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SEXUAL MEDICINE AND SEX THERAPY: WHERE DOES PLEASURE FIT IN YOUR DEFINITION OF SEXUAL HEALTH?

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00:08
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00:35
Thank you so much. I'm so delighted to be here, and part of this wonderful conference. So let's just get going because there's so much I want to share. This is some information about CME and other declarations. I have no disclosures.

00:58
So, what are we going to do? Our objectives here today are to look at the role of addressing sexual pleasure and satisfaction in sexual health management overall and in prevention. We're going to give you a couple of simple tools, and also help you identify people in your region that may be helpful when you feel that there's something that needs further addressing, and we'll talk all about that.

01:34
So, first, a word about words. I try in my presentations to use non gendered language. I do have to be clear, then most research that's been conducted in this area has been done with cisgender, heterosexual individuals and couples. That's changing, more recent research includes recognition of diverse sexualities and gender identities, but we're still left with some thorny issues of language around gender. When we're discussing sexual functioning concerns today, I feel it's helpful to think more about anatomy than gender identity. So when I use anatomic terms, please recognize that they don't have a bearing on how one might identify their gender. As well, outside of research findings, when I use the terms women and men, I'm referring to those who identify as such.

02:31
So first, I want to start with a little information from you. We're going to use an audience engagement system called MENTI.com. I'd like to learn a little bit about how you define sexual health right now, before we get started. You can take a picture of this QR code to go to the website, or go to MENTI.com and use the following code 10332483. And that will come up again in just a moment. And while you all get there, I thought it'd be nice to share a little music with you. [music plays]

04:21
So clearly, you all have read ahead in the presentation as you are identifying pleasure as one of the key phrases and words that you think of, when you think of sexual health. But we are thinking also about safety and consent and health of the vagina or uterine health, penile health, organ systems testing, intercourse, sexual orientation. All kinds, all of these things absolutely fit

in when we're thinking about sexual health. So I hope that you are familiar with the following definition of sexual health from the World Health Organization in 2006. So this was a pretty bold statement and continues to be in 2021 because of one word, pleasure. Other large medical organizations have historically avoided this word when addressing issues of sexual health. In fact, a quick search of the CDC website that I did again this morning didn't yield more than one reference to sexual pleasure. In Dr. Urban's presentation yesterday, I was delighted to see the word pleasure on the New York State Department of Health AIDS Institute 2020 Sexual Health Priorities draft. That was very exciting. So medical providers get a pretty good overall training in the reproductive health and infectious disease aspect of this definition. Well, of course, there's still a lot of work to be done here. And modestly good training in helping with sexual safety. But I'm going to go out on a limb and say that few medical providers were taught to consider pleasure as an aspect of sexual health. And some would even argue that our patients sexual pleasure is none of our business.

06:37
So why consider sexual pleasure when there is the important work before us of preventing disease, making sure children who come into the world are healthy and wanted, and that people are not having coerced or non consensual sex? And how about the work of getting clear information to young people about the consequences of so called risky sexual behavior? Now, please note, when we call it risky sexual behavior, we're saying something, there's an implicit message there. Now how I hear it, risky sexual behavior is an idea that sexual pleasure in young people seems kind of dangerous and overall might best be avoided. So humans find themselves to be sexual, for a wide variety of reasons. In one large research study, they identified 237 reasons that people have sex. But for the most part, humans have sex because it feels good. Well, pleasure is a prime motivator, and the motivation for pleasure often overrides motivations for other aspects of health. Pleasure in its many forms is a key element of human experience and can be a marker of well being. And importantly, sexual pleasure requires honoring our own, as well as others' sexual rights. And what are sexual rights? Well, the freedom from discrimination, having a say with regard to what happens with one's body, the freedom to pursue healthy sexuality, and the freedom to express sexuality. And mutual sexual pleasure, pleasure between two or more people, requires an environment of safety based on these rights.

08:30
Sex therapist Doug Braun-Harvey distills the World Health Organization's sexual health definition in this way, utilizing these six key principles, which he emphasizes are deeply interdependent. So let's think about teens and sex. Can you imagine a world where we use a definition of sexual health like this, and acknowledge and honor the motivator of pleasure for young people and emphasize sexual expression as important rather than dangerous? I suspect it might make it easier to make the case for protection, honesty, consent and non exploitation, and make it clearer that in order to achieve the goal of mutual pleasure, all five other principles are vital elements.

09:18

And there's some evidence that teaching young people in this way as effective. In October 2020's Systematic Review in The Journal of Adolescent Health of over 30 years of literature on comprehensive sex education concludes that evidence points to the effectiveness of approaches that address a broad definition of sexual health and take a positive, affirming, inclusive approach to human sexuality. But what about disease prevention? Does focus on pleasure help us in any way? In a 2019 paper on the efficacy of pleasure inclusive sexual health interventions, the authors concluded that compared to risk focused interventions, pleasure inclusive interventions improved knowledge, attitudes, and were more effective at achieving disease oriented goals. We also have evidence that harm reduction focused interventions, which may omit information that the goal of partnered sex is mutual pleasure, may allow for ideas of sex as a tool for attaining social or interpersonal power, and these ideas may go unchecked. Consent skills, especially consent that's inclusive of discussions of STI risk and prevention, are enhanced when we emphasize that mutual pleasure is more salient than any individual's pleasure. When we eroticized condom use, promote lubricants, make consent sexy, and help people have conversations about pleasure and sexual satisfaction, this may be more effective in improving partner communication, condom use and safer sex behaviors. Pleasure gets our attention. And if pleasure helps us move in a direction of other aspects of health, why not harness this powerful tool? So why has pleasure been taken out of the conversation? Perhaps pleasure gets equated to hedonism, a pleasure becomes a gateway drug to harm. Do we see pleasure as the antithesis of responsibility leading to an either/or dynamic? Either I'm responsible, no pleasure, or I do whatever I want, I have pleasure. Is it possible that we avoid pleasure because of its association to masturbation, or as I prefer to call it self stimulation or self loving? If there's any activity that's more focused on sexual pleasure as its sole aim, it's self loving. Now, these are all ideas that are deeply culturally embedded. And while we're not going to dive into these questions, I hope that you'll give yourself the opportunity to think critically about these messages that have been overlaid on this important aspect of human experience.

12:10

So let's talk about a case. India is a 25 year old assigned male at birth, a person who identifies as gender queer and uses they pronouns. They're currently unpartnered, and they identify as pansexual, meaning not that they're attracted to all people, but they're attracted to and enjoy having sex with people of any or no gender identity. They're currently only interested in casual sexual relationships, and they desire erections for their sexual play. And their preferred sexual play includes oral hand, penile vaginal, and penile anal play. And they're on spironolactone as a testosterone blocker, and small doses of estrogen. Since starting these medications, they've had significant benefits in terms of mood, they feel more aligned with their gender, happier with their gender expression. However, they're no longer having erections as easily. There was one occasion with a partner that they were deeply interested in, in which there was a complete lack of erection. This was embarrassing, devastating, and since then, it's been hard to get an erection in any partnered sexual play. They're using Viagra from a friend, but sometimes even this isn't working. They've noticed that if they don't use a condom, they have more arousal, and it's somewhat easier to have an erection. Due to anxiety about their erectile issue, they are seeking out frequent new partners, largely because they feel compelled to check to see if the erectile concern is still there. Their anxiety generally is increasing when they go out with somebody new, so they're drinking more alcohol to deal with that anxiety. Over time, the sexual

difficulty is on their mind more and more, and they drink to try and push away these uncomfortable feelings. Now I'm sure there are many aspects of India's sexual health that you're concerned about.

14:16
So sexual functioning also drives sexual behaviors and can affect sexual health in a disease oriented perspective. Our expectations about how bodies should function during sexual play come from a wide variety of sources. They may come from media for example, the mind blowing orgasm that occurs in the coat closet after three vaginal thrusts. Or other societal messages, sex, specifically penis vagina intercourse, is required in a part of a marriage and it is something that must be done like any other chore, or sex should be natural and spontaneous. These ideas also can be relational expectations, one partner has sexual outlet needs once a week and the other has sexual outlet needs once a day or once a year. People also compare sexual function with other points in their own lifespan. If vaginal lubrication was instantaneous at the sight of a desired partner at 18, then what's wrong with me or with my partner if that's not the case at 45? Not living up to those expectations, even if everything in the body is working well, may cause distress and drive sexual behaviors. Of course, there are also myriad changes that can occur in the body that can affect desire, arousal, and orgasm, or cause sexual pain. And many medical treatments, medications, surgeries, other medical procedures, can impact sexual functioning. So when sexual functioning changes, people can feel quite alone and broken, especially when they feel like they can't talk to their medical providers about these issues. And this leads to attempts to fix the problem with solutions from the internet or hearsay or just hoping things will change back. And this can lead to repeated checking for function, like picking a scab to see if the skin underneath has healed, substance abuse to deal with distress or to manage the concern, alterations to safer sex practices in order to manage the sexual functioning. For example, a person with erectile function like India might be led to make choices they might not otherwise, not using a condom, finding new partners in order to see if the problem can be solved by a change in circumstance or an increase in arousing stimuli. A person with sexual pain or early orgasm, also called premature ejaculation, might use sedating medications or alcohol to mitigate their pain or delay ejaculation, so they can have the sexual experience they want, leading to altered decision making regarding safer sex. So if we're not addressing distress about sexual functioning when that arises, if we're not addressing the issue that may be getting in the way of a person's pleasure, we may have difficulty achieving other goals regarding their safety and health.

17:24
There's additionally the issue of sexual shame. This was defined by Dr. Noel Clark as a visceral feeling of humiliation and disgust about one's body and sexual identity. And this sexual shame also drives sexual behaviors and contributes to sexual functioning problems, as well as distress. Sexual shame largely derives from messages we've received around sexuality and our body's experience of pleasure. These messages may come from our families as explicit messages or when sex is not discussed at all. Messages also can come from sex education that does not include information about pleasure. Religious beliefs, the media. And one of the problematic effects of sexual shame is that we may not feel able to make decisions about our own safety or autonomy in sexual relationships, leading to behaviors that can put us at risk. So even when

we've had fairly positive messages about sex, most people feel some shame around what gives them pleasure, where where does that come from? All those messages around us. Don't touch yourself. Since sex is dirty, save it for your marriage, etc. Our minds are incredible meaning making devices and we get confused. Sex is bad, but it feels good. So the body codes, oh, it's bad because it feels good. And some take it a little further. If I enjoy feeling good in this way, I must be bad. And shame develops around the feeling of pleasure. So you as healthcare providers have the power to turn this ship around. When you talk to your patients about pleasure, you're helping them unlearn these messages.

19:11
So let's talk about talking to your patients about sex and pleasure. I feel like this crowd really has the first five aspects of this sexual screening history nailed. We ask about partners, avoid assumptions based on cis and heteronormative, monogamy normative perspectives, we ask about specific sexual practices, as well as STI and reproductive history and goals. But do you find out if your patients have concerns about pleasure? The key here is ask. Just ask. Ask specifically. Now, this is a crowd who isn't afraid to ask about partners, about practices, about protection. Why not pleasure? Starting these conversations is not as hard as you may think. There are a few simple tools. The first most important thing is providing permission. Permission to discuss these issues. And this permission needs to come from us as healthcare providers. If we wait for patients to bring these concerns up, they won't, because they're predicting our discomfort, our judgment, our lack of resourcefulness on the topic. A majority of sexual function concerns can be resolved by simply talking with an open minded, non shaming and informed healthcare provider. Most people just need to know they're okay, that their pleasure is important and that there's cause for hope. As an example, many people are quite conflicted about masturbation, but in many ways it's a healthy practice physiologically, as well as for sexual release and pleasure. Using normalizing and universalizing statements can be tremendously helpful and provides an efficient and easy way to put people at ease and elicit their concerns. A statement such as, many people notice changes to their sexual desire, arousal, or orgasm over time, some even have pain with some aspects of sexual play, has anything like this happened with you? Often providers are concerned that these discussions will be time consuming and wide ranging, opening up a can of worms. A direct way to get to the point is assessment of impact and distress. What impact has the sexual pain had on your relationship? How much distress is this desire problem causing you? And finally, it's helpful to let people know, let your patients know, that these problems are worth our time. This may mean you need to make a follow up appointment to more fully address their concern, and take time to get the whole story. On this slide, I have some examples of permission giving questions.

21:52
So let's go back to MENTI.com. And we are going to practice some questions that might get this conversation about sexual function and pleasure going. So what I'd like you to think about is our case. Our patient is coming back in, and they are having some urethral discharge, and they're requesting HIV testing. How do you begin the conversation with this patient about their sexual pleasure? So if you go to MENTI.com, and go to the next question, you will see an opportunity to give some permission giving statements. Asking about satisfaction quite directly is a good way to do this. We certainly do want to ask about condoms and sex, how is sex for you these

days? So one of the key things is specific language, sometimes we need to really model that sexual functioning includes a variety of phases of the sexual cycle. So asking specifically about desire, asking specifically about arousal, erection, vaginal lubrication, and asking about orgasm, and asking about satisfaction. I love this, let's talk about pleasure as a part of sex. How's it going with your sex life lately? Are you having orgasms? Fantastic! We definitely need to ask about behaviors. Wonderful. So keep them coming. I will come back to to this slide again.

24:22

So one of the things that we need to think about when these concerns, when these issues come up in a visit, is it a question, a concern or a problem? So not everything that comes up regarding sexual function is a problem to be addressed, right? Sometimes it's just a question. So I've never had a vaginal orgasm, am I okay? Or it may be a concern, I'm worried that sometimes my orgasm and ejaculation happens too quickly for my partner's satisfaction. And sometimes it's a problem that needs to be addressed. So we're gonna, again, go back to MENTI.com and look at questions, problems, questions, concerns, and problems. So if you go to the next question in MENTI.com, give me some examples of questions that might come up about sex. For instance, that question about vaginal orgasm, what other questions might come up where people might just want to know they're okay versus something that's a concern? Absolutely, that's one that comes up frequently. Right, so somebody may not think that sexual pain is a problem, they think that maybe it's normal. So that's a question that comes up. Yes. Is it okay to be dry vaginally? So these questions about how my body works may lead to things that are problems or real concerns, but they may not be concerns or problems on the face of it to begin with. So we're going to go to the next question here, give me some examples of concerns. Some did come up on the last page. Any concerns that people have brought up in your visits with them? Spotting after sex. I have no excitement about sex. Yes, that is an example of a concern that may lead to a problem that may need to be addressed, but it may be that their sexuality is one that they don't find a lot of enjoyment in sex, though asexuality as a sexual orientation is about desire for partnered sex, it really doesn't have much to do with arousal, so that could be about the enjoyment. Fantastic. So let's look at what might lead us to think that something is a sexual concern that may qualify as a problem to be addressed. I think on this question you have an opportunity to answer as many, there's no right answer. It's you answer as many as you want. This is great, thank you for participating. So we're pretty clear as a group that impact on the individual or relationship, make something qualify as a problem. Distress and degree of distress in the individual qualifies this as a problem. And the patient has tried a number of solutions and the concern persists, means this is a problem.

29:34

According to definitions, we're not going to go through all the definitions, but we're going to review the ICD 11 chapter on sexual health. A duration of a problem is also an aspect of something that makes a concern qualify as a problem. The things here that do not make a sexual concern qualify as a problem, and I should probably include here sort of as a problem, a medical problem. And so we can think about this in a variety of ways. But so if the concern is related to a conflict with societal values, that is not a problem in the individual, that's a problem with their resolution of values and that may be something that is useful to talk with a therapist, a sex therapist, about. But it's not, that is not one of the things that makes a sexual concern

qualify as a problem. A partner's distress when the individual isn't distressed may create relational concern, but it's not a problem for the individual. And a paraphilia, or a fetish, that occurs between consenting adults, also, as you'll see in the ICD 11 categories is not a problem to be addressed. Perhaps an internal conflict about that may be a problem. So, thank you, that is wonderful.

31:17
So here's the ICD 11 conditions related to sexual health. As medical and mental health providers, you may be familiar with the housing of sexual dysfunction concerns as outlined in the DSM, the Diagnostic and Statistical Manual, but the DSM as a bible of psychiatric illness does not address the fact that there are often biological aspects to symptoms, and reflects a now outdated mindset that sexual problems are simply psychological. This is just not the case and is not reflective of the last 25 years of sexual science. International medical societies devoted to the study of sexual issues have come together to describe this diagnostic classification system that is more reflective of the current scientific evidence and best practices, and this will be used in the International Classification of Diseases 11. This new classification system recognizes that aspects of many sexual concerns are not significantly different between genders, among genders, and is more reflective of the mind, body, social reality of sexual concerns. Additionally, this chapter on sexual health summarized here eliminates past guidelines that impose a normative standard for sexuality, and remove all categorizations that selectively target people with same sex orientation, or gender diversity. Paraphilic disorders are defined as disorders that have to do with non consent situations, or situations in which harm is caused.

32:59
Now, while these diagnostic categories are useful for research and for billing, I find it's more helpful to consider sexual function concerns in this way, when I'm thinking clinically. Concerns generally fall in the domains of desire, arousal, orgasm, or pain, as well as concerns about ability to have vaginal or anal entry. And another important point here is that these concerns often overlap. And when we're thinking about these concerns, we need to recognize the truth that in sexual functioning and satisfaction, the interplay between biology, psychology, interpersonal aspects, and sociocultural beliefs, values, and expectations, is complex. So we need to consider biological and psychological domains, as well as relational and sociocultural factors.

33:54
So, here's the bottom line. We can't go into all of these, all of these sexual functioning concerns today, invite me back, I'd love to talk with you about every single one of them. But here's the bottom line, just ask. And if a problem or a concern comes up, then discuss it. Pursue some additional education for yourself and for the patient about it and follow up on it. If the problem persists, know to who you can refer, and then follow up again to make sure they got resolution. So when somebody does encounter a problem with sexual functioning that's causing distress, to whom do they go? Well, they might try a medical doctor first, their primary care doc, a gynecologist, a urologist, or a psychiatrist, all of whom may have had as little education, very little education regarding sexual anatomy and physiology, let alone solutions for sexual

concerns beyond Viagra. They might try their therapist, even a specialist in couples therapy, but these providers too have not routinely been provided training in sexual function concerns. It's highly likely that a typical couples therapist might not even broach the topic of sex. They might go to the Internet where there is some good information increasingly, but still more bad information than good. And they might end up feeling more hopeless and broken as internet and media tend to reinforce cultural scripts about sexual functioning that are unrealistic, even harmful.

35:30
So when concerns about sexual function and pleasure remain unresolved, certified sex therapists or sexual medicine specialists may be useful. Now what is sex therapy? So certification in sex therapy requires a chunk of additional knowledge, techniques, and skills that a general mental health professional may not have. Sex therapy is therapy focused on sexual problems, or sexually informed psychotherapy. For instance, for those with diverse gender identities or sexualities, not only regarding sexual orientation, but also regarding sexual practices, such as those with kink interests or who are in other relationships structures such as polyamory or consensual non monogamy. It may also be general mental health treatment when a sexual concern is an aspect of their experience, such as with bipolar disorder with manic phase sexual symptoms, or generalized anxiety manifesting as a difficulty with arousal. AASECT is the American Association of Sexuality Educators, Counselors, and Therapists is the most prominent certifying body in the US. So sex therapists use a wide variety of techniques, including helping individuals and those in relationships develop sexual communication skills. Sex therapy also begins with making sure that patients have accurate information about sexual function, breaking down many of the myths that exist. Sex therapists are known for their prescriptions of home play, and they do sometimes direct clients to books with accurate sexual health information. But increasingly, mindfulness as a focus of treatment can be helpful for helping clients become more attuned to what's occurring in their bodies. An approach to trauma is important, as trauma while it isn't the source of the vast majority of sexual concerns, may be a contributor. Often approaches take into account the individual or couple or relationship, both as a system and within systems, as well as activating systemic solutions to concerns. What sex therapy is not, sexual surrogacy or any kind of touch related therapy.

37:50
So what about a sexual medicine specialist? And what is sexual medicine anyway? Briefly, sexual medicine is the branch of medicine concerned with human sexuality and its disorders, or as Dr. Charles Moser puts it, the medical aspects of sexual problems and the sexual aspects of medical problems. Certification is available in Europe, the fellow of European Committee on Sexual Medicine, and this is for physicians from a wide variety of specialties that treat sexual concerns, primary care, psychiatry, urology, gynecology, endocrinology, neurology, oncology, etc. However, there's no board certification here in the US. The practice of sexual medicine here in the US tends to be siloed in the largely surgical fields of gynecology and urology, despite the fact that sexual concerns are often similar among genders and rarely requires surgical solution. And residency programs in urology or gynecology get as little medical education in sexual function and dysfunction than most other areas. Sexual medicine is about understanding what's

going on in an individual or a relationship from a true biopsychosocial, sometimes spiritual, perspective.

39:11
So what kinds of concerns in which a sexual medicine consultation would be helpful? Sexual pain is an example of a concern where a medical provider who has expertise in this area really should be involved. There are many biological causes of sexual pain. It has profound individual, psychological, as well as relational effects. Only one quarter of those with sexual pain pursue treatment, and most who have pursued treatment feel dismissed and see an average of seven providers before they arrive at a useful diagnosis or treatment plan. Lifelong early ejaculation, PE, which is orgasm typically within a minute or less of penile penetration, often does not respond to behavioral interventions alone. And when behavioral interventions are combined with medical interventions, there's real hope of improvement. Many chronical medical conditions, as well as the medications used to manage them, affect various aspects of the sexual response cycle. A sexual medicine specialist can start to untangle these knots with deeper knowledge of the impact of these factors. Persistent genital arousal disorder is an extremely distressing condition in which a person has a persistent unwanted feeling of genital arousal that may or may not be relieved by orgasm. There are neurological causes, medication causes, many other causes that can be explored, and medications that can be helpful. There are two new FDA approved medications for pre menopausal, it's identified for cisgender women, but actually it's a medication that can be used in any people of any gender, actually, but it's FDA approved for pre menopausal women with low desire. And then there's the highly effective and very safe testosterone supplementation for postmenopausal women. Sexual desire is often the first thing to go for people who are cisgender men who have low testosterone and testosterone replacement can be a game changer for them. Cancer, and more specifically, cancer treatments have myriad effects on sexual function. Oncologists often don't address these issues. Treatments exist even when hormone therapy is off the table. There's really no reason to endure suffering about the loss of sexual pleasure, or a sexual relationship, on top of the suffering of the cancer experience. And sometimes people just don't want to pursue a psychological fix, or psychological interventions have failed.

41:58
A lot of what I do is education, a lot of myth busting around the physiology of sex, and sometimes the most healing intervention I perform is telling people they're not broken. I also collaborate with other medical providers to find medication regimens that'll allow a client to meet their sexual goals. For instance, some blood pressure or mood management meds have a greater impact on erections, and arousal, and orgasm, than others, and a medication adjustment can help. There are medications that may be helpful with a number of other sexual concerns. And pelvic floor physical therapy is a very important and valuable tool. And when we've fully explored other options, sometimes procedures or surgical interventions are necessary. But the vast majority of cases I see do not require these more aggressive interventions.

42:51

So where do you find a certified sex therapist and sexual medicine specialist near you? Fortunately, these organizations have provider listings, and you may want to look for, if you are looking for somebody who is working with a vagina or a vulva, who has a vagina or vulva, then you may want to look for an ISSWSH, International Society for the Study of Women's Sexual Health fellow. And these are all providers who have a specific interest and additional education with regard to sexual medicine, you can also look for somebody who is a fellow of the European Committee on Sexual Medicine, like myself. If you're looking for a sex therapist, both AASECT and SSTAR have provider listings as well. Of course, the Rochester Center for Sexual Wellness is very happy to help you. Please give me a call, give us a call at any time and we'd be happy to direct you to help near where you are, if we can't help ourselves.

44:04
So how do we know if we've accomplished what we set out to do in sex therapy and sexual medicine? What is our patient oriented outcome measure? Pleasure. It's not a side effect. It's the evidence of our cure. I hope that you have enjoyed this time and I eagerly look forward to your questions. Thank you so much.

44:37
Thank you, Dr. Kranz. Excellent talk. We do have a lot of questions. And we'll start off with a great question here. What is sexual science saying about the impact of trauma on sexual function?

44:54
So certainly trauma has a wide variety of impacts on sexual function, it has more impact on how we respond to a change in sexual function than the creation of sexual functioning concerns. So, as an example, sexual pain, in the past people have thought that there might be an association, a direct association of sexual trauma to having sexual pain. And in this case, I'm referring to people who have vaginas and vulvas, what I'm thinking about right now. Now, a history of trauma can certainly contribute to a decrease in arousal, distracting thoughts, taking away from arousal, making it harder to have a physiologic arousal, lubrication and blood flow to the genitals, and that may contribute to sexual pain. Somebody could be anxious or have a trauma response to a situation in which they have a sexual situation, and may guard by contracting the pelvic floor muscles. Now, those are ways that a history of trauma can impact those issues. But it does not, it does not create the problem at the level of the skin or the problem at the level of the muscles. The problem at the level of the skin and the problem at the level of the muscles with sexual pain needs to be addressed by looking at the skin in the muscles. Addressing the trauma may be an important part of getting back to sexual pleasure and a sexual experience that is satisfying, but a trauma does not create sexual pain. So that's just one example. I could give many more. I could go on all day about that.

47:12
Great, thank you. Next, what do you think the role of healthcare providers is in this area if they don't have a specific focus on sexual health?

47:24

That is a fantastic question. So the role of providers is to be the frontline, non shaming, positive, non judgmental, ear to hear about sexual functioning concerns. And should all enhance, in my ideal world, we would all enhance our education on how to address these issues and be able to take care of first line treatments for sexual functioning concerns. But the most important thing is to be willing to discuss pleasure and sexual functioning with your patients. And as I talked about before too, even just by bringing up pleasure, we are offering people an opportunity to have less shame, we're offering a treatment by being willing to talk with our patients about pleasure, satisfaction and sexual functioning.

48:42
Got it. So just keeping an open line of communication and just making sure to bring it up so they feel comfortable bringing it up.

48:50
That's right, absolutely.

48:53
Any information on STI impact on sexual pleasure and the example this writer here gives is for HSV, patients with HSV.

49:06
So certainly having pain related to an infection like HSV can have an impact on arousal and orgasm and desire. I've seen a lot of patients in my own practice who have profound effects on sexual desire in the presence of a sexually transmitted infection. The feeling of brokenness and shame can have an enormous impact on desire, arousal, and certainly could have an impact on pain as well. So there are a number of HIV medications, treatment medications, that can impact sexual functioning. And there is some evidence that long term survival in the presence of HIV with treatments can lead to desire and arousal concerns. Arousal concerns can lead to orgasm concerns. And so in those ways, those are the ways that are coming to mind right at the moment, but okay, as an example.

50:41
Thank you. This is a question that I think relates to, earlier in the talk you mentioned the discussion of adolescence, and the sort of implications that come with using this risk related terminology in these discussions about sex and pleasure. So this question is, do you have any strategies for convincing decision making individuals like school administrators, teachers, organizational management, etc, that including pleasure in sex education is appropriate and effective?

51:18
Yes, this October 2020 article that reviewed 30 years of sex education research, by Eva Goldfarb, and forgive me, I can't remember the other author's name. This is a very convincing document saying that comprehensive sex education is an important factor when we're thinking about disease related outcomes. There's also a wonderful article from the World Association of Sexology that came out in 2019 that also makes the case for how effective pleasure inclusive

interventions are. I think evidence is our best tool. So the gathering of more evidence is critical. But we already have some that says that this is an important and useful way to address sex education. We can also, of course, look to other countries as well, where there's more pleasure inclusive sex education. And there's evidence in other countries as well, that being able and keeping an open communication with our young people, and recognizing the reality that they're having sex because it feels good, that most of the time they're having sex because it feels good, that can be incredibly effective in helping people make their own decisions. Like if the communication isn't open between parents and children, on values and what your values are with regard to sexual health and pleasure, then it's just such a lost opportunity.

53:48
Right, thank you. We do have several questions. We'll probably have time for one or two more, but we'll prepare a list of responses to questions that we don't have time to answer during the talk, and we'll get those up on the conference website for everyone. The next question here, is there a precedent for sexual health clinics as a collaboration, as a multi specialty collaboration, for example, ID, urology, GYN, things like that?

54:21
Hit me with that question again.

54:23
So is there precedent for sexual health clinics as a collaboration between something like infectious disease, urology, and gynecology?

54:34
So there are a few sexual medicine clinics. So collaboration across the board has a long way to go, right? And there are mainly sexual medicine specialists who know some sex therapist, have some sex therapists in the community that they collaborate with, and they may collaborate with other medical providers, OBGYNs and urologists. And there are a few clinics across the country that are urologists, gynecologists, as well as sex therapists sort of really dealing in a comprehensive way. I as a family medicine physician, you know, have training in urology and gynecology, though not the surgical aspects and there are collaborative environments that are increasing in number, but there are not a lot. There's one in San Diego. There is one in Washington DC. There is one in North Carolina, and there's one here in Rochester.

56:06
Great. Thank you. So thank you, Dr. Kranz, so much for your talk.

[End]