*Presented by Elke Reissing, Ph.D. and Heather Andruff, B.A.* |
| 3:15-3:45PM | Sandra R. Leiblum Student Paper Award<br>Moderator: Stephanie Kuffel, Ph.D.<br>"A Taxometric Analysis of Pedophilia"<br>*Recipient: Julia Elizabeth Mackaronis, BA* |
| | Student Poster Award Announcement |
| 3:45-4:15 PM | Break |
| 4:15-5:15 PM | Debate: Controversies in Diagnostic Nomenclature: Hypersexuality as Sexual Compulsion versus Sexual Addiction<br>*Presented by Eli Coleman, Ph.D. and Jon Grant, M.D.*<br>Moderator: Bonnie R. Saks, M.D. |
| 6:00 - 8:00 PM | BBQ Reception – Omphoy Ocean Resort —*preregistration required*<br>Dinner Plans |

**SATURDAY, APRIL 2, 2011**

| | |
|---|---|
| 7:30 AM–5:00 PM | Conference Registration |
| 7:30-8:30 AM | Breakfast Roundtables with Speakers |
| 8:30-10:30 AM | Symposium II: Pharmacologic Innovations in the Treatment of Sexual Dysfunction<br>Moderator: Michael A. Perelman, Ph.D.<br><br>Depression-Related Sexual Dysfunctions<br>*Presented by Robert Taylor Segraves, M.D., Ph.D.*<br><br>Hypoactive Sexual Desire Disorder<br>*Presented by Len Derogatis, Ph.D.*<br><br>Erectile Dysfunction<br>*Presented by Arthur Burnett, M.D.*<br><br>Innovations in the Treatment of Premature Ejaculation<br>*Presented by Stanley Althof, Ph.D.* |
| 10:30-11:00 AM | Break |
| 11:00-12:00 PM | Debate: Controversies in Diagnostic Nomenclature: Proposed DSM-5 Sexual Interest/Arousal Diagnosis versus DSM-IV Distinct and FSAD<br>*Presented by Lori Brotto, Ph.D. and Anita Clayton, M.D.*<br>Moderator: Marta Meana, Ph.D. |
| 12:00-1:00 PM | Business Meeting & Lunch (Members Only) |
| 1:00-2:00 PM | Invited Lecture II: Diagnosis and Treatment of Paraphilias/Pedophilia<br>*Presented by Fred Berlin, M.D.*<br>Moderator: Len Derogatis, Ph.D. |
| 2:00-3:15 PM | Clinical Case Presentation:<br>*Presented by Ruth Morehouse, Ph. D.*<br>Moderator: S. Michael Plaut Ph.D. |
| 7:00-9:00 PM | Fellowship Dinners at Local Restaurants |

**SUNDAY, APRIL 3, 2011**

**HALF-DAY ETHICS WORKSHOP (9:00-12:00 PM)**
Ethical Dilemmas and Clinical Conundrums in Sex Therapy:
Withstanding Assaults on Professional Integrity
*Presented by Daniel Watter, Ed.D. and Peggy Kleinplatz, Ph.D.*

# POSTERS

**1. Gender Differences in Observer Stance as a Predictor of Subjective and Genital Sexual Arousal**
*Jennifer Bossio, BA, Jessica Spape, BA, & Meredith Chivers, Ph.D.*

**2. Impact of Radical Trachelectomy on Sexual Distress: A Pilot Study**
*Lori A. Brotto, Ph.D. & Erin Breckon, BA*

**3. An Open Label Trial of Milnacipran in the Treatment of Women with Provoked Vestibulodynia—Research in Progress**
*Candace Brown, MSN, Pharm D*

**4. Ethnic Differences in Sexuality: Variations in Sexual Behavior Among Caucasion, Chinese, Japanese and Korean Students**
*Cara Dunkley, BA, Sabrina Chang, BA, Boris Gorzalka, Ph.D. & Steven Hobkirk*

**5. Temperament as a Predictor of Low Sexual Desire**
*Karen Brash McGreer RN, LMFT*

**6. Sexual Activity Frequency and Body Esteem Predict Sexual Desire in Young Women**
*Annia W. Raja, BBA, Yasisca P. Khouri, MA, & Cindy M. Meston, Ph.D.*

**7. Sexual Boundary Violations by Health Professionals: Offender Risk Factors**
*Katherine Rios, S Michael Plaut, PhD, Janet Brown, JD MSW, Robert Wilbur,MA & Mira Braneu, Ph.D.*

**8. Biological Markers of Asexuality: A Pilot Study of Sexual Orientation Groups**
*Morag Yule, BSc, BA & Lori Brotto, Ph.D.*

# Workshop Abstracts

## THE NATURE, ETIOLOGY, AND TREATMENT OF ASSESSMENT AND TREATMENT OF MALE SEXUAL DYSFUNCTIONS

**Donald S. Strassberg, Ph.D., ABPP**

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Men can experience difficulty at every stage of a sexual experience. They may have (1) diminished or absent sexual interest, (2) difficulty obtaining or maintaining an adequate erection, (3) problems in reaching orgasm despite significant sexual arousal, (4) difficulty sustaining high levels of sexual arousal for more than a brief period before reaching orgasm, or (5) experience pain associated with arousal or orgasm. These conditions can be the result of psychological factors, medical/organic factors, or (quite commonly) the interaction of both.

The introduction of Sildenafil (Viagra) and the other oral ED drugs has, more than any single event in history, made more people more aware than ever before of male sexual dysfunctions. Despite the current availability of effective treatments for many of these dysfunctions, men with these problems often still fail to seek treatment, and those seeking treatment may still not receive the most effective intervention(s) available.

This workshop will consider the nature and etiology of each of the male sexual dysfunctions. In addition, the role of sex therapy, psychotherapy, pharmacology, and their combination, as interventions will be discussed.

**Behavioral Learning Objectives:**

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

1. Identify and distinguish among the most common male sexual dysfunctions.
2. Illustrate the psychological, biological, and interpersonal factors underlying the etiology and maintenance of male sexual dysfunctions.
3. Describe the primary psychological and pharmacological approaches, and particularly their combination, in the treatment of male sexual dysfunctions.

**References:**

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Perelman, M.A., (2009). The sexual tipping point: A mind/body model for sexual medicine. *Journal of **Sexual** Medicine*, *6*, 2009, 629-632.

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Perelman, M.A., McMahon, C., & Barada, J. (2004). Evaluation and treatment of the ejaculatory disorders. In T. Lue (Ed.), *Atlas of Male Sexual Dysfunction* (pp. 127-57). Philadelphia: Current Medicine, Inc.

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Strassberg, D.S. & Perelman, M. A. (2009). Sexual dysfunctions. In P.H. Blaney & T. Millon (Eds.), *Oxford Textbook of Psychopathology* (2nd Ed.). New York: Oxford University Press, 399-430.

Wincze, J.P. (2009). *Enhancing Sexuality: A Problem Solving Approach to Treating Dysfunction (Treatments That Work).* New York: Oxford University Press.

**Biography:**

Donald Strassberg, Ph.D., ABPP, is Professor in the Department of Psychology at the University of Utah (Salt Lake City) where he has been a faculty member for over 35 years. His research focuses on various aspects of normal, dysfunctional, and deviant sexuality. He serves, or has served, on the editorial boards of *Archives of Sexual Behavior*, the *Journal of Sex and Marital Therapy*, *Sexual Abuse: A Journal of Research and Treatment*, and *The Journal of Sex Research*. He maintains a part-time private practice as a clinical psychologist, specializing in the treatment of sexual dysfunctions, and often offers workshops and classes in the diagnosis and treatment of sexual problems.

## ASSESSMENT, DIAGNOSIS AND TREATMENT OF FEMALE SEXUAL DISORDERS

**Sheryl A. Kingsberg Ph.D.**

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Since the Victorian era discovery that female orgasm was not necessary for conception, female sexuality has, at best been ignored, and often demonized. Women have had a long slow struggle against cultural taboos to reclaim their right to a satisfying sexual life. In 2009, the concept of healthy sexuality has, in theory, become an accepted entitlement of women and sexual problems have become more widely discussed. Further, epidemiologic research has now confirmed a high prevalence (12%) of female sexual disorders. Yet, for a myriad of reasons, such as lack of time, patient or provider embarrassment, lack of ,FDA approved treatments, healthcare providers and their patients continue to evade the topic in clinical visits which results in a significant void in comprehensive healthcare.

Although varying models for understanding the female sexual response have been proposed, all generally include the elements of desire, arousal, orgasm, and resolution and current research also emphasizes the importance of evaluating pain as a source of sexual problems. Current models reflect the biopsychosocial and multifactorial nature of the female sexual response. Basson's model of female sexual function acknowledges the importance of emotional intimacy, psychological factors, and sexual stimuli and posits that in women arousal often precedes desire. This description updates the traditional linear models of Masters and Johnson as well as Kaplan, in which desire precedes arousal. Levine suggests that desire has 3 distinct but interrelated components—drive (spontaneous biologically driven sexual interest), cognitive factors (expectations, beliefs, and values about sex), and motivation (emotional and interpersonal factors)—further emphasizing the complexity of female sexuality.

In this workshop, I will provide an overview of the female sexual disorders, how to assess and diagnose female sexual disorders, provide treatment options and review patient related outcome measures for screening and diagnosis.

**Learning Objectives**

1. Define the Female Sexual Disorders
2. Outline techniques for assessment and diagnosis of sexual disorders
3. Identify treatment options for each of the sexual disorders

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## Biography

Sheryl A. Kingsberg is a clinical psychologist and Professor in the Departments of Reproductive Biology and Psychiatry at Case Western Reserve University School of Medicine, and is the chief of the division of behavioral medicine in the department of OB/GYN at Case Medical Center, University Hospitals of Cleveland.

Dr. Kingsberg is the Immediate Past President of the International Society for the Study of Women's Sexual Health (ISSWSH) and served on the Executive Council for the Society of Reproductive Technologies (SART) from 2006-2009. She is an active member in numerous other national and international organizations including the American Psychological Association (APA), the American Society for Reproductive Medicine (ASRM), the Society for Sex Therapy and Research (SSTAR) and the North American Menopause Society (NAMS).

Dr. Kingsberg has authored numerous peer-reviewed manuscripts as well as several book chapters on topics including menopause and sexuality, sexual aversion disorder, the treatment of psychogenic erectile dysfunction, oocyte donation and infertility.

Dr. Kingsberg sits on the editorial boards for the journals Menopause and the International Journal of Impotence Research. Dr. Kingsberg's main research interests are in sexual medicine and the psychological aspects of infertility and menopause.

# VULVAR PAIN AND SEXUAL PAIN DISORDERS

**Andrew T. Goldstein, M.D.**

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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) and vaginitis (candidiasis, desquamative inflammatory vaginitis.) We will discuss local non-surgical therapies (lidocaine, capsaicin, interferon), systemic treatment options (antidepressants, anti-convulsants), and surgery (vulvar 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. Describe a patient treatment plan based on the specific cause of dyspareunia.
3. Identify non-medical methods of treatment

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**Biography**

Dr. Andrew T. Goldstein grew up in Bridgeton, New Jersey and graduated from the University of Virginia and the University of Virginia School of Medicine. He pursued his internship and residency in obstetrics and gynecology at the Beth Israel Medical Center. After completing his residency, Dr. Goldstein moved to Annapolis, Maryland and started the Sexual Wellness Center which is devoted to the treatment of female sexual dysfunction. In 1999, he joined the faculty of the Johns Hopkins School of Medicine and he became the director of the Center for Vulvovaginal Disorders in Washington, D.C. and New York City in 2002.

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 (ISSVD) and to the American Society for Colposcopy and Cervical Pathology (ASSCP). Dr Goldstein is a grant recipient of the National Vulvodynia Association, and is President-Elect of the International Society for the Study of Women's Sexual Health (ISSWSH). He co-authored the chapter on female sexual dysfunction for the *Johns Hopkins Manual of Gynecology and Obstetrics* and the second edition of his book *Reclaiming Desire* was published in June 2009. He is a co-editor for a textbook entitled *Female Sexual Pain Disorders: Evaluation & Management* that was published in 2009. His third book *When Sex Hurts* was released in February 2011.

Dr. Goldstein is actively involved in research and has published more than 75 peer-reviewed articles, abstracts, and book chapters on female sexual dysfunction, sexual pain disorders, lichen sclerosus, lichen simplex chronicus, vulvodynia, and vulvar vestibulitis syndrome.

# CANCER, CARDIAC DISEASE, AND SEXUAL DYSFUNCTION: ISSUES AND ANSWERS

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Chronic medical illnesses like cardiovascular disease and cancers can impact the sexual response cycle and result in both personal and marital and sexual distress. The importance of identifying and addressing medical health concerns are critical when completing a comprehensive sexual evaluation for the patient. Cancer and cardiovascular disease can impact neurobiology, anatomy of genito-pelvic region as well as impact overall general health and wellness. Coupled with the medical changes many psychological and psychosexual changes can occur including relationship dynamic changes, role changes, changes in sexual self esteem, stress and fatigue. Understanding medical illness and the medications that are often used to treat a variety of conditions can help the health care professional, therapist and sexual expert in their multidimensional assessment and provide insight when formulating a differential diagnosis. Some simple therapeutic interventions can be implemented with the patient and can help treat sexual problems resulting in enhanced couple intimacy.

**Behavioural Learning Objectives:**

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

Identify common sexual complaints in patients who have concurrent cardiovascular disease

Identify common sexual complaints in patients who have concurrent cancer or are undergoing cancer treatment.

Design and begin implementation of treatment care plans to help begin treatment for sexual complaints

Identify both medical and psychological treatment options for those who have sexual complaints and cardiovascular disease or cancer.

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**Biography:**

Michael L. Krychman, MDCM, is the Medical Director of The Sexual Medicine Center at Hoag Hospital and the Executive Director of the Southern California Center for Sexual Health and Survivorship Medicine located in Newport Beach California. He is the former Co Director of The Sexual Medicine and Rehabilitation Program at Memorial Sloan-Kettering Cancer. He also is a clinical sexologist and has completed his Masters in Public Health and Human Sexuality. Dr Krychman is also an AASECT certified sexual counsellor. He is on faculty at University of Southern California.

His special interests include sexual pain disorders, loss of libido, chronic medical illness and its impact on female sexual function as well as breast cancer sexuality. He is a well known speaker who is featured locally, nationally and internationally. He has published countless articles in peer reviewed journals and has been featured in many magazines. Dr Krychman is on the editorial board for the Journal of Sexual Medicine, Current Sexual Medicine. He is the Scientific Co Chairman for the 2010 International Society for the Study of Women's Sexual Health annual educational meeting. He is an active member in good standing in ISSM, ESSM ISSWSH and AASECT.

Dr. Krychman's book, 100 Questions & Answers for Women *Living with Cancer: A Practical Guide to Female Cancer Survivorship h*as been recently published. His third patient educational book, 100 Questions and Answers about Women's Sexual Wellness and Vitality. He has been featured in the New York Times and US News and World Report World Report, The Wall Street Journal, New York Times, Health Magazine and many others.

# COMBINATION THERAPIES IN THE TREATMENT OF SEXUAL DYSFUNCTION

**Michael A. Perelman, Ph.D.**

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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 and female sexual disorders (SD). Combination Treatment (CT) 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 pharmaceutical. Health Care Physicians (HCP) 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 HCPs 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 SD. However, the mind and body both inhibit and excite sexual response, as described by the Sexual Tipping Point® model (STP). 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. Every man (whether he experiences a "normal," premature, or delayed ejaculatory latency) 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 utilized to provide 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 SD 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 SD.

The workshop will incorporate diagnostic and case management examples 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. 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:**

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. Outline the treatment of sexual disorders, through the lens of a revised/updated PLISSIT model.

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* Perelman M. "The Sexual Tipping Point®: A Mind/Body Model For Sexual Medicine." *Journal of Sexual Medicine,* 2009;6(3):629-32.

**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 Ph.D. 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 of The Society for Sex Therapy and Research (SSTAR). He was elected a Fellow of the Sexual Medicine Society of North America (SMSNA) and was named to the Standards Committee of the International Society for Sexual Medicine (ISSM). He 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), , 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 IMPULSIVE AND COMPULSIVE SEXUAL BEHAVIOR**

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The workshop will provide an introduction to the assessment and treatment of impulsive/compulsive sexual behavior. Impulsive/compulsive sexual behavior (ICSB) has been defined as a clinical syndrome characterized by the experience of sexual urges, sexually arousing fantasies, and sexual behaviors that are recurrent, intense, and a distressful interference in one's daily functioning. CSB has also been referred to in the literature as hypersexuality, sexual addiction, sexual compulsivity, sexual impulsivity, or paraphilia-related disorder**.** Individuals with ICSB often perceive their sexual behavior to be excessive but are unable to control it; they act out impulsively and/or are plagued by intrusive, obsessive thoughts and driven behaviors. Some have more problems with impulsivity and, for others, it is more of a problem of a compulsive drive. CSB can cause emotional suffering and potentially lead to social, ethical, and legal sanctions and increased health risks, such as HIV infection.

This workshop will describe assessment and treatment approaches and practical techniques for the various types of ICSB with an emphasis on the non-paraphilic types. Assessment approaches will include history taking, testing and questionnaires. Treatment approaches will include psychoeducational, psychotherapeutic and pharamacologic approaches. Various techniques in psychotherapy will be discussed within the main treatment modalities - individual, group and family therapy. The goals of the therapy are not only to gain control over impulsive/compulsive behaviors but to improve sexual functioning and overall sexual health. The various pharmacotherapies that have been found to be effective will also be reviewed. A multimodal, multidisciplinary approach to impulsive/compulsive sexual behavior will be described.

**Behavioral Learning Objectives:**

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

1. Diagnose the various types of impulsive/compulsive sexual behavior
2. Provide new treatment approaches to treat impulsive/compulsive sexual behavior
3. Describe both psychological and medical methods of treatment.

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Raymond, N., Grant J. E., Coleman, E. (2010). Augmentation with Naltrexone to Treat Compulsive Sexual Behavior: A Case Series. *Annals of Clinical Psychiatry, 22*(1), 56-62.

**Biography:**

Eli Coleman, PhD is professor and director of the Program in Human Sexuality, Department of Family Medicine and Community Health, University of Minnesota Medical School in Minneapolis. He is the author of numerous articles and books on compulsive sexual behavior, sexual offenders, sexual orientation, gender dysphoria, chemical dependency and family intimacy and on the psychological and pharmacological treatment of a variety of sexual dysfunctions and disorders. Professor Coleman is the founding editor of the *International Journal of Transgenderism* and is the founding and current editor of the *International Journal of Sexual Health*. He is one of the past-presidents of the Society for the Scientific Study of Sexuality, the World Professional Association for Transgender Health (formerly the Harry Benjamin International Gender Dysphoria Association), the World Association for Sexual Health, and the International Academy for Sex Research. He has been a frequent technical consultant on sexual health issues to the World Health Organization (WHO), the Pan American Health Organization (the regional office of WHO), and the Centers for Disease Control and Prevention (CDC). He has been the recipient of numerous awards including the US Surgeon General's Exemplary Service Award for his role as senior scientist on *Surgeon General's Call to Action to Promote Sexual Health and Responsible Sexual Behavior*, released in 2001. He was given the Distinguished Scientific Achievement Award from the Society for the Scientific Study of Sexuality and the Alfred E. Kinsey Award by the Midcontinent Region of the Society for the Scientific Study of Sexuality in 2001. In April, 2007, he was awarded the Gold Medal for his lifetime contributions to the field of sexual health by the World Association for Sexual Health. In May of 2007, he was appointed the first endowed Chair in Sexual Health at the University of Minnesota Medical School. In May of 2009, he was awarded the Masters and Johnson Award by the Society for Sex Therapy and Research.

## ENDURING DESIRE: BUILDING A STRONG, RESILIENT COUPLE SEXUALITY

**Barry McCarthy, Ph.D.**

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This clinically-oriented workshop focuses on the psychobiosocial model of understanding, assessing, treating, and relapse prevention of sexual desire issues. Using couple scenarios and describing psychosexual skill exercise to promote sexual desire workshop participants will explore three core issues:

1. Couple sexual style and the value of tailoring interventions toward the strengths and vulnerabilities for the couple's chosen sexual style.
2. The new mantra for healthy couple sexuality-finding the right level of intimacy, utilizing non-demand pleasuring, integrating erotic scenarios and techniques, and positive ,realistic sexual expectations which promote satisfaction.
3. Accepting the Good Enough Sex model with a special focus on the strengths and problems of synchronous (mutual) sexual experiences as opposed to asynchronous sexual scenarios and techniques.

**Learning objectives:**

After attending this workshop, participants will be able to:

1. Employ the psychobiosocial model to assess, treat, and design a relapse prevention program to promote strong, resilient sexual desire.
2. Tailor sexual scenarios and psychosexual skill exercises to the couple's chosen sexual style.
3. Help couples revitalize sexual desire and enhance sexuality in their 60's, 70's, and 80's.

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**Biography**

Barry McCarthy is a diplomate in both clinical psychology and sex therapy. He is a professor of psychology at American University and practices at the Washington Psychological Center. He has published 92 professional articles, 22 book chapters, written 17 books, and presented over 300 workshops nationally and internationally.

# Presenter Abstracts

## SYMPOSIUM: PSYCHOLOGICAL INNOVATIONS IN TREATING SEXUAL DYSFUNCTIONS

## APPLICATIONS OF MINDFULNESS IN THE TREATMENT OF WOMEN'S SEXUAL DIFFICULTIES

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**Introduction**: Mindfulness is the practice of intentionally being fully aware of one's thoughts, emotions and physical sensations in a nonjudgmental way. Although mindfulness is rooted in Eastern spiritual practices, it is rapidly being embraced in Western approaches to both physical and mental health care.

**Method:** The empirical literature testing mindfulness for sexual problems is limited to two non-controlled studies and one qualitative study in non-distressed couples. Among the latter, a mindfulness-based intervention significantly enhanced relationship satisfaction and reduced distress (Carlson, Carlson, Gil, & Baucom, 2004). In the two non-controlled studies, a 3-session mindfulness-based group therapy significantly improved several indices of sexual function and reduced sexual distress in women with iatrogenic sexual desire and arousal difficulties (Brotto, Basson, & Luria, 2008) and in women with sexual arousal disorder associated with gynecologic cancer (Brotto, Heiman, et al., 2008). The goal of this presentation is to discuss the findings from four controlled trials evaluating a mindfulness-based cognitive behavioral sex therapy in diverse samples of women.

**Results:** To be presented.

**Discussion**: Among different samples of women with (1) Provoked Vestibulodynia, (2) sexual dysfuntion associated with gynaecologic cancer, (3) iatrogenic hypoactive sexual desire disorder, and (4) sexual distress associated with a history of childhood sexual abuse, a 4-session mindfulness-based cognitive behavioral intervention significantly improved several indices of sexual function and significantly reduced distress compared to a wait-list control group. These studies provide further support for the utility of incorporating mindfulness into an array of complex sexual symptom presentations.

**Behavioral Learning Objectives:**
After attending this presentation, the participants will be able to:

1. Define mindfulness and understand how mindfulness complements traditional cognitive behavior therapy
2. Describe how mindfulness might particularly target sexual symptoms presented by women

3. Identify recent evidence testing a mindfulness-based cognitive behavioral program in four diverse samples of women with sexual symptoms

**References:**

Brotto, L. A., Basson, R., & Luria, M. (2008). A mindfulness-based group psychoeducational intervention targeting sexual arousal disorder in women. J Sex Med, 5, 1646-59.

Brotto, L. A., Heiman, J. R., Goff, B., Greer, B., Lentz, G. M., Swisher, E., et al. (2008). A psychoeducational intervention for sexual dysfunction in women with gynaecologic cancer. Arch Sex Behav, 37, 317-29.

Carson, J. W., Carson, K. M., Gil, K. M., & Baucom, D. M. (2004). Mindfulness-based relationship enhancement. Behav Ther, 35, 471-94.

**Biography:**

Lori Brotto has a PhD in clinical psychology from the University of British Columbia (UBC) and completed a Fellowship in Reproductive and Sexual Medicine from the University of Washington. She is an Associate 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. 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, the Journal of Sex Research, 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, and is on the Sexual and Gender Identity Disorders workgroup for DSM-5.

**NEW DEVELOPMENTS IN COGNITIVE-BEHAVIORAL THERAPY FOR SEXUAL PAIN: TARGETING PARTNER AND PAIN-RELATED FACTORS**

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**Pelvic pain problems affecting women's sexual and reproductive health** are poorly understood and often misdiagnosed or ignored. In addition to their high prevalence rates, ranging from 12 to 21% in community samples, these conditions can impinge on patients' sexual functioning, general psychological well being and overall quality of life. Up until recently, little had been done to develop novel targeted psychotherapy interventions for this population, partly because there was a lack of empirical research focusing on the role of psychosocial factors in the experience of genital pain and associated sexual and psychological distress. The purpose of this presentation is to outline new foci for intervention in individual and couple cognitive-behavioral therapy (CBT). Specifically, fear avoidance, self-efficacy and partner variables will be discussed. In a randomized trial comparing a topical application to CBT, we found that higher levels of pre-treatment fear of pain and catastrophizing contributed to higher pain intensity at six-month follow-up of group CBT treatment, whereas higher levels of pain self-efficacy were associated with less pain, independent of baseline pain. In another study focusing on the role of dyadic factors in dyspareunia, results indicated that higher solicitous partner responses were associated with higher levels of women's pain intensity, independent of depressive symptoms. In addition, controlling for sexual function and dyadic adjustment, greater solicitous partner responses predicted women's greater sexual satisfaction, whereas partner responses were not associated with women's sexual function. New strategies for sex and couple therapy interventions will be proposed based on these findings, including the development of facilitative partner responses.

**Behavioral Learning Objectives:**
After attending this presentation, the participants will be able to:

1) To identify which cognitive, affective and relationship factors play a role in the experience of dyspareunia and associated sexual difficulties
2) To describe psychological predictors of cognitive-behavioral treatment outcome
3) To apply targeted sex and couple therapy interventions focusing on specific cognitive, affective and relationship factors influencing dyspareunia

**References:**

Arnold, L. D., Bachmann, G. A., Rosen, R., Kelly, S., & Rhoads, G. G. (2006). Vulvodynia: Characteristics and Associations With Comorbidities and Quality of Life. *Obstetrics & Gynecoly, 107*, 617-624

Rosen, N. O., Bergeron, S., Leclerc, B., Lambert, B., & Steben, M. (in press). Woman and

partner-perceived partner responses predict pain and sexual satisfaction in vestibulodynia couples. *Journal of Sexual Medicine.*

Desrochers, G., Bergeron, S., Khalifé, S., Dupuis, M-J, & Jodoin, M. (2010). Provoked vestibulodynia: Psychological predictors of topical and cognitive-behavioral treatment outcome. *Behaviour Research and Therapy, 48*, 106-115.

**Biography:**

Sophie Bergeron, Ph.D., is an Associate Professor of Psychology at Université de Montréal and a Clinical Psychologist at the Sex and Couple Therapy Service of the McGill University Health Centre (Royal Victoria Hospital). She received her Ph.D. in Clinical Psychology from McGill University in 1999 under the supervision of Dr. Irv Binik. The author and co-author of several articles, chapters, and conferences on the topics of dyspareunia and vulvodynia, Dr. Bergeron's research focuses on the treatment outcome of dyspareunia as well as on the role of psychosocial variables in the experience of sexual pain. She has served on the Executive Committee of the Society for Sex Therapy and Research, is an editorial consultant for Archives of Sexual Behavior and an advisor to the DSM-V Workgroup on Sexual and Gender Identity Disorders.

## A MODEL FOR COMBINED PSYCHOTHERAPY/ PHARMACOTHERAPY

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**Introduction**: Over the past decade, a variety of pharmacological compounds have been developed for the treatment of women's sexual dysfunction. Additionally, numerous psychotherapy approaches have been proposed to treat sexual dysfunction. What would be like if we combined psychological and pharmacological treatment for female sexual dysfunction (Althof, 2006)?

**Discussion**: Data from studies that combined biological and psychological treatments for male (Perelman, 2005; Rosen, 2000) and female (Meston, Rellini, & Telch, 2008) sexual dysfunction will be discussed and literature on the treatment of a variety of psychiatric disorders will be reviewed to further inform the field of sex research and therapy.

**Behavioral Learning Objectives:**

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

1. Describe empirical evidence for pharmacological and psychological treatment for female sexual dysfunction
2. Identify the theoretical effects of combining psychological to biological approaches to sexual dysfunction
3. Propose potential new ways to combine pharmacotherapy to psychotherapy approaches

**References:**

Althof, S. (2006). Sex therapy in the age of pharmacotherapy. *Annual Review of Sex Research*, *18*,116–32.

Perelman M. (2005). Combination therapy for sexual dysfunction: Integrating sex therapy and pharmacotherapy.In: Balon R, Segraves R, eds. *Handbook of sexual dysfunction* (pp 13-41). New York: Taylor and Francis.

Meston, C. M., Rellini, A. H. & Telch, M. (2008). An outcome study on gingko biloba and sex therapy for the treatment of female sexual dysfunction. *Archives of Sexual Behavior, 37*(4), 530-547.

Rosen R. (2000). Medical and psychological interventions for erectile dysfunction; toward a combined treatment. In: Leiblum S, Rosen R, eds. *Principles and practices of sex therapy*. New York: Guilford Press.

**Biography:**

Dr. Rellini received her Ph.D. from the University of Texas at Austin in 1997, after completing a Clinical Fellowship at Yale University. She has been on faculty in the Department of Psychology at the University of Vermont since 2007, where she directs the Sexual Health Research Clinic, a laboratory dedicated to the translational study of sexual dysfunction in men and women.

# WOMEN'S SEXUAL HEALTH AND SENSORIMOTOR APPROACHES TO THERAPY

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**Introduction:**Many women have had experiences ranging from boundary violations to full-blown trauma in the areas of gender and sexuality. Sensorimotor and other body- and mindfulness-based approaches to therapy are increasingly being used to treat trauma (Levine & Frederick, 1997; Ogden, Minton, & Pain, 2006). However, there is very little evidence to demonstrate: 1) how these approaches might be applied to therapy focusing on sexual and relationship issues or 2) how women with sexual dysfunctions might benefit from these approaches.
**Method:**Participants arebeing recruited from two women's sexual health groups. All participants have access to a monthly sensorimotor intervention with their own weekly therapy group. A series of standardized scales are used to collect data on sexual functioning, body connection and mindfulness both before and after the end of the intervention. A focus group with each group of participants will also be carried out after the end of the intervention. One of the researchers also serves the role of participant-observer during the session and writes field notes from an ethnographic perspective.
**Results:**This study is new and ongoing. Initial findings from the first group of participants will be ready for presentation for the SSTAR meeting. Findings will include both qualitative and quantitative data.
**Discussion**:Body-based approaches to psychotherapy have not yet been documented in relation to their potential use in sex therapy, especially when dealing with women presenting with sexual dysfunction. Yet these women often present with issues that are manifesting in a physical manner and that cannot always be successfully addressed through talk-therapy alone. The findings will help us illustrate the opportunities and limitations of this novel approach.
**Utility/Limitations/Risks**: The results of this study will help therapists and researchers working with this population, but the results are limited by the small sample size and by the fact that this is a pilot study.

**Behavioral Learning Objectives:**
After attending this presentation, the participants will be able to:

1. Describe how a sensorimotor approach can be applied to sex therapy;
2. Outline the benefits and limitations of using a sensorimotor approach with a women's sexual health group;
3. Identify key issues and implications for further research in this field.

**References**

Levine, P. with Frederick, A. (1997). *Waking the Tiger: Healing Trauma*. Berkeley, CA: North Atlantic Books.

Ogden. P., Minton. K. & Pain, C. (2006). *Trauma and the Body: A Sensorimotor Apporach to Psychotherapy*. New York: W.W. Norton and Company, Inc.

**Biography:**

Dr. Iantaffi is currently a researcher in the School of Public Health at the University of Minnesota, as well as Editor-in-Chief for the Journal of Sexual and Relationship Therapy. His research interests and publications have been focused on gender, sexuality and relationships.

Dr. Mize is a licensed psychologist and Assistant Professor at the Program in Human Sexuality in the Department of Family Medicine and Community Health at the University of Minnesota. She is a clinician and educator. She is certified in Sensorimotor Psychotherapy and uses this modality frequently with the populations she serves.

## NEW ISSM GUIDELINES FOR PREMATURE EJACULATION

**Stanley E. Althof, Ph.D. for the ISSM PE Guidelines Committee**

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**Introduction:** Over the past 20 years our knowledge of premature ejaculation (PE) has significantly advanced. Given the abundance of high level research it seemed like an opportune time for the International Society for Sexual Medicine (ISSM) to promulgate an evidenced-based, comprehensive and practical set of clinical guidelines for the diagnosis and treatment of premature ejaculation.

**Method:** Reviewing the literature and developing graded recommendations using the Oxford Centre of Evidence-Based Medicine system.

**Results:** The attached table outlines the recommendations regarding the definition, prevalence, assessment and varied methods of treatment.

**Conclusion and Limitations:** Development of guidelines is an evolutionary process that continually reviews data and incorporates the best new research. We expect that ongoing research will lead to a more complete understanding of the pathophysiology as well as new efficacious and safe treatments for this sexual dysfunction. Therefore, it is strongly recommended that these guidelines be re-evaluated and updated by the ISSM every 4 years.

**Behavioral Leaning Objectives**
After attending this presentation, the participants will be able to:

1. Identify the definition, prevalence, assessment, and physiological and psychological contributions to PE
2. Describe the various treatment options for PE

**References:**

1. Althof S, Abdo C, Dean J, Hackett G, McCabe M, McMahon, Rosen R, et al International Society for Sexual Medicine's Guidelines for the Diagnosis and Treatment of Premature Ejaculation. Journal of Sexual Medicine, in press.

**Biography:** Dr. Althof is Executive Director of the Center for Marital and Sexual Health of South Florida and a Voluntary Professor at the University of Miami Miller School of Medicine. He and his two former partners were the 2005 recipients of SSTAR's prestigious Masters and Johnson Lifetime Achievement Award.

**Table 1 - Summary of PE Guideline Recommendations**

| Topic | Recommendation |
|---|---|
| **Definition of Lifelong PE** | A male sexual dysfunction characterized by ejaculation which always or nearly always occurs prior to or within about one minute of vaginal penetration, and the inability to delay ejaculation on all or nearly all vaginal penetrations, and negative personal consequences, such as distress, bother, frustration and/or the avoidance of sexual intimacy |
| **Definition of Acquired PE** | There are insufficient published objective data to propose a new evidence-based definition of acquired PE, although it believed the proposed criterion for lifelong PE might be applied to acquired PE as well |
| **Prevalence of PE** | Statistical analysis of population-based data indicate that 1%-3% of men ejaculate in under 1 minute. |
| **Average Ejaculatory Latency** | In multinational studies the median IELT is 5.4 minutes and decreased significantly with age. Median IELT may differ between countries. |
| **Quality of Life** | Negative effects on quality of life and interpersonal difficulty related to their PE have been consistently been reported by men and their partners |
| **Etiology** | The etiology of premature ejaculation is not known. To date, no biological factor has been shown to be causative in the majority of men with PE. |
| **Assessment** | The committee agreed that there was inadequate evidence to recommend screening or case-finding for PE, either in a general population or in any sub-population. However, it is recommended that men with ED be screened for PE |
| | It is recommended that clinicians utilize the screening questions in Table 2 and that clinicians take a medical and psychosocial history |
| | Since patient self-report is the determining factor in treatment seeking and satisfaction, it has been recommended that self-estimation by the patient and partner of ejaculatory latency be routinely assessed in clinical practice when PE is present |
| | The PEP or IPE are currently the preferred questionnaire measures for assessing PE, particularly in the context of monitoring responsiveness to treatment |
| | For lifelong PE, a physical examination is highly advisable but not mandatory and should be conducted in most if not all patients |
| | For acquired PE a targeted physical examination is mandatory to assess for associated/causal diseases such as ED, thyroid dysfunction or prostatitis |
| **Treatment** | There is robust evidence to support the efficacy and safety of on-demand dosing of dapoxetine for the treatment of lifelong and acquired PE. It has been approved in some countries |
| | There is robust evidence to support the efficacy and safety of off-label daily dosing of the SSRIs paroxetine sertraline, citalopram, fluoxetine, and the serotonergic tricyclic, clomipramine, and off-label on-demand dosing of clomipramine and paroxetine, for the treatment of lifelong and acquired PE |
| | There is good evidence to support the efficacy and safety of off-label on-demand topical anaesthetics in the treatment of lifelong PE |
| | There is contradictory evidence to support the efficacy and safety of off-label on-demand or daily dosing of PDE-5 inhibitors in the treatment of lifelong PE in men with normal erectile function. Treatment of lifelong PE with PDE-5 inhibitors in men with normal erectile function is not recommended and further evidence-based research is encouraged to further understand conflicting data |
| | Treatment of PE with Tramadol cannot be recommended |
| | There is modest evidence supporting the efficacy of psychological/behavioral interventions in the treatment of PE |
| | Combining pharmacological and psychological/behavioral treatments may be especially |

**Table 1 - Summary of PE Guideline Recommendations**

| | |
|---|---|
| | useful in men with acquired premature ejaculation where there is a clear psychosocial precipitant or lifelong cases where the individual or couple's responses to PE are likely to interfere in the medical treatment and ultimate success of therapy |
| | There is reliable evidence to support the treatment of PE and co-morbid ED with ED pharmacotherapy. There is level 3c evidence to support the treatment of PE and co-morbid ED with ED pharmacotherapy in combination with PE pharmacotherapy |
| | Selective dorsal nerve neurotomy or hyaluronic acid gel glans penis augmentation may be associated with permanent loss of sexual function and is not recommended in the management of PE |
| **Outcome** | Treatment outcome can be addressed in one simple, brief and validated question known as the Clinical Global Impression of Change (CGIC). It asks patients, "Compared to before starting treatment, would you describe your premature ejaculation problem as: much worse, worse, slightly worse, no change, slightly better, better, or much better?" |

**LOW CARDIOVASCULAR EVENT RATE IN POST-MENOPAUSAL WOMEN WITH INCREASED CARDIOVASCULAR RISK; TWO YEAR BLINDED SUMMARY FROM THE ONGOING LIBIGEL® (TESTOSTERONE GEL) CARDIOVASCULAR SAFETY STUDY**

**Michael C. Snabes, MD, Ph.D. and Joanne Zborowski, BSN**

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**Introduction:** To obtain an indication for low-dose testosterone (LibiGel®) treatment of postmenopausal women with Hypoactive Sexual Desire Disorder (HSDD), long-term cardiovascular (CV) and breast safety must be demonstrated. The LibiGel placebo-controlled safety study is now entering its 3rd year of blinded treatment. Herein we report on its progress.

**Method:** This is a Phase III, CV events-driven, adaptive design, randomized, double-blind, placebo-controlled, multi-center comparison of LibiGel® and identical placebo gel in postmenopausal women with HSDD and known CV risk. The primary safety outcome measure is the effect of treatment on the incidence of comprehensive, adjudicated CV events. The governance of the study includes an independent Data Monitoring Committee (DMC), the only group that is un-blinded to treatment, a cardiovascular events adjudication committee and a breast cancer committee.

**Results:** Over 2,400 post-menopausal women, mean age 60.1 years and elevated CV risk have been enrolled. The composite rate of adjudicated, protocol-mandated CV events of subjects exposed to an average of 9 months of study drug is 0.61% and the breast cancer rate is 0.32%. The DMC has recommended that the study continue without changes after 3 separate un-blinded data reviews.

**Discussion:** These data demonstrate a very low rate of CV events and breast cancers to date in subjects who are at the higher end of CV risk continuum for the intended treatment population.

**Utility/Limitations/Risks:** Though we are still blinded to treatment we conclude that the continued low rate of CV events and breast cancers supports a lack of effect of testosterone on these systems in postmenopausal women and suggests that that LibiGel will be safe for treating women with HSDD.

**Behavioral Learning Objectives:**

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

1. Describe the regulatory requirements to demonstrate the safety of testosterone in postmenopausal women.
2. Identify the low cardiovascular and breast cancer event rates in an ongoing, blinded safety study in support of the long-term safety of low dose testosterone treatment of postmenopausal women with HSDD.

**References:**

Snabes, MC and SM Simes Approved Hormonal Treatments for HSDD: an Unmet Medical Need. J Sexual Medicine 2009; 6 (7) 146-9

**Biography:**

Michael C. Snabes, M.D., Ph.D is a reproductive endocrinologist and the Senior Vice President of Medical Affairs at BioSante Pharmaceuticals, Inc. His most recent faculty appointment was in the Department of Obstetrics and Gynecology at the University of Chicago Pritzker School Of Medicine. He has more than 145 abstracts and peer reviewed publications in numerous therapeutic areas including women's health.

# TREATMENT OF HYPOACTIVE SEXUAL DESIRE DISORDER (HSDD) OFTEN REQUIRES CONCOMITANT TREATMENT OF MOOD DISORDERS – A ROLE FOR GEPIRONE-ER

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**Introduction:** A relationship between sexual dysfunction and mood disorders has been established long ago (Ace 2007). Depression and anxiety can occur secondary to sexual dysfunction (Derogatis 1981), and sexual dysfunction can occur secondary to anxiety and depression (Ace 2007). Often the nature of the association is not clear with all three symptoms occurring at the same time (Laurent and Simons 2009). Practitioners who treat sexual dysfunction are not those that usually treat anxiety and depression and vice versa. We propose that the adequate treatment of sexual dysfunction requires concomitant treatment of anxiety and depression.

Gepirone-ER, a 5-$HT_{1A}$ partial agonist, has been shown to treat Major Depression (Feiger et al. 2003), as well as Generalized Anxiety Disorder (De Veaugh-Geiss 2010) and sexual dysfunction (Fabre and Smith 2010).

The objective of this paper is to determine whether relief of depression and anxiety contributes to the overall treatment of sexual dysfunction.

**Methods:** In 3 short term studies of Major Depression, entry criteria required depressive symptoms and not sexual dysfunction. At baseline and each subsequent visit, depression was measured by the HAMD-17 total score, anxiety by the HAMD–item 12 psychic anxiety, and sexual desire by the Derogatis Inventory of Sexual Function (DISF) cognitive/fantasy domain which measures desire. In all, 705 women and 304 men were enrolled in the studies. Antidepressant responders were subjects that had a 50% or more reduction in HAMD-17 total score from baseline to endpoint; non-responders less than a 50% reduction. Anxiolytic responders were those subjects who scored 0 or 1 (none to mild) on the HAMD-17 item 12 (psychic anxiety) at endpoint; non-responders scored 2, 3 or 4, moderate to severe anxiety. A meta-analysis of these three studies was used to arrive at the combined p values for each population category.

**Results:** Both antidepressant responders and non-responders had statistically significant improvement on the DISF desire domain (Goldstein et al. 2010). Similarly, both anxiolytic responders ($p = 0.01$) and non responders ($p = 0.03$) had statistically significant improvement on the DISF desire domain. These results indicate that the total gepirone-ER effect on the DISF desire domain is made up of three positive factors: a pro-sexual effect, an antidepressant effect, and an anxiolytic effect. The large resultant gepirone-ER effect is the combined effect of the three factors.

**Discussion:** These results indicate that treatment of depression and anxiety contributes to the overall treatment of sexual dysfunction. While it is well documented that the best results in the treatment of psychiatric subjects are obtained by combined psychotherapy and pharmacotherapy (Pampallona et al. 2004), this is rarely the case in current practice. There is no currently

approved pharmacotherapy of HSDD. Currently available antidepressant/anxiolytics such as the SSRIs make sexual function worse. Combinations of sex therapy, antidepressant therapy (such as bupropion) and anxiolytic therapy (such as buspirone) have not been studied. However, this may be the best option with currently available treatments. There is an unmet medical need for effective pharmacotherapy of HSDD.

**Utility/Limitations/Risks:** Gepirone-ER is currently an unavailable unapproved medication. Alternative combination treatments have not been studied.

**Behavioral Learning Objectives:**
After attending this presentation, the participants will be able to:

1. Outline the contributions of anxiety and depression to sexual dysfunction.
2. Describe the use of both psychotherapy and pharmacotherapy in the treatment of sexual dysfunction

**References:**


1. Ace, K. J. (2007). Mental Health, mental illness, and sexuality. In: M. S. Tepper & A. F. Owens (Eds.), *Sexual health volume 1: Psychological foundations* (pp. 301-329). Westport, CT: Praeger Publishers/Greenwood Publishing Group.
2. DeRogatis, L. R., Meyer, J. K., & King, K.M. (1981). Psychology in individuals with sexual dysfunction. *American Journal of Psychiatry*, 138, 757-763.
3. Laurent, S. M. & Simons, A. D. (2009). Sexual dysfunction in depression and anxiety: Conceptualizing sexual dysfunction as part of an internalizing dimension. *Clinical Psychology Review,* 29, 573-585.
4. Feiger, A. D., Heiser, J. F., Shrivastava, R. K., Weiss, K. J., Smith, W. T., Sitsen, J. M., & Gibertini, M. (2003). Gepirone extended-release: new evidence for efficacy in the treatment of major depressive disorder. *Journal of Clinical Psychiatry,* 64, 243-249.
5. De Veaugh-Geiss, J. (2010) Gepirone-IR treatment of generalized anxiety disorder (GAD). 50th New Clinical Drug Evaluation Unit (National Institute of Mental Health) (NCDEU) Annual Meeting. June 14-17, 2010. Boca Raton, FL.
6. Fabre, L. F., & Smith, L. C. (2010). Hypoactive Sexual Desire Disorder and Female Sexual Arousal Disorder should not be combined in DSM-V. *Journal of Sexual Medicine*, 7, 1998-2014.
7. Goldstein, I. M., Smith, L. C., & Fabre, L. F. (2010) Gepirone-ER Effects on Sexual Desire in Women with Major Depressive Disorder (MDD). The 14th World Meeting of the International Society for Sexual Medicine. September 26-30, 2010. Seoul, Korea.
8. Pampallona, S., Bollini, P., Tibaldi, G., Kupelnick, B., & Munizza, C. (2004). Combined pharmacotherapy and psychological treatment for depression: a systematic review. *Archives of General Psychiatry,* 61,714-719.


**Biography:**
Dr. Fabre received a PhD in Endocrinology from Case-Western Reserve in 1966, and an MD from Baylor College of Medicine in 1969. He did his psychiatric residency at Baylor Affiliated Hospitals and is a Board Certified Psychiatrist. He has been developing drugs to treat psychiatric and related disorders since 1972.

## CANCER SURVIVORSHIP AND MEN'S SEXUAL HEALTH FUNCTION OUTCOMES, A UROLOGIST'S PERSPECTIVE

**Gregory A. Broderick M.D.**
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**Introduction:** In the United States 5 year overall cancer survival rates for patients diagnosed between 1996 and 2003 was 65%, with an estimated 11.1 million cancer survivors (Ries 2005). The Institute of Medicine has addressed post-treatment needs for cancer survivors. The IOM in its report *From Cancer Patient to Cancer Survivor: Lost in Transition* emphasized both quality of life issues and the role providers must play in the long-term care of survivors (Hewitt et al 2006). There are long term physical and psychological factors that significantly impact sexual function and psycho-sexual health in cancer survivors. For the male patient these include: erectile dysfunction, ejaculatory dysfunction, loss of desire/arousal, infertility, pain, changes in body image, depression and anxiety. For the female patient these include: body image, reconstructive surgery, absence of a functional vagina, surgical or chemically induced menopause, infertility, loss of desire/arousal, depression and anxiety. Future care plans for cancer survivors must directly address sexual dysfunctions. Reproductive and sexual health needs are largely unmet for cancer survivors; embedding that expertise within cancer centers would provide education, research and best practice standards for cancer patients.

**Discussion:** Numerous studies have documented sexual dysfunctions in cancer survivors. Twenty to 30% of breast cancer survivors, 80% of prostate cancer survivors, 37% of Hodgkins survivors and 58% of head and neck cancer survivors describe sexual difficulties as a result of their cancer therapies (Kornblith 2003, Siegel 2001, Kornblith 1992, Monga 1997). Park et al (2009) surveyed physicians associated with a North American medical school with respect to sexual function in cancer survivors. Of the 277 respondents 88% acknowledged that they were "somewhat/very" comfortable providing care to adult cancer survivors; only 46% reported that they were "somewhat/very" likely to initiate conversation about sexual dysfunction, and 62% of internists "never/rarely" addressed sexual dysfunction in cancer survivors. In this study unlike others, 'lack of time' was not considered a barrier by respondents, but an internist's perceived lack of preparation and training were associated with avoiding conversations about sexual dysfunctions. Huyghe et al (2009) conducted a needs assessment survey to justify establishing a reproductive health clinic at UT M.D. Anderson Cancer Center in Houston, Texas. They surveyed patients who had received therapies for cancer at M.D. Anderson (800 patients); response rates were 29% for men and 26% for women. They noted that most sexual problems were related to cancer treatments; in men 49% reported 'having trouble getting and or keeping a firm erection' as a new problem after cancer, with only 12% reporting ED 'before and after cancer'. Orgasmic or ejaculatory dysfunction (have trouble reaching orgasm or climax is very weak) was reported by 30% of men as a new problem after cancer and in 9% as a problem before and after cancer. At time of cancer diagnosis 80% of men were sexually active (by retrospective recall) and 60% remained active at time of survey. There were a variety of reasons cited for becoming sexually inactive highlighting the complexities of sexual dysfunctions and the interplay of patient and partner factors: 27% of males cited lack of a sexual partner versus 51% of female cancer survivors. Women were more likely to have lost desire than men (34% versus 13%). Women were more likely to describe feeling unattractive than men (28% versus 16%). ED or ill health (64%) was the primary reasons for men becoming sexually inactive. Infertility is

a unique issue for younger survivors, at least a third of patients under age 50 would have liked a consultation for fertility before initiating cancer therapies at MD Anderson.

Given the significant prevalence of sexual dysfunctions among cancer survivors, the severity of those dysfunctions and the lack of specific training in sexual health – the ultimate resource for cancer survivors seeking assessment and care may reside in the office of specialists. Who will provide care for the sexual health concerns of survivors? Are their sufficient specialists embedded in our current cancer centers with requisite skills to manage the physical and psychological sexual problems of cancer survivors? Will primary care givers need to be educated in sexual function outcomes of cancer interventions in order to provide care for cancer survivors?

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Monga U, Tan G, Ostermann HJ, Monga TN. Sexuality in head and neck cancer patient. Arch Phys Med Rehabil. 1997; 78(3):298-3-4.

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Park ER, Bober SL, Campbell EG, Recklitis CJ, Kutner JS, Diller L. General internist communication about sexual function with cancer survivors. J Gen Intern Med. 2009; 24(Supl 2):407-411.

Siegel T, Moul JW, Spevak M, Alvord WG, Costagbile RA. The development of erectile dysfunction in men treated for prostate cancer. J Urol. 2001; 165(2):430-5.


**Behavioral Learning Objectives:**

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

1.Identify the sexual health function outcomes for male and female cancer survivors.

2.Describe the prevalence of sexual dysfunctions among cancer survivors.

**Biosketch:**

Dr. Broderick is Professor of Urology at the Mayo Medical School, and Program Director of the Urology residency at Mayo Clinic Florida. He is an adult urologist with a practice focused on men's sexual health (erectile dysfunction, Peyronie's disease, penile implants), BPH, urethral stricture disease, male urinary incontinence and minimally invasive therapies for prostate cancer. He served as President of Sexual Medicine Society of North America (2005-06) and is currently Chair of Publications SMSNA. His projects for SMSNA include: a magazine and website for patient and physician education, *2006 - Sexual Health and Medicine* and www.sexhealthmatters.org; 2008-09 *A National Conversation on Men's Health*; *A Town Hall Meeting on Men's Health* and *A Consumer's Virtual Guide to Men's Sexual Health*. He has served the American Urological Association as committee member and author of *Clinical Guidelines: Priapism 2003, Premature Ejaculation 2004, and Erectile Dysfunction 2005 and 2006.* He has represented SMSNA at the International Consultation on Sexual Dysfunctions (1999, 2004, 2009). At the third ICSM (2009) he co-chaired the Committee on Priapism.

## ERECTILE DYSFUNCTION: THE CANARY IN THE COAL MINE

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(a) Introduction: Recent evidence suggests that the man with erectile dysfunction (ED) and no cardiac symptoms is a cardiac/vascular patient until proven otherwise. Because normal erectile functioning is chiefly a vascular phenomenon, alterations to this may be an early warning sign of vascular damage with its attendant risks of heart attack and stroke. (b) Method: A review of the latest evidence about the link between ED and cardiac disease was reviewed.
(c & d) Results and Discussion: The evidence linking ED with a subsequent cardiovascular event is strong for subsequent cardiovascular events (e.g. heart attack) in men with ED. (e) Utility: ED is the canary in the coal mine for cardiac disease and early accurate identification of men with ED could save lives.

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

1. List the factors causing ED in otherwise healthy men that could indicate silent cardiac disease.
2. Describe the tests that these men need to rule out cardiac disease.
3. Identify the latest evidence supporting the treatment of ED in men.

**References:**

Jackson G, Rosen R, Kloner R, Kostis J. Second Princeton Consensus on sexual dysfunction and cardiac risk: New guidelines for sexual medicine. *Journal of Sexual Medicine 2006*; 3: 28 – 36.

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Schwartz ER, Rodriguez J. Sex and the heart. *International Journal of Impotence Research 2005*; 17: S4 – S6.

**Biography:**

Anne Katz is the sexuality counselor at CancerCare Manitoba. She is the author of *Breaking the Silence on Cancer and Sexuality: A Handbook for Health Care Providers* (Oncology Nursing Society 2007), *Woman Cancer Sex* (Hygeia Media 2009), *Man Cancer Sex* (Hygeia Media 2009) [both of which received EXCEL Publication Awards in 2010], *Sex When You're Sick: Reclaiming Sexual Health after Illness or Injury* (Greenwood 2009) and *Girl in the Know: Your Inside and Out Guide to Growing Up* (KidsCan Press 2010).

# ANXIETY, CATASTROPHIZING AND SELF-EFFICACY PREDICT PAIN INTENSITY AMONG WOMEN WITH PROVOKED VESTIBULODYNIA: A PROSPECTIVE STUDY

**Katy Bois, B.Sc., Sophie Bergeron, Ph.D., Natalie Rosen, Ph.D., and Serena Corsini-Munt, MA**

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**Introduction:** With a prevalence of 12%, provoked vestibulodynia (PVD) is the most common subtype of dyspareunia and is characterized by an acute recurrent pain localized within the vulvar vestibule[1]. Several cross-sectional studies have found that anxiety, catastrophizing and self-efficacy are associated with pain intensity and sexual function in women with PVD[2]. Although informative, this research has not allowed the establishment of causal inferences between these cognitive and affective variables and 1) pain and 2) sexual function outcomes. The present study examined the predictive value of these variables using a prospective methodology.
**Method:** 102 women with PVD completed self-report questionnaires on two occasions separated by a two-year interval. Women indicated on a horizontal analog scale their average level of pain during intercourse and completed the Female Sexual Function Index. Women also completed the Spielberger State-Trait Anxiety Inventory, the Painful Intercourse Self-Efficacy Scale and the Pain Catastrophizing Scale. Regression analyses were performed to examine whether Time 1 cognitive and affective variables predicted Time 2 pain and sexual function.
**Results:** Results show that higher trait anxiety, higher catastrophizing (rumination) and lower self-efficacy at Time 1 predicted 10.8% of the variance in women's vulvo-vaginal pain intensity two years later. However, only trait anxiety explained a unique portion of the variance. Anxiety, catastrophizing and self-efficacy at Time 1 dit not predict women's sexual function at Time 2.
**Discussion:** Results suggest that cognitive and affective factors, in particular trait anxiety, may intensity the experience of pain in women with PVD.
**Utility/Limitations/Risks:** Findings may lead to the development of targeted interventions focusing on reducing anxiety and related factors in women with PVD. More research with larger samples is needed to provide additional support to the present findings.

**Behavioral Learning Objective:**
After attending this presentation, the participants will be able to:
1. Outline PVD psychological correlates
2. Describe pain intensity predictors among PVD women.

**References:**
1. Bergeron, S., Binik, Y. M., Khalifé, S., Pagidas, K., & Glazer, H. I. (2001) Vulvar vestibulitis syndrome: Reliability of diagnosis and evaluation of current diagnostic criteria. *Obstetrics & Gynecology*, *98*, 45–51.
2. Desrochers, G., Bergeron, S., Khalifé S., Dupuis, MJ., & Jodoin, M. (2009). Fear avoidance and self-efficacy in relation to pain and sexual impairment in women with provoked vestibulodynia, *The Clinical Journal of Pain*, *25* (6), 520-527.

**Biography:** Katy Bois is pursuing doctoral studies in clinical psychology at the University of Montreal under the supervision of Dr. Sophie Bergeron. She is the recipient of the Joseph-Armand Bombardier Canada - SSHRC Graduate Scholarship.

## PHYSICAL THERAPY INTERVENTIONS FOR LIFELONG VAGINISMUS

**Elke D. Reissing, Ph.D. and Heather Andruff, B.A.**

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**Introduction**: The pelvic floor physiotherapy (PT) approach for the treatment of sexual pain disorders has received considerable attention as a first-line treatment in general, and for PVD in particular. No formal information is available on the use and effectiveness of PT in women with lifelong vaginismus. Recent findings from a RCT (terKuile et al., 2007) suggest that the reduction of coital fears may be the most effective treatment intervention. PT therapists may be best trained to desensitize women to vaginal touch and penetration thereby reducing coital fears.

**Method**: Researchers conducted an anonymous, retrospective chart review of 49 patients with vaginismus. Ten patients participated in a telephone interview (including the FSFI and FSDS).

**Results**: Women with lifelong vaginismus consulted for PT on average 20 sessions (R=1-127). Treatment consisted of patient education (100%), internal manual therapy (100%), home exercises (98%), Kegel exercises (94%), use of dilators (83%), biofeedback (78%), home exercises with partner (71%), and electrical stimulation (37%). Milestones were reached on average by session: use of small (6), medium (8), large (13) dilator, tampon use (10), intercourse (18), dildo (20), speculum and gynaecological exam (22). Anxiety at first pelvic floor examination and severity of pelvic floor pathology were not related to the number of sessions required for successful termination. Time since treatment termination for interview participants was an average of 25 months (R=9-44). Confidence in PT interventions significantly improved after 5 visits and 100% of the women would recommend PT. Patients' treatment objectives were reduction of pain (55%), anxiety (36%), ability to have gynaecological examination (36%), intercourse (67%), and conception (18%) and were on average achieved by 90% of the women. Satisfaction with PT outcome was 9.4/10 (R=8-10). Internal manual techniques were considered most the most effective intervention (73%). Participants maintained treatment outcome for tampon use (82%), gynaecological exams (83%), enjoyment of sex (91%), intercourse (92%), and better understanding (100%). At the time of the interview, overall sexual function was in the normal range (FSFI) with no sexually related personal distress (FSDS).

**Discussion**: PT interventions for lifelong vaginismus appear to be an excellent treatment option with relatively fast attainment of major outcome objectives and optimal maintenance of treatment gains.

**Utility/Limitations/Risks**: This study was retrospective in nature (chart review) with a limited (one clinic), self-selected (interviews) sample. The results however, provide a potent incentive to conduct a larger, prospective treatment outcome study using the PT approach.

**Behavioural Learning Objectives:**

1. Outline the basic techniques of PT used for the treatment of lifelong vaginismus.
2. Identify the average amount of sessions needed to attain major therapy milestones.
3. Describe how the long-term maintenance and improvement of sexual function.

**References:** ter Kuile et al. (2007). Cognitive behavioral therapy for women with lifelong vaginismus: process and prognostic factors. *Behavior Research and Therapy, 45,* 359–73.

**Biography:** Elke Reissing received her Ph.D. in clinical psychology from McGill University in 2002; then joined the faculty of the School of Psychology at the University of Ottawa. She remains at U of O and is director of the Human Sexuality Research Laboratory and sex therapy training at the Centre for Psychological Services. In 2006 she received the President's New Researcher Award from the Canadian Psychological Association for her research on vaginismus and dyspareunia.

# A TAXOMETRIC ANALYSIS OF PEDOPHILIA

**Julia Mackaronis, B.A., Don Strassberg, Ph.D., and David Marcus, Ph.D.**

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**Introduction**: Sexologists continue to lack understanding about a fundamental aspect of pedophilia: do men with pedophilia represent a unique group distinguished by their sexual interests, or are they high-scorers on a continuum of sexual interest in children? No existing evidence points conclusively to pedophilia having either a categorical or continuous latent structure, but each possibility has different implications for our understanding of the etiology of the disorder, which populations are appropriate for pedophilia research, and treatment development. This central question about the construct of pedophilia may be aided by taxometrics, the statistical procedures that provide evidence for whether particular disorders are categorical or continuous.

**Method**: The present research utilized three taxometric procedures to analyze the latent structure of pedophilia in a sample of 371 convicted child sex offenders who completed the Multiphasic Sex Inventory (MSI), a self-report measure designed specifically to assess sex offenders.

**Results**: Results across the three procedures converged to indicate that pedophilia (as measured by the MSI) is dimensional.

**Discussion**: Among this large sample of child sex offenders, variability in pedophilic traits seems to reflect differences in degree (i.e., more or less pedophilic) rather than differences in kind (i.e., pedophile versus non-pedophile). An immediate implication of this study relates to the use of the MSI in classification and research. Given the dimensional results of our analyses, any MSI-based "cut-off" score to identify pedophiles would necessarily be an arbitrary cut-point. Furthermore, the present study provides sufficient evidence to discourage using MSI scores to dichotomize child sex offenders into "pedophiles" and "non-pedophiles" for the purpose of research. These cautions may well also apply to other methods of assessing pedophilic interest (e.g., phallometric data), should other data look similarly dimensional in nature.

**Utility/Limitations/Risks**: Replications of the present research will be strengthened by both increasing sample size (which was relatively small, for taxometric research) and by including indicators of pedophilia that are not solely self-report measures.

**Behavioral Learning Objectives:**

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

1. Explain the difference between a dimension and a taxon.
2. Identify the implications for etiology, research, and treatment if pedophilia is taxonic versus if it is dimensional.
3. Describe the results of a preliminary analysis of the latent structure of pedophilia.

**Biography:**

Ms. Mackaronis anticipates receiving her M.S. in psychology from the University of Utah in May of 2011, where she is pursuing her Ph.D. in clinical psychology. This is her second SSTAR meeting.

**DEBATE: CONTROVERSIES IN DIAGNOSTIC NOMENCLATURE: HYPERSEXUALITY AS SEXUAL COMPULSION VERSUS SEXUAL ADDICTION**

**Eli Coleman, Ph.D. and Jon Grant, M.D.**

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In this debate I will explore the various models of understanding impulsive/compulsive sexual behavior. While the paraphilias are quite defined, there is quite a debate about whethers some of these should be classified as mental disorders and, if so there are new proposed changes for DSM-V that are still discussion. The most perplexing is what to call normophilic impulsive/compulsive sexual behavior. It is a paraphilic-related syndrome? Or is it the other end of the continuum of sexual drive – a drive dysregulation phenomenon? Some have suggested that this phenomenon is better explained as a behavioral addiction. I will argue against conceptualizing this as a behavioral addiction. While there has been no agreed upon conceptualization of how to categorize this syndrome, various terms have been proposed to describe it. Most recently, the DSM task force has proposed a new category of Hypersexual Disorder – although it is unclear where this will fit in the schema of sexual disorders. Each model makes assumptions about etiology and treatment and I will explore these with the audience.

**Behavior Learning Objectives:**

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

1. Describe various models of conceptualizing and classifying impulsive/compulsive sexual behavior.
2. Describe the various theories of etiology of impulsive/compulsive sexual behavior
3. Describe the implications for treatment based upon the various models.

**Biography**

Eli Coleman, PhD is professor, director, and academic chair of sexual health at the Program in Human Sexuality, Department of Family Medicine and Community Health, University of Minnesota Medical School in Minneapolis. He is the author of numerous articles and books on impulsive/compulsive sexual behavior, sexual offenders, sexual orientation, gender dysphoria, chemical dependency and family intimacy and on the psychological and pharmacological treatment of a variety of sexual dysfunctions and disorders. Professor Coleman is the founding editor of the *International Journal of Transgenderism* and is the founding and current editor of the *International Journal of Sexual Health*. He is one of the past-presidents of the Society for the Scientific Study of Sexuality, the World Professional Association for Transgender Health (formerly the Harry Benjamin International Gender Dysphoria Association), the World Association for Sexual Health, and International Academy for Sex Research. He has been a frequent technical consultant on sexual health issues to the World Health Organization (WHO) the Pan American Health Organization (the regional office of WHO) and the Centers for Disease Control and Prevention (CDC). He has been the recipient of numerous awards including the US Surgeon General's Exemplary Service Award for his role as senior scientist on *Surgeon General's Call to Action to Promote Sexual Health and Responsible Sexual Behavior*, released in 2001. He was given the Distinguished Scientific Achievement Award from the Society for the Scientific Study of Sexuality and the Alfred E. Kinsey Award by the Midcontinent Region of the

Society for the Scientific Study of Sexuality in 2001. In April, 2007, he was awarded the Gold Medal for his lifetime contributions to the field of sexual health by the World Association for Sexual Health. In May of 2007, he was appointed the first endowed Chair in Sexual Health at the University of Minnesota Medical School. In May of 2009, he was awarded the Masters and Johnson Award by the Society for Sex Therapy and Research.

# AN ADDICTION MODEL FOR HYPERSEXUALITY

**Jon E. Grant, M.D.**

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Hypersexuality as a behavioral symptom may reflect several distinct underlying pathophysiologies. One of these may be a constellation of symptoms that reflect tolerance, withdrawal and dysfunction, akin to what is seen in substance addictions. This talk will discuss the relationship of hypersexuality to substance use disorders. Clinical and biological similarities between hypersexuality and substance addictions will be reviewed, as well as response to treatment.

**Behavioral Learning Objectives:**
After attending this presentation, the participants will be able to:

1. List the core features of hypersexuality
2. Outline the similarities between hypersexuality and substance addictions
3. Describe how the addiction model may further treatment options for hypersexuality

**References:**
Garcia FD, Thibaut F. Sexual addictions. Am J Drug Alcohol Abuse. 2010 Sep;36(5):254-60.

Frascella J, Potenza MN, Brown LL, Childress AR. Shared brain vulnerabilities open the way for nonsubstance addictions: carving addiction at a new joint? Ann N Y Acad Sci. 2010 Feb;1187:294-315.

**Biography:**
Dr. Grant is a Professor of Psychiatry at the University of Minnesota in Minneapolis, where he also supervises an outpatient clinic for impulse control disorders. An author of over 200 peer-reviewed articles, Dr. Grant's research has been supported by NIMH and NIDA. He is the Director of a Center of Excellence in Gambling Research supported by the National Center for Responsible Gaming and is the editor-in-chief of the *Journal of Gambling Studies*.

# DEPRESSION AND SEXUAL DYSFUNCTION

**Robert T. Segraves, MD, Ph.D.**

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It is well established that depression is associated with sexual dysfunction; especially decreased libido. This has been found for both dysthymic and major depressive disorders. Conversely, mania is frequently associated with increased libido and increased sexual activity. Pharmacological treatment of depression is frequently associated with sexual dysfunction, especially especially delayed orgasm. the effect of pharmacotherapy on libido is more difficult to predict as the alleviation of depression may be associated with increased libido whereas certain antidepressants may decrease libido. establishment of baseline sexual dysfunction prior to the o set of depression is the best way to ascertain if sexual dysfunction is secondary to depression itself or its treatment frequently.

## Behavioral Learning Objectives

1. Participants will describe the association of untreated depression with sexual dysfunction.

2. Participants will identify the sexual side effects of the pharmacotherapy of depression.

## References

Balon R, Clayton A, Segraves R. Sexual dysfunction, disorder, or variation alone normal distribution : toward rethinking DSM criteria of sexual dysfunction. Amer J Psychiatry, 2007, 164, 198-200.

Segraves R, Lee J, Stevenson R, Walker D, Wang C, Dickson R. Tadalafil for treatment of erectile dysfunction in men on antidepressants. J Clin Psychopharmacol 2007; 27:62-66.

## Biographical Sketch

Robert Taylor Segraves, MD, PhD received his medical training at Vanderbilt University in Nashville, Tennessee and completed his psychiatric residency at the University of Chicago. He also obtained a PhD in Psychology at the University of London. He has spent most of his career studying and treating sexual disorders. He was on the American Psychiatric Association Taskforce on Psychosexual Disorders for DSM III R DSM IV , DSM IV TR and DSM V.. He is a past president of the Society for Sex Therapy and Research, and is the current editor of the Journal of Sex and Marital Therapy.

He has over 200 publications in the area of human sexuality , numerous national and international presentations, and five texts (the latest of which is Clinical manual of Sexual Disorders, co-edited with Richard Balon ). He is currently Professor of Psychiatry at Case Western Reserve University in Cleveland , Ohio.

# HYPOACTIVE SEXUAL DESIRE DISORDER

**Leonard R. DeRogatis, Ph.D.**

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Innovations in the Pharmacologic Treatment of Hypoactive Sexual Desire Disorder (HSDD)

**Introduction:** This presentation will review and briefly assess the safety and efficacy of recent pharmacologic gents in treating premature HSDD. Outcomes from a variety of Phase II and Phase III clinical trials will be reviewed and discussed concerning the treatment efficacy and safety data from several different investigational drugs.

**Method:** Literature review

**Results:** All of the investigational agents reviewed have demonstrated statistically significant differences when compared to placebo in randomized clinical trials, and most have shown clinically significant differences as well. Safety profiles are well within the acceptable range for these drugs, with most adverse events recorded being mild to moderate and transient in nature.

**Conclusion and Limitations**: A number of apparently safe and efficacious drugs have shown promise in the treatment of HSDD. The field is currently without an approved drug for the treatment of HSDD in women, a highly prevalent and disconcerting sexual dysfunction. These data on safety and efficacy bode well for the ultimate approval of one of these drugs by federal regulators.

**Behavioral Leaning Objectives**

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

1. Outline the pharmacological options under development for the treatment of HSDD.
2. Describe paradigms which might employ combination therapy to treat HSDD .

**References:**

Labrie, F, Archer, D., Bouchard, C., et.al., Effect of intravaginal dehydroepiandrosterone (Prasterone) on libido and sexual function in women. *Menopause.* 2009; 16; 1-9.

Jolly, E., Derogatis, LR, Komer, L., et. al., Efficacy of flibanserin in premenopausal women with hypoactive sexual desire disorder:the Violet study. *Obstet. Gynecol*. (in press, 2011)

**Biography:** Dr. Derogatis is the Director of the Center for Sexual Medicine at Sheppard Pratt and Associate Professor of Psychiatry at Johns Hopkins University School of Medicine. He was a charter member of E.A.S.T, the progenitor organization of SSTAR, and has worked in sexual medicine for approximately four decades. He has previously served as Chief Psychologist of the Johns Hopkins Hospital, Chairman of the Department of Clinical Health Psychology at Hahnemann University, and Director of the Sexual Behaviors Clinic at Hopkins. He is currently principally involved in conducting clinical drug trials in sexual medicine.

# INNOVATIONS IN THE TREATMENT OF ERECTILE DYSFUNCTION

**Arthur L. Burnett, M.D.**

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**Introduction:** Sexual function incorporates physiological processes and regulation of the central and peripheral nervous systems, the vascular system, and the endocrine system. Recent advances in sexual medicine research have led to an improved knowledge of the underlying molecular biological factors and mechanisms governing the display of sexual functions, including penile erection. Such advanced knowledge offers opportunities for developing new and increasingly effective treatments in sexual medicine.

**Discussion:** This presentation provides a current review of the state of knowledge of molecular biological factors and mechanisms governing penile erection. It also defines new approaches for the treatment of erectile dysfunction based on recent scientific discoveries in the field. It is recognized that similar advances have been made for all forms of sexual dysfunction, although this presentation centers on the matter of erectile dysfunction.

**Behavioral Learning Objectives:**

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

1. Outline the current knowledge of the major cellular and molecular targets of biological systems responsible for penile erection, which may lead to novel pharmacotherapies for erectile dysfunction.
2. Identify the integrative roles of possible future treatment delivery approaches, e.g., growth factor therapy, gene therapy, stem and cell-based therapies, and regenerative medicine, to treat erectile dysfunction, in combination with pharmacologic approaches.

**References:**

Burnett, A.L., Goldstein, I., Andersson, K.E., Argiolas, A., Christ, G., Park, K., & Xin, Z.C. (2010). Future sexual medicine physiological treatment targets. *J Sex Med,* 7, 3269-3304.

Harraz, A., Shindel, A.W., & Lue, T.F. Emerging gene and stem cell therapies for the treatment of erectile dysfunction. *Nat Rev Urol,* 7, 143-152.

**Biography:**

Dr. Arthur (Bud) Burnett received his A.B. degree in Biology from Princeton University and M.D. and M.B.A. degrees from Johns Hopkins University. His post-graduate training in general surgery, urology, and reconstructive urology and urodynamics was performed at the Johns Hopkins Hospital. He received an American Foundation for Urologic Disease scholarship and joined the faculty at the Johns Hopkins University School of Medicine. He is currently the Patrick C. Walsh Professor of Urology and is the Director of the Basic Science Laboratory in Neuro-urology of the James Buchanan Brady Urological Institute and Director of the Male Consultation Clinic. He is an alumni member of the Alpha Omega Alpha Honor Medical Society and Fellow of the American College of Surgeons.

# INNOVATIONS IN THE TREATMENT OF PREMATURE EJACULATION

**Stanley E. Althof, Ph.D.**

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**Title: Introduction:** This presentation will review recent innovations in treating premature ejaculation. Outcomes from clinical trials of PSD-502 (a eutectic mixture of lidocaine and prilocaine that is applied to the glans penis in a metered dose) will be presented along with a series of combined pharmacological and psychological treatments for PE.

**Method:** Literature review

**Results:** In contrast to placebo, by the end of treatment PSD-502 treated subjects experienced an 8 fold increase in intravaginal ejaculatory latency time (IELT) compared to baseline. Additionally, there were significant improvements on the Index of Premature Ejaculation and the Premature Ejaculation Profile, both validated measures for assessing PE outcomes. Adverse events were reported at 5% for men and 6% for women.

Three studies describe combined pharmacological and behavioral treatment of PE. Pharmacotherapy was given in conjunction with a behavioral treatment and compared with pharmacotherapy alone. Each study reports on a different medication- sildenafil, citalopram, and, clomipramine. In all three studies, combination therapy was superior to pharmacotherapy alone on either IELT and/or questionnaire measures.

**Conclusion and Limitations:** If approved PSD-502 may offer an effective and safe treatment for premature ejaculation. Data continues to support the efficacy of combination therapy over pharmacotherapy alone.

## Behavioral Leaning Objectives

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

1. Describe PSD-502 as a potential treatment option for PE.
2. Outline the value in employing combination therapy in treatment for men with PE .

## References:

1. Althof S, Abdo C, Dean J, Hackett G, McCabe M, McMahon, Rosen R, et al 2010, International Society for Sexual Medicine's Guidelines for the Diagnosis and Treatment of Premature Ejaculation. Journal of Sexual Medicine. 7: 2947-2969
2. Yuan P, Dai J, Yang Y, Guo J, Liang R. A comparative study on treatment for premature ejaculation: Citalopram used in combination with behavioral therapy versus either citalopram or behavioral therapy alone. Chin J Androl. 2008;22:35–8.

**Biography:** Dr. Althof is Executive Director of the Center for Marital and Sexual Health of South Florida and an Emeritus Professor at Case Western Reserve University School of Medicine. He and his two former partners were the 2005 recipients of SSTAR's prestigious Masters and Johnson Lifetime Achievement Award.

## DEBATE: EVIDENCE SUPPORTS THE EXPANDED DEFINITION OF SEXUAL DESIRE DISORDER IN WOMEN

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The DSM-5 Task Force and Work Group members are working to develop criteria for the fifth revision of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), to be published in May 2013. In an effort to address the compelling empirical data and clinical observation of the lack of distinction between sexual desire and arousal, the Sexual Dysfunctions subworkgroup has proposed that the condition "Sexual Interest/Arousal Disorder in Women" replace "Hypoactive Sexual Desire Disorder" and "Female Sexual Arousal Disorder" in DSM-5. This debate will integrate findings from the Incentive Motivation model, quantitative, and qualitative studies to illustrate the benefits of merging arousal and desire disorders and of an expanded definition of desire disorder, which encompasses difficulties with subjective sexual excitement and non-genital and genital sensations.

**Behavioral Learning Objectives:**

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

1. Identify past criticisms of the diagnostic criteria for HSDD and FSAD

2. Describe the empirical and clinical evidence supporting an expanded definition of sexual desire disorder in women for DSM-5

3. Outline the benefits of this expanded definition of Sexual Interest/Arousal Disorder in Women over HSDD and FSAD as separate entities

**References:**

Brotto, L. A. (2010). The DSM diagnostic criteria for Hypoactive Sexual Desire Disorder in women. *Archives of Sexual Behavior, 39*, 221-239.

Graham, C. A. (2010). The DSM diagnostic criteria for Female Sexual Arousal Disorder. *Archives of Sexual Behavior*, *39*, 240-255.

**Biography:**

Lori Brotto has a PhD in clinical psychology from the University of British Columbia (UBC) and completed a Fellowship in Reproductive and Sexual Medicine from the University of Washington. She is an Associate 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. 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, the Journal of Sex Research, 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, and is on the Sexual and Gender Identity Disorders workgroup for DSM-5.

# PROPOSED DSM-5 SEXUAL INTEREST/AROUSAL DISORDER VERSUS DSM-IV DISTINCT HSDD AND FSAD

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**Introduction:** Changes to the DSM require significant published scientific evidence to support the modifications. The proposed change is based on frequent co-morbidity of HSDD and FSAD, theoretical models that have been found to represent < one-third of women, and expert disagreements over definitions of desire and arousal. No real life field-testing will be done prior to implementation – such testing is necessary and must include general psychiatrists and primary care providers, as well as, sexual medicine experts.

**Discussion:** Many psychiatric disorders occur co-morbidly (e.g. depression and anxiety); however, diagnostic criteria that allow for understanding of separate disorders provide for better treatment outcomes than assuming related disorders represent a homogeneous population. Recently published imaging studies demonstrate clear differences in brain responses in women with HSDD vs. those without, supporting separate diagnoses of HSDD and FSAD. Clinical studies also support maintaining discrete diagnoses. Definitions of phases of the sexual response cycle with applicability to theoretical models that reflect the majority of women are more likely to serve a larger segment of the population than minority definitions/models. There are no studies to support the proposed change, so there is no evidence that the proposed combined criteria accurately describe the clinical population, that they are reliable when used in any/all clinical settings, or that they don't cause additional problems with regards to diagnostic or research accuracy. Thus, the separate diagnoses of HSDD and FSAD must be maintained in DSM-V.

**Behavioral Learning Objectives:**
After attending this presentation, the participants will be able to:
1. Describe the requirement that published studies in peer-reviewed scientific journals support proposed changes to DSM-V
2. List the reasons that separate diagnoses of HSDD and FSAD must be maintained
3. Outline the need for accuracy of a proposed diagnosis that can be reliably and consistently used in a general population without specialized training

**References:**
DeRogatis LR, Clayton AH, Rosen RC, Sand M, and Pyke RE. (14 October 2010). Should sexual desire and arousal disorders in women be merged? Arch Sex Behav, Online First
Clayton AH, DeRogatis LR, Rosen RC, Pyke R, Garcia M, Sand M. (2010). Do clinical andresearch data support sexual desire and arousal disorders as distinct diagnoses? J Sex Med 7(Suppl 3), 143-144.
DeRogatis LR. (in press). The differential risks of lumping and splitting as strategies in developing an FSD nosology for DSM-V. J Sex Med

**Biography:**

Dr. Clayton received her MD from the University of Virginia, completed her residency there, and has been on faculty at UVA since 1990. She is the David C. Wilson Professor of Psychiatry and is Professor of Clinical Obstetrics & Gynecology. Her research interests include the effects of psychiatric and medical illness on sexual function, sexual side-effects of medications, diagnosis and treatment of primary sexual disorders, and reproductive-related mood and anxiety disorders.

## COMMENTARY REGARDING PEDOPHILIA AND DSM-V

**Fred S. Berlin, M.D., Ph.D.**

When addressing the issue of psychiatric categorization, it is important to keep in mind the intended purpose of making a diagnosis. In simple terms, any medical and/or psychiatric diagnosis merely constitutes a shorthand means of conveying relevant information. For example, a diagnosis of either diabetes mellitus, or schizophrenia, conveys a great deal of useful information to a properly-trained physician. Ordinarily, a psychiatric, and/or medical, diagnosis is not made merely because of some observable difference (e.g., blue eyes versus brown). Instead, in most instances a diagnosis is made only when the condition in question has either (a) the potential to seriously impair function (e.g., as in the case of congestive heart failure, or schizophrenia), or (b) when it causes distress or suffering (e.g., as in the case of severe depression).

Arriving at a diagnosis often requires making a clinical judgment (e.g., distinguishing between "pathological grief" and the more customary grieving process). In addition, although frequently unacknowledged, inherent to most diagnoses is the presence of an implicit value judgment. Respiration is a "good thing" – a biological process that does not require a diagnosis. Rapid cellular proliferation (cancer) is a "bad thing" – a biological process that should be diagnosed.

An adult heterosexual makeup is different from an adult homosexual makeup. However, neither impairs an individual's capacity to perform sexually with a willing partner whose sexual orientation is similar. In addition, neither orientation (heterosexual or homosexual), in and of itself, causes intrinsic suffering. Beyond that, in contemporary society, a consensus has emerged (albeit with some dissenters) to the effect that neither orientation is a "bad thing."

In defining either heterosexuality or homosexuality (or for that matter, bisexuality), rarely does a description contain language (such as that used in the DSM when categorizing pedophilia) that refers to the presence of "recurrent, intense sexually arousing fantasies" and "sexual urges."[1] Instead, as suggested by Blanchard, an individual would ordinarily be considered to have an adult sexual orientation when the act, or fantasy, of engaging in sexually-explicit activities with another adult, is a repeated, or an exclusively-enduring, method of achieving sexual excitement.[2] Though ordinarily not acknowledged, one reason why an adult sexual orientation does not, in and of itself, lead to a psychiatric diagnosis is because of the implicit assumption that such an orientation is not a "bad thing."

In contemporary society, having a pedophilic sexual orientation (whether of the exclusive or non-exclusive form) is considered to be a "bad thing." In a society that felt otherwise, such a condition might not be construed as psychiatric pathology. To suggest that the inclusion of pedophilia in the DSM is not at least partially dependent upon making such a value judgment would be disingenuous.

In today's world, for good reasons, having a pedophilic sexual makeup can be a "bad thing" – which is not to say that persons with such a makeup are bad people. Society has the responsibility of protecting children. Persons, who through no fault of their own are sexually attracted to children, may be in need of psychiatric assistance in order to be able to resist the temptation of acting on those attractions.[3] They (and of course others as well) can also suffer a great deal of discomfort if they are unable to maintain full control of themselves through willpower alone. The fact that such persons may be in need of mental-health assistance

constitutes an important basis for considering pedophilia to be a psychiatric disorder – even if that consideration is based, at least in part, upon an implicit set of values.

In keeping with Blanchard's definition of an adult sexual orientation, an individual could be considered to have a pedophilic sexual makeup when the act, or fantasy, of engaging in sexually-explicit activities with prepubescent children is a repeated, or an exclusively-enduring, method of achieving sexual excitement.[2] Arguably, a more detailed operational definition may be required in further developing DSM-V diagnostic parameters. However, the phrase "recurrent, intense sexually arousing fantasies, sexual urges, or behaviors" that is currently a part of the DSM-IV-TR definition may be unnecessarily esoteric, as well as potentially confusing.

At present, the DSM confuses the extent to which pedophilia represents a qualitative, as opposed to a quantitative, variation in sexual makeup. Heterosexual men share in common the fact that they experience eroticized desires, or urges, for women that are sustained over time, at least intermittently. That shared qualitative aspect of their sexual makeup is independent of the intensity of their desire for women; an intensity that can vary at any given moment from high to low. A heterosexual makeup is still just that, even if and when the intensity of desire is low. Pedophilic men share in common the fact that they experience eroticized urges for prepubescent children that are sustained over time, at least intermittently. Yet "Criterion A" of the current DSM definition of a pedophilic disorder specifies the presence not only of such urges, but of intense urges (a quantitative concept). A man who experiences eroticized urges for prepubescent children that are sustained over time should still be seen as having a pedophilic sexual makeup (of either the exclusive, or non-exclusive form), irrespective of the intensity of his urges.

"Criterion B" of the current DSM requires either (1) that an individual has acted upon his eroticized urges, or (2) that those urges or fantasies have caused interpersonal difficulty, or marked distress, before the diagnosis of a pedophilic disorder can actually be made.[1] That is so, at least in part, because differences in sexual makeup that are not acted upon, and that are not associated with either personal distress, or interpersonal difficulty, may not be of clinical concern. Thus, a person can differ from the norm in experiencing recurrent sexual attractions to prepubescent children, but if he is in full-control of himself, has not acted, and is not distressed by those attractions – under such circumstances, such a difference in sexual makeup would not need to be classified as a "disorder."[4]

It is in addressing DSM "Criterion B" that the intensity of one's pedophilic urges may become most relevant. That is so because persons with intense pedophilic urges may experience heightened difficulties in resisting temptation (i.e., they may be more volitionally impaired) than would be the case for persons whose pedophilic urges are less intense.[5] In that sense, all else being equal, persons with more intense urges would likely be at greater risk of acting upon them – potentially causing both interpersonal difficulties and distress ("Criterion B"). Parenthetically, it might be noted that it is such an impairment in volitional capacity (an impairment that may be proportional in its degree to the intensity of sexual cravings) that has been used to justify the involuntary civil commitment of some individuals with pedophilia.[6]

Finally, Blanchard has recently proposed that an option for DSM-V might be to return to the earlier language of DSM-III which had conceptualized pedophilia as an "erotic preference."[2] The term preference can suggest many meanings. A person does not develop pedophilia in the first place because it had been his preference to have it, and his preference may be that he not succumb to his pedophilic urges. Including the word preference within the diagnostic criteria for a pedophilic disorder would likely do more to confuse than elucidate.

**Behavioral Learning Objectives:**

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

1. Outline at least two controversies with the diagnosis of pedophilia
2. List the ways in which the diagnosis of pedophilia can be improved

**References**


1. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, Washington, D.C. American Psychiatric Association, 2000, 571-572.

2. Blanchard R. Paraphilias vs. Paraphilic Disorders, Pedophilia vs. Pedo and Hebephilia, and Autogynephilic vs. Fetishistic Transvestism. Proceedings of the 34th Annual Meeting, Society for Sex Therapy and Research, Arlington, Virginia, April 3, 2009, 32-33.

3. Berlin FS, Krout E. Pedophilia: Diagnostic Concepts, Treatment and Ethical Considerations. American Journal of Forensic Psychiatry, 7, 1, 1986, 13-30.

4. Berlin FS. Pedophilia: When is a Difference a Disorder? Peer Commentaries on Green (2002) and Schmidt (2002), Archives of Sexual Behavior, 31, 6, 2002, 1-2.

5. Fagan PJ, Wise TN, Schmidt CW, Berlin FS. Pedophilia. JAMA, 288, 19, 2002, 2458-2465.

6. Kansas vs. Crane. (00-957) U.S. 269 KAN 578. 7P3d 285, vacated and remanded (2002).

## RESOLVING SEXUAL DESIRE DIFFICULTIES

**Ruth Morehouse, Ph.D.**

Co-Director
Marriage and Family Health Center, Evergreen, Colorado

This case presentation involves a heterosexual couple married for ten years who sought therapy at the Marriage and Family Health Center due to ongoing conflicts about sexual frequency, initiation, and lack of emotional connection during sex. Arguments over differences in sexual desire had infiltrated other aspects of the partnership and led to overall dissatisfaction with their relationship and uncertainty about their future. At the time they entered therapy, they had not had sex with each other for over two years. Therapy was precipitated by an excellent job offer in another state for one spouse, which forced both partners to consider the fragile state of their relationship and determine if the marriage was viable enough to warrant them moving together to a new location.

Case discussion will focus on addressing desire issues using the Crucible® Approach, a differentiation based therapy model founded by Schnarch. The presentation will demonstrate how High Desire Partner/Low Desire Partner (HDP/LDP) systemic dynamics interact with partners' level of differentiation to create emotional gridlock and sexual difficulties in normal healthy couples. Crucible Therapy focuses on resolving sexual conflict in ways that enhances personal growth. We will explore using sex as an "elicitation window" as well as developing isomorphic interventions that enhance therapeutic progress. Use of activities such as Hugging 'til Relaxed and Heads on Pillows to enhance intimacy, self-regulation, and positive brain neuroplasticity will be discussed with this case.

### Behavior Learning Objectives

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

1. Describe the impact of LowerDesirePartner/HigherDesire Partner (LDP/HDP) dynamics in a committed relationships.
2. Outline the role of differentiation in dealing with partners' sexual desire differences in committed relationships.
3. State the benefits of using sex as an elicitation window in couples therapy.
4. Explain how activities such as Hugging 'til Relaxed can facilitate positive brain plasticity.

Ruth Morehouse is a licensed psychologist and certified sex therapist (Diplomat, AASECT) who has been doing couples therapy for over 30 years. She is Co-Director of the Marriage and Family Health Center and the Crucible Institute in Evergreen, Colorado. Dr. Morehouse currently serves as Vice President for Practice for the Society of Family Psychology (Division 43) of the American Psychological Association. Dr. Morehouse is a frequent speaker at national and international professional conferences. She has taught the Crucible Approach in hundreds of presentations across the United States and in 9 foreign countries.

# ETHICAL DILEMMAS AND CLINICAL CONUNDRUMS IN SEX THERAPY: WITHSTANDING ASSAULTS ON PROFESSIONAL INTEGRITY

**Daniel N. Watter, Ed.D. and Peggy J. Kleinplatz, Ph.D.**

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All too often, ethics workshops focus on *risk-management* 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 ethical guidelines and matters of integrity. How do politics, morals and values combine to create a climate in which it is difficult for sex therapists to maintain their integrity while attempting to best serve their patients?

Through a combination of didactic presentation, case examples/vignettes, and dailogue, the presenters hope to guide the participants to a greater awareness of the complexities of ethical decision-making as it relates to our efforts to maintain our integrity in the face of pressures from third-party payers, patient demands, and industry influences. 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. 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 principles of Virtue Ethics as described by Radden & Sadler (2010). Virtue Ethics focus on the *character* and integrity of the practitioner as a guide to ethical decision-making in contrast to risk-management practices. The emphasis on the character of the practitioner encourages us to focus less on those traits that can be governed by rules and regulations, but rather place a great emphasis on those traits that help us be the type of healers we would hope to be. The cultivation of personal traits such as honesty, integrity, courage, fairness, warmth, trustworthiness, contentiousness, respectfulness, nonmalevolence, benevolence, justice, truthfulness, faithfulness, caring, and compassion should be encouraged in the education and training of all healthcare practitioners (Beauchamp & Childress, 2009; Radden & Sadler, 2010). The burden of Virtue Ethics requires we shift our focus toward the ideals we believe healthcare professionals should strive for, and away from a simple reliance on rudimentary, often reductionist rules of behavior.

Content will include a discussion of ethical conflicts due to industry influence for therapists and researchers; issues of confidentiality in couples therapy; the timely focus on diagnosis due to the current DSM revisions, and a focus on billing and third party payments

**Behavioral Learning Objectives:**

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

1. Describe the ethical constructs of Principlism and Virtue Ethics as a means of understanding the creation and application of ethical principles to clinical decision-making.
2. Identify several ethical dilemmas and their impact on our use of diagnoses, insurance coding, and industry sponsorship of our research and activities.

**References:**

Beauchamp, T.L. and Childress, J.F. (2009). *Principles of biomedical ethics, 6th edition.* New York: Oxford University Press.

Radden and Sadler (2010). *The virtuous psychiatrist: character ethics in psychiatric practice. New York: Oxford University Press*

**Biography:**

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 and Ethics. 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. A graduate of Drew University's post-graduate program in Medical Humanities with a concentration in Biomedical Ethics, Dr. Watter is a member of the State of New Jersey Board of Psychological Examiners. He has recently completed his second term as chair of the New Jersey Psychological Association's Ethics Committee. Dr. Watter has been a member of SSTAR since 1989, and currently serves as the organization's Secretary/Treasurer.

Peggy J. Kleinplatz, Ph.D. 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. Her work focuses on optimal sexuality, eroticism and transformation, particularly in the elderly and other marginalized populations.

# Poster Abstracts

## GENDER DIFFERENCES IN OBSERVER STANCE AS A PREDICTOR OF SUBJECTIVE AND GENITAL SEXUAL AROUSAL

**Jennifer Bossio, BA, Jessica Spape, BA & Meredith Chivers, PhD**

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**Introduction**: Money and Ehrardt (1972) first postulated that, while watching erotic films, women use "projection", or identify with the female actor, while men are more likely to "objectify" the presented actors. Janssen et al. (2003) found that both "imagining oneself as an observer" and "imagining oneself as a participant" were significant predictors of men's subjective sexual arousal, while only the "participant" stance significantly predicted women's subjective sexual arousal. The current study had four objectives: 1) replicate the findings by Janssen et al. (2003); 2) extend observational stance findings to genital arousal; 3) examine how observational stance predicts participant's subjective and genital sexual arousal to video clips of gay and lesbian sex; and 4) examine the relationship between subjective sexual arousal, observational stance, sexual orientation and stimulus type.
**Method**: Participants (men n = 47, women n = 49) are the same sample used in Chivers, Seto, and Blanchard (2007). Experimental stimuli are the same as those employed by Chivers et al. (2007). Genital response was measured using a vaginal photoplethysmograph (women) or penile plethysmograph (men). Subjective sexual arousal and observer stance (whether they watched as a participant or as an observer) were measured using self-report following the presentation of each stimulus.
**Results**: Viewing sexual stimuli as both an observer and a participant significantly predicted women's subjective sexual arousal to heterosexual, gay and lesbian stimuli but did not predict women's genital sexual arousal. Watching as a participant significantly predicted men's subjective and genital sexual arousal to all stimuli. Furthermore, a significant three-way interaction between observer stance, sexual orientation and the sexual orientation of the couple presented in the sexual stimuli was identified for both men and women.
**Discussion**: Contrary to Money and Erhardt (1972), our results indicate that men identify with the actors in pornographic films whereas women are more fluid in the observational stance they adopt, either identifying with the actors, objectifying them, or a combination of both. Results are discussed in the framework of specificity of sexual arousal (males have high specificity while females show non-specificity). Female results are also partly explained by the low concordance between subjective and physical sexual arousal (Chivers, Seto, Lalumière, Laan & Grimbos, 2010). ANOVA results indicate that observational stance and subjective sexual arousal vary with the sexual orientation of the viewer and with the couple in each stimulus.
**Utility/Limitations/Risks**: A more complete understanding of the factors influencing normal sexual arousal may provide a useful framework through which to study sexual arousal dysfunction. Limitations include small sample size, and the use of self-report measures.

**Behavioral Learning Objectives:**

After attending this presentation, participants will be able to:

1. Understand the importance of observer stance in human sexual arousal.
2. Identify the relationship between sexual arousal, sexual orientation, and observational stance.

**References:**


Chivers, M. L., Seto, M. C., & Blanchard, R. (2007). Gender and sexual orientation differences in sexual response to sexual activities versus gender of actors in sexual films. *Journal of Personality and Social Psychology, 93*, 1108–1121.

Chivers, M. L., Seto, M. C., Lalumière, M., Laan, E., & Grimbos, T., (2010). Agreement of Self-reported and Genital Measures of Sexual Arousal in Men and Women: A Meta-Analysis. *Achieves of Sexual Behavior, 39*, 5–56

Janssen, E., Carpenter, D., & Graham, C. A. (2003). Selecting films for sex research: Gender differences in erotic film preferences. *Archives of Sexual Behavior, 32*, 243–251.

Money, J., & Ehrhardt, A. A. (1972). Man and woman boy and girl: The differentiation and dimorphism of gender identity from conception to maturity. Baltimore: Johns Hopkins University Press.1–21.


**Biography:**

Jessica Spape completed her Bachelor of Arts in honours psychology at Concordia University. She completed two undergraduate projects with Dr. James Pfaus. Currently, Jessica is completing her Master's degree in Clinical Psychology at Queen's University under the supervision of Dr. Meredith Chivers.

Jennifer Bossio completed her Honours Bachelor of Arts degree in psychology with a minor in Health Studies at McMaster University in 2008. Jennifer is currently completing her Master's degree in Clinical Psychology at Queen's University under the supervision of Dr. Meredith Chivers.

**IMPACT OF RADICAL TRACHELECTOMY ON SEXUAL DISTRESS: A PILOT STUDY**

**Lori A. Brotto, PhD, Erin Breckon, BA (Hons)**

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**Introduction:** Radical trachelectomy (RT), a relatively new treatment option for early stage cervical cancer, differs from radical hysterectomy (RH) in that the uterus is left intact while removing the cervix, parametrium and upper one third of the vagina, preserving women's ability to bear children. Quality of life and sexual health concerns following RH have been well documented; however, the extent to which these changes are related to cervical or uterine removal has been debated. Carter et al. (2010) found no significant differences in post-operative sexual functioning (using the FSFI) between women treated by RT versus RH. Because sexual distress is often an unrelated entity to sexual functioning, the goal of this pilot study was to explore the impact of RT and RH on sexual distress.

**Methods:** Twenty-four women scheduled for a RH (13) or a RT (11) through the BC Cancer Agency (Vancouver) completed a battery of questionnaires before, and at one and 6 months post-surgery (FSDS, BDI, BAI, DAS, & Rand SF-36). Preliminary findings from preoperative and one month post-treatment data are presented.

**Results:** No significant differences were found between the RT and RH groups on any outcome measures. There was a main effect of surgery on anxiety (decreased post-surgery), physical function and resulting limitations (both decreased post-surgery), and general pain (increased post-surgery).

**Discussion:** Consistent with findings by Carter et al. (2010), our pilot study suggests no significant negative impact of RT on sexual distress.

**Utilities/ Limitations/ Risks:** Despite expectations, women's levels of sexual distress and other QOL sequelae following RT were not found to be lower than those for women treated with RH one month postoperatively; however our results are limited due to a very small sample size and lack of long-term follow-up data.

**Behavioral Learning Objectives:**
After attending this presentation, individuals will be able to:
1. Understand the indications for RT among early-stage cervical cancer patients.
2. Recognize that negative sexual side effects of RT may be similar to those of RH.

**References:**
Bergmark, K., Avall-Lundqvist, E., Dickman, P. et al. (1999). Vaginal changes and sexuality in women with a history of cervical cancer. *New England Journal of Medicine, 340,* 1383-1389.

Carter, J., Sonoda, Y., Baser, R. et al. (2010). A 2-year prospective study assessing the emotional, sexual, and quality of life concerns of women undergoing radical trachelectomy versus radical hysterectomy for treatment of early-stage cervical cancer. *Gynecologic Oncology, 119,* 358-365.

**Biography:**
Since receiving her BA in Psychology (Hons) in 2009, Erin Breckon has been working as a RA at the UBC Sexual Health Laboratory (supervisor Dr. Lori Brotto) and the Prostate Centre (supervisor of Dr. Joyce Davison), and attending UBC as an unclassified student. She plans to start her MA degree in Counseling Psychology in fall of 2011.

# AN OPEN LABEL TRIAL OF MILNACIPRAN IN THE TREATMENT OF WOMEN WITH PROVOKED VESTIBULODYNIA – RESEARCH IN PROGRESS

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**Introduction:** Up to 16% of women are diagnosed with provoked vestibulodynia (PVD), a centrally-mediated pain syndrome similar to fibromyalgia that is characterized by severe pain in the outer vagina. Milnacipran is a selective serotonergic reuptake inhibitor (SNRI) recently approved for the treatment of fibromyalgia. Because PVD often co-exists with fibromyalgia and the two conditions display similarities in diagnostic findings and clinical symptoms, a trial of milnacipran is indicated.

**Method:** The primary aim is to determine the efficacy of milnacipran in reducing pain in 20 women with PVD in an 18-week, open-label, flexible-dose trial. We will also determine whether associated symptoms in PVD, including psychological distress, impairment of sexual function, physical function, and quality of life, are correlated with a reduction in vulvar pain.

**Results:** Repeated Measures ANOVA will be used to compare differences between baseline and 4, 8, and 12-week treatment measures on the McGill Pain Questionnaire (MPQ). The association between pain scores and emotional function, sexual function, quality of life, and physical function will be determined using a Spearman Rho Correlation Coefficient.

**Discussion:** We anticipate completing 10 subjects by March, 2011 and will present interim results.

**Utility/Limitations/Risks:** The results of this trial may provide a treatment option for sufferers of this condition, but are limited by a nonexperimental research design and small sample size.

**Behavioral Learning Objectives:** After attending this presentation, the participants will be able to:
1. Discuss the similarities in clinical symptoms between PVD and fibromyalgia.
2. Understand the rationale for investigating the efficacy of milnacipran in the treatment of PVD.
3. Explain the need to measure multiple pain domains in this condition.

**References:**

Mease PJ, Claw DJ, Gendreau M, et al. (2009). The efficacy and safety of milnacipran for treatment of fibromyalgia. A randomized, double-blind, placebo-controlled trial. *Journal of Rheumatology*, 36, 398-409.

Pukall CF, Strigo IA, Binik YM. (2005). Neural correlates of painful genital touch in women with vulvar vestibulitis syndrome. *Pain*, 115, 118-127. (5 ln)

**Biography:** Dr. Brown received her PharmD from the University of Washington in 1985 and has been on faculty in the Colleges of Pharmacy and Medicine at the University of Tennessee Health Science Center since 1987. She has conducted numerous clinical trials in women's chronic pain and sexual disorders and is a member of SSTAR.

**ETHNIC DIFFERENCES IN SEXUALITY: VARIATIONS IN SEXUAL BEHAVIOR AMONG CAUCATION, CHINESE, JAPANESE AND KOREAN UNIVERSITY STUDENTS**

**Cara Dunkley, BA, Sabrina Chang, BA, Boris Gorzalka, PhD & Steven Hobkirk**

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**Introduction:** When examining differences between East Asian and Western sexuality, researchers have typically combined Chinese, Japanese and Korean participants into a single category as though they were a homogeneous population. Such studies have consistently demonstrated differences between East Asian and Western sexuality (e.g. Meston, Trapnell & Gorzalka, 1996; Kennedy & Gorzalka, 2002). However, there is currently no empirical justification in the literature for consolidating these ethnicities into one homogeneous group in sexuality studies. Given the divergence in various facets of Chinese, Japanese and Korean cultures, there are likely to be considerable differences in sexual practices and behaviors. The goal of the present study is to examine whether there are disparities in sexual behavior between undergraduate students of these East Asian ethnicities. Specifically, the aim of this study is to ascertain whether significant differences in sexual expression, practice and behavior arise when comparing Chinese, Japanese and Korean participants with each other and with Euro-Caucasian students.

**Method:** Euro-Caucasian, Chinese, Japanese and Korean undergraduate students completed an online questionnaire which assessed their interpersonal sexual behavior, intrapersonal sexual behavior, sociosexual restrictiveness and degree of traditional gender role adherence.

**Results:** The questionnaire responses of Chinese, Japanese and Korean students will be compared to each other with regards to sexual practices, expression, functioning and behaviors. These three groups will also be individually compared to a group of Euro-Caucasian students. Differences in sexuality between males and females of each ethnicity will be examined as well. The results will be presented at the conference.

**Discussion:** It is hypothesized that significant interethnic differences will be uncovered. Additionally, it is expected that both heritage culture adherence and mainstream culture acculturation will be correlated with several measures of sexual behaviors. If we observe no differences between Chinese, Japanese and Koreans in sexual behaviors, our results will serve as the first empirical rationale for examining these ethnicities together in future cross-cultural sexuality studies. If the comparison reveals significant interethnic differences, a re-evaluation of previous work on the differences between East Asian and Western sexuality may arise. Finding these differences would also affect clinical practice, as it will allow practitioners to tailor their approach to Chinese, Japanese and Korean clients instead of examining them within the sociocultural value system that is currently deemed suitable for all clients of East Asian descent.

**Utility/Limitations/Risks:** The discovery that individuals from various East Asian cultures differ on different types of sexual behavior will have important implications for clinical practice, as well as for future research examining sexuality within a cross-cultural framework. However, the generalizability of our results may be limited by our samples consisting exclusively of undergraduate students.

**Behavioral Learning Objectives:**
After attending this presentation, the participants will be able to:

1. Understand how the various East Asian cultures compare and contrast with each other in regards to sexual practices and behaviors.

2. Recognize the importance of distinguishing between Chinese, Japanese and Koreans in clinical practice and research.

**References:**

Kennedy, M. A. & Gorzalka, B. B. (2002) Asian and non-Asian attitudes towards rape, sexual harassment and sexuality. *Sex Roles*, *46*, 227-238.

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**Biographies:**

Cara Dunkley received her Bachelor of Arts Degree with Honors in Psychology at the University of Victoria in 2009. As an undergraduate, Cara worked as a research assistant in the University of Victoria Cognitive Psychology Laboratory. Currently, she is working as a research assistant at the University of British Columbia Sexual Psychophysiology and Psychoneuroendocrinology Laboratory and at the Simon Fraser University Close Relationships Laboratory.

Steven Hobkirk is finishing his Bachelor of Arts Degree in Psychology at the University of British Columbia. He has research experience working in various areas of psychology and is currently a research assistant in the University of British Columbia Sexual Psychophysiology and Psychoneuroendocrinology Laboratory.

# TEMPERAMENT AS A PREDICTOR OF LOW SEXUAL DESIRE

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**Introduction**: Temperament remains a relatively underestimated and unmeasured aspect of sexual desire. Using the Kiersey Temperament Sorter (aka The Myers-Briggs test), based on Jungian psychology, cases were studied, exploring relationships between low sexual desire and temperament.

**Method**: Analysis was conducted of 50 randomly selected marital/sex therapy cases where low sexual desire in either partner was a factor in relationship unhappiness.

**Results:** There was a positive correlation between introversion and a presentation of low sexual desire. This is especially true in women, but some highly introverted men may have low desire too.

**Discussion**: Although there are more than a dozen predictors of low sexual desire, the significance of temperament may be overlooked in the treatment of frustrated partners. Carl Jung postulated four types of personality in his model: 1.) Extraverts or Introverts, 2.) Feelers or Thinkers, 3.) Intuitives or Sensors, and 4.) Judgers or Perceivers. Sexual combinations can look like: Helpmates, Playmates, Soulmates, and/or Mindmates. For example, Introverts may be more self-contained and reserved, initiating sex less often. Extroverts may find themselves pursuing and overwhelming their partners.

**Utility**: Therapists may want to take the free test themselves at HumanMetrics.com, and then direct clients to the site. Understanding differences can build bridges between partners with conflicts over sexual desire and style. There is potential for greater self-acceptance, as well as understanding and acceptance of the partner. There may be less of a tendency to pathologize partners as crazy, or flawed, or wrong because they are different. Introverts and Extraverts may create great partnerships.

**Behavioral Learning Objectives**:
After attending this presentation, participants will be able to:

1. Discuss how temperament affects sexual style and desire.
2. Assist clients to understand and accept their differences, while increasing the collaborative alliance in the sexual relationship, especially between introverts and extraverts.
3. Teach partners to be better lovers to one another based on specifics temperaments.

**References:**

Keirsey, David, *Please Understand Me II: Temperament, Character, and Intelligence*. (1998) Del Mar, CA: Prometheus Nemesis Books.
Kroeger, Otto & Thuesen, Janet M. (1994). *16 Ways to Love Your Lover*. New York, NY, Delacorte.
Pearman, Roger R. & Albritton, Sarah C. (1997). *I'm Not Crazy, I'm Just Not You: Secrets to How We Can Be So Alike When We're So Different: The Real Meaning of the Sixteen Types.* Palo Alto, CA: Davis-Black.

**Biography:**

Karen Brash McGreer has been an ASSECT certified Sex Therapist since 1978, and a SSTAR member since 1990. She has been an RN since 1968, and a Marriage and Family Therapist since 1986. She last presented at a SSTAR meeting in 2003.

**SEXUAL ACTIVITY FREQUENCY AND BODY ESTEEM PREDICT SEXUAL DESIRE IN YOUNG WOMEN**

**Annia W. Raja, B.B.A., Yasisca P. Khouri, M.A., Cindy M. Meston, Ph.D.**

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**Introduction**: Recent findings suggest that a biopsychosocial model for female libido may have merit. Laan and Both (2008) argue for a "pull" model in which sexually relevant stimuli "pull" women toward sex, rather than innate desire impelling women to seek sex. Meston and McCall (2006) found that increased cues to sexual activity relate to more frequent sexual activity. Thus, sexual desire may increase due to sexual excitement activated by relevant cues. This study aimed to predict sexual desire from sexual activity frequency, body esteem, and other relevant variables.

**Methods**: Female undergraduate participants ($N = 432$) were recruited to complete an online questionnaire. The questionnaire battery contained sexual activity frequency, sexual functioning (FSFI), body esteem (BES), sexual satisfaction (SSS-W), and dyadic adjustment (DAS).

**Results**: Significant positive correlations between sexual desire and sexual functioning, body esteem, sexual activity frequency, and sexual satisfaction were found. A multiple regression showed that high body esteem related to sexual attractiveness, ($\beta = .25$, $p < .000$) and higher frequency of sex fantasies ($\beta = .19$, $p < .000$), viewing internet erotica ($\beta = .19$, $p < .000$), intercourse ($\beta = .12$, $p < .000$), and petting/foreplay ($\beta = .10$, $p = .001$) predicted greater sexual desire.

**Discussion**: Sexual activity frequency and body esteem for sexual attractiveness play an important role in sexual desire. Seeking sexual activity less often may be a potential cause of low libido. High body esteem may serve as a relevant visual and psychological cue to increasing one's desire.

**Utilities/Limitations/Risks**: These results can assist researchers investigating female sexual desire and provide therapists with behavioral approaches in treatment of low desire.

**Behavioral Learning Objectives:**
After attending this presentation, the participants will be able to:

1. Explain the importance of sexual activity frequency in female sexual desire
2. Discuss the merits of viewing sexual desire as possibly resulting from relevant stimuli

**References**:

Laan, E., & Both, S. (2008). What makes women experience desire? *Feminism & Psychology, 18*(4), 505-514. doi: 10.1177/0959353508095533

McCall, K., & Meston, C. (2006). Cues Resulting in Desire for Sexual Activity in Women. *Journal of Sexual Medicine, 3*(5), 838-852. doi: 10.1111/j.1743-6109.2006.00301.x

**Biography:**
Annia Raja received her B.B.A from The University of Texas at Austin in 2007. She worked as a management consultant at The Boston Consulting Group from 2007-2009. She has since returned to school to finish a psychology B.A. in hopes of pursuing a Ph.D. in clinical psychology in the future.

# SEXUAL BOUNDARY VIOLATIONS BY HEALTH PROFESSIONALS: OFFENDER RISK FACTORS

**Katherine Rios, S. Michael Plaut, Ph.D., Janet Brown, JD, MSW, Rebecca Wilbur, MA and Mira Brancu, Ph.D.**

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**Introduction:** Health professionals need to maintain boundaries with their patients for there to be a sound clinical relationship. Sexual boundary violations can have severe consequences for both the patient and offender.

**Method:** The participants in this retrospective study consisted of 42 offenders from a number of professions, found by their respective licensing boards in Maryland to be in violation of crossing sexual boundaries; and who were required to attend an educational tutorial in professional ethics.

**Results:** A number of offender risk factors were identified, including such things as relationship problems, professional isolation, depression, and substance abuse.

**Discussion:** Prevention methods are necessary, in terms of pre-degree school training and continuing education. Rehabilitation should be a requirement, after a violation, before a health professional can return to practice.

**Utility/Limitations/Risks:** The results of this study will help reduce the prevalence of boundary violations by helping health professionals identify the warning signs; however, the sample size is small and restricted to the State of Maryland.

**Behavioral Learning Objectives:**

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

1. Discuss health professional risk factors associated with sexual boundary violations.
2. Identify risk factors, enhancing the prevention of boundary violations.
3. Recognize that sexual boundaries are important for all health professions.

**References:**

Gabbard, G.O. (1989) (Ed.) *Sexual Exploitation in Professional Relationships*. Washington, D.C.: American Psychiatric Press, pp. 193-209.

Peterson, M.R. (1992). *At Personal Risk: Boundary Violations in Professional Relationships.* New York: W.W. Norton & Co.

Plaut, S.M. (2008). Sexual and nonsexual boundaries in professional relationships: Principles and teaching guidelines. *Sexual and Relationship Therapy*, 23, 85-94.

**Biography:**

Katherine Rios will receive her BA degree in Psychology, with Honors, from the University of North Carolina Wilmington in December 2010. She participates in research at the university and looks forward to pursuing this as a career, as well as, being a clinician. She is a member of Psi Chi and wishes to one day become a member of SSTAR.

# BIOLOGICAL MARKERS OF ASEXUALITY: A PILOT STUDY OF SEXUAL ORIENTATION GROUPS

**Morag A. Yule, BSc (Hons), BA, and Lori A. Brotto, Ph.D.**

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## Introduction:

Asexuality is loosely defined as lifelong lack of sexual attraction. In the last six years since the publication of the first empirical paper on human asexuality, there have been a number of empirical examinations focused on the description of asexuality and the characterization of asexual individuals (Bogaert, 2004; Prause & Graham, 2007; Brotto *et al.*, 2010). The only existing study to explore the prevalence of asexuality found that approximately 1% of the population self-identify as asexual (Bogaert, 2004). A recent frenzy of media attention focused on asexuality has suggested that asexual individuals experience hypoactive sexual desire disorder (HSDD), and that they may represent the polar lower end of the desire continuum. However, the existing data suggest that asexuals do not experience distress nor want to be "fixed" (Brotto *et al*., 2010), making asexuality fundamentally different from HSDD. The precise delineation between lifelong HSDD and asexuality is unclear, and this "gray zone" requires further study. In fact, among asexuals, there are advocacy efforts towards destigmatizing asexuality and legitimizing it as a sexual orientation. Recent research has examined elements of physical development (e.g., height, weight, age of puberty) and their relationship to sexual orientation, suggesting that gay/bisexual men are shorter and lighter than heterosexual men, and that lesbian/bisexual women are taller and heavier than heterosexual women (e.g., Blanchard & Bogaert, 1996). These findings have been disputed by more recent research (Bogaert, 2010) that does not support this pattern in non-heterosexual women. Further, the ratio between the second and fourth digits (2D:4D - which is thought to serve as a marker for prenatal androgen signaling) has also been linked to sexual orientation. A recent meta-analysis (Grimbo *et al*., 2010) found that heterosexual women had higher (more feminine) 2D:4D ratios than lesbian women, although this pattern was not apparent in men. The aim of this pilot study was to compare physical development and finger-length measurements in asexual and non-asexual women in order to gain some preliminary insight into the physical health and prenatal development patterns of asexual women, and to compare this to previous research on sexual orientation. We predicted that asexual women would be shorter and lighter, and have had puberty at a later age than non-asexual women, and that asexual women would show atypical patterns on a measure of prenatal development (i.e., 2D:4D finger-length ratios) compared to sexual women.

## Method:

Thirty-eight women between the ages of 19 and 55 (10 heterosexual, 10 bisexual, 11 homosexual and 7 asexual) completed a battery of questionnaires, including measures of physical development (e.g., height, weight, age of menarche). Following completion of questionnaires, 2D:4D finger-length ratios were measured using a standard computer scanner.

## Results:

Overall, the findings revealed no significant differences between asexual women and heterosexual, homosexual, or bisexual women on measures of physical development or finger-length ratios.

## Discussion:

Our finding that there is no significant difference in measures of physical development between asexual and sexual women is in keeping with previous research on physical development and sexual orientation.

The lack of a significant difference in finger-length ratios is discordant with previous research investigating this relationship in heterosexual and lesbian/bisexual women. While this pilot study did not obtain significant results, this line of research is an important addition to the limited scientific research investigating asexuality, as it is important to distinguish whether asexuality is a sexual dysfunction or better conceptualized as a sexual orientation. Upon presentation to a clinic, perhaps at the insistence of a distressed or dissatisfied partner, a clinician may suggest pharmaceutical or hormonal treatment for a life-long lack of low sexual desire. If asexuality is best thought of as a sexual orientation, it may be more effective to use therapy to treat discordant desire for sex within a sexual/asexual couple, than attempting to treat lifelong low sexual desire with treatments such as sensate focus or sexual psychopharmaceuticals. We are currently replicating this pilot study in a much larger sample of asexual and sexual men and women in the hopes that further research into biological markers of asexuality may lead to educating and reducing stigma surrounding asexuality, and will further elucidate how asexuality differs from sexual dysfunction, and in fact may represent a sexual orientation. In addition to contributing to the very small literature on asexuality, the findings will shed light on potential medical and clinical implications with interest to the wider community.

**Utility/Limitations/Risks:**

This study adds to the growing literature on asexuality, and is the first to investigate physical development and finger-length ratios in asexual women. While this pilot study had non-significant findings, the results of this line of research could have important ramifications for whether asexuality is viewed as a sexual orientation vs. a sexual dysfunction, such as HSDD. Important limitations of this study include the small sample size of asexual women (n = 7). We are currently in the process of replicating this pilot study in a much larger sample of asexual men and women using an online survey.

**Behavioural Learning Objectives:**

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

1. Describe the relationship between measures of physical development and finger-length ratios in asexual and non-asexual women.
2. Discuss the proposition that asexuality be characterized as a sexual orientation and not as a sexual dysfunction.

**References:**


Blanchard, R., & Bogaert, A.F. (1996). Biodemographic comparisons of homosexual and heterosexual men in the Kinsey interview data. *Archives of Sexual Behavior, 25,* 551–579.

Bogaert, A.F., (2010). Physical development and sexual orientation in men and women: An analysis of NATSAL-2000. *Archives of Sexual Behavior, 39*, 110-116.

Bogaert, A.F. (2004). Asexuality: Prevalence and associated factors in a national probability sample. *Journal of Sex Research, 41*, 279-287.

Brotto, L.A., Knudson, G., Inskip, J., Rhodes, K., & Erskine, Y. (2010). Asexuality: A mixed-methods approach. *Archives of Sexual Behavior, 39,* 599-618.

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Prause, N., & Graham, C.A. (2007). Asexuality: Classification and characterization. *Archives of Sexual Behavior, 36,* 341-356.


**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 sexuality research since 2007, and is presently a Master's student in the Clinical Psychology program at the University of British Columbia under the supervision of Dr. Lori Brotto.

## Index of First Authors by Last Name