

# SSTAR



SOCIETY FOR  
SEX THERAPY AND  
RESEARCH

37<sup>TH</sup> ANNUAL MEETING ABSTRACTS

**SEXUAL WELL-BEING:**

Crossroads of Culture, Psychology & Physiology

InterContinental Hotel  
Chicago, IL  
March 29 – 31, 2012

Thursday March 29, 2012

Recent Advances in  
Assessment & Treatment of  
Sexual Disorders

ABSTRACTS

## **AN UPDATE ON SEXUAL PHARMACOLOGY AND ITS USE TO REVERSE ANTIDEPRESSANT-INDUCED SEXUAL DYSFUNCTION**

Adam Keller Ashton M.D., M.S., D.F.A.P.A.  
Partner Suburban Psychiatric Associates  
85 Bryant Woods South  
Amherst, NY 14228  
USA  
Telephone#: 716-689-3333  
Fax#: 716-689-9695  
E-Mail: [aashton@suburbanpsych.org](mailto:aashton@suburbanpsych.org)

Sexual dysfunction is a common problem even in relatively young individuals. This difficulty frequently is compounded by antidepressant use. This presentation will describe phenomenology involved with prevalence of this problem and ways to assist with diagnosis clinically. Many strategies have been proposed to manage this problem including waiting for spontaneous remission, dosage reduction, drug holiday, and adjunctive pharmacologic antidote use, with the latter often being the most successful intervention. Off-label use of many agents has been proposed. This lecture will conclude with evaluation of the literature and clinical discussion of how to use medications to reverse antidepressant-induced sexual dysfunction in both men and women.

### **Behavioral Learning Objectives:**

After attending this presentation participants will be able to:

1. Differentiate antidepressant-induced sexual dysfunction from a primary sexual problem.
2. Describe strategies to manage iatrogenic sexual dysfunction.
3. Suggest specific pharmacologic intervention to help minimize sexual dysfunction caused by antidepressants.

### **References:**

1. Ashton, A. K., Weinstein, W. L., Jamerson, B. D., Wagoner, C. (2005). Which side effects affect patient compliance: Results of a patient survey. *Current Therapeutic Research*, 66 (2): 96-106.
2. Ashton, A. K., Mahmood, A, Iqbal, F. (2005). Reversal of SSRI-induced sexual dysfunction by switching to escitalopram, *Journal of Sex and Marital Therapy*, 31 (3): 257-262.
3. Balon, R. (1999) Management approaches to antidepressant-induced sexual dysfunction. *Primary Psychiatry*, 6 (11), 50.
4. Clayton, A. H. , Pradko, JS, Croft, H. A., Montano, C. B., Leadbetter, R. A., Bolden-Watson, C, Bass, K. I., Donahue, R. M. J., Jamerson, B. D., Metz, A (2002). Prevalence of sexual dysfunction among newer antidepressants. *Journal of Clinical Psychiatry*, 63, 357-366.

### **Biography:**

Adam Keller Ashton M.D., M.S., D.F.A.P.A. is clinical professor of psychiatry with the State University of New York at Buffalo and distinguished fellow of the American Psychiatric Association along with working in full-time private practice with Suburban Psychiatric Associates. He has over 80 published book chapters, abstracts, posters and articles and written extensively for psychiatric journals on treatment-induced sexual dysfunction. He has lectured widely having given over 1700 presentations and has been an invited guest lecturer at numerous national symposia. He also was awarded the 2007 State University of New York at Buffalo, Department of Psychiatry teaching award for outstanding contributions to medical student education.

Dr. Ashton received his bachelor's degree from Cornell University, College of Arts and Sciences. He received his medical degree from the State University of New York at Buffalo School of Medicine after completing his master's degree at the same facility. He was elected to Alpha Omega Alpha Medical Honor Society. He completed his residency in psychiatry also at the State University of New York at Buffalo where he was chief resident, with subsequent training in sex therapy at the Robert Wood Johnson School of Medicine in New Jersey.

## **ASSESSMENT, DIAGNOSIS & TREATMENT OF FEMALE SEXUAL DYSFUNCTIONS**

Bat Sheva Marcus, LMSW, MPH, PhD

The Medical Center for Female Sexuality  
2975 Westchester Avenue  
Purchase, New York 10577  
914.328.3700  
[www.centerforfemalesexuality.com](http://www.centerforfemalesexuality.com)

There is much debate about the causes, prevalence or even existence of the condition we call Female Sexual Dysfunction. However, common consensus seems to be that it is generally caused by a combination of physiological, psychological, emotional and situational factors. The successful practitioner will be able to help the patient sift through the many variables and then work together to create a treatment plan.

This workshop will look at the treatment of female sexual dysfunction primarily through a medical lens. It will outline the four categories of FSD as delineated in the DSM IV and then describe the symptoms and common presentation of these. It will then summarize common etiologies as well as current practice for medical treatment. The following four areas will be covered:

FSDD – Female Sexual Desire Disorder

FSAD – Female Sexual Arousal Disorder

Pain Syndromes – Vaginismus, Vulvodynia, Vulvar Vestibulitis and Dyspareunia

Orgasm Problem – Both primary and Secondary

Treatment practice will review the use of oral medications, anti anxiety medications, hormone therapy, topical treatments, dilators and vibrators. It will not focus on the psychological treatment of these conditions, other than to delineate the way in which they contribute.

### **Biography:**

Bat Sheva Marcus, PhD is one of the founders and the Clinical Director of The Medical Center For Female Sexuality. The Center, founded in 2000, is dedicated to helping women with a variety of sexual issues including lack of desire, inability to become aroused, pain and difficulty with orgasm. Dr. Marcus has also been involved in numerous drug studies on female sexual dysfunction including studies on Viagra testosterone and Flibanserin.

Bat Sheva earned her PhD at the Institute for the Advanced Study of Human Sexuality in San Francisco, CA. Her dissertation research was on vibrator use in women. Dr. Marcus also holds a masters degree in social work from Columbia University as well as a masters degree in public health. She has long history of work with non-profit and feminist organizations and has lectured internationally on women's issues. She has been a guest on numerous radio and television shows including CBS News, News 12 Westchester and Z100, and has appeared in the New York Times, Time Magazine and Westchester Magazine.

## SO CALLED SEXUAL PAIN: “NEW” APPROACHES TO THE DIAGNOSIS AND TREATMENT OF DYSPAREUNIA AND VAGINISMUS

**Yitzchak M. Binik PhD**

Dept. of Psychology, McGill University  
Sex and Couple Therapy Service  
McGill University Health Center  
Montreal, Quebec, Canada, H3A 1B1  
514-398-6095; 514-398-4896 (fax)  
[binik@ego.psych.mcgill.ca](mailto:binik@ego.psych.mcgill.ca)

Until recently there has been little new research interest or therapeutic innovation concerning dyspareunia and vaginismus. This stagnation has probably occurred for at least two reasons. First, the DSM-IV-TR definitions of dyspareunia and vaginismus have been accepted with little discussion for almost 150 years. Second, Sex Therapy based treatment has been considered highly efficacious. Recent research has challenged both of these ideas. Recent diagnostic (including the DSM-5 proposals) and therapy outcome research will be reviewed with a view to suggesting new diagnostic definitions and a more comprehensive treatment program.

### Behavioral Learning Objectives

1. Review the history of and problems with the diagnosis of dyspareunia and vaginismus.
2. Review the treatment outcome literature for dyspareunia and vaginismus.
3. Suggest a new diagnostic formulation and more comprehensive treatment strategy.

Binik, Y. M. (2010). The DSM diagnostic criteria for dyspareunia: Review and recommendations prepared for the sexual and gender identity disorders work group for DSM-V. *Archives of Sexual Behavior, 39*, 292-303

Binik, Y. M. (2010). The DSM diagnostic criteria for vaginismus: Review and recommendations prepared for the sexual and gender identity disorders work group for DSM-V. *Archives of Sexual Behavior, 39*, 278-291

ter Kuile, M. M., Bulté, I., Weijenorg, P. T. M. Beekman, A., & Melles, R. (2009). Therapist-aided exposure for women with lifelong vaginismus; A replicated single-case design. *Journal of Consulting and Clinical Psychology, 77*, 149-159.

van Lankveld, J. D. M., ter Kuile, M. M., de Groot, H. E., Melles, R., & Nefs, J. (2006). Cognitive-behavioral therapy for women with lifelong vaginismus: A randomized waiting list controlled trial of efficacy. *Journal of Consulting and Clinical Psychology, 74*, 168-178.

### Biography

Dr. Binik received his Ph.D. in clinical psychology from the University of Pennsylvania in 1975. He is professor of psychology at McGill University and the Director of the Sex and Couple Therapy Service at the McGill University Health Center (RVH). He is the recipient of the Masters and Johnson award from SSTAR for lifetime achievement and a member of the DSM-5 workgroup on sexual and gender identity disorders.

## TALKING ABOUT SEX IN CLINICAL PRACTICE

**Derek C. Polonsky, M.D.**

Clinical Instructor in Psychiatry  
Harvard Medical School  
Private Practice, Brookline, MA  
Phone and Fax: 617-566-7508  
[derek44@earthlink.net](mailto:derek44@earthlink.net)

The frequency of sexual difficulties among both men and women is high, and yet few clinicians have much training in talking directly with their patients about sex. The view that patients will spontaneously discuss concerns if they have any, is often a reason given for the clinician's silence. Yet the shame and embarrassment many people feel when they have a sexual problem often makes raising the issue with the therapist difficult.

There is much to be learned in asking patients about their sexuality. For many, this is the first opportunity to have a conversation with an informed adult about the topic. Sexual difficulties have profound effects on an individual's sense of self and almost always has an impact on the partners with whom they are involved.

The pattern of the sexual script often provides a valuable understanding of the dynamics of the couple relationship. The sexual arena in many instances reflects the subtle and yet powerful cues that may affect the nature of the relationship.

This lecture will provide a model for introducing the subject of sex and an outline of the questions that comprise a complete sexual history. A brief overview of the sexual dysfunctions with specific focus on the questions to be asked to understand the nature of the problem will be provided.

### **Behavioral Learning Objectives:**

After attending this presentation, participants will be able to:

- 1 Introduce the topic in a sensitive way.
- 2 Ask questions related specifically to sexual development, knowledge and behavior.
- 3 Elicit information that defines accurately the nature of any sexual difficulty affecting a particular patient.

### **Biography:**

Derek Polonsky is a Clinical Instructor in the Department of Psychiatry at Harvard Medical School where he has been on the faculty for the past 35 years. He has a private practice in Brookline, MA., where he sees individuals and couples. He has been a member of SSTAR since 1982 and has served on its Executive Council as Treasurer, Local Events Chair in 1999, 2005 and 2010.

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

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

Professor, Department of Psychology, University of Utah

380 S. 1530 E., Room 502

Salt Lake City, Utah 84112

Phone: (801) 581-7559 Fax: (801) 581-5841

[donald.strassberg@psych.utah.edu](mailto:donald.strassberg@psych.utah.edu)

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. Understand 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:

- Bella, A.J., Perelman, M.A., Brant, W.O., & Lue, T.F. (2007). Peyronie's disease. *Journal of Sexual Medicine*, 4, 1527-1538.
- Leiblum, S.R. (2006) *Principles and Practice of Sex Therapy*, Fourth Edition. Guilford Press.
- Perelman, M.A., (2009). The sexual tipping point: A mind/body model for sexual medicine. *Journal of Sexual Medicine*, 6, 2009, 629-632.
- Perelman, M.A. & Rowland, D.L. (2008). Retarded and inhibited ejaculation. In D. Rowland & L. Incrocci (Eds.), *Handbook of Sexual and Gender Identity Disorders*. Hoboken, NJ; John Wiley & Sons Inc, pp. 100-121.
- Strassberg, D. S. (1994). A physiologically based model of early ejaculation: A solution or a problem? *Journal of Sex Education and Therapy*, 20, 215-217.
- Strassberg, D.S. & Perelman, M. A. (2009). Sexual dysfunctions. In P.H. Blaney & T. Millon (Eds.), *Oxford Textbook of Psychopathology* (2<sup>nd</sup> 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 36 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.

Thursday, March 29, 2012

Annual Meeting Presentation  
Workshops

**ABSTRACTS**

## MINDFULNESS-BASED COGNITIVE THERAPY FOR WOMEN WITH SEXUAL DIFFICULTIES

**Lori A. Brotto, PhD**

Department of Obstetrics and Gynaecology

2775 Laurel Street, 6<sup>th</sup> Floor

Vancouver, BC, V5Z 1M9 Canada

Telephone: (604) 875-4111 x68898 Fax: (604) 875-4869 E-mail: lori.brotto@vch.ca

**Introduction:** Mindfulness has a 4,000 year history in the Eastern world. Over the past three decades, mindfulness has made its way into western health care and has been shown in numerous studies to be an effective treatment for a variety of medical and psychiatric conditions, including, pain, depression, anxiety, child behavior problems, substance use, and borderline personality disorder. In the past eight years, mindfulness skills have been integrated into traditional cognitive behavioral sex therapy and applied to various groups of women with sexual concerns. The goal of this workshop is to provide empirical support for mindfulness-based cognitive therapy (MBCT) in addressing women's low sexual desire and arousal, provoked vestibulodynia, and sexual distress. A secondary goal is to practice a variety of mindfulness exercises commonly used.

**Method:** Using a combination of data analysis and experiential practice, participants will be introduced to a variety of mindfulness practices, including, the Eating meditation, the Body Scan, 3-minute breathing space, mindful breath, and mindfulness of thoughts. We will use a portion of the time during the workshop to practice these skills, then participants will be guided through a detailed inquiry, which serves to continue the practice and review the experience.

**Discussion:** By the end of this workshop, participants will have a detailed overview of how MBCT has been applied to women with sexual difficulties, and understand the kinds of individual characteristics and clinical profiles that might be best suited for such an approach. Participants will also have gained valuable experiential practice and be provided with information and resources for their patients as well as for themselves for ongoing practice.

**Utility/Limitations/Risks:** This workshop is designed to integrate empirical findings and experiential practice to provide participants a thorough introduction into the use of MBCT for sexual concerns in women.

### **Behavioral Learning Objectives:**

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

1. To describe what is mindfulness-based cognitive therapy and review some outcome literature on its efficacy in many domains of healthcare
2. To discuss mechanisms underlying the purported benefits of mindfulness for women's sexual difficulties
3. To gain experiential practice in mindfulness-based CBT

### **References:**

Brotto, L.A., & Heiman, J.R. (2007). Mindfulness in sex therapy: Applications for women with sexual difficulties following gynaecologic cancer. *Sexual and Relationship Therapy, 22*(1), 3-11.

Brotto, L.A., Woo, J.S.T. (2010). Cognitive-behavioral and mindfulness-based therapy for low sexual desire. In: Leiblum, S. R. (Ed.). *Treating Sexual Desire Disorders: A Clinical Casebook*. Guilford Press, New York, NY, pp. 149-164.

Hanh, T. N. (1976). *The Miracle of Mindfulness: A Manual on Meditation*. (Boston, Beacon Press).

Kabat-Zinn, J. (1990). *Full catastrophe living: Using the wisdom of your body and mind to face stress, pain, and illness*. (New York, NY, Dell Publishing).

Segal, Z. V., Williams, J. M. G., & Teasdale, J. D. (2002). *Mindfulness-based cognitive therapy for depression: A new approach to preventing relapse*. (New York, Guilford Press).

### **Biography:**

Dr. Brotto received her Ph.D. from the University of British Columbia in 2003 and completed a Postdoctoral Fellowship in Sexual and Reproductive Medicine at the University of Washington. She has been on faculty in the Department of Obstetrics and Gynaecology at the University of British Columbia since 2005. Her research focuses on developing and testing psychological interventions for a variety of women's sexual concerns. She is also a Registered Psychologist in Vancouver, Canada.

## UNDERSTANDING AND TREATING LOVE/LUST SPLITS

**Jack Morin, Ph.D.**

Private Practice; California Institute of Integral Studies

423 Gough Street, Suite D

San Francisco, CA 94102

Telephone: (415) 552-9560 Fax: (650) 631-5825 E-mail: jmorinphd@yahoo.com

**Introduction:** Of all the erotic conflicts to which humans are vulnerable, none is more vexing than a longstanding, fundamental rift between one's capacities for lust and affectionate connection. Love/lust splits may be *developmental* (embedded in one's core eroticism) or *situational* (tied to dynamics of a specific relationship). Likewise, these splits may be paraphilic (highly focused) or non-paraphilic (involving a wider variety of turn-ons). Clinicians are often asked to provide support and guidance in resolving these splits.

**Method:** Clinical process notes were collected during thirty-five years of practice with clients troubled by love/lust splits. Notes were qualitatively analyzed to identify commonly-recurring themes in the development and resolution of these splits. Furthermore, specific, representative cases were developed in greater detail to reveal the complex dynamics involved.

**Results:** The most challenging love/lust splits typically arise in childhood and adolescence when love and lust develop on separate tracks. Clients tend to seek help when they have begun a relationship and become painfully aware that sex in this context is difficult or impossible. Complicating matters, those immersed in *disconnected lust* are often plagued by shame and a variety of other problems. Nonetheless, it is possible for clients to consciously develop their capacity for, and comfort with, *relational sex*. Paradoxically, successful exploration of relational sex is more likely if it is accompanied by deep acceptance of one's primary lusty turn-ons.

**Discussion:** By exploring relatively extreme conflicts between love and lust, it becomes clear that similar concerns are an integral part of human erotic expression. Love and lust are two different experiences which can be stubbornly at odds, but also overlap to varying degrees. The search for stable connections, both emotional and sexual, requires coming to terms with competing desires and needs.

**Utility/Limitations/Risks:** Developing a clearer understanding of how love/lust splits develop and evolve will help clinicians to be more empathetic about the complexities of these problems. In addition, specific interventions will increase therapist effectiveness with this population. Clinicians and clients alike will need to come to terms with less-than-perfect resolutions.

### **Behavioral Learning Objectives:**

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

1. Describe the formation of a love/lust split.
2. Distinguish between developmental and situational love/lust splits.
3. Name three clinical interventions for resolving these splits.

### **References:**

Morin, J. (1995). *The Erotic Mind*. New York: HarperPerennial.

Perel, E. (2006). *Mating In Captivity*. New York: Harper.

Money, J. (1986). *Lovemaps*. New York: Irvington.

### **Biography:**

Dr. Morin received his Ph.D. in clinical psychology from Saybrook University in 1978. He has been in private practice since 1976. He is the author of *Anal Pleasure and Health* (2010, 4th Ed.) and *The Erotic Mind* (1995). He has been on the faculty of California Institute of Integral Studies since 1996.

March 29, 2012

Poster

**ABSTRACTS**

## ATTACHMENT STYLE DIFFERENCES IN SEXUAL FUNCTIONING

Silvain Dang, BS, Cara Dunkley, BA, Sabrina Chang, BA, & Boris Gorzalka, PhD

### Silvain Dang

Department of Psychology, University of British Columbia  
2136 West Mall, Vancouver, British Columbia V6T 1Z4, Canada  
Telephone: (778) 887-6609 ♦ E-mail: silvain.dang@gmail.com  
Telephone: (604) 992-7099 ♦ E-mail: caradunkley@gmail.com

**Introduction:** A proliferation of research examining the importance of sexuality in close relationships has emerged in recent years. The expansion of Bowlby's (1970) developmental theory of attachment and its application to adult romantic relationships has received particular attention. According to Bowlby's theory, children's initial years of formative infant-caregiver interactions are internalized to create specific styles of attachment: Secure, Avoidant and Anxious-Ambivalent. Hazan and Shaver (1987) describe that the three primary attachment styles present from infancy persist into adulthood, and influence the manner in which adults experience and behave in romantic relationships. To date, attachment style differences in sexual functioning remain relatively unstudied. Thus, the primary aim of the current study is to investigate disparity in various facets of sexual functioning among individuals with differing attachment styles.

**Method:** Participants complete an online questionnaire comprised of scales assessing attachment style and sexual functioning.

**Results:** Based on preliminary findings, we predict that disparity in the prevalence rates of sexual dysfunctions will emerge among the different styles of attachment. Respectively, secure individuals are hypothesized to report the lowest levels of sexual dysfunction, anxious individuals the highest, and those classified as avoidant falling in between. Gender and ethnicity are anticipated to function as moderating factors.

**Discussion:** Information regarding the connection between attachment style and sexual functioning may be beneficial for developing therapies for individuals who suffer from sexual dysfunctions. Such knowledge has the potential to aid practitioners in clinical assessment, as well as allow clinicians to tailor their approach to an individual's style of attachment.

**Utility/Limitations/Risks:** This is the first study to examine attachment style and sexual functioning across gender and ethnicity.

**Behavioural Learning Objectives:** After attending this presentation, the participants will:

1. Understand the relation between attachment style and sexual functioning.
2. Recognize the interplay of ethnicity and gender with regards to attachment style and sexual functioning.

### References:

- Bowlby, J. (1970). Disruption of affectional bonds and its effect on behavior. *Journal of Contemporary Psychology*, 2, 75-86
- Hazan, C., & Shaver, P. R. (1987). Romantic love conceptualized as an attachment process. *Journal of Personality and Social Psychology*, 52, 511-524.

### Biographies:

Silvain Dang received his Bachelor of Science Degree in Psychology at the University of British Columbia (UBC) in 2011. Cara Dunkley received her Bachelor of Arts Degree (Honors) in Psychology at the University of Victoria in 2009. Both Silvain and Cara currently work as research assistants at the UBC Sexual Psychophysiology and Psychoneuroendocrinology Lab.

## ATTITUDES TOWARD SEEKING HELP FOR SEXUAL DYSFUNCTIONS

Linnea Bergvall and Melissa Himelein, PhD

Linnea Bergvall

Department of Psychology, University of North Carolina Asheville, CPO # 1630,  
Asheville, NC 28804 USA

Telephone: (828) 250-3896 Fax (828) 251-6422 E-mail: lbergval@unca.edu

**Introduction:** Individuals with psychological disorders frequently do not seek treatment, most likely due to stigma associated with mental illness. To what extent do individuals with sexual dysfunctions follow this same pattern? The present study sought to examine help-seeking and stigma related to sexual problems, issues largely neglected by previous researchers. The impact of culture on stigma was also explored by comparing attitudes of individuals from two different countries.

**Method:** In the effort to recruit comparable samples, we surveyed college students from a small, public university in the U.S. ( $n = 78$ ) and a midsized public university in Sweden ( $n = 81$ ). The two groups did not differ in gender, marital status, race, or religion, although the Swedish sample was significantly older ( $M = 23.3$  vs.  $20.2$ ). Participants completed a survey containing three scales of stigma and help-seeking adapted from previously validated measures of help-seeking for general psychological disorders. In addition, participants were asked to rate the likelihood that they would seek help for sexual problems from each of five different types of professionals.

**Results:** Participants in both countries expressed moderate willingness to seek help for sexual problems ( $M = 11.90$  [U.S.] and  $11.93$  [Sweden]; theoretical maximum = 16), relatively low levels of perceptions of stigmatization by others ( $M = 5.57$  [U.S.] and  $5.15$  [Sweden]; maximum = 15), and moderate levels of self-stigma ( $M = 12.67$  [U.S.] and  $11.50$  [Sweden]; maximum = 25). Gender differences were apparent on the latter measure, with females overall ( $M = 11.29$ ) expressing less self-stigma than males overall ( $M = 13.04$ ). Participants reported that they would be most likely to seek help for sexual problems from gynecologists/urologists and family physicians, followed in order by sex therapists, psychologists, and counselors.

**Discussion:** Despite differing sociocultural and political perspectives, the two samples were more alike than different in attitudes toward seeking help for sexual dysfunctions. Participants from both countries expressed more comfort with requesting help from physicians, who may not have the time or training to treat sexual dysfunctions, than from sex therapists.

**Utility/Limitations/Risks:** It is imperative that sex therapy professionals are aware of patient characteristics and attitudes that may inhibit their likelihood of seeking help.

**Behavioral Learning Objectives:** After viewing this poster, the participants will be able to:

1. Compare attitudes toward seeking help for sexual problems in Sweden and the U.S.
2. Explain from which professionals students with sexual problems are most likely to seek help.
3. Discuss the relationship between stigma and help-seeking with regard to sexual problems.

### References:

- Elhai, J. D., Schweinle, W., & Anderson, S. M. (2008). Reliability and validity of the Attitudes Toward Seeking Professional Psychological Help Scale-Short Form. *Psychiatry Research, 159*, 320-329.
- Vogel, D. L., Wade, N. G., & Ascheman, P. L. (2009). Measuring perceptions of stigmatization by others for seeking psychological help: Reliability and validity of a new stigma scale with college students. *Journal of Counseling Psychology, 56*, 301-308.
- Vogel, D. L., Wade, N. G., & Haake, S. (2006). Measuring the self-stigma associated with seeking psychological help. *Journal of Counseling Psychology, 53*, 325-337.

**Biography:** Linnea Bergvall is a B.A. psychology student at the University of North Carolina Asheville. She moved from Sweden to Asheville, North Carolina, four years ago and is planning to remain in the U.S. to study family and sex therapy.

# THE ASSOCIATION BETWEEN SEXUAL SATISFACTION AND OVERALL LIFE SATISFACTION FOR WOMEN WITH IMPAIRED SEXUAL FUNCTIONING

Kyle R Stephenson, MA, Parrish Williams, and Cindy M Meston, PhD

Department of Psychology  
The University of Texas at Austin  
1 University Station A8000  
Austin, TX 78751 USA

Telephone: 512-232-4805 \_E-mail: [krstephenson@gmail.com](mailto:krstephenson@gmail.com)

**Introduction:** Although some research has explored the link between sexual satisfaction and overall life satisfaction (Brody & Costa, 2009; Apt, Hurlbert, Pierce, & White, 1996; Woloski-Wruble, Oliel, Leefsma, & Hochner-Celnikier, 2010), few of these studies have examined non-linear associations between the two constructs. Additionally, almost none of these studies have included women with sexual dysfunctions. Our goal in the current study was to test both the linear and quadratic the association between sexual satisfaction and life satisfaction for women reporting impaired sexual functioning.

**Method:** Female participants in sexually active relationships who were currently experiencing one or more difficulties with sexual functioning ( $n = 50$ ,  $M$  age = 28.08) were interviewed by researchers and completed cross-sectional self-report questionnaires, including the Female Sexual Function Index (FSFI) and the Satisfaction With Life Scale (SWL).

**Results:** Using a linear regression model, we found a significant quadratic relationship between sexual satisfaction and life satisfaction. Specifically, at high levels of sexual satisfaction, sexual and life satisfaction were weakly associated whereas, at low levels of sexual satisfaction, sexual and life satisfaction were strongly associated.

**Discussion:** Sexual satisfaction and life satisfaction are positively associated, but the strength of this association differs across the range of sexual satisfaction. When sexual satisfaction is generally low, small changes in sexual satisfaction may be associated with significant changes in overall life satisfaction.

**Utility/Limitations/Risks:** These results suggest that improving a woman's sexual satisfaction could possibly improve her overall well-being and happiness. However, this association may be much stronger for women presenting with sexual difficulties who are very dissatisfied with their sex lives. These findings have a number of implications for clinical trials of treatments for sexual dysfunction. Our results are limited by a relatively small sample size and the use of cross-sectional measurement.

## **Behavioral Learning Objectives:**

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

1. Understand the relationship between sexual satisfaction and life satisfaction
2. Discuss how this relationship could impact treatment-induced changes in well-being

## **References:**

- Woloski-Wruble, A. C., Oliel, Y., Leefsma, M., & Hochner-Celnikier, D. (2010). Sexual activities, sexual and life satisfaction, and successful aging in women. *Journal of Sexual Medicine*, 7(7), 2401-2410.
- Apt, C., Hurlbert, D., Pierce, A., & White, L. (1996). Relationship satisfaction, sexual characteristics and the psychosocial well-being of women. *Canadian Journal of Human Sexuality*, 5(3), 195-210.
- Brody, S., & Costa, R. (2009). Satisfaction (sexual, life, relationship, and mental health) is associated directly with penile-vaginal intercourse, but inversely with other sexual behavior frequencies. *Journal of Sexual Medicine*, 6(7), 1947-1954. doi:10.1111/j.1743-6109.2009.01303.x

## **Biography:**

Parrish Williams is an undergraduate senior studying Psychology at the University of Texas at Austin. She works as a research assistant in the Sexual Psychophysiology Lab under Dr. Cindy Meston. She plans to continue her education in graduate school where she hopes to study sexuality.

# BEHAVIORAL AND PERSONALITY CORRELATES OF MEN WITH SEXUAL INTEREST IN TRANSEXUALS

Kevin J. Hsu, A. M. Rosenthal, MS, and J. Michael Bailey, PhD

Kevin J. Hsu

Department of Psychology

Northwestern University

Cresap Hall, 2029 Sheridan Road, Room 225

Evanston, Illinois 60208 USA

Telephone: (847) 491-3820 Fax: (847) 491-7859 E-mail: khsu@northwestern.edu

**Introduction:** Gynandromorphophilia (GAM) is the sexual interest in cross-dressed or anatomically feminized men (Blanchard & Collins, 1993). Most men are attracted to features of only one sex, but men with GAM are attracted to individuals with both male and female features such as penises and breasts. GAM has been hypothesized to co-occur with autogynephilia, which is sexual arousal by the idea of oneself as a woman. Autogynephilia is associated with both fetishistic cross-dressing and bisexual identity. We examined the self-reported sexual identity, personality, and erotic interests of men with GAM recruited via the Internet.

**Method:** Participants were 205 men recruited from Internet personal advertisement lists where men sought transsexuals for dates or sexual encounters. Participants completed relevant measures.

**Results:** Most participants identified as heterosexual (50.7%) or bisexual (41.0%). Among heterosexual participants, 23.5% had previously considered identifying as bisexual or homosexual solely because of their interest in transsexuals. Men with GAM did not differ from heterosexual controls on gender atypicality. When asked about their ideal sex partner, 55% said it would be a woman, 36% a transsexual, and 5% a man. Participants were asked about 11 other paraphilic interests. Participants reported an average of 3.7 additional sexual interests; voyeurism, transvestism, fetishism, and exhibitionism were the most prevalent. On the Blanchard Autogynephilia Scale, participants' mean score was 3.3. Interestingly, the majority of participants reported having never cross-dressed (65.8%).

**Discussion:** GAM is predominantly an erotic interest of men who are otherwise sexually attracted to women. A substantial minority of men with GAM prefer transsexual sex partners above all others. Sexual identity among men with GAM was correlated with several variables, including gender atypicality and autogynephilia. The precise nature of the relation between GAM and autogynephilia requires further study.

**Utility/Limitations/Risks:** The results of our study will aid therapists and researchers working with men with GAM as well as the transsexual women with whom they have relationships. However, given our recruitment source, the results may not be representative of typical men with GAM.

## **Behavioral Learning Objectives:**

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

1. Identify the most common sexual identities among men with GAM
2. Predict the other unusual erotic interests and sexual behaviors of men with GAM
3. Explain the putative relationship between autogynephilia and GAM

## **References:**

Blanchard, R., & Collins, P. I. (1993). Men with sexual interest in transvestites, transsexuals, and she-males. *Journal of Nervous and Mental Disease*, 181, 570-575.

## **Biography:**

Kevin Hsu is a senior undergraduate at Northwestern University who has studied sexual orientation, transsexualism, and paraphilias since 2009 under the direction of J. Michael Bailey.

# CATASTROPHIZING, VULVAR PAIN, AND THE 'PAIN MATRIX': AN FMRI STUDY

Kate S Sutton, MA, Caroline F Pukall, PhD, Susan Chamberlain, MD, Conor Wild, MSc

## Kate S Sutton, MA

Department of Psychology, Queen's University  
62 Arch Street, Kingston ON Canada K7L 3N6  
Tel: 613-533-3276 email: [ksutton2@gmail.com](mailto:ksutton2@gmail.com)

### Introduction:

Women with provoked vestibulodynia (PVD) perceive pain at lower thresholds and have greater psychosocial impairment, including higher levels of catastrophizing, as compared with healthy control women. These findings are similar to those of patients with other chronic pain conditions. In addition, there are parallel areas of the brain activated during painful stimulation; these areas are part of a system termed the 'pain matrix'. Further, high levels of catastrophizing are associated with increased activation in affective areas of the pain matrix in individuals with fibromyalgia. The current study examines the association between catastrophizing and pressure-pain in women with and without PVD.

**Method:** Participants underwent a gynaecological examination to determine eligibility, followed by an interview/questionnaire session, psychophysical testing, and an fMRI session in which painful and non-painful pressures were applied to the vulvar vestibule using vulvalgesiometers. The pressure applied to each participant was one that corresponded to a 4/10 on a pain intensity rating scale. Groups were matched on age, parity, and hormonal contraceptive status.

**Results:** In PVD women, greater levels of reported pain intensity during intercourse ( $p < .05$ ) and the cotton-swab test ( $p < .01$ ) were associated with greater activation of the pain matrix during the experimental procedure. Higher catastrophizing (as measured by the Pain Catastrophizing Scale) was associated with higher activity in areas of the pain matrix associated with emotional processing, such as the anterior cingulate cortex (ACC;  $p < .05$ ) and the insula ( $p < .05$ ) for women with PVD, but not controls. The amount of pressure applied in grams had no significant correlations with brain activation for PVD women, but was correlated with activation in the ACC ( $p < .05$ ) for controls.

**Discussion:** Women with PVD show similar activation patterns to individuals with other chronic pain conditions. Findings will be discussed in terms of their contribution to understanding the role of catastrophizing in the cycle of chronic pain.

**Utility/Limitations/Risks:** The current study is helpful for understanding PVD as a chronic pain and the manner in which catastrophizing helps to maintain such pain. Limits include a small sample.

### Behavioural Learning Objectives:

1. To explain the utility of fMRI research in the chronic pain literature.
2. To further understand the role of catastrophizing in chronic pain conditions, specifically PVD.

### References:

Gracely, R.H., Geisser, M.E., Giesecke, T., Grant, M.A.B., Petzke, F., Williams, D.A., & Clauw, D.J. (2004). Pain catastrophizing and neural responses to pain among persons with fibromyalgia. *Brain*, 127, 835-843.

Sullivan, M.J.L., Thorn, B., Haythornthwaite, J.A., Keefe, F., Martin, M., Bradley, L.A., & Lefebvre, J.C. (2001). Theoretical perspectives on the relation between catastrophizing and pain. *The Clinical Journal of Pain*, 17, 52-64.

### Biography:

Kate Sutton obtained her MA in 2007 and is presently working on her PhD under the supervision of Dr. Caroline Pukall at Queen's University. She is currently on internship at the Centre for Addiction and Mental Health (CAMH). Her research interest is in women's health, specifically the relationship between psychosocial and psychophysical/physiological measures.

# COULD VULVODYNIA BE NEUROPATHIC? AN EXAMINATION OF PAIN SYMPTOM PROFILES IN WOMEN WITH PROVOKED VESTIBULODYNIA

Emma Dargie, MSc, and Caroline Pukall, PhD

Emma Dargie, MSc

Department of Psychology

Queen's University

Kingston, Ontario, K7L 3N6

Telephone: 613-533-3276 ♦ Fax: 613-533-2499 ♦ E-mail: [5eed@queensu.ca](mailto:5eed@queensu.ca)

**Introduction:** Despite the high prevalence of Provoked Vestibulodynia (PVD), it is poorly understood. Although it is currently recognized as a pain condition by most, its pain characteristics have not been fully explored and, as such, the pain of PVD remains to be formally classified. Some believe PVD is a neuropathic pain (NP) but none have empirically evaluated this hypothesis. This knowledge has strong potential to guide treatment.

**Method:** We recruited participants for an anonymous online survey assessing pain characteristics. Our sample consisted of 56 women with PVD and 23 women with Post-Herpetic Neuralgia (PHN), an established NP condition. The McGill Pain Questionnaire (MPQ) and the Self-Report Leeds Assessment of Neuropathic Symptoms and Signs (S-LANSS) were utilized to assess pain.

**Results:** Women with PVD and PHN both exceeded published NP cut-off scores. Further, there was no significant difference between these pain groups on total and subscale scores. When pain symptom profiles were generated, women with PVD commonly endorsed burning, stabbing, stinging, and grueling pain, in addition to pain in response to rubbing and pressure, and sensitivity. Women with PHN endorsed a different set of symptoms, some of which were not often endorsed by PVD women (e.g., tingling, aching, heavy, electric, shooting, and exhausting).

**Discussion:** Taken together, this pattern of responses from the PVD group is suggestive of sensory abnormalities in the form of evoked pain accompanied by a lack of negative sensory deficits. These results suggest that PVD could be classified as pain of "possible" neuropathic origin.

**Utility/Limitations/Risks:** The results of this study will help physicians tailor the assessment and treatment of PVD, potentially reducing the time spent on the trial-and-error approach. This study is limited by the self-report nature of the information, and by the small size of the PHN sample.

## Behavioural Learning Objectives

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

1. Identify common symptoms experienced by women with PVD
2. Compare pain qualities of PVD with another established NP condition
3. Diagnose PVD patients with possible NP, with the help of the S-LANSS

## References

- Bennett, M. I., Smith, B. H., Torrance, N., & Potter, J. (2005). The S-LANSS score for identifying pain of predominantly neuropathic origin: Validation for use in clinical and postal research. *Journal of Pain*, 6, 149-158. DOI: 10.1016/j.jpain.2004.11.007
- Lynch, M. E. (2001). Antidepressants as analgesics: A review of randomized controlled trials. *Journal of Psychiatry and Neuroscience*, 26, 30-36.

**Biography:** Ms. Dargie received her Master's degree in Clinical Psychology from Queen's University in the fall of 2011. She is currently pursuing her PhD under the supervision of Dr. Caroline Pukall. Her dissertation will expand on the topic of pain classification in vulvodynia, and include multi-modal pain assessment and collaboration with physicians in the medical field.

## HOW DOES IMPAIRED SEXUAL FUNCTIONING AFFECT WOMEN'S SEXUAL EXPERIENCES?

Kyle R Stephenson, MA, Parrish Williams, and Cindy M Meston, PhD

Department of Psychology  
The University of Texas at Austin  
1 University Station A8000  
Austin, TX 78751 USA

Telephone: 512-232-4805 \_E-mail: [krstephenson@gmail.com](mailto:krstephenson@gmail.com)

**Introduction:** Recent research has highlighted the fact that not all cases of impaired female sexual functioning in women are distressing to the individual and/or harmful to her relationship (Oberg & Fugl-Meyer, 2005; Shifren, Monz, Russo, Segreti, & Johanes, 2008), suggesting the need for a greater understanding of how sexual functioning and distress are related. A first step in exploring this area is to outline the specific ways in which impaired sexual functioning affects women's sexual experiences. Our goal in the current study was to assess the consequences of impaired sexual functioning and to establish relationships between specific consequences and the various domains of female sexual functioning (desire, arousal, lubrication, orgasm, and sexual pain).

**Method:** Female participants in sexually active relationships who were currently experiencing one or more difficulties with sexual functioning ( $n = 50$ ,  $M$  age = 28.08) were interviewed by researchers and completed cross-sectional self-report questionnaires, including the Female Sexual Function Index (FSFI) and a measure of sexual consequences. Participant also completed a number of daily online measures assessing their sexual experiences.

**Results:** Our measure adequately captured the range of sexual consequences resulting from impaired sexual functioning. In general, levels of sexual functioning were significantly associated with frequency and severity of negative consequences both between subjects and within subjects. Subjective sexual arousal and sexual pain were most strongly tied to a range of negative consequences; lubrication was most weakly tied to negative consequences.

**Discussion:** Impaired sexual functioning affects women's sexual experiences in a number of ways that can be assessed using a single, relatively short measure. Sexual functioning is significantly associated with these consequences, but certain aspects of functioning are likely more central than others.

**Utility/Limitations/Risks:** Understanding the sexual consequences of impaired sexual functioning can improve our understanding of sexual dysfunction and aid in treatment. Our results are limited by a relatively small sample size and a lack of assessment of the sexual partner.

### **Behavioral Learning Objectives:**

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

1. Understand impaired sexual functioning and sexual distress as independent constructs
2. Discuss the ways in which impaired sexual functioning can influence one's sexual experiences
3. Predict the likely consequences of different types of impaired sexual functioning.

### **References:**

- Oberg, K., & Fugl-Meyer, K. (2005). On Swedish women's distressing sexual dysfunctions: Some concomitant conditions and life satisfaction. *Journal of Sexual Medicine*, 2, 169-180.
- Shifren, J., Monz, B., Russo, P., Segreti, A., & Johanes, C. (2008). Sexual problems and distress in United States Women: Prevalence and correlates. *Obstetrics & Gynecology*, 112, 970-978.

### **Biography:**

Kyle Stephenson received his Bachelor's Degree from Santa Clara University in 2007 and his Master's degree in clinical psychology from The University of Texas at Austin in 2011. He is currently a doctoral candidate in clinical psychology at The University of Texas. He has been conducting research on sexual well-being since 2007.

# HOW HAS VULVAR PAIN CHANGED YOUR LIFE? AN EXAMINATION OF SEXUAL AND RELATIONSHIP FUNCTION, AND HEALTH-RELATED QUALITY OF LIFE

Emma Dargie, MSc, and Caroline Pukall, PhD

Emma Dargie, MSc

Department of Psychology

Queen's University

Kingston, Ontario, K7L 3N6

Telephone: 613-533-3276 ♦ Fax: 613-533-2499 ♦ E-mail: [5eed@queensu.ca](mailto:5eed@queensu.ca)

**Introduction:** Many women suffer from chronic vulvar pain, which interferes with numerous aspects of their lives. However, few studies directly compare women with vulvar pain with women who have other troubling pain conditions. It is important to determine how such pain is similar to and different from other pain conditions so that treatment can be tailored accordingly.

**Method:** We recruited participants for an anonymous online survey assessing how pain impacts one's life. Our sample consisted of 79 pain-free control women, 56 women with Provoked Vestibulodynia (PVD), and 23 women with Post-Herpetic Neuralgia (PHN), an established neuropathic pain condition.

**Results:** Women with PVD reported significantly lower sexual function than controls and women with PHN. There were no differences in relationship satisfaction among the three groups. Finally, different patterns of health-related quality of life (HRQOL) were observed for each group examined. Overall, women with PHN tended to report the poorest HRQOL. Women with PVD did not report difficulty with role limitations or social functioning, but they did report difficulty with pain, physical functioning, and general health, energy/fatigue, and emotional well-being.

**Discussion:** These results highlight particular areas that are problematic for women with PVD, areas that should be acknowledged and targeted during treatment. Interestingly, the observed patterns of interference are similar to patterns observed in those with neuropathic pain.

**Utility/Limitations/Risks:** The results of this study will help identify problematic areas to target in treatment, and lend credence to the conclusion that PVD is a chronic, perhaps neuropathic, pain condition. This study is limited by self-report, and by the small size of the PHN sample.

## Behavioural Learning Objectives

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

1. Identify important health-related and relationship features of PVD
2. Discuss similarities and differences between PVD and PHN

## References

- Meyer-Rosberg, K., Burckhardt, C. S., Huizar, K., Dvarnstrom, A., Nordfors, L.-O., & Kristofferson, A. (2001) A comparison of the SF-36 and Nottingham Health Profile in patients with chronic neuropathic pain. *European Journal of Pain*, 5, 391-403. DOI: 10.1053/eujp.2001.0260
- Desrochers, G., Bergeron, S., Landry, T., & Jodoin, M. (2008). Do psychosexual factors play a role in the etiology of provoked vestibulodynia? A critical review. *Journal of Sex and Marital Therapy*, 34, 198-226. DOI: 10.1080/00926230701866083

**Biography:** Ms. Dargie received her Master's degree in Clinical Psychology from Queen's University in the fall of 2011. She is currently pursuing her PhD under the supervision of Dr. Caroline Pukall. Her dissertation will expand on the topic of pain classification in vulvodynia, and include multi-modal pain assessment and collaboration with physicians in the medical field.

## HOW SHOULD WE BE MEASURING AND DEFINING SUCCESS IN VULVODYNIA TREATMENT STUDIES?

Corrie Goldfinger, MSc, Caroline F. Pukall, PhD, Stephanie Thibault-Gagnon, BSc (PT),  
Linda McLean, Ph.D (PT), and Susan Chamberlain, MD

**Corrie Goldfinger, MSc**

Department of Psychology

Queen's University

62 Arch St.

Kingston, Ontario K7L 3J4 Canada

Telephone: (613) 533-3276 Fax: (613) 533-2499 E-mail: 5cg24@queensu.ca

**Introduction:** Recent reviews highlight the lack of standardization in measuring outcomes in vulvodynia treatment studies. Although a biopsychosocial approach to understanding vulvodynia is well-accepted, many studies fail to investigate the impact of treatment on psychological and sexual consequences of pain. Inclusion of multiple outcomes in treatment studies is imperative, yet it complicates data analytic methods and how we define success. Results from a study comparing the effectiveness of cognitive-behavioural therapy (CBT) and pelvic floor rehabilitation (PFR) for provoked vestibulodynia (PVD) will be utilized to explore issues related to measuring and defining success. Important questions that will be discussed include what outcome measures should be used, how best to define success, and how to incorporate client goals into the measurement of success.

**Method:** Twenty women with PVD were randomly assigned to eight sessions of either individual CBT or PFR. Participants were assessed at pre-treatment, post-treatment, and 6-month follow-up via gynecological examination, structured interviews and standardized questionnaires measuring pain, psychological, and sexual variables, and pelvic floor muscle evaluation.

**Results:** Preliminary findings demonstrate numerous possible endpoints that may be used to measure success. Although some outcome measures were correlated with one another, this was not always the case, leading to difficulties in determining the best definition of success. Comparisons between researcher-defined success and client-defined success measures were also not uniformly consistent.

**Discussion:** We emphasize the importance of measuring multiple biopsychosocial outcomes in vulvodynia treatment studies and encourage the collaboration of clinicians and researchers in the field to come to a consensus on the core outcome domains to be included in future treatment studies.

**Utility/Limitations/Risks:** The discussion will help researchers in planning comprehensive vulvodynia treatment studies consistent with a biopsychosocial approach. Consistency in the measurement and definition of success in future studies will permit meta-analysis of vulvodynia treatment studies with the aim of determining the strength of evidence for various treatment options.

### **Behavioral Learning Objectives:**

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

1. Identify some of the important outcomes that should be measured in vulvodynia treatment studies
2. Discuss the issues associated with using multiple outcome measures and defining success

### **References:**

- Andrews, J. C. (2011). Vulvodynia interventions—systematic review and evidence grading. *Obstetrical and Gynecological Survey, 66*, 299-315.
- Dworkin, R. H. et al. (2008). Interpreting the clinical importance of treatment outcomes in chronic pain clinical trials: IMMPACT recommendations. *The Journal of Pain, 9*, 105-121.
- Landry, T., Bergeron, S., Dupuis, M. J., & Desrochers, G. (2008). The treatment of provoked vestibulodynia: A critical review. *Clinical Journal of Pain, 24*, 155-171.

### **Biography:**

Ms. Goldfinger is undertaking her PhD in Clinical Psychology at Queen's University under the supervision of Dr. Caroline Pukall. Her research focuses on treatment options for vulvar pain.

## LIBIGEL<sup>®</sup> (TESTOSTERONE GEL) SAFETY STUDY COMPLETES ENROLLMENT AND CONTINUES WITH A LOW CV EVENT RATE

**Michael C. Snabes, MD, PhD and Joanne Zborowski, BSN**

BioSante Pharmaceuticals, Inc.

111 Barclay Blvd, Ste 280

Lincolnshire, IL 60069

Telephone (847) 478-0500 x105 ♦ Fax: (847) 478-9152 ♦

E-mail: msnabes@biosantepharm.com

**Introduction:** LibiGel<sup>®</sup> is in Phase III development for treatment of postmenopausal women with Hypoactive Sexual Desire Disorder (HSDD). FDA approval requires demonstration of long-term cardiovascular (CV) and breast safety. Herein we report on study progress. The objective of the study is to establish the safety of LibiGel treatment of postmenopausal women.

**Method:** This is a Phase III, randomized, double-blind, placebo-controlled, multi-center CV events-driven, adaptive design comparison of daily LibiGel<sup>®</sup> testosterone gel versus identical placebo gel in postmenopausal women with HSDD and CV risk. Design of the study incorporated enrollment completion prior to the maximum of 4,000 subjects if the unblinded, independent Data Monitoring Committee (DMC) statistician calculated the predictive probability of study success to be  $\geq 90\%$  after continuing the study for an additional 12 months after enrollment completion using prospectively designed Bayesian modeling of the distribution of endpoint CV events. The primary safety outcome measure is the effect of treatment on the incidence of a composite of adjudicated CV events.

**Results:** Based on the results of the adaptive design sample size algorithm, enrollment was completed at 3,656 randomized subjects. In addition, the DMC has recommended that the study continue as planned after each of the 6 separate unblinded data evaluations. The mean age of subjects at randomization is 58.6 years: two thirds are hypertensive, 65% dyslipidemic, 21% smokers and 20% diabetic. More than 4,000 subject-years of exposure already have been accrued. The rate of adjudicated, protocol-mandated CV events of subjects is 0.58% and the breast cancer rate is 0.24%.

**Discussion:** The LibiGel safety study continues to accrue event and other safety data and is blinded to all except the DMC. Even with an enhanced-risk patient population, the CV event rate remains quite low. Successful completion of the LibiGel clinical program could result in the first approved pharmacologic therapy for women with HSDD.

**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. Discuss the regulatory requirements to demonstrate the safety of testosterone for HSDD in postmenopausal women.
2. Appraise 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 150 abstracts and peer reviewed publications in numerous therapeutic areas including women's health.

## A REVIEW OF PREGNANCY AND CHILDBIRTH OUTCOMES IN VULVODYNIA

Kelly B. Smith, PhD; Lori A. Brotto, PhD; Leslie Sadownik, FRCPS;  
Rosemary Basson, MD; Kaitlyn Goldsmith

**Kelly B. Smith, PhD**

Department of Obstetrics & Gynaecology

University of British Columbia

2775 Laurel Street

Vancouver, BC V5Z 1M9 CANADA

Telephone: 604-875-4111 ext. 68901; Fax: 604-875-4869; E-mail: [Kelly.Smith@vch.ca](mailto:Kelly.Smith@vch.ca)

**Introduction:** Vulvodynia refers to female chronic genital pain and is a major health concern for many women. Women with vulvodynia often experience severe pain during sexual intercourse and avoid sexual contact to prevent such pain; as well, affected women may experience increased rates of psychological distress, including fear of pain and anxiety (Desrochers et al., 2008). Anecdotal evidence is that women with vulvodynia express anxiety and concern about conceiving a child when intercourse is painful; however, little research has investigated affected women's pregnancy and childbirth outcomes, and information that is available for vulvodynia patients who wish to become pregnant is based largely on expert opinion. The goal of this presentation is to critically and thoroughly evaluate the existing literature on pregnancy and childbirth outcomes among women with vulvodynia. On this basis, we have designed a comprehensive program to evaluate the association between vulvodynia and childbirth intentions, pregnancy, delivery, and post-partum.

**Method:** A literature review was conducted to summarize pregnancy and childbirth outcomes among women with vulvodynia.

**Results:** Only a handful of studies have addressed pregnancy and childbirth among women with vulvodynia. Specifically, two studies reported how women's vulvar pain symptoms changed during pregnancy and two reported an association between vulvodynia and parity status. Just one study has examined rates of pregnancy and delivery experiences among vulvodynia-affected women (Burrows et al., 2011); in this study, rates of term pregnancy and delivery, method of delivery, and delivery-related lacerations were examined among women who received surgery for vulvar pain.

**Discussion:** Large gaps exist in our knowledge of how vulvodynia may affect pregnancy and childbirth outcomes. As well, there is currently little empirical information regarding how pregnancy and childbirth experiences may impact vulvodynia symptoms. Research is also needed to better understand how health care providers manage pregnancy/delivery among affected women.

**Utility/Limitations/Risks:** This review will inform clinicians and researchers of the current state of the literature regarding pregnancy, childbirth, and vulvodynia.

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

1. Identify current knowledge gaps regarding pregnancy/childbirth outcomes in vulvodynia.
2. Recognize the need for systematic research in this area.

### References:

Burrows, L. J., Sloane, M., Davis, G., Heller, D. S., Brooks, J., & Goldstein, A. T. (2011). Parturition after vestibulectomy. *Journal of Sexual Medicine*, 8, 303-05.

Desrochers, G., Bergeron, S., Landry, T., Jodoin, M. (2008). Do psychosexual factors play a role in the etiology of provoked vestibulodynia? A critical review. *Journal of Sex and Marital Therapy*, 34, 198-226.

**Biography:** Dr. Kelly Smith received her PhD in Clinical Psychology from Queen's University. She is currently a Post Doctoral Fellow at the University of British Columbia where she is supervised by Dr. Lori Brotto and supported by the Michael Smith Foundation for Health Research.

## SEXUAL FUNCTIONING OF INDIVIDUALS WITH SEXUALLY TRANSMITTED INFECTIONS

Lyndsay Foster, B.A. and E. Sandra Byers, Ph.D.

Psychology Department

University of New Brunswick, P.O. Box 4400

Fredericton, New Brunswick, E3B 5A3

Telephone: 1-(506)-453-4707; Fax: 1-(506)-447-3063; Email: [lyndsay.foster@unb.ca](mailto:lyndsay.foster@unb.ca)

**Introduction:** Many people report negative psychosocial consequences from their STI diagnosis, largely due to the associated stigma (Newton & McCabe, 2008). However, there has been little research on the sexual functioning of individuals diagnosed with STIs other than HIV/AIDS. We compared the sexual functioning of individuals with incurable, curable, and multiple STI diagnoses. Based on stigma theories suggesting that disruptiveness results in worse psychosocial outcomes (Fortenberry, 2004), we predicted that more severe symptoms, a more recent diagnosis, and experiencing greater stigmatization would be related to poorer sexual functioning.

**Method:** Participants were 177 women and 51 men with a STI who completed an online survey that measured STI history, time since diagnosis, internalized and external stigma, and sexual functioning (sexual problems, sexual anxiety, sexual satisfaction, and sexual self-esteem).

**Results:** On average, participants reported low sexual anxiety and high levels of sexual satisfaction and sexual self-esteem. Approximately 10% of participants reported *often* or *always* experiencing a sexual problem. There were no differences in functioning by STI diagnostic type,  $F(8, 432) = 1.74, p = .09$ . Four multiple regression analyses were used to examine the relationships between the predictors and the sexual functioning measures. Individuals with more severe symptoms and greater stigmatization reported poorer sexual functioning across all indicators. Time since diagnosis was related only to greater sexual anxiety and lower sexual self-esteem. Only the stigma variables contributed uniquely to the prediction of sexual problems, sexual anxiety, and sexual self-esteem.

**Discussion:** We found that individuals with STIs reported generally positive sexual functioning, regardless of the type of STI with which they were diagnosed. Further, sexual functioning was related to both physical symptoms and stigma experiences. Therapy focused on stigma in addition to symptom management may be beneficial for individuals with an STI who report sexual difficulties.

**Utility/Limitation/Risks:** The results are limited in that we did not examine participants' pre-diagnostic sexual functioning. Nonetheless, the study results can help clinicians better understand the sexual functioning of individuals with STI diagnoses.

**Behavioral Learning Objectives:**

After this presentation, participants will be able to:

1. Discuss the relationship of stigmatization to the experiences of individuals with STIs.
2. Describe the sexual functioning of individuals with STIs.
3. Discuss factors associated with poorer sexual functioning among individuals with STIs.

**References:**

- Fortenberry, J. D. (2004). The effects of stigma on genital herpes care-seeking behaviors. *Herpes, 11*, 8 – 10.
- Newton, D. C., & McCabe, M. (2008). Sexually transmitted infections: Impact on individuals and their relationships. *Journal of Health Psychology, 13*, 864 – 869.

**Biography:**

Lyndsay Foster is a clinical psychology doctoral student at the University of New Brunswick studying under the supervision of Dr. Sandra Byers. She has been conducting sexuality research since 2004 and has presented her work at several conferences in both the United States and Canada.

## USING MUSIC TO INTRODUCE TOPICS WHEN TEACHING HUMAN SEXUALITY

**Eric W. Corty, PhD**

School of Humanities & Social Sciences  
Penn State Erie, The Behrend College  
4701 College Drive  
Erie, PA 16563 USA

Telephone: (814) 898-6238 ♦ Fax: (814) 898-6032 ♦ E-mail: ewcorty@gmail.com

Students find the topic of human sexuality inherently interesting and there is little instructors need to do to motivate students to attend class. However, pedagogical techniques can be useful in fostering discussion, building a class culture, breaking the ice on controversial topics, and highlighting diversity.

The last times I've taught human sexuality, I've started each class with a song relevant to the topic of the day. For example, the first class begins with "Let's Talk About Sex" by Salt-N-Pepa, a class on the use of condoms may use "Bareback Rider" by Gaye Adegbalola, a class on gender roles may start with "A Hymn to Him" from My Fair Lady, and a class on gender identity disorder may involve "For Today I Am a Boy" by Antony & The Johnsons.

The songs play before class starts, set the tone for the day, encourage early arrival at class, and signal the start of class when the music stops.

This poster presentation will make available a playlist of songs and topics.

**Utility/Limitations/Risks:** This material will be useful to participants who teach human sexuality. Some students may find some of the lyrics in some of the songs offensive.

### **Behavioral Learning Objectives:**

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

1. List songs relevant to different topics in a human sexuality course.

### **Biography:**

Eric Corty received his PhD from Indiana University. He has taught human sexuality since 1987. He has been a member of SSTAR since the early 1990s. At present he is a professor of psychology at Penn State Erie, The Behrend College.

# WHAT'S PAIN GOT TO DO WITH IT? GYNECOLOGICAL, PSYCHOSEXUAL AND PAIN-RELATED CORRELATES OF THE INABILITY TO HAVE INTERCOURSE

Stéphanie C. Boyer, MSc & Caroline F. Pukall, PhD

Stéphanie C. Boyer, MSc

Department of Psychology, Queen's University  
62 Arch Street, Kingston, ON K7L 3N6 CANADA

◆Telephone: (613) 533-3276 ◆Fax: (613) 533-2499 ◆E-mail: 6scb2@queensu.ca

**Introduction:** There is great debate about the categorization and definition of sexual pain disorders, including evidence of overlap in the symptoms of dyspareunia and vaginismus. In line with cognitive-behavioural models of sexual pain, recent research has demonstrated that cognitions and avoidance behaviour related to vaginal penetration may discriminate between these conditions (Klaassen & ter Kuile, 2009; Reissing et al., 2004).

**Method:** Forty-eight women unable to engage in penetrative intercourse were matched on age and relationship status to dyspareunia and control participants able to engage in intercourse (N=144). Via an online survey, participants were asked about their experiences with different vaginal penetration situations. Gynecological, pain, and sexual history information was also collected.

**Results:** Eighty-five percent of women unable to have intercourse experienced chronic pain during intercourse attempts. They reported significantly more negative cognitions related to vaginal penetration compared to the dyspareunia group. The groups also significantly differed with regards to non-sexual penetration, including use of tampons and pelvic examination experiences. Additional analyses were performed for matched pairs experiencing dyspareunia (able versus unable to have intercourse; N=78). A logistic regression analysis predicted group membership in 83% of cases based on self-reported pain intensity, pain/catastrophizing cognitions, and their interaction.

**Discussion:** Chronic pain during intercourse attempts was highly prevalent in this sample of women unable to have intercourse, supporting previous research. Pain, psychosexual and gynecological characteristics of the groups will be discussed in the context of current theory and research.

**Utility/Limitations/Risks:** Although based solely on self-report, the results have theoretical implications with regards to our understanding of sexual pain disorders, including the relationship between genital pain and the inability to have intercourse. The findings also have implications for the assessment and treatment of women experiencing difficulty with intercourse.

## **Behavioral Learning Objectives:**

After attending this presentation, participants will be able to:

1. Compare the vaginal penetration experiences of women unable to have intercourse to those of women with dyspareunia, and women who do not experience pain.
2. Discuss the results in the context of current research and theory related to sexual pain disorders.

## **References:**

- Klaassen, M., & ter Kuile, M. M. (2009). Development and initial validation of the vaginal penetration cognition questionnaire (VPCQ) in a sample of women with vaginismus and dyspareunia. *Journal of Sexual Medicine*, 6, 1617-1627.
- Reissing, E. D., Binik, Y. M., Khalifé, S., Cohen, D., & Amsel, R. (2004). Vaginal spasm, pain, and behavior: an empirical investigation of the diagnosis of vaginismus. *Archives of Sexual Behavior*, 33, 5-17.

## **Biography:**

Stéphanie Boyer is a doctoral student in Clinical Psychology at Queen's University, under the supervision of Dr. Caroline Pukall. She has been a student member of SSTAR since 2007.

# THE YOUNG AND THE RESTLESS? AGE AS A MODERATOR OF THE ASSOCIATION BETWEEN SEXUAL DESIRE AND SEXUAL DISTRESS IN WOMEN

Kyle R Stephenson, MA and Cindy M Meston, PhD

Department of Psychology  
The University of Texas at Austin  
1 University Station A8000  
Austin, TX 78751 USA

Telephone: 512-232-4805 \_E-mail: [krstephenson@gmail.com](mailto:krstephenson@gmail.com)

**Introduction:** Low sexual desire is the most commonly reported difficulty with sexual functioning in the U.S. (Hayes, Bennet, Fairley, & Dennerstein, 2006), however, recent research has highlighted the fact low sexual desire is more strongly associated with subjective distress in some cases than in others (Stephenson & Meston, 2010). One potential moderator is age, with recent research suggesting that desire may be more weakly associated with distress in older women (Rosen et al., 2009). Our goal was to expand on this previous work, assessing the degree to which age moderates the association between sexual desire and sexual distress (both personal and relational) in women.

**Method:** We combined four independent data sets which yielded a total sample of 771 women (M age = 27.76, SD = 9.64) who had completed the Sexual Satisfaction Scale for Women (SSS-W) and the Female Sexual Function Index (FSFI).

**Results:** Desire interacted with age quadratically in predicting both personal and relational sexual distress such that desire was more strongly associated with distress for younger women as compared with both middle-aged and older women.

**Discussion:** Age is an important moderator of the association between sexual functioning and sexual distress in women.

**Utility/Limitations/Risks:** These findings have a number of implications for the treatment of female sexual dysfunction, but the results are somewhat limited due to the self-report and cross-sectional nature of the measures.

## **Behavioral Learning Objectives:**

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

1. Understand impaired sexual functioning and sexual distress as independent constructs
2. Discuss age as a moderator of the association between sexual desire and distress
3. Take these findings into account when planning treatment and/or clinical trials on female sexual dysfunction

## **References:**

- Hayes, R., Bennett, C., Fairley, C., & Dennerstein, L. (2006). What can prevalence studies tell us about female sexual difficulty and dysfunction? *Journal of Sexual Medicine*, 3, 589-595.
- Rosen, R. C., Shifren, J. L., Monz, B. U., Odom, D. M., Russo, P. A., & Johannes, C. B. (2009). Correlates of sexually related personal distress in women with low sexual desire. *Journal of Sexual Medicine*, 6, 1549-1560.
- Stephenson, K. R., & Meston, C. M. (2010). When are sexual difficulties distressing for women? The selective protective value of intimate relationships. *Journal of Sexual Medicine*, 7, 3683-3694.

## **Biography:**

Kyle Stephenson received his Bachelor's Degree from Santa Clara University in 2007 and his Master's degree in clinical psychology from The University of Texas at Austin in 2011. He is currently a doctoral candidate in clinical psychology at The University of Texas. He has been conducting research on sexual well-being since 2007.

# YOUNG WOMEN'S DESCRIPTIONS OF SEXUAL DESIRE IN LONG-TERM RELATIONSHIPS

Sarah H. Murray, MSc & Olga Sutherland, PhD

**Sarah H. Murray, MSc**

Department of Family Relations and Applied Nutrition  
University of Guelph

50 Stone Rd, Guelph, Ontario, Canada, N1G 2W1

Phone: (519) 824-4120 ext. 52248, Fax: (519) 123-4568 E-mail: [murrays@uoguelph.ca](mailto:murrays@uoguelph.ca)

**Introduction:** Increasing relationship duration (Klusmann, 2002; Murray & Milhausen, in press) and increasing age (Buster, 2005) are negatively associated with women's sexual desire. These findings do not lend themselves to describe how sexual desire might be experienced for young women who are in long-term relationships. To help elucidate how age and relationship length intersect when impacting sexual desire, the current study explored how women in this demographic make sense of and experience sexual desire in their long-term relationships.

**Method:** Twenty semi-structured interviews were conducted with women in long-term relationships (2.5 years or longer) in emerging adulthood (ages 18-29) regarding their experiences of sexual desire. In order to ensure a range of experiences, we recruited two groups of women: those who were "wondering where the passion has gone" and those who felt "the passion was still alive." Data were analyzed using grounded theory methodology.

**Results:** Women provided various explanations for why they continued to experience high desire, or experienced a decrease in desire. These included expectations regarding the way sexual desire would be experienced as a relationship progressed, attributing levels of sexual desire to individual sexual agency (versus relationship characteristics), and varying levels of reported desire discrepancy.

**Discussion:** Similarities and differences between the two groups of women's responses are explored. Therapeutic implications, such as normalizing young women's experiences of desire, are discussed.

**Utility/Limitations/Risks:** Admittedly, sexual desire is not experienced at a dichotomized level; this limitation is also discussed and future areas for research are suggested.

## **Behavioral Learning Objectives:**

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

1. Recognize that young women's sexual desire is more complex than past literature suggests
2. Identify various reasons that women attribute as influencing their level of sexual desire
3. Compare experiences and descriptions of women with higher and lower levels of desire

## **References:**

- Buster, J. E. (2005). Aging, androgens, and female sexual desire: Can we restore what time takes away? *Sexuality, Reproduction, & Menopause*, 3, 3-7.
- Klusmann, D. (2002). Sexual motivation and the duration of partnership. *Archives of Sexual Behavior*, 31, 275-287.
- Murray, S. H. & Milhausen, R. R. (in press). Sexual desire and relationship duration in young men and women. *Journal of Sex & Marital Therapy*.

## **Biography:**

Sarah Murray is a PhD student at the University of Guelph in Family Relations and Applied Nutrition with a specialization in Human Sexuality. She received her MSc from the same program in 2011. Sarah is a student member of AAMFT and is training in couple and relational therapy in addition to conducting sexuality research through the university and community-based research agencies such as the AIDS Committee of Guelph.

**March 30-31, 2012**

**ANNUAL MEETING**

**ABSTRACTS**

## AFRICAN AMERICAN COUPLES AND SEX

**Shalonda Kelly, PhD**

Graduate School of Applied & Professional Psychology  
Rutgers, The State University of New Jersey  
152 Frelinghuysen Road, Piscataway NJ, 08854-8085  
Phone: (848) 445-3922, Fax (732) 445-4888 Email: skelly@rci.rutgers.edu

**Introduction:** The sexuality field has been criticized for pathologizing African Americans and failing to contextualize data showing greater frequency of sex and higher rates of relationship dissolution (e.g. McGruder, 2009). This presentation provides an approach to address this issue.

**Method:** Drawing from a literature review and clinical experience with many African American couples, I will provide a context that attends to historical, socialization, and oppression factors that they disproportionately experience, and the maladaptive sexual coping methods used by some African Americans to address these factors. I also focus on the sexuality-related and general strengths of African Americans that can often go overlooked in the face of stigma and oppression.

**Results:** A case example details the results of using cultural knowledge and awareness to build skills in affirming African American couples and using their strengths to address sexual problems.

**Discussion:** While many African American couples have healthy intimate relationships, this group faces many challenges to developing healthy sexual identities. Assessment, education, and interventions that contextualize African Americans' sexual problems can help them to work together better to counteract the impact of oppression on their sexual relationships.

**Utility/Limitations/Risks:** This approach stems from data on African American's sexual profile and contextual risk and protective factors, as well as clinical observations. Thus, it may help therapists and researchers working with African Americans. Yet the approach has not been empirically tested.

### **Behavioral Learning Objectives:**

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

1. Explain the key contextual factors that adversely impact African Americans' sexual relationships.
2. Identify sexuality-related and general strengths of African Americans that often go overlooked.
3. Identify ways to tailor their treatment of sexual problems to African Americans.

### **References:**

- Kelly, S. & Boyd-Franklin, N. (2009) Joining, understanding, and supporting Black couples in treatment. In M. Rastogi & V. Thomas (Eds.), *Multicultural couple therapy* (pp 235-254). Thousand Oaks: Sage.
- Kelly, S. & Shelton, J. (in press). African American Couples and Sex. In K. Hall & C. Graham (Eds.), *The Cultural Context of Sexual Pleasure and Problems*. New York: Routledge
- Mahalik, J.R., Good, G.E., & Englar-Carson, M. (2003). Masculinity scripts, presenting concerns, and help seeking: Implications for practice and training. *Professional Psychology, Research and Practice*, 34, 123-131.
- Stephens, D.P., & Phillips, L.D. (2003). Freaks, gold diggers, divas, and dykes: the sociohistorical development of adolescent African American women's sexual scripts. *Sexuality and Culture*, 7, 3-49.
- Tucker, C.M. (1980) Strategies for counseling blacks with sexual problems. *Journal of non-white concerns in personnel and guidance*, 8, 62-69.
- Wingood, G.M., DiClemente, R.J., Bernhardt, J.M., Harrington, K., Davies, S.L., Robillard, A., & Hook, E.W. (2003). A prospective study of exposure to rap music videos and African American female adolescents' health. *American Journal of Public Health*, 93, 437-439.

### **Biography:**

Dr. Kelly received her PhD from Michigan State University in 1998 and has been on faculty in the clinical department of the Graduate School of Applied & Professional Psychology since then, and has a private practice. Her primary research foci are couple relationships and racial/cultural issues.

## CANCER AND FEMALE SEXUALITY: MOVING FROM OBSERVATION TO EVIDENCE-BASED CARE

Stacy T. Lindau, MD, MAPP

Stacy T. Lindau, MD, MAPP

Departments of Obstetrics and Gynecology and Medicine-Geriatrics

University of Chicago

5841 S. Maryland Ave., MC2050

Chicago, IL 60637

Telephone: (773) 834-8986 Fax: (773) 834-5664 Email: [slindau@uchicago.edu](mailto:slindau@uchicago.edu)

**Introduction:** Gynecologic and breast cancers are the most prevalent cancer types among female survivors. Sexual problems can result from cancer and its treatments. We propose a talk to address 1) What is known about cancer and female sexuality; 2) The current state of the science; and 3) What research is needed to provide evidence-based care.

**Methods:** High demand for a clinic to address sexual concerns at the interface of cancer was demonstrated via a needs assessment implemented in the Section of Gynecology Oncology at the University of Chicago. This prompted the development of the multi-disciplinary and cross-institutional Program in Integrative Sexual Medicine for Women and Girls with Cancer (PRISM). In conjunction with provision of clinical care, a prospective, longitudinal research registry was established in order to track objective measures of consented patients' sexual function and treatment. Also, in collaboration with Memorial Sloan-Kettering Cancer Center, a national network of active clinicians and researchers in this field was formed.

**Results:** Building on a prior study from MD Anderson, a retrospective needs assessment and medical chart review showed that almost half of gynecology oncology patients surveyed (n=261) were interested in receiving care, yet only 7% had recently sought care. The PRISM Clinic has seen 127 individual patients since its inception in 10/2008, most of whom have cancer or are at risk for cancer (73%). The main distribution of cancer types among patients include breast (49%) and gynecologic cancer (39%). The methods for building the PRISM Registry were presented at the 1<sup>st</sup> National Scientific Conference on Cancer and Female Sexuality in Chicago in 10/2010, along with two other key topics around key life course sexuality issues and implementing sexual health assessments. In attendance were 43 PhD researchers, physicians and other health professionals with representation from 20 institutions, 14 states and 6 NCI-funded Cancer Centers.

**Discussion:** The PRISM Program is meeting the needs of female cancer patients with sexual concerns while generating new knowledge to accelerate the evidence base for the field.

**Utility/Limitations/Risks:** This presentation aims to increase awareness of sexuality issues faced by women with cancer, but is limited by the paucity of evidence-based research in this area.

**Behavioral Learning Objectives:** 1) To discuss the current state of knowledge and research around cancer and female sexuality; 2) To recognize the importance and facility, interdisciplinary and cross-institutional research; and 3) To identify gaps in research around cancer and female sexuality.

**References:**

Huyghe, E., Sui, D., Odensky, E., Shover, L.R. (2009). Needs assessment survey to justify establishing a reproductive health clinic at a comprehensive cancer center. *Journal of Sexual Medicine*, 6, 149-163.

Hill, E.K., Sandbo, S., Abramsohn, E.M., Makelarski, J., Wroblewski, K., Wenrich, E.R., McCoy, S., Temkin, S.M., et al. (2011). Assessing gynecologic and breast cancer survivors' sexual health care needs. *Cancer*, 117(12), 2643-51.

**Biography:** Dr. Lindau is a practicing gynecologist and translates her expertise in population-based research into clinical care through her role as the Director of the Program in Integrative Sexual Medicine for Women and Girls with Cancer.

# CHALLENGING CONTEMPORARY CONSTRUCTIONS OF THE VULVA TO IMPROVE WOMEN'S SEXUAL HEALTH: EXPLORING THE REPRESENTATION, INTERNALIZATION AND MANIFESTATION OF FEMALE GENITAL AESTHETIC IDEALS

**Vanessa R Schick, PhD**

Center for Sexual Health Promotion  
Indiana University  
1025 E. 7th St., HPER 116,  
Bloomington, IN, 47403

Telephone: 812.856.0790 E-mail: vschick@indiana.edu

**Introduction:** The recent surge in women's elective genital reconstructive surgeries suggests that some women may be dissatisfied with the deviation of their vulva from an appearance ideal (e.g., Miklos & Moore, 2008; Tiefer, 2008). Given the integral role of genitals in many sexual behaviors, genital appearance concerns have the potential to impede women's sexual experiences (Herbenick & Reece, 2010). Thus, sex researchers and therapists may benefit from knowledge regarding the construction and disruption of the internalization of these ideals.

**Method:** In order to understand the process through which women come to learn about their genitals, I utilized multiple study designs including a content analysis of a sexually explicit magazine over half a century, several experiments, and a series of quantitative/qualitative survey research projects with diverse populations.

**Results:** Pubic hair was rarely visible in recent issues of the sexually explicit magazine. Along with the elimination of pubic hair was a corresponding disappearance of inner labia. Participants who viewed images from the magazine reported significantly larger inner labia than participants who viewed images with visible/protruding inner labia. In a separate study, over 25% of women reported a concern with the size, shape or color of their inner labia. Further, in additional studies, this was related to a less satisfying sexual experience and a decreased likelihood to seek gynecological care.

**Discussion:** A sizable minority of women experience concerns with the appearance of their vulva. These concerns may be a function of exposure to airbrushed vulva imagery. In turn, women may benefit from the availability of more diverse, realistic vulva imagery.

**Utility/Limitations/Risks:** While the conclusions from these research studies may help guide therapists and researchers who wish to promote genital appearance satisfaction amongst women, the success of such interventions have never been assessed longitudinally.

## **Behavioral Learning Objectives:**

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

1. Discuss how genital imagery has changed over time
2. Explain a path through which genital perceptions may impede women's sexual experiences
3. Explore an intervention to normalize women's perceptions of their genital appearance

## **References:**

Herbenick, H. & Reece, M. (2010). Development and validation of the female genital self-image scale. *Journal of Sexual Medicine*, 7(5), 1822-1830.

Miklos, JR & Moore RD. (2008). Labiaplasty of the labia minora: Patients' indications for pursuing surgery. *Journal of Sexual Medicine*, 5(6), 1492-1495.

Tiefer, L. (2008). Female genital cosmetic surgery: Freakish or inevitable? Analysis from medical marketing, bioethics, and feminist theory. *Feminism & Psychology*, 18(4): 466-479.

## **Biography:**

Dr. Schick received her Ph.D. in Applied Social Psychology and is currently a research scientist at the Center for Sexual Health Promotion, Indiana University.

## CHARACTERISTICS OF HEALTH PROFESSIONALS ASSIGNED TO AN ETHICS TUTORIAL AFTER VIOLATING SEXUAL BOUNDARIES WITH PATIENTS

S. Michael Plaut, PhD, Janet Klein Brown, JD, MSW, Rebecca C. Wilbur, MA,  
Mira Brancu, PhD, and Katherine Rios, BA

**S. Michael Plaut, Ph.D.**

Department of Psychology  
University of North Carolina Wilmington  
Wilmington, NC 28403  
910-270-2833 ♦ smplaut@gmail.com

**Introduction:** When health professionals violate sexual boundaries, licensing boards may revoke or suspend a license or place offenders on probation, often requiring rehabilitation as a condition of reinstatement. However, little is known about characteristics or effectiveness of such programs.

**Method:** Characteristics and behaviors before, during, and after a mandated ethics tutorial were assessed retrospectively in 39 offenders from 6 professions found by their licensing boards to have crossed sexual boundaries with patients.

**Results:** Offender and victim characteristics were noted as were apparent risk factors, level of compliance and recidivism, and secondary effects of disciplinary action. Observations of denial, rationalization, externalization, entitlement, resistance, and remorse throughout the rehabilitation period reflected levels of progress. For some, expressions of remorse reflected greater concern with offenders' own personal and professional welfare than concern for patients or professional standards.

**Discussion:** Detailed knowledge about offender attitudes and behaviors should help in developing more effective preventive and rehabilitation programs.

**Utility/Limitations/Risks:** This is the first known study of the characteristics of health professionals who violate sexual boundaries and experience a rehabilitation program. However, the sample is small, restricted to one educational tutor in Maryland, and no control conditions were studied.

### **Behavioral Learning Objectives:**

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

1. Discuss the relative merits of a tutorial educational rehabilitation program for health professionals who violate sexual boundaries with patients.
2. Identify possible risk factors and prevention strategies for sexual boundary violations.

### **References:**

- Plaut, S.M. (2010). Understanding and managing professional-client boundaries. In Levine, S.B., Risen, C.B., & Althof, S.E. (Eds.). *Handbook of Clinical Sexuality for Mental Health Professionals*. New York: Routledge, pp. 21-38.
- Schoener, G.R. (1999). Preventive and remedial boundaries training for helping professionals who have engaged in boundary violations. *Journal of Sex Education and Therapy*, 24, 209-217.

### **Biography:**

Dr. Plaut, a past-President of SSTAR, has studied professional-client boundaries for three decades. Formerly with the University of Maryland School of Medicine, he now practices in North Carolina.

## CLINICAL CARE AND GENDER-DYSPHORIC ADOLESCENTS

**Kenneth J. Zucker, Ph.D.**

Gender Identity Service  
Child, Youth, and Family Program  
Centre for Addiction and Mental Health  
250 College St.  
Toronto, Ontario M5T 1R8, Canada

Telephone: 416-535-8501, ext. 4040; Fax: 416-979-4668; e-mail: Ken\_Zucker@camh.net

**Introduction:** In the past few years, there has been a remarkable increase in referrals of adolescents who show behavioral patterns consistent with the DSM-IV diagnosis of Gender Identity Disorder (Gender Dysphoria [GD] in the currently formulated proposal for DSM-5) (Zucker et al., 2008).

**Method:** I will summarize some of the quantitative data about changing patterns in adolescent referrals, on the basis of data from our own clinical service as well as from the literature.

**Results:** In addition to the marked increase in referrals, there is also evidence for other new developments: a shift in the sex ratio favoring males to favoring females, an increase in the percentage of “late-onset” clients (i.e., those who showed no obvious signs of an atypical gender identity during childhood), and an increase in the percentage of GD adolescents with a co-occurring autism-spectrum disorder. The mass media (television, magazines, newspapers), film, and the Internet in particular have all contributed notably to the “normalization” of a transgendered identity status. With the increasing acceptance of puberty-blocking treatments during early adolescence (Zucker et al., 2011), if not earlier, clinicians are under more pressure to make rapid decisions about treatment than has been the case in the past.

**Discussion:** These developments have led to some clinical conundrums regarding best-practice care of GD adolescents. In particular, I will consider the role of psychologic counselling in helping adolescents decide on an optimal developmental pathway regarding gender development in particular and psychosocial adaptation in general.

**Utility/Limitations/Risks:** The praxis consequences and long-term outcomes are yet to be studied systematically.

### **Behavioral Learning Objectives:**

1. To familiarize the audience with the new developments in referral patterns of adolescents with gender dysphoria.
2. To discuss the contemporary debate about therapeutic approaches with GD adolescents.
3. To discuss the role of social and cultural factors in the shaping of transgendered identities in the post-modern era.

### **References:**

- Zucker, K. J., Bradley, S. J., Owen-Anderson, A., Kibblewhite, S. J., & Cantor, J. M. (2008). Is gender identity disorder in adolescents coming out of the closet? [Letter to the Editor]. *Journal of Sex and Marital Therapy*, 34, 287-290.
- Zucker, K. J., Bradley, S. J., Owen-Anderson, A., Singh, D., Blanchard, R., & Bain, J. (2011). Puberty-blocking hormonal therapy for adolescents with gender identity disorder: A descriptive clinical study. *Journal of Gay & Lesbian Mental Health*, 15, 58-82.

### **Biography:**

Dr. Zucker received his Ph.D. in developmental psychology at the University of Toronto in 1982. He is the Psychologist-in-Chief at the Centre for Addiction and Mental Health and the Head, Gender Identity Service in the Child, Youth, and Family Program at CAMH. Dr. Zucker is the Chair of the DSM-5 Work Group on Sexual and Gender Identity Disorders and has been Editor of the *Archives of Sexual Behavior* since 2002.

## CONTEMPORARY CONCEPTUALIZATIONS OF MALE CHRONIC PELVIC PAIN: A MULTIDISCIPLINARY PERSPECTIVE

Seth N. Davis, BA, Yitzchak M. Binik, PhD, Serge Carrier, MD

Department of Psychology

McGill University

1205 Rue Dr. Penfield

Montreal, Quebec, Canada, H3A1B1

Telephone: (514) 398-5323 E-mail: seth.davis@mail.mcgill.ca

**Introduction:** Urological Chronic Pelvic Pain Syndrome (UCPPS) accounts for approximately 2 million outpatient visits each year in the United States (Collins, 1998). The most common symptom is pain on ejaculation, although other diffuse pelvic and/or genital pains are common, as are a number of urinary symptoms and high rates of sexual dysfunction. Not surprisingly, there is a negative impact on quality of life.

**Method:** MEDLINE and PUBMED searches were performed for male genital and pelvic pain. In addition, our research data will be presented.

**Discussion:** Understanding of the etiology of UCPPS remains unclear, which may be due to an overly broad diagnostic category. More recent conceptualizations of UCPPS utilize the UPOINT system, which examines *U*rological, *P*sychosocial, *O*rgan specific, *I*nfection, *N*eurological, and *T*enderness aspects within individual patients (Nickel, 2009). This system appears to better capture the diversity of symptoms in men with UCPPS, and may allow more targeted treatment. Recent meta-analysis has found a combination of antibiotics and alpha blockers to be the most effective treatment in clinical (Anothaisintawec, 2011). New treatments, such as pelvic floor physical therapy and cognitive behavioral therapy appear promising, but have yet to undergo large-scale randomized control trials. New treatments will most likely need to be targeted towards specific UPOINT symptoms to be effective.

**Utility/Limitations/Risks:** This review will help clinicians identify men with UCPPS and target treatments most effectively.

### Behavioral Learning Objectives:

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

1. Define UCPPS in men
2. Identify men with UCPPS
3. Discuss potential treatment options for men with UCPPS

### References:

Collins MM, et al. (1998). How common is prostatitis? *Journal of Urology*, 159(4), 1224-1228.

Nickel JC & Shoskes DA (2009). Phenotypic approach to the management of chronic prostatitis/chronic pelvic pain syndrome. *Current Urology Reports*, 10(4), 307-312.

Anothaisintawee T, et al. (2011). Management of chronic prostatitis/chronic pelvic pain syndrome. *Journal of the American Medical Association*, 305(1), 78-86.

### Biography:

Seth Davis is completing the final year of his PhD in clinical psychology at McGill University. His main thesis topic has been to identify specific sub-groups within the overarching category of UCPPS, with the aim being to better develop treatments.

## COREY: WORKING WITH TRANSGENDER YOUTH FROM A 'QUEER' PERSPECTIVE

Margaret Nichols, Ph.D.

Institute for Personal Growth

8 South Third Avenue, Highland Park, New Jersey 07302 USA

Telephone: (732)246-8439 Fax: (732)246-8081 E-mail: [logcounseling@gmail.com](mailto:logcounseling@gmail.com)

Introduction: Sex therapists and researchers see gender variance as a DSM disorder. But outside of the academy, a much larger L/G/B/T/Q/A community, and professionals working within it, have an opposing view. This case presentation provides an opportunity for SSTAR members to understand the 'queer' perspective in a way that productively informs their clinical practice and research.

Case Description: Corey is a transgender genetic male adolescent. This presentation describes the clinician's journey with Corey and her family over three years. Emphasis is placed on: how a 'queer' perspective informs therapy; decisions to endorse 'growth blocking' hormones and cross-gender hormones; the counter-transferential issues triggered by work with transgender youth. The presentation includes video clips and photos of Corey and her family.

Discussion: The treatment of gender variant children is controversial among sex therapists and researchers and is a hot button in the L/G/B/T/A community. The use of 'growth blockers,' cross-gender hormones, and 'social transitioning' among minors is new and growing rapidly despite the disapproval of many professionals. The evolution of the transgender community increasingly confirms a continuum view of gender that is not reflected in research or traditional practice. This presentation addresses all these controversies and more.

Behavioral Learning Objectives: participants will be able to:

1) explain the difference between a traditional and 'queer' view of gender variance; 2) discuss the controversy regarding hormone treatment of minors; 3) recognize common countertransference issues in working with transgender youth

### References:

Lev, A. I. (2004) *Transgender emergence: Therapeutic guidelines for working with gender-variant people and their families*. New York: Haworth.

Brill, S.& Pepper, R. (2008). *The transgender child: A handbook for families and professionals*. San Francisco: Cleis Press.

### Biography:

Dr. Nichols received her Ph.D. from Columbia in 1981 and is a clinical psychologist and certified sex therapist. She is the founder and Executive Director of the Institute for Personal Growth, an outpatient psychotherapy organization specializing in work with the L/G/B/T/Q/A community. Dr. Nichols writes and speaks extensively on issues involving sexual and gender variant minorities

## CURRENT TRENDS IN GENDER-TRANSITION CARE

**Heino F.L. Meyer-Bahlburg, Dr. rer. nat.**

NYS Psychiatric Institute / Department of Psychiatry, Columbia University  
1051 Riverside Drive, Unit 10  
New York, NY 10032, USA

Telephone: (212) 543-5299•Fax: (212) 543-6003•E-mail: meyerb@nyspi.columbia.edu

**Introduction:** In line with overall social developments in post-industrial Western societies, gender roles have undergone significant changes in recent decades. As a consequence, clinical perspectives on persons with gender identity variants and guidelines for the clinical management of gender change are in a period of transition.

**Methods:** We review the work of recent Task Forces and Work Groups of several professional societies and resulting reports that focus on the clinicians' roles in their work with persons with GIV.

**Results:** Over the last decade or so, the emphasis on identifying GIVs as psychopathology and, therefrom, deriving justification for medical treatment, has shifted to human rights considerations. With it, the role of the mental-health clinician has shifted from that of a gate keeper for access to medical treatment of persons with GIV to one of a collaborative assistant to the patient, and the question whether GIV should be categorized at all as a mental illness is under divisive debate.

**Discussion:** This shift in clinical approach and clinicians' roles has led to a considerable relaxation of restrictions and demands to which persons with a GIV had previously been exposed, while at the same time the number of such persons seeking help in respective clinics is increasing and the age of formal gender transitioning is decreasing.

**Utility/Limitations/Risks:** The effect of the changing clinical approach on long-term outcome of persons with GIV, including potential risks of this development, has not yet been systematically documented, and is in urgent need of conceptual scrutiny and empirical investigation.

### **Behavioral Learning Objectives:**

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

1. Understand the recent changes in clinical policy towards persons with GIV.
2. Discuss the changes in role and function of the gender clinician.
3. Ascertain some of the major unresolved issues associated with the changes in clinical policies.

### **References:**

World Professional Association for Transgender Health. *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People. Version 7.* (To be publicized September 26, 2011.)  
American Psychiatric Association Task Force on Treatment of Gender Identity Disorder. Report, May 4, 2011.

### **Biography:**

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

## HORMONES AND DESIRES TESTOSTERONE AND SEXUALITY IN SOCIAL AND PSYCHOLOGICAL CONTEXT

**Sari M. van Anders PhD**

Departments of Psychology and Women's Studies, Neuroscience & Reproductive Sciences  
University of Michigan  
530 Church Street  
Ann Arbor, MI 48109 USA

Telephone: (734)647-6981; Fax: (734)763-7480; E-mail: [smva@umich.edu](mailto:smva@umich.edu)

**Introduction:** Research on sexual desire typically focuses on dyadic desire and either includes psychosocial factors OR testosterone (T). In addition, T is generally understood to explain sex differences in desire and to be linked directly to desire in both healthy women and men, despite null or conflicting findings. This talk presents a neuroendocrine investigation into desire in healthy women and men that also incorporates psychosocial variables and measures both solitary and dyadic desire. Understanding the multifaceted nature of desire and its associations with social and psychological variables should be critical to a comprehensive understanding of the basics of sexual desire and physiology, but also for clinical insights into sexual desire.

**Method:** Participants were 115 women (mean age 21.96 yrs) and 120 men (mean age 22.93 yrs) who were diverse by ethnicity, religion, and relationship status, and were mostly U.S. citizens students or had received higher education. Participants provided a saliva sample for measurement of T and cortisol, and completed a set of questionnaires to assess desire and three psychosocial domains: address Sexual-Relational, Stress-Mood, and Body-Embodiment issues.

**Results:** T was positively linked to solitary desire in women, but masturbation influenced this link. In contrast, T was negatively correlated with dyadic desire in women, but only when stress and cortisol were controlled. Replicating past findings, no correlations between T and desire in men were apparent, but the present study also showed that the null association was robust and not due to confounds or psychosocial variables. Men showed higher desire than women, but masturbation frequency rather than T explained this difference.

**Discussion:** Findings are discussed in light of their challenges to gendered assumptions about T and desire, given the null effects in men and the clear psychosocial rather than hormonal influences on gender differences. Also discussed is the evidence demonstrating related but distinct aspects of desire, given the opposing correlations between T and solitary vs. dyadic desire. The importance of incorporating psychosocial context and behavior, especially masturbation and stress-related variables, in characterizing and researching desire even in behavioral neuroendocrinology is also highlighted. Potential implications for clinical approaches to desire difficulties are explored.

**Utility/Limitations/Risks:** The results of this study will help therapists and researchers working with low-desire clients, but the results are limited by the young and highly educated sample.

**Behavioral Learning Objectives:**

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

1. Explain the value of incorporating psychosocial perspectives into neuroendocrine research.
2. Define important non-hormonal correlates of desire.
3. Compare solitary desire and sexuality to partnered desire and sexuality.

**Biography:**

Dr. van Anders received her Ph.D. in behavioral and cognitive neuroscience from Simon Fraser University in 2007. She joined the University of Michigan in 2008 as an Assistant Professor of Psychology and Women's Studies, and is affiliated with Neuroscience and Reproductive Sciences. Dr. van Anders' research program focuses on social neuroendocrine approaches to intimacy (sexuality, nurturance, partnering), along with gender/sex and sexual diversity.

## LONG-TERM EROTIC COUPLES: DISCOVERIES FROM THOSE WHO'VE MADE IT WORK

**Jack Morin, Ph.D.**

Private Practice; California Institute of Integral Studies  
423 Gough Street, Suite D  
San Francisco, CA 94102

Telephone: (415) 552-9560 Fax: (650) 631-5825 E-mail: jmorinphd@yahoo.com

**Introduction:** Clinicians are frequently consulted by couples, including (or especially) those in positive relationships, who are having trouble maintaining a sexual life after many years together. A steady stream of books, articles and TV experts offers advice on revitalizing sexual passion. Yet there have been few attempts to ask sexually active couples for their “secrets.”

**Method:** Since 1996, I've interviewed 97 couples (together and individually) who continued to enjoy satisfying sex after 10–32 years together. All sexual orientations were included. The vast majority were in couples therapy for concerns other than sex. Key themes were compared with those expressed by sexually-troubled couples. In recent years, I've also interviewed a growing convenience sample of couples not in therapy.

**Results:** Whereas couples struggling with sex understandably become demoralized, irritable, self-critical, and/or avoidant, erotic couples are far less likely to do so. Even though most face sexual issues and dry spells, they generally continue to have “maintenance sex,” complete with predictable initiation rituals. Consequently, they have an ongoing framework for sex to become more passionate under optimal conditions. These couples tend to normalize sexual cooling over time and often joke about it. They rarely lose sight of the “otherness” of the partner, often encountering their differences on a regular basis. Many are sexually energized by insecurities and jealousies. Though a large minority say the partner is not “my type,” they frequently refer to their original and evolving attractions. Generally, at least one partner maintains a rich private erotic life.

**Discussion:** Couples who wait for sex to be passion-driven are far less likely to be sexual than those who are “game” to try even when they're not “horny.” The current emphasis on creating desire as a prerequisite for good sex is the opposite approach followed by most erotic couples. The tendency of the friendliest couples to downplay differences and disagreements appears to be the enemy of sexual interest. This study offers considerable support to Schnarch's differentiation model of desire.

**Utility/Limitations/Risks:** Lessons from erotic couples can be used to motivate and inspire struggling couples, and carry more credibility than abstract ideas alone. Lesbian couples are under-represented in this sample. Therapy-based interviews may skew the results.

### **Behavioral Learning Objectives:**

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

1. Describe three characteristics of long-term erotic couples.
2. Explain why “passion promotion” approaches to low desire are often ineffective.

### **References:**

- Morin, J. (1995). *The Erotic Mind*. New York: HarperPerennial.  
Ogden, G. (2008). *The Return of Desire*. Boston: Trumpeter.  
Schnarch, D. (2009). *Intimacy and Desire*. New York: Beaufort Books.

### **Biography:**

Dr. Morin received his Ph.D. in clinical psychology from Saybrook University in 1978. He has been in private practice since 1976. He is the author of *Anal Pleasure and Health* (2010, 4th Ed.) and *The Erotic Mind* (1995). He has been on the faculty of California Institute of Integral Studies since 1996.

## PEYRONIE'S DISEASE

### Laurence A. Levine, MD

Professor of Urology  
RUSH University Medical Center  
1725. W. Harrison Street Suite 352  
P: (312) 563-5000  
F: (312) 563-5007  
[drlevine@hotmail.com](mailto:drlevine@hotmail.com)

There are many misconceptions about Peyronie's disease, including that it is a rare disorder and that it frequently resolves spontaneously. It is also widely held that there are no effective non-surgical treatments. All of these notions are inaccurate. There is no cure, but effective treatment may at minimum stabilize the scarring process and may result in improvement of sexual dysfunction.

Proper treatment of the man with erectile dysfunction and Peyronie's remains controversial and not well understood. Yet there are clear pathways for treatment of such men. In addition it appears that the number of men with Peyronie's presenting to the practicing urologist world-wide is growing rapidly. Thus it appears valuable to understand how to evaluate men at the initial visit and then offer appropriate treatment options. A standardized evaluation will be presented. A practical surgical algorithm will be presented to guide appropriate reconstruction when the patient is a surgical candidate. The components of a proper operative consent will be presented as well. Surgical techniques will be reviewed with outcome analysis presentations.

#### Course Learning Objectives:

1. Enumerate the historical misconceptions regarding the demographic and natural history of Peyronie's disease.
2. Propose a treatment strategy for the patient with Peyronie's disease in all of its manifestations-active vs. stable disease; calcified vs. non calcified plaques; comorbidity with erectile dysfunction; mild, moderate vs. severe curve with and without hinge effect.

**Brief Bio:** Laurence A. Levine, MD, is Professor in the Department of Urology at Rush University Medical Center in Chicago, Illinois. Dr. Levine received his medical degree from the University of Colorado Medical School in Denver. He completed an internship and junior residency in general surgery at Tufts–New England Medical Center, and a residency in urology at Brigham and Women's Hospital in Boston, Massachusetts. Dr. Levine has also made a substantial contribution to the medical press in the form of peer-reviewed articles, abstracts, book chapters, and Internet publications regarding male sexual dysfunction, Peyronie's disease, fertility, and reconstructive urology. He is a Diplomate of the American Board of Urology. He is the editor of the first textbook on Peyronie's disease and the author of a patient's guide to *Understanding Peyronie's Disease*. He was co-chair of the Peyronie's disease and Genital trauma committee for the International Consultation on Sexual Medicine in 2009. He is a Past-President of the Sexual Medicine Society of North America (2007-2008), and the Chicago Urologic Society (2004-2005).

#### References:

1. Taylor FL and Levine LA. Peyronie's Disease. In Urologic Clinics of North America. Allen Seftel, ed. Elsevier, Philadelphia, PA., Urol Clin N. America. 34(4):517-34, 2007.
2. Ralph D, Gonzalez-Cadavid N, Mirone V, Perovic S, Sohn M, Usta M, Levine LA. The Management of Peyronie's Disease: Evidence-based 2010 Guidelines. J Sex Med 2010; 7. 2359-2374.

# PROXIMATE AND REMOTE PREDICTORS OF ORGASMIC PLEASURE IN THE LABORATORY

Laurel Paterson, BA and Yitzchak Binik, PhD

Laurel Paterson, BA

Department of Psychology, McGill University  
1205 Dr. Penfield Avenue Montreal, Quebec H3A 1B1 Canada  
Telephone: (514) 398-5323 Fax: (514) 398-4896 E-mail: laurel.paterson@mail.mcgill.ca

**Introduction:** Masters and Johnson (1966) stated that women's orgasm varied greatly in intensity and duration, whereas "the male tends to follow standard patterns of ejaculatory reaction with less individual variation" (p. 6). Indeed, many studies have examined the physiological and subjective changes associated with different 'types' of orgasm in women (e.g., clitoral vs. vaginal), with little consideration of the potential variability in normal men's orgasmic experience. In addition, no study has examined what predicts orgasmic pleasure in either gender. The aim of this study was to investigate the extent of men's orgasmic variability and the correlates of orgasmic pleasure.

**Method:** Thirty-eight male participants (*M* age = 21 years) masturbated to orgasm in the laboratory, using their typical masturbatory technique, while their genital sexual arousal was measured using a TSA ImagiR thermographic camera. Participants completed questionnaires on their levels of sexual arousal and sexual desire at four time-points (at baseline, after masturbating almost to orgasm, immediately after orgasm, and 15 minutes after orgasm) and on their orgasm experience.

**Results:** Participants masturbated for an average of 9.6 minutes and all reached orgasm. Both subjective sexual arousal ratings and penile temperature on the ventral glans and shaft increased significantly from baseline to directly before orgasm (by 3.6/10 and 4.1 and 1.4° C, respectively), and these were significantly positively correlated at all time-points. Ratings of orgasmic pleasure ranged from 4 to 9 out of 10, with an average of 7.1 (with 10 = "the most pleasurable orgasm I've ever experienced"), virtually identical to women's ratings in our previous orgasm study (Paterson, Amsel, & Binik, submitted). Orgasmic pleasure ratings were correlated with a) higher ratings of sexual arousal, sexual desire, desire to masturbate, and desire to have an orgasm before orgasm, but not masturbation duration or genital temperature, b) orgasmic intensity, satisfaction and number and duration of orgasmic sensations, and c) sexual desire following orgasm, as well as d) higher masturbation frequency and lower partnered sex frequency over the past month.

**Discussion:** Overall, orgasmic pleasure is predicted by psychological rather than physical factors and appears to depend on one's sexual activity preferences and/or frame of reference: those who had recently masturbated more and had less partnered sex rated their orgasmic pleasure the highest.

**Utility/Limitations/Risks:** This study demonstrates the feasibility of studying orgasm in the laboratory using a non-invasive measure of physiological sexual arousal which is anatomically non-specific and therefore can be used with both men and women.

### **Behavioral Learning Objectives:**

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

1. Identify the reasons for the scarcity of male orgasm research.
2. Discuss the relative importance of psychological and physical predictors of orgasmic pleasure.

### **References:**

Masters, W., & Johnson, V. (1970). *Human Sexual Inadequacy*. Boston: Little, Brown.  
Paterson, L. Q. P., Amsel, R., & Binik, Y. M. (submitted). Changes in women's genital and non-genital sensitivity with high levels of sexual arousal and orgasm.

### **Biography:**

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

## **RISK FACTORS FOR EARLY-ONSET SEXUAL INTERCOURSE: ARE OBSERVED ASSOCIATIONS CAUSAL?**

**KELLY L. DONAHUE**  
**Dept. of Psychological and Brain Sciences**  
**Indiana University**  
**1101 East 10th Street**  
**Bloomington, IN**

Adverse childhood experiences and substance use have been identified as potential causal risk factors for early-onset sexual intercourse. While it is possible that exposure to these risk factors directly increases the likelihood of engaging in early intercourse, an alternative explanation is that observed associations between these variables are due to shared familial confounds. These unmeasured confounds may increase the likelihood of exposure to such risk factors and of engaging in early intercourse. Participants in a population-based study of Swedish adult twins (ages 19–47; N=12,126) reported on their history of exposure to early physical and sexual abuse, cigarette use, and cannabis use. We investigated the nature of the association between these risk factors and young age at first intercourse, using a comparison of twins differentially exposed to each risk factor. When compared to nonexposed, unrelated individuals, participants who reported adverse childhood experiences or who engaged in early cigarette use or cannabis use were more likely to engage in early intercourse. However, cotwin-comparisons indicated that observed associations between these risk factors and early intercourse may be due to familial factors shared within twin pairs and may not lead directly to early intercourse. Our results suggest that preventing trauma exposure or preventing or delaying adolescents' cigarette smoking or cannabis use may not effectively delay intercourse onset; instead, other aspects of the adolescent's environment should be addressed.

## SEXUAL ABUSE AND THE CATHOLIC CHURCH A REPORT TO THE US CATHOLIC BISHOPS

**Julian Slowinski, Psy.D., ABPP**

Department of Psychiatry - Pennsylvania Hospital  
700 Spruce Street, Suite 501 Duncan Bldg.  
Philadelphia, PA 19106 USA

Telephone: (215) 829-5534: Fax: (215) 829-6426: Email: [jslow007@comcast.net](mailto:jslow007@comcast.net)

**Introduction:** The Roman Catholic Church has been shaken by reports of sexual abuse of minors by clergy. Both secular and religious groups have cried out for action to be taken by religious leaders for a swift and thorough response to the crises, its causes, and its elimination.

**Method:** The US Conference of Catholic Bishops responded by initiating a study of sexual abuse by minors by American catholic clergy. The John Jay College of Criminal Justice was commissioned to investigate the problem. Their report was released in May, 2011: *The Causes and Context of Sexual Abuse of Minors by Catholic Priests in the United States, 1950-2010*. The goal of the study was to understand the historical, psychological, socio-cultural and situational factors that led to the increase in abuse during the 1960 and 1970s, and then to the sharp decline in the 1990s. The analysis was based on multiple sources of empirical data supplied by the church.

**Results:** In summary, the John Jay findings ranged from stating that there was no single cause of the abuse crises: individual characteristics of priests do not predict subsequent sexual abuse; most of the abusers were not pedophiles (the report used a definition of sexual contact with prepubescent children) ; homosexuality was not a cause of the abuse, nor was celibacy; situation factors and opportunity played a significant role in the onset and continuation of abusive acts; previously established guides for responding to reports of sexual abuse were inadequately implemented in many dioceses; the primary response of bishops to allegations of abuse was to focus on the priest-abuser (often neglecting the victims.) the Church must increase its level of transparency in response to the problem.

**Discussion:** The report states that their evaluation of the data eliminates pedophilia, homosexuality, and celibacy as causes of the abuse crises. It suggests that general cultural factors of the 60s and 70s contributed to an increased deviance in society. Critics of the report will argue about the reliability of the study data as it was provided by the bishops; abuse has also been reported in other countries that did not go through the American cultural turmoil; the lack of an in-depth study of institutional dynamics, and that the culture of clericalism was not addressed as a possible contributor to the crises; the role of the hierarchy in protecting perpetrators while not responding sufficiently to victims of abuse and their families.

**Utility, Limitations, and Risks:** The report will satisfy many by the areas which were investigated, but it also points to areas that need much more careful attention: seminary formation of priesthood and religious order candidates begs careful oversight through programs that are realistic and include a better understanding of human sexuality and personal awareness. Bishops and religious superiors need to follow established guidelines of action in both preventative and policy areas, including cooperating with legal authorities, sensitivity to the needs of victims, and more transparency in general. It would be a gross failing if religious leaders used the John Jay report findings as a vehicle for feeling that main questions have been answered and they can go back to business as usual. The report is just a first step.

### **Behavioral Objectives:**

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

1. Be better informed with the crises of sexual abuse in the Roman Catholic Church
2. Be familiar with the findings and limitations of the causes of clerical sexual abuse
3. Be more knowledgeable of clerical culture as a potential barrier to progress and justice

### **References:**

John Jay College of Criminal Justice Research Team: Terry, K. et al. (2011) *The Causes and Context of Sexual Abuse of Minors by Catholic Priests in the United States, 1950-2010*. United States Conference of Catholic Bishops, Washington, DC

John Jay Report is Just a First Step: Editorial: June 9, 2011. *National Catholic Reporter* Kansas City, MO.

### **Biography:**

Julian Slowinski received his doctorate in clinical Psychology from Rutgers University in 1977. He is in private practice at Pennsylvania Hospital in Philadelphia, and has been on the clinical faculty in psychiatry at the University of Pennsylvania School of Medicine since 1978. A longtime member of SSTAR, he has a special interest in the area of sexuality and religion.

## SEXUAL FUNCTION AND BEHAVIOR OF WOMEN WITH LIFELONG VAGINISMUS

Rebecca Cherner, Ph.D. (abd) and Elke Reissing, Ph.D.

Rebecca Cherner, Ph.D. (abd)

School of Psychology, University of Ottawa

136 Jean-Jacques Lussier, Ottawa, ON, K1N 6N5 Canada

Telephone: (613) 562-5800 ext 4449 • Fax: (613) 562-5169 • Email: [rcherne@uottawa.ca](mailto:rcherne@uottawa.ca)

**Introduction:** Vaginismus is classified as a sexual dysfunction, yet there is a paucity of information on the sexual function and response of women with this disorder. This is the first comprehensive investigation of the sexual health of women with vaginismus, and includes a multi-method approach to explore self-reported behavior, function, physiological response and emotional evaluation.

**Method:** One hundred and sixty women with lifelong vaginismus, lifelong dyspareunia or no history of sexual pain completed standard questionnaires that explored sexual function (FSFI), sexual arousability and anxiety (SAI-E), and repertoire and frequency of specific sexual behaviors (SAQ). Fourteen of the women with vaginismus were matched on parity with women with dyspareunia and those with pain-free intercourse. This subset of women viewed two series of sexual film clips, one that depicted vaginal penetration and one that did not. Vulvar temperature was measured using thermal imaging during the films and participants reported their emotional responses.

**Results:** Women with vaginismus and dyspareunia reported difficulty with several aspects of sexual functioning. However, only women with vaginismus reported a restricted lifetime repertoire of sexual behaviors beyond coitus. Participants had similar changes in vulvar temperature in response to the sexual films as well as similar ratings of subjective sexual arousal. Women with vaginismus reported more negative emotions in response to the sexual films, in particular disgust and anxiety.

**Discussion:** Women with vaginismus and dyspareunia have sexual difficulties beyond impaired functioning during penetrative sexual activities. However, the difficulties of women with vaginismus extend to negative emotional responses to sexual stimuli and a restricted range of sexual activity.

**Utility/Limitations/Risks:** Despite similarities between the sexual health of women with vaginismus and dyspareunia, some group differences were observed. Restricted sexual repertoire and negative emotional reactions to sexual stimuli further support a fear and disgust based etiology in vaginismus compared to a pain/fear of pain based etiology in women with dyspareunia.

### Behavioral Learning Objectives:

1. Compare the sexual functioning of women with vaginismus and dyspareunia.
2. Discuss the physiological and emotional impact of erotic stimuli on women with vaginismus.

### References:

- ter Kuile, M. M., van Lankveld, J. J. D. M., de Groot, E., Melles, R., Neffs, J., & Zandbergen, M. (2007). Cognitive-behavioral therapy for women with lifelong vaginismus: Process and prognostic factors. *Behavior Research and Therapy*, 45, 359-373.
- Borg, C., de Jong, P., & Weijmar Schultz W. (2010). Vaginismus and dyspareunia: Automatic vs. deliberate disgust responsivity. *Journal of Sexual Medicine*, 7, 2149-2157.

**Biography:** Rebecca Cherner is a Ph.D. candidate in clinical psychology. She is an associate researcher in the Human Sexuality Research Laboratory and research coordinator in the Centre for Research on Educational and Community Services at the University of Ottawa, Canada.

Elke Reissing received her Ph.D. in clinical psychology from McGill University in 2002. She is the assistant director of the School of Psychology and director of the Human Sexuality Research Laboratory, University of Ottawa, Canada. She is an editorial board member of the Archives of Sexual Behavior, Journal of Sexual Medicine, Canadian Journal of Sex Research, and the Canadian Journal of Behavioural Science. She is also a clinical supervisor for sex therapy services at the Centre for Psychological Services and has a private practice working mainly with sexual pain disorders.

## SEXUAL HEALTH AND BILATERAL SALPINGO-OOPHORECTOMY

Cara Dunkley, BA, Lori Brotto, PhD, & Nadia Branco, MSc

Cara Dunkley, BA

Department of Gynaecology, University of British Columbia Sexual Health Laboratory  
2775 Laurel Street, Vancouver, British Columbia V5Z 1M9  
Telephone: (604) 992-7099 ♦ E-mail: caradunkley@gmail.com

**Introduction:** This study examines the impact of the prophylactic bilateral salpingo-oophorectomy (BSO), or the surgical removal of both ovaries, on sexual function. Women with mutations in BRCA1 and BRCA 2 genes are at increased risk for the development of ovarian cancer, and often elect to have a BSO as a means of reducing that risk (Rebbeck, Lynch, Neuhausen, Narod, Van't Veer, Garber, et al., 2002). Women also undergo BSO surgery for benign gynecologic indications. Many studies suggest that gynecologic surgery is not associated with impaired sexual function or distress, however, other studies, particularly those concerning gynecologic cancer, suggest a negative impact on sexual function (Bergmark, Avall-Lundqvist, Dickman, Henningsohn & Steinbeck, 1993). The purpose of this research was to investigate changes in sexual function following BSO, and to explore whether differences in sexual after-effects arise when contrasting BRCA carriers and women receiving BSO for benign indications.

**Method:** Our sample was comprised of 26 BRCA carriers and 13 women who had BSO for a benign indication. Participants completed questionnaire packages that included validated measures of sexual response, sexual distress, sexual self-image, and mood. Fifteen of these women participated in a follow-up interview, which included open-ended questions regarding their sexual health and relationship functioning in the context of receiving a BSO.

**Results:** No significant quantitative group differences in post-operative sexuality, mood or relationship satisfaction. Qualitative results suggested that BRCA carriers experienced more negative sexual sequelae than the benign group, an effect possibly mediated by age. Through content analysis of interviews, four main themes were identified (1) Pre-operative knowledge of sexual side effects, (2) Pre-operative drive to educate oneself on BSO side-effects, (3) Partner support, and (4) Treatment for sexual side effects. Pre-operative knowledge was highly correlated with patient satisfaction and inversely correlated with post-operative sexual distress.

**Discussion:** These results suggest that gynecological surgery itself may lead to sexual functioning impairments, opposed to surgery specifically for gynecological cancer. The inclusion of a control group may be needed to elucidate these findings. Future studies are necessary in order to analyze the impact of prospective determinants on pre-surgery sexual function, such as age, on subsequent sexual dysfunction. The importance of pre-operative knowledge substantiates the necessity of pre-operative counseling with regards to sexual health.

**Utility/Limitations/Risks:** This was the first study to utilize both quantitative and qualitative measures to examine women's sexual function after prophylactic BSO.

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

1. Understand the health and relationship factors that influence how women who have undergone BSO experience subsequent changes in sexual functioning.
2. Recognize the importance of pre-operative knowledge on sexual side effects.

### **References:**

Bergmark, K., Avall-Lundqvist, E., Dickman, P.W., Henningsohn, L., Steinbeck, G. (1999). Vaginal changes and sexuality in women with cervical cancer. *NEJM*, 340, 1383-9.  
Rebbeck, T. R., Lynch, H. T., Neuhausen, S. L., Narod, S. A., Van't Veer, L., Garber, J. E., et al. (2002). Prophylactic oophorectomy in carriers of BRCA mutations. *NEJM*, 346,1616-22.

### **Biography:**

Cara Dunkley received her Bachelor of Arts Degree (Honours) in Psychology at the University of Victoria in 2009. She is currently a study coordinator at the UBC Sexual Health Laboratory.

## Similarities and Differences between Asexuality and HSDD

Morag A. Yule, MA, Lori A. Brotto, PhD, and Boris B. Gorzalka, PhD

**Morag A. Yule, MA**

Department of Psychology  
University of British Columbia  
2136 West Mall

Vancouver, B.C. V6T 1Z4 Canada

Telephone: (604) 317-6866 ♦ Fax: (604) 822-6923 ♦ E-mail: moragy@gmail.com

**Introduction:** Asexuality is loosely defined as lifelong lack of sexual attraction, and 1% of the population is thought to be asexual (Bogaert, 2004). It has been suggested that asexual individuals experience hypoactive sexual desire disorder (HSDD), and some asexual individuals may meet current diagnostic criteria for HSDD, due to resultant interpersonal distress. However, existing data suggest that asexuals do not experience distress directly related to their lack of sexual attraction (Brotto *et al.*, 2010), making asexuality fundamentally different from HSDD. The precise delineation between lifelong HSDD and asexuality is unclear, and this requires further study. The aim of this study was to compare asexual men and women with sexual individuals who met diagnostic criteria for HSDD in order to gain insight into the similarities and differences between these two groups.

**Method:** Six hundred ninety-eight men and women between the ages of 19 and 55 (403 asexual (86 men, 317 women), 295 sexual (85 men, 210 women)) who reported experiencing low sexual desire completed a battery of online questionnaires, including diagnostic criteria for HSDD.

**Results:** Eleven percent of asexual and 45% of sexual individuals met diagnostic criteria for HSDD. Of these, 88% of asexual and 29% of sexual individuals reported a lifelong lack of sexual desire, compared to 11% of asexual and 71% of sexual individuals reporting acquired low desire. Asexual women had greater orgasm and sexual satisfaction scores, less pain, and lower sexual desire than women with HSDD. Asexual men had greater overall sexual satisfaction, but reported similar erectile function, orgasmic function, and sexual desire compared to men who met HSDD criteria.

**Discussion:** 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. However, the current findings suggest that there are significant differences between asexual individuals and those with HSDD which may alter the course of potential treatment.

**Utility/Limitations/Risks:** This study adds to the growing literature on asexuality, and is the first to compare asexuality and HSDD. The findings have clinical implications for therapists working with individuals with low sexual desire. This is a preliminary study, and further research is required to disentangle these two concepts.

### **Behavioural Learning Objectives:**

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

1. Describe similarities and differences between asexuality and HSDD.
2. Discuss implications for the sex therapist working with a sexual/asexual couple.

### **References:**

- 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.

**Biography:** Morag Yule received her MA in 2011. She has been conducting sexuality research since 2007, and is presently a PhD student in the Clinical Psychology program at the University of British Columbia.

## SITUATING SEXUALITY IN SURVIVORSHIP

**Anne Katz RN PhD**

CancerCare Manitoba

675 McDermot Avenue

Winnipeg, MB R3E 0V9 Canada

Telephone: 204 787 4495 ■ Fax: 204 786 0637 ■ Email: [anne.katz@cancercare.mb.ca](mailto:anne.katz@cancercare.mb.ca)

(a) Introduction: 80% of cancer survivors report challenges to their sexuality. With almost 13 million cancer survivors in the US today, this represents a significant burden to couples and a challenge to sex therapists, counselors, primary care and oncology providers (b) Method: A thorough review of the literature on cancer and sexuality was conducted in addition to a review on cancer survivorship. (c & d) Results and Discussion: Cancer survivors experience multiple unmet needs in the domains of sexuality and sexual functioning as a result of cancer and its treatments. While certain cancers (breast, prostate, gynecological) are easily identified as causing sexual problems, all cancers, including those diagnosed in childhood and adolescence, lead to long term problems for survivors. (e) Utility: With 13 million cancer survivors living in the US today, we need to recognize their unmet needs and be prepared to work with survivors to address a vital component of quality of life.

### **Objectives:**

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

1. Recognize that sexual challenges exist for cancer survivors beyond breast, prostate and gynecological cancer.
2. Discuss ways of identifying cancer survivors in practice and providing them with evidence-based strategies to support them.
3. Highlight the unique issues for survivors of childhood and adolescent cancers.

### **References:**

- Horeden, A. & Street, A. (2007). Issues of intimacy and sexuality in the face of cancer: the patient perspective. *Cancer Nursing* 30, E11-E18.
- Katz, A. (2007). *Breaking the Silence on Cancer and Sexuality: A Handbook for Healthcare Providers*, Pittsburgh: Oncology Nursing Society.
- Katz, A. (2009). *Woman Cancer Sex*. Pittsburgh: Hygeia Media.
- Katz, A. (2009). *Man, Cancer Sex*. Pittsburgh: Hygeia Media.
- Stanton, A. L., Ganz, P. A., Rowland, J., Meyerowitz, B. E., Krupnick, J. L., & Sears, S. (2005). Promoting adjustment after treatment for cancer. *Cancer*, 104, 2608-2613.

### **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), *Girl in the Know: Your Inside and Out Guide to Growing Up* (KidsCan Press 2010) and *Surviving after Cancer: Living the New Normal* (Rowman and Littlefield 2011).

## STILL BREAKING ALL THE RULES: TEACHING SEX IN CYBERSPACE

Betty Dodson, Ph.D  
Private Practice  
New York, New York

The health of each person's sex life rests upon childhood masturbation—the foundation upon which all of human sexuality is based. Sexual repression begins the moment a parent or caregiver punishes a child's natural curiosity for touching their own sex organs. These negative messages do not stop at the threshold of the family home but are perpetuated in sex (mis)education, and society at large. Negative messages about sexuality and about touching one's own genitals are more often and more blatantly directed towards girls. Stories from women around the globe attest to the damage that is done to women's sexuality as a result. But these stories also demonstrate how, with knowledge and encouragement to explore their own bodies and their own genitals, women can experience sexual pleasure and orgasm. Drawing upon decades of experience liberating women one orgasm at a time this talk will trace the path of Dodson's career to the present challenge of liberating women globally. With data and clinical material from the website [dodsonandross.com](http://dodsonandross.com) this talk will highlight the challenges and successes of sex education in cyberspace.

### **Behavioral Learning Objectives:**

1. To understand the connection between masturbation and female orgasm
2. To become more familiar with technology as a tool for educating women about sex and orgasms

### **References:**

Dodson, B (2010). *My romantic love wars* (Kindle Version). Retrieved from Amazon.com

Dodson, B. (1996). *Sex for one: The joy of self loving*. New York: Three Rivers Press.

### **Biography:**

Betty Dodson, artist, author, and PhD sexologist has been one of the principal voices for women's sexual pleasure and health for over three decades. Betty continues her private practice as a sex coach in New York City. With Carlin Ross she maintains an active website: [dodsonandross.com](http://dodsonandross.com).

## A STREETCAR NAMED DEROUSAL? AN EMPIRICAL EXAMINATION OF THE DESIRE-AROUSAL DISTINCTION

Sabina Sarin, M.S., and Yitzchak M. Binik, Ph.D.

**Sabina Sarin, M.S., M.Phil**

Department of Psychology, McGill University

1205 Dr. Penfield Avenue

Montreal, QC H3A 1B1

Tel: 514-398-5323; Fax: 514-398-3848; Email: [sabina.sarin@mail.mcgill.ca](mailto:sabina.sarin@mail.mcgill.ca)

**Introduction:** A controversial proposal to collapse disorders of desire and arousal is currently pending in the *DSM-5*. This proposal rests on limited empirical evidence, as to date, no study has examined whether these disorders are empirically distinguishable by using explicit operational criteria to recruit and compare distinct groups of low desire (HSDD) versus low arousal (FSAD/ ED) sufferers. The primary goal of the current study was to assess whether it was possible to find medically healthy men and women meeting clearly operationalized DSM-IV-TR criteria for HSDD and/ or FSAD/ ED, and to compare groups to matched controls on their patterns of desire and arousal. A secondary goal was to evaluate the relative utility of the proposed DSM-5 criteria.

**Method:** To assess operational criteria, respondents completed a comprehensive telephone screening interview assessing DSM-IV-TR and proposed DSM-5 criteria, as well as a standardized self-report measure of sexual functioning (International Index of Erectile Functioning for men; Female Sexual Function Index for women).

**Results:** The use of operationalized DSM-IV-TR criteria to recruit participants led to the exclusion of over 75% of those reporting arousal and desire difficulties, with the primary reason for exclusion being the failure to meet one or more central diagnostic criteria for FSAD/ED or HSDD (e.g., not wanting sex despite having regular sexual fantasies). The application of the proposed *DSM-5* criteria was even more restrictive, and led to the exclusion of all but 4 men and 1 woman using the 2009 four-symptom criteria, and 4 men and 5 women using the 2011 three-symptom criteria. Results from principal component analyses supported the distinction between desire and genital arousal difficulties, and offer an alternate conceptualization of these sexual difficulties.

**Discussion:** Results speak to the crucial importance of the operational definition used when recruiting subjects, and point to fundamental problems with the current and proposed DSM criteria, which are failing to capture concerning clinical phenomena in many people's lives.

**Utility/Limitations/ Risks:** Results urge researchers to be more explicit in their operational criteria and chosen target demographic. While our operational criteria and assessment methods were not without flaw, they provide a starting point and a template for comparison with future research, and indicate the need for clearer definitions of these distinct constructs.

### **Behavioural Learning Objectives:**

1. To identify the flaws in current and proposed DSM criteria for desire/ arousal disorders
2. To discuss the impact of operational criteria in shaping data and in data interpretation

### **References:**

Brotto, L.A. (2009). The DSM diagnostic criteria for hypoactive sexual desire disorder in women. *Archives of Sexual Behaviour*, 39, 221-239.

Graham, C.A. (2009). The DSM diagnostic criteria for female sexual arousal disorder. *Archives of Sexual Behaviour*, 39, 240-255.

**Biography:** Sabina Sarin received her Masters degrees from Yale University in 2007, and has been working on her Ph.D. at McGill University since 2008. She conducts research on sexual desire, arousal, and their distinction, and is a recent student member of SSTAR.

## WHAT LEADS TO OPTIMAL SEXUAL EXPERIENCES?

Peggy J. Kleinplatz, Ph.D., A. Dana Ménard, M.A., Meghan Campbell, Psy.D.,  
Nicolas Paradis, M.Ed., Lianne Rosen, B.A. (Hon.)  
Christopher Wannamaker, B.A. (Hon.) and Shannon Lawless, M.Sc.

Faculty of Medicine and School of Psychology  
University of Ottawa

Ottawa, Ontario, K1N 6N5, Canada

Telephone: (613) 563-0846 E-mail: [kleinpla@uottawa.ca](mailto:kleinpla@uottawa.ca)

**Introduction:** There is extensive literature on factors that cause sexual difficulties. There is no literature on which factors contribute to optimal sexual experiences. In previous studies, we identified the components of optimal sexuality. The objective of this investigation was to formulate a comprehensive description of the factors that lead to optimal sexuality in order to help those so inclined to improve their sex lives.

**Method:** Detailed, semi-structured interviews were conducted with 75 men and women who reported having experienced optimal sexual relations (i.e., key informants). Interviews were transcribed, coded and analyzed by 5 raters plus one “blind” rater to identify thematic content.

**Results:** Seven major themes and accompanying sub-themes were identified including individual and relationship *developmental* factors, *enduring* individual and relationship characteristics, as well as aspects of individual and interpersonal sexual expression that occur *in preparation*, immediately prior to and *during* sex which eventuate in optimal experiences.

**Discussion:** Optimal sexual experiences were viewed by participants as a function of the qualities of the individual and relationship rather than the use of novel techniques. The participants reported that they were not born as “great lovers” but rather, developed the capacities to experience extraordinary sexual relations. These findings may provide guidance to therapists in aiding dysfunctional or even “normal” clients who wish to overcome difficulties and explore the breadth of their sexual potential.

**Utility/Limitations:** The facilitating factors described here are not a checklist of requirements; they are intended to provide specific examples of the contributions of various factors to optimal sexual experiences. These factors have particular clinical implications for dealing with desire problems.

### Behavioral Learning Objectives:

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

1. Describe the factors which contribute to optimal sexual experiences.
2. Describe the implications of these findings for improving sexual relations

### References:

- Kleinplatz, P.J., Ménard, A.D., Paquet, M.-P., Paradis, N., Campbell, M., Zuccarini, D., & Mehak, L. (2009). The components of optimal sexuality: A portrait of “great sex”. Canadian Journal of Human Sexuality, *18*(1-2), 1-13.
- Kleinplatz, P.J., Ménard, A.D., Paradis, N., Campbell, M., Dalgleish, T., Segovia, A., & Davis, K. (2009). From closet to reality: Optimal sexuality among the elderly. The Irish Psychiatrist, *10*(1), 15-18.

### Biography:

Peggy J. Kleinplatz, Ph.D. is Professor of Medicine and Clinical Professor of Psychology at the University of Ottawa, Ontario, Canada. Since 1983, she has been teaching Human Sexuality at the University of Ottawa, where she received the Prix d'Excellence in 2000. She has edited three books, most recently, *New Directions in Sex Therapy: Innovations and Alternatives* (2012) (2<sup>nd</sup> Edition).

## WHAT THE BRAIN TELLS US ABOUT MALE GENITAL PAIN

**Melissa A. Farmer, PhD**

Department of Physiology  
Northwestern University  
Feinberg School of Medicine  
303 E. Chicago Avenue  
Chicago, IL 60611 USA

Telephone: (312) 501-1319 Fax: (312) 501-5101 E-mail: [melissa.farmer@northwestern.edu](mailto:melissa.farmer@northwestern.edu)

**Introduction:** Given the heterogeneity of the condition, research efforts are underway to identify potential etiological and/or symptomatic subtypes of prostatitis in an effort to develop individualized treatment approaches (Nickel & Shoskes, 2009). The majority of physiological research on men with chronic prostatitis/chronic pelvic pain syndrome has focused on peripheral causes of pelvic pain (Karlovsky, & Pontari, 2002). However, little is known about the unique neural mechanisms that underlie this painful condition.

**Method:** Nineteen male CP/CPSP patients provided continuous ratings of their spontaneous (unprovoked) pelvic pain during a functional magnetic resonance imaging (fMRI) scan, and pain-specific brain activity was evaluated using an event-related general linear modeling approach. Using voxel-based morphometry, the gray matter density of the brain regions that characterized pelvic pain from fMRI analyses was correlated with pain-related clinical parameters. CP/CPSP brain structure was compared with that of age- and gender- matched controls.

**Results:** Neural activity in the right anterior insula, right dorsolateral prefrontal cortex, thalamus, and bilateral posterior parietal cortex uniquely characterized prostatitis pain. No group differences were found in global or regional grey matter density between patients and controls, yet regional gray matter density in pain processing areas (anterior insula and anterior cingulate cortices) was positively correlated with pain intensity and duration.

**Discussion:** Unique patterns of brain function characterize prostatitis pain, and regional alterations in gray matter volume in areas associated with acute pain perception reflect clinically-relevant measures of prostatitis pain. This work results strongly suggest that the brain actively adapts to the persistent presence of pelvic pain, and thus CP/CPSP pathology is not limited to peripheral pain processing. As the first evaluation of brain functional and structural changes in men with CP/CPSP, these findings indicate that brain imaging will prove to be a useful tool in future efforts to tease apart mechanisms underlying chronic pelvic pain.

**Utility/Limitations/Risks:** These findings emphasize how chronic pain can alter how the brain processes pain-related information, potentially through the alteration of brain anatomy. These findings require replication in a larger sample of men with CP/CPSP.

### **Behavioral Learning Objectives:**

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

1. Identify the limitations of current research on the causes and consequences of CP/CPSP pain.
2. Summarize impact of pelvic pain on the way the brain processes pain-related information.
3. Discuss the implications of altered brain anatomy in relation to clinically meaningful measures of pain severity.

### **References:**

- Farmer, M. A., Chanda, M. L., Parks, E. L., Baliki, M. N., Apkarian, A. V., & Schaeffer, A. J. (2011). Brain functional and anatomical changes in Chronic Prostatitis / Chronic Pelvic Pain Syndrome. *Journal of Urology*, 186, 117-124.
- Karlovsky, M. E., & Pontari, M. A. (2002). Theories of prostatitis etiology. *Current Urology Reports*, 3, 307-12.
- Nickel, J. C., & Shoskes, D. (2009). Phenotypic approach to the management of chronic prostatitis/chronic pelvic pain syndrome. *Current Urology Reports*, 10, 307-12.

### **Biography:**

Dr. Farmer received her Ph.D. in clinical psychology from McGill University in 2011 and is currently a Postdoctoral Fellow at Northwestern University. She has developed animal models of genital pain and currently continues her interest in pelvic pain with human neuroimaging research.

## WORRY ABOUT LONG TERM HEALTH OF TRANSSEXUALS

**Stephen B. Levine, MD**

Clinical Professor of Psychiatry  
Center For Marital And Sexual Health  
23230 Chagrin Boulevard  
Beachwood, Ohio 44122

216-831-2900 Fax 216-831-3406 [sbl2@case.edu](mailto:sbl2@case.edu)

**Introduction** The treatment of adults with Gender Identity Disorder is undergoing liberalization despite reasonable concerns about the patients' long-term adjustment.

**Methods** Two recent European studies that were not discussed or referenced in the recently published Standards of Care are presented. The Swedish study of every person who had SRS over a 30 year period (n=324) found that the hazard ratios after SRS were: all causes mortality =2.9; suicide =19.1; psychiatric hospitalizations=4.2; substance misuse=3.0; cardiovascular disease=2.6; suicide attempts=7.6; all crime=1.9; violent crime 2.7. Mortality was dramatically evident beginning a decade after SRS. A Dutch study of 965 MtF followed over 18 years demonstrated: total mortality was 51% higher than in the general population, mainly from suicide, acquired immunodeficiency syndrome, cardiovascular disease, drug abuse, and unknown cause. Rate of suicide after SRS in Sweden are similar to suicide rates of those with bipolar and unipolar disease.

**Discussion** The Swedish study adds vital missing information about the fate of those who undergo SRS. With an average follow-up of 11.4 years, it is apparent that if SRS does indeed cure gender dysphoria, it does not eradicate serious psychosocial problems of many of those who have been operated upon. Previous work has raised concern that political considerations were skewing the perceptions of adults with GID. Now that outcome measures that do not depend on questionnaires, clinical assessments, self-assessment are available, professionals can separate themselves from transsexuals by stopping the rhetoric about the absence of inherent psychopathology and ceasing to claim that any psychiatric co-morbidity is due to sexual minority stress. It is time for science to dominate the discussion. The natural history of a condition such as GID, treated or untreated, is the ultimate basis for understanding the effectiveness of treatment.

**Conclusion:** The SOC needs to be immediately rewritten.

**Limitations:** The fate of the 480 Swedes with GID who did not have SRS is not known. The ratio of the healthy (by predefined parameters)/unhealthy patients after SRS is not known. Perhaps the current care of GID is so superior to past care that the European studies can't be used as evidence.

### Learning Objectives

1. To recognize the scientific basis for objecting to the liberalization trends embodied in the SOC
2. To conceptualize how political fashion can skew clinical perception
3. To stimulate interest in benefit/risk of harm ratio for individual patients and society

### References

1. Dhejne C, Lichtenstein P, Boman M, Johansson ALV, Langstrom N, Landen M. (2011) Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden. Plos One 6(2) February
2. Asscheman H, Giltay EJ, Megens JA, de Ronde WP, van Trotsenburg MA, Gooren LJ. A Long-term Follow-up Study Of Mortality In Transsexuals Receiving Treatment With Cross-sex Hormones. Eur J Endocrinol. 2011 Apr;164(4):635-42 Epub 2011 Jan 25
3. Levine S, Solomon A. (2009) Meanings and Political Implications of "Psychopathology" in a Gender Identity Clinic: Report of 10 cases. Journal of Sex and Marital Therapy 35(1): 40-57.
4. Citrome L. (2011) Number needed to treat: What it is and what it isn't, and why every clinician should know how to calculate it. J.Clin Psychiatry 72(3):412-413.
- 5.

### Biography

Dr. Levine has been involved with care of people with GID since 1974. In 2007 he set up a GID program for the Massachusetts Department of Corrections after each of 12 prisoners received the same recommendation for SRS based on SOC despite their diverse situations. He has been an Expert Witness in two federal cases involving males who murdered.

# SAVE THE DATES!

## 2012 FALL CLINICAL MEETING

October 5, 2012 | New York, NY  
The Penn Club of New York

## 38th ANNUAL MEETING

April 4 - 7, 2013 | Baltimore, MD  
Hyatt Regency Baltimore on the Inner Harbor



SOCIETY FOR  
SEX THERAPY AND  
RESEARCH