Doctor in My Bedroom: Physicians' lack of sexual health education, its effects on patient welfare and the development of a new paradigm

A Dissertation

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By

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DISSERTATION APPROVAL

This dissertation submitted by Renee Michaels, LCSW, has been read and approved by an approved three member committee.

The final copies have been examined by the Dissertation Committee and the signatures which appear herein verify the fact that any necessary changes have been incorporated and that the dissertation is now given final approval with reference to content, form and mechanical accuracy.

This dissertation is therefore accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Clinical Sexology.

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VITA

Renee Michaels is a licensed clinical social worker and certified addiction professional. Renee received her bachelors degree in Social Work from the University of South Florida where she held the office of President of the USF-NASW Sub-Unit in 1991-1992. Her graduate degree is from Florida State University in Tallahassee Fl. where she became a member of Phi Alpha National Honor Society in Social Work.

She has worked with geriatric populations in home health, psychiatric and chemical dependency populations in hospital settings. She has worked with children in crisis, been involved in PHP, as well as working with persistently mentally ill in supervised apartment settings. Renee does family, couple and individual therapy and has a vast pharmaceutical background and knowledge.

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TABLE OF CONTENTS

Abstract

The following is a multi-method study designed to impart basic descriptive data about the lack of physicians' sexual health education in medical curriculum and its' effect on the health care consumer. It includes a voluntary survey and an interview with a sexual health educator in a medical school setting teaching across all four years of medical school education.

Additionally, the author prescribes a shift in thinking or new paradigm in ways to increase assessment, education and treatment of sexual health/relational concerns. Participants (N-73) came from a private psychiatric clinic with two locations of a time limitation of three a week period.

The results reflected that many physicians do not ask about the sexual health of their patients and this study found fewer female physicians asked about the sexual health of their patients. This study also found that there is a necessity for physicians to inquire/ assess their patients sexual health as evidenced by the number of participants who reported sexual health or satisfaction issues such as problems with libido/sexual desire, erectile dysfunction and vaginal pain with attempt of intercourse and refer to appropriate professionals to assist the patient with their concern.

In general, participants reported they were less likely to ask their physicians sexual health questions and preferred the physician to inquire about sexual health matters of the patient.

I regard sex as the central problem of life...sex lies at the root of life, we can never learn to reverence life until we know how to understand sex.

Havelock Ellis

CHAPTER 1

Introduction

Like our physical health, our sexual health should also take an important place setting in the realm of health care today. With the incidence of STI/STD's skyrocketing on college campuses and beyond, our physicians are an integral part of the equation to help people not only be educated on healthy sex practices, but on having healthy sexual organs and satisfactory performance/pleasure.

Sexuality is a core element of romantic relationships, procreation, and self-determination of all life. Recently, the discourse of human sexuality has been reduced to sports bar diatribes on female and male body parts and hookups void of emotional intimacy, rather than talking honestly and openly about our sex lives and sexual health as a natural revered part of human existence and pleasure.

In 2001, the U.S. Surgeon General, David Satcher prompted a *Call to Action,* to promote sexual health and responsible sexual behavior, the first ever of its kind. According to the 2011 report from the Surgeon Generals' office, many measures of adverse sexual health have increased, including but not limited to, unplanned pregnancy and a rise in STI's (Centers for Disease Control and Prevention. 2010).

Donna Freitas posits in *The End of Sex* (2013) that the hookup culture is dominating the lives of college students where much of the incidence of STI/STD's are occurring, without relevance to emotional or sexual intimacy. In fact, the CDC released on Janurary 8th 2014, that syphilis and gonorrhea are increasing as evidenced by 334,826 cases of gonorrhea which is caused by a bacteria which grows in warm and moist parts of the body and an increase by 4.1percent since 2011. According to the report, there are 15,667 cases of primary and secondary syphilis in 2012 and increased 11.1 percent since 2011 (Huffingtonpost.com, 2014).

Indeed, the lack of emotional or sexual intimacy as well as STI/STD's in the *hookup culture* is imprinting young people today, which could cause them harm in committed relationships in the future.

Since we are living longer and not necessarily healthier, cancer and diabetes as well as mental health concerns and the medications one takes to heal or lessen symptoms of physical and emotional maladies, also cause an iatrogenic effect on the aspect of sexual health. Because of the increased need to visit with physicians more often for our physical health, the inclusion of sexual health concerns need to be addressed in those visits.

Women are suffering in silence with a condition called vaginismus, essentially a panic attack of the vagina, (Katz and Tabisel, classroom lecture, Dec 2012 on Female Sexual Dysfunction) which can be cured. Men are experiencing a lasting emotional effect of erectile dysfunction (ED) and the medicalization of ED by physicians is doing men a disservice to their physical and emotional health. To ignore or to entirely medicalize these sexual health issues without considering a multi-modal approach to treatment would be malfeasant.

Additionally, we must take note that 70 million copies of the trilogy *Fifty Shades of Gray, (2011-2012)* have been sold worldwide, which may also speak to the idea that we are not getting our sexual needs met in the bedroom, and the need for open and thoughtful dialogue on the topic of sex with a qualified clinical sexologist is warranted. If one does not know where to find a qualified clinical sexologist, he/she will often turn to their medical doctor.

PROBLEM

Physicians and Nurse Practitioners, (NP's) may be the first line of defense in assessing consumers for sexual health issues, but they may not be able to treat all sexual health issues because of lack of time in this age of managed care and/or lack of knowledge. In the age of managed care, population growth, a larger aging population and a more medically complex environment, the days of Dr. Welby are over. Many sexual health and intimacy concerns may be better treated by qualified clinical sex therapists. However, physicians must first recognize a sexual health concern.

This dissertation questions whether the physician is using his/her role as the head of health care to provide patients with the most comprehensive sexual assessment and education when possible. Furthermore, we question when to enhance greater knowledge on sexual health and when physicians may need to access the field of clinical sexology for their patients. In addition, this author will address the problem of lack of physician intervention on behalf of their patients in assessing and assisting in patient sexual health concerns and evidence of the particular needs of their patients further implicating the need for qualified clinical sexologists as a referral source and the development of a new paradigm on the topic of sexual health.

Finally, this text will provide an unfolding of a story about the import of human sexuality, and weave together the subplots that will plateau and climax, while bringing this text to a full resolution by providing suggestions and recommendations for an integrated bio-psycho-social healthcare approach to a fulfilling and healthy human sexual life.

METHODOLOGY

The author will glean data collected from a consumer sexual health survey. Also included is an interview with Dr. Carey Bayer, Ed.D, R.N., assistant professor at Morehouse School of Medicine.

CHAPTER 2

LITERATURE REVIEW

Adequate assessment in all areas of health is paramount to appropriate diagnosis and treatment. A bio-psycho-social approach to healthcare is a systematic model of assessment, diagnosis and treatment developed by Drs. George Engel and John Romano at the University of Rochester in 1977 (urmc.rochester.edu).The approach systematically includes biological, psychological and social factors and their complex interactions in understanding health, illness, and health care delivery. Borrell-Carrio' et.al, (2004), suggest a new paradigm to the bio-psycho-social approach which is more elaborate than when first developed. The authors suggest that the clinician should have (1) appropriate self-awareness, (2) an active cultivation of trust, (3) an emotional style characterized by empathic curiosity, i.e. *bed-side manner* (4) self-calibration as a way to reduce bias, (5) education of the patients to assist with diagnosis and forming therapeutic relationships, (6) using informed intuition and (7) communicating clinical evidence, not only the mechanical application of protocol. The bio-psycho-social model refers to a holistic approach, as in the *entire person* or *whole* of a person when considering and determining a person's maladies.

> He (Geroge Engel) formulated his model at a time when science itself was evolving from an exclusively analytical, reductionistic, and specialized endeavor to become more contextual and cross-disciplinary. Engel did not deny that the mainstream of biomedical research had fostered important advances in medicine, but he criticized it's excessively narrow (biomedical) focus for leading clinicians to regard patients as objects and for ignoring the possibility that the subjective experience of the patient was amenable to scientific study. (Borrell-Carrio'et.al., 2004).

Sexual health is an integral part of overall health and is often overlooked and underserved (Nusbaum, et.al.2002). "Sexual health is an integrated care-delivery concept that recognizes sexual expression as normative and encompasses preventative and treatment services throughout the life span" (Swartzendruber and Zenilman, 2010). Sexual health should be included in this model for assessment, diagnosis and treatment.

According to Parish (2013), while sexual health is important to all human beings, it is rarely discussed between patients and their healthcare providers. Internists, family doctors, nurse practitioners (NP's) are on the front line of their patient's sexual health. Patients don't usually get referred out to gynecologist for women and urologist for men until there is a problem. However, a primary health provider will not know there is a problem unless the sexual health of a patient is assessed. This report by Parish states that forty percent of woman and thirty percent of men ages 18-59 have sexual health dysfunction, (Parish, 2013). Discussing sex can be difficult for physicians as well as for patients whether due to lack of knowledge, lack of time, or being uncomfortable with the subject. Doctors and patients alike may avoid the topic altogether and run the risk of decreasing the chance of a satisfactory or healthily sexual life for the patient. Parish states there are a number of screening tools available including the Female Sexual Function Index (FSFI), and Brief Sexual Function Inventory for men (BSFI) (O'Leary, 1995 in text Parish, 2013). The (FSFI) covers the variables of desire, arousal, lubrication, orgasm, satisfaction and pain (Rosen et.al., 2000). The BFSI covers five aspects of sexual functioning for men: sexual drive, erection, ejaculation, perception of problems with sexual functions in each of the areas and overall satisfaction (O'Leary et.al.,1995). In the dissertation, *Identification of Sexual Disorder in a Clinical Setting using a Brief Assessment Tool and Training Program*,

Krista Bloom (2005) developed a brief questionnaire to be used in appropriate clinical settings to identify sexual function/disorders. She used a 5-point Likert scale on ten of the questions and developed three relevant short answer questions that would glean information on sexual abuse, medical issues and medications. Due to being brief and comprehensive, it is well-suited for clinical settings as part of the initial assessment with patients, proving again that the availability of sexual assessments can be brief, comprehensive and are readily available for physicians to use.

Parish (2013) suggests that medical health providers make statements to their patients such as "Anytime you have a question about sexual health, you can bring it up" or physicians can ask an open-ended questions about any concerns patients may have regarding their sexual health."

When other physicians had an informal discussion with Donald Burnap M.D. and Joshua S. Golden, physicians reported to the authors that many of their patients have complaints of sexual problems (Sexual Problems Medical Practice,1967). Burnap and Golden further state that there are numerous reports based on clinical experiences to back up these informal discussion.

Johns Hopkins Medicine has a Sexual Behavior Consultation Unit (SBCU) under psychiatry and behavioral science for the public where medical students treat sexual problems not limited to medical issues. They report treating marital relation problems, sexual compulsive disorders, gender identity concerns, sexual/legal issues, paraphilias and sexual orientation issues. It was established in 1971 as a speciality clinic that treats psychosexual disorders in children, adolescents and adults (Johns Hopkins Medicine, Psychiatry and Behavioral Sciences).

While Johns Hopkins is a forward thinker in all things medical and psychological, including, but not limited to sexual health, it is a teaching hospital not a medical curriculum provider. Dahir (2011) states that there is a lack of knowledge regarding sexual medicine among health care providers due to lack of a sexual curriculum in medical and nursing schools. She also states that medical schools offered three to ten hours of education in human sexuality and it was mostly taught under the psychiatry department. Leiblum (2001) wrote in her article on human sexuality about curriculum in medical schools, that a study by Solursh (2000) surveyed North American medical schools and found that the majority (sixty-one percent) provided ten hours or less of human sexuality education. It was reported that seventeen percent provided eleven to nineteen hours of education while only fifteen percent of medical schools mandated twenty hours or more.

In an interview with Carey Roth Bayer (2013), an assistant professor in the School of Medicine at Morehouse College. Dr. Bayer vehemently states that medical students do not get enough sex education while they are in medical school. The World Health Organization (WHO) in 1974 published their view of their findings and the dilemma in the state of affairs on sexual health curriculum. “[I]t must be stated very emphatically that a knowledge of reproduction and contraception does not of itself provide the training needed to deal with sexual problems” (WHO, 1974 in text from CESH, 2009).

> In relation to human sexuality as a health entity, the role of medicine has been far from clear. To a large extent the health professions have avoided involvement by the simple expedient of providing no sex education at the professional level in medical and nursing schools. Consequently, the physician and the nurse often lack essential knowledge and,

> naturally enough, prefer not to become involved
> in a branch of medicine in which they find themselves
> personally embarrassed and professionally incompetent.
> (WHO,1974 in text CESH,2009).

Prior to the 1974 report by the WHO, significant work in the field was attributed to Dr Harold Lief. In 1963, he published a paper on what medical schools were teaching in the way of sexual health education. In 1960, Dr. Lief, a psychiatrist and psychoanalyst, started organizing the Center for the Study of Sex Education in Medicine at the University of Pennsylvania, where he was a professor of psychiatry. It became a base for his goal of making sex education and the treatment of sexual disorders more scientific (nytimes, 2007).

While significant gains have been made since then in medical school curriculums on sexual health, Marwick (1999) suggests that practicing physicians and other health professionals are not adequately prepared.

According to the book, *Psychiatry and Sexual Health: An Integrative Approach* (2006), interviewing patients, gathering information and proper recording of clinical data is important to develop a comprehensive treatment plan.

> …"It is recommended that education and professional
> institutions and health care professionals and trainees do
> the following:
> 1) Be comfortable enough with their understanding of
> human sexuality as to provide a supportive, nurturing
> and nonjudgemental environment for relevant discussion
> (Cohen and Alfonso, 1997 p 48).
> 2) Always explore patient's sexuality and sexual disorders and
> allow the patient the opportunity to discuss his or her sexual
> concerns in a flexible and comfortable way
> (Parra and Hernandez, 1995 p 48).
> 3) Evaluate the sexuality disordered patient using a
> bio-psycho-social framework, since most sexual problems

> are generally affected by biological, psychological, intrapsychic, interpersonal, social, cultural, and ethnic variables (Cohen and Alphonso, 1997, p 49).
> 4) Always explore comorbidities, including the presence of various sexual disorders, other mental disorders, other general medical disorders and the consequences of medical interventions in order to ensure a competent handling of the clinical condition of the patient" (Mezzich and Hernandez-Serrano, 2006. p 49).

Physicians and NP's must be capable of initiating a sexual assessment with their patients. Knowing where and how to start comes from specific training from medical students educational system. Some physicians can be uncomfortable with their patients' sex-related questions because they may not feel they have enough clinical knowledge on the subject. Physicians can improve their comfort level by obtaining more knowledge on the subject post medical school and through continuing medical education units (CME's) on sexuality and recognize patients face sex-related problems whether by iatrogenic effect or otherwise. Additionally, knowing their professional limitations and the ability to refer to experts in the field of sexology can increase a patient's trust in their physician (Stevenson et.al.,1983).

Dahir references in her article in Urological Nursing (2011), that Charles Marwick (1999), states that many health care providers do not ask their patients about their sexual functioning due to time restraints and lack of training.

This author believes that while these issues do exist, it is not adequate reason to ignore the problems that may be standing in the way of good patient health care. Markwick (1999) also suggests that eighty-five percent of women would like to discuss sexual health concerns but do not do so for fear of embarrassing their health care providers. In a study by Metz and Seifert

(1990), sixty-two men were studied for their expectations of primary care physicians regarding sexual health concerns. According to the responses, these men most preferred their primary care physicians (PCP's) to be their primary source of information regarding sexual concerns. Ninety-seven percent of the men reported prior sexual concerns, but only nineteen percent had discussed these issues with their physician. They also desired the physician to initiate the discussion.

In the book, *Psychiatry and Sexual Health* (2006), the authors write, "taking a sexual history should be approached as part of a routine evaluation. Sexual history-taking is vital for therapeutic and preventive reasons. It can lead to diagnosis and treatment of sexual dysfunction." These authors also believe that ignoring the sexual health of the patient can lead to stress, depression and anxiety, which can further lead to non-compliance of treatment in other areas (Mezzich and Hernandez-Serrano, editors, 2006).

Additionally, it is important to note that often other areas of treatment, such as psychotropic medications and anti-hypertensives, can lead to sexual dysfunction. While this may be a secondary or iatrogenic cause of sexual dysfunction, addressing these issues is paramount to a person's overall health and well-being and can increase a patient's trust in their physicians.

In 2010 there was a report in Academic Psychiatry (citing previous research), that less than half of American medical schools have formal sexual health curricula (Galletly et.al). If that is true, are physicians prepared to address the sexual health needs of their patients? Galletly further states that many medical schools only focus on areas such as STI's and the effects of illness and medications on sexual health. Most psychotropic medications cause sexual side effects, but this is rarely discussed by psychiatrists, as evidenced by a great number of patients inquiring with this writer about such matters. Also, the reticence of physicians to speak about

sexual side effects of any medication is due to the idea that patients may be psychologically influenced by the comment from a physician, which may include having the side effect mentioned and possible refusal to take the medication. Further complicating the already inadequate provision on sexual health with otherwise healthy patients, there are the patients who may have greater need of the information than most (Galletly, 2010).

In a study on primary care and time constraints for prevention care, the authors write that time constraints do pose a problem for physicians in a primary care setting. They report that it would take 7.4 hours per working day to comply with the preventative service recommendations of the US Preventative Services Task Force (USPSTF) advice on prevention such as sexual history taking and education (Yarnall et.al. 2003). Time restraints may pose a problem in a healthcare setting due to managed care mandates; however, sexual health should not be overlooked.

U.S. SEXUAL HEALTH POLICY

> The United States lacks an integrated approach to sexual health. As a result, sexual health indicators are poor. Incidence of HIV has not decreased since the 1990's, and rates of STD's unintended pregnancy, teen pregnancy, and abortion are higher than in many developed countries. "Sexual health" does not appear once in the more than 1000 pages of the new health care legislation.
> Nevertheless, the public is keenly interested in sexual health, as evidenced by the uptake of recent medical advances.
> (Swartzedruber and Zenilman, 2010).

Sexual health policy arrises from the baseline studies completed. The U.S. lacks an integrated approach to sexual health. This further compounds the lackadaisical approach to sexual health assessment by medical professionals. Public health programs such as sexually

transmitted diseases including but not limited to HIV prevention and family planning, are "categorically funded and organizationally fragmented" according to Swartzendruber and Zenilman,(2010). They posit that because of this, sexual health indicator outcomes are poor.

The World Health Organization (2009) was cited in this work as defining sexual health as a ..."state of physical, emotional, mental and social well-being in relation to sexuality: it is not merely the absence of disease, dysfunction or infirmity."

The authors state that parts of a national strategy already exists.

This strategy includes: HIV/AIDS, new initiavites to reduce teen pregnancy and national program to prevent infertility and eliminate syphilis. However, no strategy exists to ensure the successful coordination of these services to provide comprehensive prevention and care (Swartzendruber and Zenilman, 2010). They state non-prevention and care (Swartzendruber and Zenilman, 2010). They state non-implementation of a National Sexual Health Strategy has potential risks to the public including perpetual stigma about sexual infections, fragmented health services, poor health indicators, disregard for prevention which translates into increased costs, a disregard for human rights, lost global competitiveness, decreased productivity, increase health care costs, reduced troop readiness due to unintended pregnancy. Their answer to promote sexual health is to have open public discussions to change the stigma around sexual health issues in addition to the delivery of high-quality sexual health services that are incorporated into primary care settings and provide comprehensive sex education as well as ensuring funding for access to contraception and other sexual health services (Swartzendruber and Zenilman, 2010). The authors agree that promotion of abstinence-only policy is outdated and not useful or effective.

Health Care Consumer Populations

Men

A man's sexual health is primarily focused on the ability to achieve and maintain and erection. Over the last twenty years, the boom of treatment for Erectile Dysfunction has been biomedical (Weeks and Gambescia, 2009, 1-2).

Viagra was the first medication of its' kind, brought to market in 1998 to treat ED, not as a long-term fix for ED but on an *as needed* basis, as ED has more than a biological component. Although the drugs for ED are generally safe and well tolerated, they may prove ineffective if significant relationship issues, desire deficits, partner sexual dysfunctions or other medical conditions are ignored, according to Raymond Rosen in his paper on Erectile Dysfunction: Integration of Medical and Psychological Approaches (Leiblum, 2007, 277). Rosen states that ED is highly prevalent among aging men, with 50% of men older than sixty complain about the quality or reliability of their erection (Leilblum, 2007, 277). Because men rely so heavily on their erectile abilities for feeling competent, a problem in this area can be devastating. Men often hope that the problem will go away on its' own. Because men who suffer with ED see themselves as *abnormal,* they will often not seek treatment due to shame and embarrassment (Weeks and Gambescia, 2009, 9). However, ED is not the only concern in men's sexual health. According to the DSM-5 (2013), men can have a number of sexual health dysfunctions and any combination thereof. Most of the attention for medical treatment is on ED. While ED for all intent appears to be biological, there is a need for increased awareness to not only recognize ED as a bio-psycho-social illness but to treat it as such (Leilblum, 2007,8). "While many patients ask for pills as a

quick fix for their sexual difficulties, others are less receptive to pharmacological treatment" (Rosen, quoted in Leiblum, 2007,13).

Men have expectations of physicians regarding sexual health. In a study about men's expectations of physicians, sixty-two men reported that they expected their primary care physician to attend to sexual health concerns.

Men looked for qualities of professionalism, empathy, trust and comfort in their physicians. While ninety-seven percent of the men reported prior sexual concerns, only nineteen percent had discussed these issues with their doctor. Most of the respondents said they were hesitant to initiate a discussion with their physician about sexual health concerns and they preferred the physician to initiate the discussion. The study reported that the findings suggested an under-utilization of sexual health care for men (Metz and Seifert, 1990).

Women

Women's health, including sexual health, is a fundamental human right. The question this dissertation proposes: is women's sexual health taken seriously by their medical professionals? Are physicians using adequate screening and assessment to discover issues women may be having? Lindau, (2012) states she is often the first physician to talk to her patients about sexual health per their report. "Sexuality is a key component of a women's physical and psychological health. Obviously, Ob-GYN's are well positioned among all physicians to address female sexual concerns. Simply asking a patient if she is sexually active does not tell us whether she has good sexual function or changes in her sexual function that could indicate underlying problems" . Gregory Salinas (2011) and others say that medical professionals report a general awareness of the high prevalence of female sexual problems and recognize the risk for substantial emotional

and psychological consequences but are unlikely to inquire about them. According to the authors, women's sexual health function has been increasingly informed by a bio-psycho-social approach in which sexuality and sexual health are understood in terms more than just physical.

If this is true, why is there not more assessment, discussion and multi-modal treatment for women's sexual health concerns? Twenty percent of women seek medical evaluation for symptoms of Female Sexual Dysfunction and less than ten percent report that a physician has asked them about their sexual health (Salinas et.al. 2011). Another study by Berman and others (2003) concluded that forty percent of women reported that they did not seek help from a physician for sexual function complaints and fifty-four percent reported that they would like to. " The extent to which health professionals currently receive exposure to training in human sexuality as well as the way in which female sexual complaints are handled in the medical setting remain ambiguous. The inflow of patients with sexual function complaints only will increase". (Berman et.al, 2003). "Although well-documented inadequacies in the sexual health education of physicians might contribute to this failure to initiate discussion, lack of knowledge does not fully account for why clinicians fail to do so." (Salinas et.al. 2011).

> If factors that determine clinician's intentions to initiate dialogue about sexual health with their patients can be identified, then there is a potential to support education interventions around those factors and subsequently improve initiation of discussion. (Salinas, 2011).

The authors initiated a study to employ the theory of planned behavior (TPB), to identify the determinants of physicians' to initiate a discussion with premenopausal women about sexual health. Their goal was to predict physicians' attitudes about women's sexual health and what would affect their communication and initiation of discussion with their patients. The barriers listed by the focus groups were reimbursement for discussion, sufficient time during the visit, availability of an approved treatment and availability for validated protocols for conducting discussions (Salinas et.al, 2011). Another area of concern is post-menopausal symptoms such as lack of lubrication, low sexual desire and increase in sexual pain (Goldstein, 2007).

Three out of four women have pain with sexual intercourse at some time during their lives (The American College of Obstetricians and Gynecologists, 2011). While that may be the sign of a gynecological problem or post-menopause, there are other reasons women have painful intercourse or pain upon attempt of intercourse. Dyspareunia is painful intercourse. Vaginismus is the instantaneous, involuntary tightening of the pelvic floor muscles in anticipation of vaginal penetration (Women's Therapy Center). While there is less attention paid to research concerning vaginismus possibly due to women's hesitance to come forward due to shame and embarrassment, more education and information needs to be available to women from their physicians (Binik,1999 et.al in text Leiblum, 2007). Treatment is available and has excellent outcomes. One hundred percent of the women who completed treatment, were successful at curing their vaginismus. Ninety-five of the one hundred percent completed the DiRoss Method of treatment were successful.

(Women's Therapy Center, Katz and Tabisel). Women no longer need to suffer in silence with unfulfilled sexual lives due to vaginismus. However, physicians need to be on top of the

assessment of women's sexual health to diagnosis vaginismus or dyspareunia correctly and refer women to treatment accordingly.

Women are more apt to be sexually victimized. Often coming forward is difficult and these women suffer in silence with the physical and psychological ramifications of sexual violence. Sexual assessment by physicians/NP's will help glean information so women can be given support and referrals to appropriate clinicians.

Disability/Chronic Medical Problems/Chronic Pain

While disability and pain are far-reaching in how and who they effect, they are quite succinct in their nature. Chronic pain is any pain lasting more than six months, and it can effect sexual function. Chronic pain and disability can interfere with sexuality. Whether the disability is physical or emotional, it can inhibit people from having an adequate sex life. The person with disabilities will most likely turn to their medical professional for help. There is more to disability than meets the eye. "Chronic medical conditions are frequently associated with sexual difficulties and problems, which are often underreported and under diagnosed. Patients may feel that sexual problems in the context of disease are not important enough to be mentioned to their physicians, and physicians feel uncomfortable and sometimes incompetent." (Bitzer et.al, 2007). According to these authors, sexual problems are frequent in many clinical conditions, but are not yet a routine part of the diagnostic workup (Bitzer et.al. 2007).

For instance, diabetes is a leading cause of disability in adults and can wreak havoc on a person's sex life. A man with diabetes can suffer from erectile dysfunction, and retrograde ejaculation. Retrograde ejaculation is the reuptake of a man's semen into the bladder during orgasm instead projection of ejaculate out of the penis. Poor glucose control and resulting nerve

damage of diabetes can cause retrograde ejaculation. A woman's sex life can be damaged by diabetes as well. She can experience a lack of lubrication which can make intercourse painful, a decrease or low desire for sexual activity, and a decreased or absent sexual response. One study found twenty-seven percent of women with type 1 diabetes experienced sexual dysfunction. Another study found that forty-two percent of women with type 2 diabetes experienced sexual dysfunction (NIDDK).

Mental illness can also affect a person's natural inclination to desire a healthy sex life. The sexual dysfunction is both related to psychopathology and pharmacology (Zemishlany and Weizman, 2008). SSRI's and anti-psychotics can cause low sex desire and inhibition of orgasm (Baldwin and Mayers, 2003). Physicians should be prepared to disclose this information to their patients and discuss alternative treatment such as decreasing doses of SSRi's and/ or increasing psychotherapy for their mental health issues (Zemishlany and Weizman). If physicians don't have understanding or knowledge of disability and sex, they may need to know who and how to refer their patient to the appropriate professionals to answer questions as well as help with sexual positions that are easier and most appropriate to achieve a successful sexual experience. Sex therapists and physical therapists are two of the disciplines to help people understand how to navigate this sensitive area.

People with disabilities/chronic pain can have a fear of rejection by a partner and/or fear of failure to perform which will increase anxiety. Maintaining intimacy in sexual relationships can improve the odds of a satisfying sex life (MedicineNet.com, 2013). According to a study on people with chronic pain attending inpatient and outpatient pain programs, the volunteers completed a survey on chronic pain and sexuality. The outcome of the study suggested that there

is a high prevalence of sexual problems in patients with chronic pain attending the chronic pain treatment sessions. The authors further state that the difficulties these people face are not only related to mood or disability. They suggest that self-esteem can also be affected, as can the anticipation of fear of pain as another common problem that stands in the way of a person's sexual function (Painful Condition News.com., 2013) They also may wish to have children, and how to make that happen may be the job of many professionals, but none more important than the help of a physician. Physicians need to be sensitive to these issues for childbearing age couples and not assume that because someone is disabled they cannot carry a child to term. If medical students are not made aware of these issues in medical school, they may miss an opportunity to help their patients through some of these challenging issues.

Minorities

Minorities are a major underserved population with regard to sexual health, according to the Centers for Disease Control (2010), as surveillance data show higher rates of reported STI/ STD's among many racial or ethnic minority groups when compared with rates of caucasian. Surveillance data are based on STD's reported to state and local health departments. Some of the conditions associated with this incidence of higher rates of STI/STD's are social and economic conditions, income inequality, unemployment and low educational attainment. This can lead to lack of adequate health insurance coverage and ability to have yearly check-ups including addressing sexual health issues and education. African-American men reported the highest sexual risks of STD's according to the report on ethnic disparities in sexual risk behaviors, relative to white peers, black and latino men have higher odds of maintaining high sexual risk and increasing sexual risk over time . Youth of color are at a disproportionate risk with their sexual

health (advocatesofyouth.org). They conclude that young African-American women are at a high-risk of HIV infection as they may experience male-dominated power imbalances and also fear negotiating condom use with their male partners. One study, found that many black and latinos held misperceptions about HIV transmission, trusted the accuracy of partners' reported histories, and particularly among women, misunderstood the meaning of safer sex (Eissien et al, 2002).

ED also increases with not only age but within minority population. Laumann and others reported in their study in 2007, that whites reported prevalence of ED at 21.9%, 24.4% in blacks and 19.9% in hispanics.

LGBT

Lesbian/gay/bisexual and transgender patients can be at a disadvantage in the already spotty recognition of sexual health concerns by physicians.

In 2006 it was estimated that there were at least 2.8% of men and 1.4% of women who identified as homosexual or bisexual.

The Joint Commission Field Report on LGBT of 2011, reports that 3.5% of American adults identify as lesbian, gay or bisexual, 0.3% identify as transgender.

It may be safe to assume that LGBT patients do not often disclose this information, and therefore educators have a duty to educate medical students how to handle disenfranchised or marginalized patients by actively asking about sexual orientation and sexual health concerns in order to decrease the disparity of proper and adequate healthcare for this population (Sanchez et.al., 2006). Physician and medical providers also need to be aware of their own biases in regard to the LGBT community in order to assess and treat these patients with efficacy.

> In 1996, the American Medical Association recommended that greater education efforts be directed to medical students and physicians focusing on the health care needs of LGBT people in the United States. Prior publications concluded that medical schools inadequately address the health care issues relevant to LGBT people (Sanchez et.al.,2006).

According to the LGBT Field Guide from the Joint Commission (2011), the LGBT population experience more disparities in health care and physical and mental health than the general population. They include stigma, lack of awareness, insensitivity to their particular needs as an LGBT community. The following are a list of disparities included in the field report:

- Less access to insurance and health care services, including preventive care
- Lower overall health status.
- Higher rates of smoking, alcohol, and substance abuse
- Higher risk for mental health illnesses, such as anxiety, and depression
- Higher rates of sexually transmitted diseases, including HIV infection
- Increased incidence of some cancer (LGBT Field Report, 2011, 7).

The above may cause the LGBT community to lack trust in their healthcare providers which may keep them from disclosing sexual information to their physicians and subsequently stand in the way of obtaining appropriate healthcare. The report further states that inequalities of the LGBT community may be more problematic in racial minorities.

> Many groups have worked to increase awareness and focus efforts at the national, state, local and organization levels to better understand the health care needs of the LGBT community, the persistence of stigma and discrimination..although this work has resulted in recent...recommendations, we cannot afford to wait for these recommendations to take hold before

> we begin to address the needs of the LGBT patients and families. (The Joint Commision, 2011, 1,2).

Physicians may have further difficulty assessing and treating people who identify as transgendered due to lack of knowledge on how to treat. Transgendered people face an inordinate amount of stigma which has led to negative bias. This has led to violent attacks, and greater rates of unemployment as well as suicide attempts (Alegria,2010). According to livescience.com, forty-one percent of transgendered people have attempted suicide and about nineteen percent report being refused medical care due to their gender-nonconforming status, and two percent have been violently assaulted in a doctor's office. This study was a survey of seven thousand transgendered people which was conducted by the National Center for Transgender Equality and the National Gay and Lesbian Task Force, released in October 2010 (Maskowitz, 2010). Because transgendered people have to go through a sort of metamorphosis, emotionally and physically, they need the support of their physician and a person specializing in this type of care as understanding and acceptance. One of the areas of understanding that needs to be acquired by medical professionals is that transgendered people have a sex they were born with, but the gender for which they really identify, does not correspond with that sex. When transgendered people are "dressed" in their gender identifying clothing, physicians would do well to use appropriate pronouns and their chosen names to speak with or when referring to a transgendered person.

Alegria (2011), reports that only ten percent of nursing students were found to have a basic level of understanding on how to treat the LGBT community. Many of these nurses may go

on to become Advanced Nurse Practitioners and be the first line of evaluation and treatment for LGBT persons.

Unless physicians and other medical professionals are knowledgeable and culturally sensitive to this community of people, they will have difficulty with the physical evaluation and any psychosocial issues that may arise for these patients, which further complicates the care and treatment of LGBT people who are already maltreated, marginalized and discriminated against in society as a whole. Physicians or NP's taking sexual history from LGBT patients need to be more sensitive to the issues these people face. The use of inclusive language, clarifying limits of confidentiality, thorough evaluation of sexual risk and identifying patient concerns with the utmost respect and care while being careful to not make assumptions, goes a long way in providing respectful and appropriate care for the LGBT community (Group of Advancement of Psychiatry, 2012). Implications of a medical practice that lends itself to a warm, knowledgeable, non-discriminatory and safe environment will contribute to an efficacious practice with gay/ lesbian/bisexual and transgendered people (Alegria, 2011). The lack of such knowledge of this population further supports the idea of need for increased cultural education in medical school curriculums.

Children and Adolescents

Sensitive populations of interest in sexual health are children and adolescents. Increasing number of adolescents are having sexual experiences at an early age and for pediatricians or family doctors to not address these issues with young people is burying their heads in the sand. Are these physicians prepared educationally to talk to people in that age group about their sexual

issues including but not limited to, STI's/STD's, teen pregnancy, or sexual trauma and domestic or dating violence and sexual abuse?

Children do not often tell anyone about sexual abuse or physical abuse, and a physician's office may be a place to consider as a safe and objective environment for children to speak openly.

Tilson et.al (2004), suggest that STD's are a major health concern among young people and can lead to the spread of HIV. A few barriers to care for adolescents are lack of knowledge of STD's, and cost of care and health screening, which can preclude families from seeing a medical provider as necessary. Additionally, the relationship of substance use among teens is a key factor for sexual activity and the acquisition of STI/STD's. While parents should be the first line of education for teens, quite often teens do not listen to their parents or a more conservative household may preclude a conversation about sex. Teens may confer with peers, who may lack good information about sexually transmitted diseases. It is a necessity for physicians to address these issues with children ages twelve and up in office visits. Sexually transmitted diseases are not the only concerns for minors sexual health. Drs. Joe McIlhaney Jr. and Freda Bush are concerned about the effect sex has on the brain of children. They founded the Medical Institute for Sexual Health to study the science of human sexual behavior and its consequences. While they were previously concerned with non-marital pregnancy and STI's, they have with their book *Hooked (2008, introduction)* introduces the effect of sex on the brain of children. In this book they talk about the chemistry of the brain when children have sex and how it can mold the brain when seeking reward. In deference to real sexual intimacy, they are concerned that sexual activity early on, can damage the meaning of sex and lead to inability to enjoy intimacy going forward due to reward chemicals in the brain.

We know this to be true about the reward center of the brain and addiction.

This underscores the idea that pediatricians should be educating minors about consequences of sexual activity. In spite of obstacles such as conservative beliefs of parents or access to healthcare, minors do have rights in some states to seek medical treatment and consultation from qualified health care providers. The guidelines are as follows: teen pregnancy, any minor living apart from a parent and financially self-reliant, a victim of sexual assault or abuse, treatment for STD's or HIV testing, contraception and pre-natal care or abortion, mental health treatment, and alcohol and drug abuse (after age 12) (Hickey, 2007). Physicians, specifically pediatricians, are first line professionals to teach parents about healthy sex play of children as children develop. Physicians may not be equipped to give advanced education on the appropriate developmental stages of children.

Children do not often tell anyone about sexual abuse or physical abuse, and a physician's office may be a place to consider as a safe and objective environment for children to speak openly. Childhelp, founded in 1959, is a coalition for the prevention and treatment of child abuse. As of 2011, a report of child abuse is made every ten seconds, that abused children are twenty-five percent more likely to experience teen pregnancy, and more than ninety percent of juvenile sex abuse victims know their perpetrator. In 2011, they reported that 9.1 % of abused children were sexually abused and still they note that a child may experience multiple types of abuse or multiple instances of the same type of abuse (Childhelp, 2011). We do not know if medical schools prepare their pediatric medical students for receiving or getting this information from children.

The American Board of Pediatrics has developed an outline for a sub-speciality in training pediatricians on how to recognize this malady.

They include physical, sexual and psychological abuse as well as drug-endangered children (American Board of Pediatrics, 2010).

However, not every pediatrician will be trained or chose to be trained to this extent. Although helpful to have as a sub-speciality, coverage of this information must be obtained in medical school as parents will not seek out pediatricians who have a sub-speciality in child abuse.

While it is understood that adolescents face major challenges when transitioning from children to teens, LGBT youth face even greater challenges from their peers, parents and community. The coming out process may create further psychosocial stressors as well as the need to keep their secret. These stressors can lead to depression, alcohol and drug use, risky sexual behavior, and even suicide attempts without complete knowledge and information (Coker et.al., 2010). Medical students may be challenged with this population but should be prepared from their curriculum of adolescent medicine. Barriers to optimal care between physicians and LGBT youth are identified as physicians not asking sexual orientation or gender identity while taking a sexual history from a sexually active adolescent. It was reported that physicians would not ask about sexual orientation of adolescents presenting with depression, suicidal thoughts or had past suicidal attempts. In the same study, if an adolescent stated that he or she was not sexually active, forty-one percent of physicians reported that they would not ask additional sex-related questions. A majority of physicians stated they did not believe that they had all the skills they needed to address issues of sexual orientation with adolescents and that sexual orientation should be

addressed more often with these patients and in the course of training. It was not determined whether education was part of the assessment (Kitts, 2010).

Aging

The opposite end of the age spectrum includes late- in -life sexual health. There is limited research on sexuality in later life, but many of the samples include sexual concerns due to medical issues and not necessarily the psychosocial issues of aging, such as loss of a partner and therefore unavailability of a sexual partner, sexual desire, and importance of sex (DeLamater and Sill, 2005). Men and women over the age of fifty-seven are less likely to be sexually active if they have health problems. In a study of sexuality and health among older adults in the U.S., it was reported that while many older adults are sexually active, sexual problems are frequent and are rarely discussed with physicians (Lindau,et.al, 2007).

Barriers to seeking treatment for sexual problems by older patients may do more damage than preclude them from asking about sexual health. If older adults are embarrassed about asking their physician about sexual matters, and they are sexually active, they are more likely to contract STI's/STD's or HIV. If the patient perceives that their physician does not think they are having sex or that older adults do not have sex or that sex is unimportant to them, they are less likely to ask the questions they need answered (Got and Hinchliff, 2003).

> Research has identified significant barriers to discussing sexual problems in primary care consultations, including lack of time, limited availability to refer to secondary care, fears about "opening a flood gate," patient embarrassment, poor knowledge, and inadequate training and skills. (Gott and Hinchliff,2003).

The findings in the above study indicate that many older patients want to discuss sexual

health concerns with their physicians but felt unable to do so.

Cancer

While cancer is not always a life-threatening event, it can create psychological and emotional well-being issues. Cancer and the effects of treatment can effect the quality of a person's sex life. Often it can be diminished in the process of treatment or sex can be painful. Patients need to be prepared for what might befall them in this area. Oncologists are seen as seers of knowing in this area and should prepare their patients for the sexual side effects of cancer and its treatment. Due to the sensitive nature of this illness such as mortality issues, physicians can alleviate some of the anxiety of their patients by letting them know before treatment what they can expect and this includes sexual dysfunction or pain. According to Anne Katz in her article in the Journal of Clinical Oncology, (2005) certain cancers such as breast, testicular, prostate, cervical can have a direct effect on a patient's sexual functioning. She writes that a multinational European study found that twenty-three percent of men with prostate cancer had received literature related to sexuality, but forty-eight percent stated that sexual counseling would have been helpful.

Sexual cancers can erode a person's self-esteem especially if it affects their ability to perform as a sexual being. A study of women diagnosed with gynecologic cancer, revealed that after they received a manual about sex and cancer and were able to talk with a person who was qualified in nursing and psychology, the outcomes were as follows: ninety-four percent of women stated after the intervention, that they had a "clearer understanding of sexuality and cancer and seventeen percent wanted more information" (A.Katz,2005). Another needs assessment of seventy-three woman with gynecologic cancer attending follow-up care, found

that almost half of the participants received almost “little or no” information on sexuality and cancer.

> Preferred timing for information was after diagnosis but before treatment (23%) or after completion of treatment (39.5%). The women in this study preferred one on one discussion with a health care provider (60.3%) or a pamphlet (44.8%) to receive this information. Women recognize that lack of information plays a role in anxiety and fear (A.Katz, 2005).

In a study examining the impact of breast cancer therapy on women’s sexual health the following information was obtained: ninety percent of the subjects continued sexual activity after treatment, but they reported an increase in sexual dysfunction which resulted in a “slight reduction” in the quality of their sex lives. Sixty-four percent of the women reported an absence of sexual desire and forty-eight percent low sexual desire, while thirty-eight percent reported dysparenia, forty-four percent frigidity and forty-two percent lubrication problems. About half of the respondents reported experiencing changes in the relationship with their partner (Barni and Mondin, 1997). While the abstract did not mention the limitations of the study, one of the limitations could be that the questionnaire did not address reasons for the change in the relationship with their partner.

Information from these studies show that patients do have sexual iatrogenic effects from a diagnosis of cancer and/or its treatment. Further, the study states that many physicians do not talk to their patients about their sex practices and little education or counseling is given or offered. For the same reasons that any physician may be reluctant to ask their patients about sex, it exists in this population of patients as well. Physicians may not be comfortable, or feel it is beyond their scope of practice to initiate or educate their patients, but due to the overwhelming statistics,

patients want to know what to expect(Lindua,2013) Physicians taking the time to educate their patient on sexual health matters in cancer treatment may gain significant trust from the patient as well as show a physicians *softer side* and possibly glean better outcomes in the treatment of cancer.

If physicians are not well-equipped to talk about sex with their patients, no matter the age or population or health condition, they must be equipped to refer patients to secondary care by a qualified professional, specifically a Clinical Sexologist.

Clinical Sexologist

Clinical sexology is the systematic study of human sexuality which includes human sexual behavior, and it synthesizes that knowledge into a clinical practice with people AACS catalog, 2013-2014) .

> Sex therapy differs from other forms of treatment for sexual dysfunctions in two respects: first its goals are essentially limited to relief of the patient's sexual symptom and second, it departs from traditional techniques by employing a combination of prescribed sexual experiences and psychotherapy (Kaplan, 1974,187).

Helen Singer Kaplan and Masters and Johnson gave us the preeminent guidelines for treatment of sexual function problems and as clinical sex therapy has advanced, so has its treatment capabilities and outcome.

The role of sex therapy is to help people explore the nature and possible causes of their sexual concerns, better communicate their sexual needs and preferences, and expand their repertoire of sensual and sexual activities. The therapist may also serve as a sex educator as people age and can come to know what to expect in age-related cases or vaginal pain syndromes.

Understanding the physiological basis of the problem often goes a long way in quelling anxiety. (health.harvard.edu).

Because clinical sex therapist are already practicing therapists, they are the most skilled practitioners in helping people improve intimacy in their relationships. Many modalities of therapy are used to assist people in their sexual function problems or sexual compulsivity's such as hypnosis, and cognitive-behavioral therapy as well as EMDR and others (Araoz et.al.,2001), (Phill, 2013), (Cox and Howard, 2007).

A clinical sexologist is a person who is licensed in their state of practice in another field such as social work, clinical psychology and marriage and family therapy, to name a few, and who have met the requirements of study in the field of sexology. This is a post-graduate education and practice and can culminate in a Ph.D in Sexology after completion of 60 hours of class work on sexuality post masters, supervision, and a written scholarly dissertation and successful oral defense. The academic program at The American Academy of Clinical Sexology in Orlando, Fl teaches on topics such as: The Social Foundations of Sexology, Sexual and Reproductive Anatomy, Clinical Treatment of Male Sexual Dysfunctions, Clinical Treatment of Female Sexual Dysfunctions, Gender Identity Disorders, Paraphilias: Diagnosis and Treatment, Clinical Management of Sexual Trauma, Forensic Sexology, Sexology and the Law, Chronic Illness and Disability, Treatment of Juvenile Sexual Offenders, survey of Sexual Literature, Comparative Religion and Sexology. The program also consists of clinical supervision, dissertation proposal and research and dissertation research and defense (American Academy of Clinical Sexology Catalog, 2013-2014). Clinical sex therapy is the integration of a bio-psycho-social or integrated approach to treatment of sexual dsyfunction (Leiblum, 2007).

A clinical sexologist can practice in a clinic, private practice setting, or may teach Human sexuality in an academic setting as well as work in public health to set sexual health policy and guidelines for places such as the Center for Disease Control, as well as becoming involved in sex research.

Where did the idea of a practice in sexology originate and why is this a needed modality for treatment?

Brief History of Sexology

Human Sexuality has been documented back to the Stone Age through cave paintings and phallic sculptures (Fankhanel, 2008). Hippocrates, Plato and Aristotle were claimed to be the forefathers of sexology. According to the Kinsey Institute, Greek physicians established the advanced study of ancient sexology. The work of the Greeks were followed by Europeans who translated the Arabic into readable texts to use in medical schools in the sixteenth, seventeenth and eighteenth centuries, respectively. Sexual study moved to the nineteenth century to the fathers of sexology that we know today to be Havelock Ellis, Iwan Bloch, Magnus Hirschfeld, Kraft-Ebbing, Sigmund Freud, and others. Most of these men were physicians (Haeberle in text Kinsey Institute, 1983). Richard von Kraft-Ebing's principal work was the *Psychopathia Sexualis* and first published in 1886. His introductory work was a collection of case studies that introduced many new psychiatric terms such as sadism and masochisim. This introduction to sexuality during the time of the Victorian Era strengthens the narrow concept of sexual propriety and what is *normal.* Sexual Victorianism was accompanied by a concern with eliminating abnormal sexual behaviors, perversions and deviations (Granzig, 2012, 6).

Pschopathia Sexulis was the first book published about sex practices that studied

homosexuality/bisexuality. Kraft-Ebing proposed that sex was for procreation, and because homosexual practice could not result in procreation, it was considered a sexual perversion. (Fankhenal, AACS class notes 2013). The term homosexuality was coined by Kentbeny in 1869, who asserted it was both normal and healthy. Havelock Ellis and Magnus Hirschfeld challenged the notion that homosexual behavior was deviant (Granzig, class notes 2012).

Havelock Ellis went on to publish works on the *Psychology of Sex, Sex and Marriage, Little Essays on Love and Virtue,* among others (Women's Health collection, marriage sexuality and birth control 1918-1950).

Magnus Hirschfeld was known for establishing the Institute for Sexology in 1913 in Berlin, and it operated until the Nazis destroyed the articles and annuals he had developed, collected and written which were about homosexuality and transvestism (Einstein of Sex Video,) Introduction of clinical sexology as a profession in the U.S. began in the twentieth century with Margaret Sanger, John Money, Alfred Kinsey, Helen Singer Kaplan, and William Masters and Virginia Johnson (Granzig, 2012).

Most people today are familiar with Kinsey due to his sexual surveys, and Masters and Johnson who did research in the 1950's concerning sexual arousal with real subjects. As a professor of the University of Indiana, Alfred Kinsey taught marriage courses and gathered information through surveys on sexual behaviors. Kinsey and staff collected over 18,000 interviews, according to the Kinsey Institute. He published *Sexual Behavior in the Human Male* in 1948 and the *Sexual Behavior in the Human Female* in 1953 from the aforementioned studies. Kinsey is also known for his development of the Seven Point Scale of Sexuality.

The scale begins with “0” meaning exclusively heterosexual behavior and it is graduated and ending with the number “6” meaning exclusively homosexual behavior (Granzig, class notes, 2012) .

Masters and Johnson followed in the 1950‘s with their groundbreaking research with singles and couples on the rate of climax as well as a development of the phases of climax and further studied couples with sexual problems (Masters and Johnson, 1970). They were the first to take personal sex histories of their research subjects to glean information for baseline diagnosis and subsequent treatment. From their research they developed sex therapy as a practice through use of dyad therapists for couples, using one male therapist and one female therapist. They further developed a tool for use with couples with low sexual desire and other maladies called sensate focus. Their landmark book *Human Sexual Inadequacy* first published in 1970, was written from their research in the 1950’s. William Masters was a medical doctor and a pioneer in sexual health medicine, which further validates the need for medical doctors, primary care, and others to develop a sexual health assessment in their practice for their patients or to use one mentioned earlier in this text.

Sexual Dysfunctions/Disorders

The American Psychiatric Association is the author of the Diagnostic and Statistical Manual of Mental Disorders. The APA first developed this manual for mental health diagnosis with the first manual dating back to 1952. It continues today with the publication of the DSM-5, published in May 2013. Sexual Dysfunctions, Gender Dysphoria as well as Paraphilic Disorders are included in the manual.

Sexual Dysfunctions: categorized as clinically significant disturbance in an individual's ability to respond sexually or to experience sexual pleasure. An individual can have more than one sexual dysfunction at a time (DSM-5 2013).

The DSM-5 notes that a diagnosis of sexual dysfunction should not be made if the individual experiences lack of sexual stimulation.

There may be a need for care, but may not warrant a diagnosis of a sexual dysfunction. Also, it may depends on patient perceptions and needs as to whether there will be treatment.

All of the sexual dysfunctions, have subtype categorizations. Generalized subtypes refer to the fact that the dysfunction is not limited to certain types of stimulation, situation or partner issues.

Situational subtypes only occur with certain types of stimulation, situations or partners. Lifelong problems are defined as being with the individual since they have been sexually active. Acquired problems are defined as a disturbance beginning after a period of relatively normal sexual function. The severity of the dysfunction is also necessary to note. They are classified as mild, moderate and severe (DSM-5, 423).

✦Delayed Ejaculation-a marked delay, marked infrequency or an absence of ejaculation (DSM-5,423).

✦Erectile Disorder-marked difficulty in obtaining or maintaining an erection during sexual intercourse, and/a marked rigidity. This disorder has the same specifications as delayed ejaculation (DSM-5 426).

✦Female Orgasmic Disorder -marked delay in, marked infrequency or, or absence of orgasm, or markedly reduction in intensity of orgasmic sensations (DSM-5, 429).

✦Female sexual Interest/Arousal Disorder -lack of, or significantly reduced, sexual interest/ arousal, as manifested by at least three of the following: 1) absent/reduced interest in sexual activity, 2) absent/reduced sexual/erotic thoughts or fantasies, 3) no/reduced initiation of sexual activity, and typically unreceptive to a partner's attempts to initiate, 4) absent/reduced sexual excitement/pleasure during sexual activity in almost all or all (approximately 75-00%) sexual encounters, 5)absent/reduced sexual interest/arousal in response to any internal or external sexual/erotic cues (written,verbal or visual), 6) absent/reduced genital or non-genital sensations during sexual activity in almost all or all (approximately 75-100%) sexual encounters (DSM-5, 433).

✦Genito-Pelvic/Penetration Disorder (formally known as Vaginismus/Dysparenia-persistent or recurrent difficulties with one or more of the following: 1)vaginal penetration during intercourse, 2)marked vulvovaginal or pelvic pain during vaginal intercourse or penetration attempts, 3)marked fear or anxiety about vulvoaginal or pelvic pain in anticipation of, during or as a result of vaginal penetration, 4) marked tensing or tightening of the pelvic floor muscles during attempted vaginal penetration (DSM-5 ,437).

✦Male Hypoactive Sexual Desire Disorder -persistently or recurrently deficient or absent sexual/ erotic thoughts or fantasies and desire for sexual activity. Most persist for more than six months (DSM-5, 440).

✦Premature (Early) Ejaculation-a persistent or recurrent pattern of ejaculation occurring during partnered sexual activity within approximately one minute following vaginal penetration and before the individual wishes (DSM-5,443).

✦Substance/Medication-Induced Sexual Dysfunction-a clinically signifiant disturbance in sexual function is predominant in clinical picture and the symptom develop during or soon after substance intoxication or withdrawal or after exposure to a medication and the substance/ medication is capable of producing the symptoms (DSM-5, 446).

Gender Dysphora-refers to the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender (DSM-5, 451).

✦Gender dysphoria in Children -a marked incongruence between one's experienced/expressed gender and assigned gender of at least 6 month's duration as manifested by at least six of the following. 1) a strong desire to be of the other gender or an insistence that one is the other gender. 2)in boys, a strong preference for cross-dressing or simulating female attire; or in girls a strong preference for wearing only typical masculine clothes and a strong resistance to the wearing of typical feminine clothing. 3) a strong preference for cross-gender roles in make-believe play or fantasy play.4) a strong preference for the toys, games or activities stereotypically used or engaged in by the other gender. 5) a strong preference for playmates of the other gender. 6) in boys, a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls a strong rejection of typically feminine toys, games and activities,7) a strong dislike of one's sexual anatomy, 8) a strong desire for the primary and/or secondary sex characteristics that match one's experienced gender (DSM-5,452).

✦Gender Dysphoria in Adolescents and Adults-a marked incongruence between one's experienced/expressed gender and primary/and/or secondary sex characteristics, of at least 6 months' duration, as manifested by at least two of the following:1) a marked incongruence between one's experienced/expressed gender, and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics), 2) a strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics), 3) a strong desire for the primary and/or secondary sex characteristics of the other gender, 4) a strong desire to be of the other gender)a strong desire to be treated as the other gender, 6)a strong conviction that one has the typical feelings and reactions of the other gender (DSM-5, 452).

✦Other Specified Gender Dysphoria -this category applies to symptoms of the disorder which are significant but does not meet the full criteria for gender dysphoria (DSM-5, 459).

✦Unspecified Gender Dysphoria -this category applies to symptoms of gender dysphoria that causes significant distress or impairment in social, occupational, or other important areas of functioning but do not meet the full criteria for gender dysphoria (DSM-5, 459).

Paraphilic Disorders-the term paraphilia denotes any intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory, fondling with phenotypically normal, physically mature, consenting human partners. A disorder of this type is noted as currently causing distress or impairment to the individual or a paraphilia whose satisfaction has entailed personal harm, or risk or harm, to others. Important to note is that a paraphilia by it self is not

sufficient condition to diagnosed as a paraphilic disorder. A paraphilia by itself does not necessarily justify or require clinical intervention (DSM-5, 685-686).

✦Voyeuristic Disorder-over a period of at least six months, recurrent and intense sexual arousal from observing an unsuspecting person who is naked, in the process of disrobing, or engaging in sexual acting, as manifested by fantasies, urges or behaviors and the individual has acted on these sexual urges with a non-consenting person, or the sexual urges or fantasies cause clinically significant distress or impairment in social, occupation, or other import areas of functioning. The individual experiencing the arousal and/or acting on the urges is at least 18 years of age (DSM-5, 687).

✦Exhibitionistic Disorder-over a period of at least six months and intense sexual arousal from the exposure of one's genitals to an unsuspecting person, as manifested by fantasies, urges or behaviors. Also. the individual has acted on these sexual urges with a non-consenting person, or the sexual urges or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (DSM-5, 689).

✦Frotteuristic Disorder-over a period of at least six months, recurrent and intense sexual arousal from touching rubbing against a non-consenting person, as manifested by fantasies, urges or behaviors. The individual has acted on these sexual urges with a non-consenting person, or the sexual urges or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning(DSM-5, 691).

✦Sexual Masochism Disorder-over a period of at least six months, recurrent and intense sexual arousal from the act of being humiliated, beaten, bound, or otherwise made to suffer, as manifested by fantasies, urges, or behaviors. The fantasies, sexual urges, or behaviors cause

clinically significant distress or impairment in social, occupation, or other important areas of functioning (DSM-5, 694).

✦Sexual Sadism Disorder -over a period of at least six months, recurrent and intense sexual arousal from the physical or psychological suffering of another person, as manifested by fantasies, urges or behaviors. The individual has acted on these sexual urges with a non-consenting person, or the sexual urges or fantasies cause clinically significant distress or in social. occupation, or other important areas of functioning (DSM-5, 695).

✦Pedophilic Disorder-over a period of at least six months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child or children (generally age 13 years or younger). The individual has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty. The individual is at least age 16 years and at least 5 years older than the children in the above criteria (DSM-5, 697).

✦Fetishistic Disorder-over a period of at least six months, recurrent and intense sexual arousal from either the use of nonliving objects or a highly specific focus on non-genital body parts as manifested by fantasies, urges or behaviors. The fantasies,sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational or other important areas of functioning. The fetish objects are not limited to articles of clothing used in cross-dressing or devices specifically designed for the purpose of tactile genital stimulations(DSM-5, 700).

✦Transvestic Disorder -over a period of at least six months, recurrent and intense sexual arousal from cross-dressing as manifested by fantasies, urges or behaviors.The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other areas of functioning (DSM-5,702).

✦Other specified Paraphilic Disorder-this category applies to presentation in which symptoms characteristic of a paraphilic disorder that cause clinically significant distress or impairment in social, occupational or other import areas of functioning predominate but do not meet the full criteria for any of the disorders in the paraphilia disorders diagnostic class (DSM-5, 705).

✦Unspecified Paraphilic Disorder-this category applies to presentation in which symptoms characteristic of a paraphilic disorder that cause clinically significant distress or impairment in social, occupational or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the paraphilic disorders diagnostic class. This diagnosis is used when the clinician choses not to specify the reason that the criteria are not met for a specific paraphilic disorder, and includes presentations in which there is insufficient information to make a more specific diagnosis(DSM-5, 705).

Summary

Due to the large representation of sexual disorders in a vast number of populations as well as dysphorias and paraphilias, it validates the need for specialized treatment and physicians to recognize when there are problems, and refer to the specialist as they would when referring to a cardiologist who treats disease of the cardiovascular system.

In order for a physician to recognize the problems that are beyond the scope of their practice, they will need to engage in sexual health assessments with their patients.

CHAPTER 3

METHODOLOGY

This chapter will consist of a mixed-method design consisting of a pilot study with a

5-point Likert scale, demographic questions and short answer. An interview which will detail descriptive attributions to the hypothesis that physicians lack training in sexual health and the impact on patient welfare was also included in the methodology. This study will help delineate the need and development of a new paradigm for improvement.

Research Design and Sample

A self-administered survey was developed by this author who also submitted it to the Dissertation Committee for approval. Two persons from the committee made changes and recommendation and the final product was approved.

The study was one and half pages in length and consisted of eighteen questions. The survey consisted of questions a 5-point Likert scale with the answers ranging from *never, rarely, sometimes, often and very often.* They were assigned number one-five. Other questions included demographic information but no identifying information. Other questions consisted of short answers.

An informed consent page was given to the participants. The survey was strictly voluntary. No incentives were offered.

Surveys were only addressed to participants over 18 years of age.

Participants had access to the survey in two private psychiatric offices; one in Largo Fl and one in St. Petersburg, Fl. The survey was accessible in the lobby of each office. The participants were patients of the office and family members.

A secure box was placed next to the survey with signage asking participants to place the completed survey inside. The author was the only person who had access to the completed

surveys.Surveys were collected everyday by this author. Only completed surveys were used to determine the outcome. All other surveys were shredded.

The survey was processed by hand due to the expense of statistical program services. Also included in the methodology section was a professional interview with Carey Roth Bayer, Ph.D. RN, an assistant professor at Morehouse School of Medicine.

The interview was conducted by phone as Dr. Bayer was in Atlanta and this author was in Florida. The interview took approximately thirty-five minutes.

Ethical Considerations

This study was only offered to voluntary participants 18 years of age and older. Participants were given an explanation of the survey in the informed consent page.

When selecting questions for the survey, graphic, or inappropriate language was not used. No questions were used to elicit information that would cause concern of an abreaction from participants.

At the end of the survey the author made a statement that allowed participants to have a discussion or a private personal session of therapy if needed as a result of participating in the survey.

Assumptions, Limitations and Delimitations

1. It is assumed that the participants of the study were truthful in their answers.
2. It is assumed that the participants believed the survey was voluntary.
3. It is assumed that the participants understood the questions in the survey.
4. A limitation of the survey was that the sample was small and it cannot be assumed that the outcome would be the same or similar in a larger sample.

5. The participants were patients or family members of patients of a private psychiatric group. Therefore the sample was of convenience rather than random.The participants were in this setting to either receive therapy or psychiatric medication assessment or medication check, or were there accompany their family members.

6. A limitation of this study was that the surveys were available for only three weeks.

7. The survey was limited by Likert scale questions and one word answers and had few qualifying questions for the participants, therefore Chapter 5 will be limited to speculation by the author of this study.

8. The delimitation of this study was the hypothesis that physicians are not adequately trained in sexual health matters and the survey was developed with that hypothesis in mind. An interview with a professor of sexual health in a medical school was also included.

More on limitations

While this researcher attempted to have both the survey and the interview be of equal import and impact in the question researched, the survey due to its nature of more personal questions to the voluntary participants, the researcher cannot equivocally state that the answers to the survey will glean and absolute concurrence with the hypothesis that medical students lack the medical education to assess and treat sexual health issues of their patients. However, the interview with an assistant professor who has made a career in sexual health education and works at a college of medicine can assume this information received is accurate and can answer the research question with greater certainty. Further study could include a physician-based survey, assuming the physicians would answer candidly to glean the most accurate data needed

to speak to the hypothesis and assuming the most pertinent questions would be asked on the survey.

The goal of using a mixed-method approach was to draw on the strengths of each method, qualitative and quantitative, to capture a clearer understanding of the hypothesis and outcome that one may not have been able to incapsulate with one approach or the other.

Summary

This chapter consists of the methodology that was used to show the problem that medical students lack the training to move into patient care in the realm of sexual health.
The next chapter will breakdown the statistics of the aforementioned, by providing the survey outcome and as well as the narrative interview.

CHAPTER 4

The purpose of this mixed method study was to explore the hypothesis that medical students are not prepared to move into patient care in the realm of sexual health. This researcher believes that a better understanding and knowledge of this phenomenon would allow educators to proceed from a more informed perspective with regard to need for a comprehensive curriculum on sexual health, patient assessment and further understanding of integrated approach to treatment.

This chapter presents the key findings from a three week survey accessed by volunteer respondents in a mental health private practice as well as an interview by a sexual health educator in a private medical college.

Profile of Participants

Total applicable sample N=73. Ten surveys were disqualified as they were not complete. Forty-nine woman answered the survey in its entirety and twenty-four men answered the survey in its entirety.

The ages ranged from 18-76. The most frequent value in age range was (51-60yrs) the least frequent was (76+) with one answer.

Men

Eight men that answered the survey were married and eight were single. One respondent was widowed. Four men had domestic partners and three were dating. Eighteen men identified as heterosexual and five identified as homosexual. One man identified as bisexual.

Thirteen of twenty-four men (54%) reported to have male physicians and ten reported to have female physicians. One reported an N/A answer. Sixty-seven percent of the men stated their doctors did not ask them about their sexual health. Thirty-three percent stated doctors did ask about sexual health. Twelve men (50%) asked their physicians about their sexual health and twelve did not. Nine of the men (38%) reported they received a satisfactory answer and five (21%) did not. All others did not answer. Six men felt uncomfortable asking their physicians sexual health questions and six felt they had no need. Ten men answered *N/A* and two men answered *other.*

Men in the 51-60 age range reported more trouble with libido issues with a report of six affirmative answers or twenty-five percent. Only three out of twenty-four stated they never had trouble with their libido.

Fifteen of twenty-four men reported issues with erection at sometime in their lives. Most of the men who reported erectile issues in some form were between the ages of 61-75. Men 61-75 also reported the most difficulty with premature ejaculation with a total number of five out of twenty-four. Less than half of the men (nine) reported out of control sexual behaviors at some time in their lives. Thirteen of twenty-four (54%) men reported that the *spark* has gone out of their sex lives. Only four of twenty-four men responded negatively to seeing a sex therapist.

Twenty of twenty-four (83%) of the men reported affirmatively to seeing a sex therapist if they needed to.

Women

Forty-nine women (50 % more than men) answered the survey. The most frequent age range per respondent was 51-60. Seventeen of forty-eight women were reported to be single and twelve reported they were married. Forty-four women (92%) reported they were heterosexual and one did not answer, one reported to be bisexual and two reported to be homosexual.

Twenty women (42%) reported to have female only physicians and eleven women (23%) reported to have male physicians and three women (6%) reported they have both a male and a female physician.

Two women reported that they *do not know* if their physician asked them about their sexual health. Twenty-three of forty-eight women (48%) reported their physicians *did not* ask them about their sexual health. Nine (19%) reported their physicians *did ask* about their sexual health. Twenty-three women reported that they have asked their physician about their sexual health and fifteen said the answers they received were satisfactory. One did not answer. Twenty-five women did not ask their physicians any sexual health questions. The majority of women

that did ask their physicians sexual health questions felt their physician gave them a satisfactory answer.

Twenty-seven women in the survey *did not feel like they needed to* ask their physicians sexual health questions. Seven women stated they felt *uncomfortable* doing so.

Eight women reported they *rarely* have involuntary spasms of the vagina.

Two women reported *sometimes* having vaginal spasms, one women *often* and one women *very often*.

Four women did not answer the question and the remainder stated they never had spasms of the vagina.

In reference to painful intercourse, two women did not answer. These were the same two women who did not answer the previous question. Almost 44% of the women answering this question stated they *never* had painful intercourse. Twenty-seven percent stated they had rare occurrences of painful intercourse. 12.5 percent reported they *sometimes* have painful intercourse. Five women reported that their sexual intercourse has *often* been painful and two women reported they had painful intercourse *very often*.

Ten women reported to have *never* had any libido issues. Twelve women reported to *rarely* having these issues. Nine women reported to *sometimes* have issues with their libido. Eight women report libido issues *often* and nine report having these issues *very often*.

Ten women, approximately 21% reported they had felt at sometime in their lives that they *had sexual compulsive behaviors or were out of control sexually.* Thirty-sex women(75%) did not and two did not answer.

Thirty-one women or 65% of the women that answered reported to have experienced the *spark* going out of their sexual relationship. One women did not answer and sixteen women or 33% reported the *spark* had not gone out of their sex life.

When queried about seeing a sex therapist if they needed to do so, one woman deferred her answer.

Twenty-two women (46%) said they would see a sex therapist if they needed to do so and the remainder said they would not.

Some of the reasons they gave for not being willing to see a sex therapist were:

"past menopause"

" I think we put too much emphasis on sex"

" age"

"Just at a point in my life when I am OK with very little sex-too old. (physical issues), and comfortable with husband"

"Not interested"

"Don't feel the need"

<u>Interview with Carey Roth Bayer, Ed.D, RN, Assistant Professor Morehouse School of Medicine</u>

Bayer: Morehouse School of Medicine this is Dr. Bayer

Renee: Hello Dr Bayer, this is Renee Michaels calling.

Bayer: Heh Renee. How are you?

Renee: Very well thank you. For full disclosure you are on speaker phone and I am recording you on Garage Band as I will not remember everything you say. (Laughter) Thank you very much for your time today. I will make this quick as possible.

Bayer: (laughs) No problem.

Renee: Why don't we just get started. Can you give me a little synopsis of your credentials?

Bayer: Sure. but before I jump in, tell me a little bit about your dissertation. The questions that you sent me scan quite bit of material, I want to make sure I am giving you the information you need for your dissertation.

Renee: Okay, the title of my dissertation is Doctor in my bedroom: Physicians lack of sexual health education, its effects on patient population and the development of a new paradigm. I am questioning whether medical students or physicians have received enough education in their medical school curriculum to either assess sexual health function or dysfunction and dysphoria and if they don't why aren't they (laughter). Actually, I am covering quite a bit. I am covering a little health policy because I believe that it informs us as human beings whether we have a sexual health policy, whether or not we are actually doing anything with that sexual health policy to educate the public.

Bayer: Okay that gives me a little better context to help you with your questions.

Renee: Fantastic.

Bayer: So, about my credentials. My bachelors is in science of nursing and I practiced clinically in pediatrics before I went on to get my masters in adult education and my doctorate in human sexuality education. After my clinical practice at Cincinnati Children's Hospital, I moved to Philadelphia and worked at the Children's Hospital of Philadelphia. I practiced there clinically before I went on to do five years of clinical research. I did my dissertation work on nurses perceptions on sexuality addressing concerns in a flexible and comfortable way
in a pediatric intensive care unit. From there, I went on to finish my doctorate and from there, I joined Morehouse School of Medicine where I have been the last seven years now and originally I came here to build a sexual scholars program but all of my time here I have been teaching across multiple audiences and my career currently is really focused on the intersection of sexuality education and health professional education. I am a Certified Sexuality Educator through AASECT and also sit on the board of the society of Scientific Study of Human Sexuality.

Renee:Where did you receive your Ed.D in Human Sexuality?

Bayer: Widner University in Chester Penn

Renee:Ok very good. Any thoughts or questions before I begin asking you these questions?

Bayer: Well, what I will say is in some of your questions and I don't know whether you have gone thru lit review yet ,but I would be glad to send you our curriculum from 2009, that has a

good summary of history of programs particularly in med schools and I have been working with Eli Goldman and a number of institutions. We convened a summit and there is a paper out in the of sexual medicine on kinda the current day scope of hours of sex ed and med-ed and I would think those would be helpful in the work you are doing.

Renee: Anything you think would be helpful would be appreciated. So do you think that physicians or first line NP should be taking sexual assessments of their patients?

Bayer: I do. I mean I think that across the… this is my bias, my career is in sexuality. (Laughter) As a health professional, there is a level of bias there but I do think that whoever comes in be it a nurse or a technician or NP or a PA or physician my dream is there would be a day where sexuality is seen as a normal part of a human being and it is not just seen as disease, disaster and dysfunction. Then all of those folks across the team would be comfortable addressing that. That is also not just penetrative behaviors. It is things like body image, self-esteem and healthy relationships so there is this tie to bio-psycho-social construct to sexuality rather than anatomy and behaviors.

Renee: Do you feel that physicians and NP are adequately trained to assess sexual health overall today?

Bayer: No, and that is where..I will send you the curriculum and JSA article that will help with that question. Particularly for physician, the average number of content is maybe 8 hours of sexuality across the 4 yr curriculum. We know that is not enough time. A part of it is having facility trained and having it ingrained as part of a curriculum.

Umm, we are seeing a push on updating gender identity and sexual orientation particularly around LGBT health with the release of the Institute of Medicine Report umm… with some of the sexual health policy pieces we are seeing changes around marriage rights, equal opportunity employment So, I think there has been some ground swell around LGBT health. umm… I work on a committee with the American Association Medical Colleges, and we recently released competencies on health around gender identity and sexual orientation pieces, like is raising the dialogue, but wouldn't say thus far we have presented any health mandate that physicians or NP walk out of their training program with meeting a certain level of knowledge skills and attitudes.

Renee: What I am finding in the research is that there is quite a bit of research on how we need to improve sexual health policy, for instance the LGBT field report of 2011, but I am not getting the connection or bridge between theory and practice. Do you get the same feeling?

Bayer:I do. Also there is a divide in LGBT sexual health in a sense they are fighting to appear to be valued and recognized in curricula. That filed that body of work, not necessarily linking the broader human sexuality picture. Just because there has been a lobby for recognition, that LGBT folks still have you know sexuality needs. It does not define who they are, but the potential is still there. I am not seeing the bridge being made particularly for LGBT individuals whether that

is breast screening cervical screening, you know…different medical screenings that are not necessarily tied to healthy relationships.

Renee: Right. And I am seeing across that board not just LGBTpeople. Where is the practice in sexual health across the board? You know what I mean?

Bayer: Yeah, I do. I mean I think where I am seeing it is… I teach across all four years of our medical school and where things kinda come into practice is through simulation labs, through opportunities where medical students actually have to practice taking sexual histories and working with standardized patients which I think it is just one small piece about asking questions like, "do you have sex with men women or both"? And obviously a very limited definition of sexuality. But if patients can walk out that some facility or some content has touched them in their medical experience umm… some medical schools are doing it thru sex week for one week they bring in different topic and speakers but how much that translates to people taking sexual histories, I am not entirely sure.

Renee: Do you think that most med schools have a person like you doing education across the board or do they…have physicians doing it?

BAyer: I mean, I would gather to say I am an aberration (Renee laughs). I think if we had to guess kinda what is being done is in the lit about 8 hours, it is primarily being done by MD's and it is probably going to come up in OB/GYN maybe just by the nature of the work that is being done. They will all follow that and will probably talk some about STD'S and about contraception. That content is usually being taught by physicians. It may be someone who believes in the role that human sexuality plays for patients. At any institution, you have to have a champion. And it has to be a champion who is willing to go to the curriculum committee and make the case as to why there should be more content.

Renee: Someone like David Satcher?

Bayer: Yeah, I mean, Dr Satcher here at Morehouse School of Medicine by releasing the *Call to Action,* and then once he came out of office to Morehouse School of Medicine, we were funded initially to build a center for sexual health program and a Center for Excellence in Sexual Health. But, I would say, yes his presence here has raised the level of awareness around sexuality umm… it has also been that we have held events here at Morehouse. We had a White House conference on LGBT and HIV. We just held the symposium on gender and sexuality. It is very helpful to have him here and the work that he has done here. As far as influencing the medical school curriculum, that has really been driven by me and other colleagues. We did that by going to the curriculum committee and saying, " heh, who is teaching this, what do you think if we come in and do more"? So, for instance one of my colleagues who had a variety of electives in pediatrics, just recently turned over the sexuality elective over to me so I have kinda reshaped that.You know you have to have champions in institutions who value it, because you are always competing for time in a curricula and often times it is driven by whatever the latest competencies

and standards are. We just… we went through a re-acredidation and one of the things that came out in the process was a need for more inclusive, equity and diversity committee, so that was formed. That was another opportunity to bring awareness around sexuality. Umm, so I think it is taking those types of opportunities. We recently just had a post-doc who was heard in our health policy program.
He helped us propel the change in equal opportunity in our employment statement to include gender identity and gender expression. So, I think it is about having champions who are willing to be professionally persistent and not let something drop.

Renee: Agreed. Umm..back to question of sexual curriculum in medical schools. Johns Hopkins has a sexual treatment unit where they treat children adolescents and adults, do you think most medical schools have something like that?

Bayer: No. You are gonna find different med schools that are affiliated with hospital systems some may have clinics or see certain types of patients umm.. there is Fenway Health Center in Boston who does a lot of work around LGBT House. Usually the way, or at least the way our med school works is, we are a school in and of ourselves and we have relationships with hospital systems in order for our students to do their clinical rotations and practice umm...but I would not say that every med school has its' own sexuality center where they can see patients. Our students are seeing different aspects of sexuality across clinical rotations, so they might see patients in their psychiatric rotation, internal or family medicine and pediatric rotations. They might see some in ob/gyn, depending on what the focus area is, but I think there is a case here and there. Nothing routine.

Renee: Ok. Moving on to question 6. You have answered the question if you think med students are adequately trained but What do you think stands in the way of physicians asking patients about their sexual health?

Bayer: So, I think some of the barriers are the way on how sexuality has been framed.
And if it were framed in more of an essential aspect of health and well-being
instead of a umm… you know… a private issue that shouldn't be addressed. I think the framing piece is one of the aspects. I think that the competition for time in a curriculum is another aspect. And I think it has been this perpetual cycle of unless you are in an institution that values sexuality then you are not going to get it.

Renee: How much do you think managed care as far as time limits and things of that nature play a part in why physicians do not ask their patients about their sexual health?

Bayer: You know that always get tossed up-the time area- again, I think it depends on speciality area because if you don't value it, you are not going to address it. I think if there are questions on intake forms or sexual history forms then it is more easily done. But sometimes I think it is used as an excuse. At sometimes it is the reality.

Renee: Ok. I want to know more about pediatrics and sexuality. I think pediatricians see children as children and starting at God knows what age, children are having sex or at least some form of sexual experimentation. What is the fine line of pediatricians, as far as the legalities, as far as asking about sexual contact or sexual abuse? Do you have information on that?

Bayer: I mean I would look at the American Academy of Pediatrics. They have been pretty progressive in umm… in how they view, recommend addressing sexuality. Whether or not individual pediatricians take that information and use it, that is another story. Just antidotally, I have a seven year old and when we went for a five year check up, we were given a sheet on what to look for developmentally as far as sexuality goes, things like masturbation and what behaviors are normal for this age, but my pediatrician never discussed it. I think we are probably seeing a little more, then again it may depend on geographic location, and community culture and climate as to what values are in play. They have brochures in the office around HPV vaccine, so there is more information out there aimed at how they are addressing violence, or inappropriate touch or abuse. Those are things that will generally come out on clinical exams. Assessment wise, through my lens of the pediatric world in Ohio and Philidelphia and here in Georgia, pediatricians are trained to see sexuality as a part of normal development but it does not mean they are comfortable or they maybe a little more likely to have it on the radar for developmentally milestones as in puberty.

Renee: Instead of sexual activity?

Bayer: Right. And some of it too depends on family-how they handle family presence whether they ask parents to stay and have conversations around boyfriends/girlfriends, behavior, etc.

Renee: Okay. I would like to move to number 10 to a more global topic. What is the status on sexual health policy on in the US today?

Bayer: ah..I guess I would say it depends on how you define sexual health policy.
There are lots and lots of policies right now that are effecting sexual health and because my lens of sexual health is beyond disease disaster and dysfunction, the right to marry, affordable care act and providing access to healthcare impacts how people get treated and seek healthcare. There is still debate on abortion, and abstinence. I think these are things that are being talked about in policy in the US.

Renee: How do you think we parlay what is in sexual health policy into real practice inside communities? Educating people inside their own communities. How can we do that?

Bayer: You know, I don't know if we are going to get to a day-we have done some work with CDC and where the topic gets always held up is what role does the government play in the bedroom and in people's sexuality.

Renee: Well..(laughter) what about STD/STI's. I mean I think that is important because in fact it does run up the rate of insurance and the budget, teen pregnancy, unintended pregnancy, unwanted pregnancy. I mean those things we need to look at inside our communities whether the government wants to or not. The government as you pointed out is now getting involved with healthcare with the Affordable Care Act so why not prevention and education? Sometimes not having the education can lead to tertiary and expensive responses not to mention hazards to self-esteem and to other people to whom these infected people come in contact.

Bayer: Yeah. The bridge is not always made to the statistics. But I think that until we are in a space where sexuality is viewed as a normal part of health, until there is an adoption across organizations on how sexual health should be viewed and addressed
-there has to be some systematic change towards value to be put at the top of the priority list, for medical professionals to address it. You asked a question about medical boards, we have gone that route. We tried to go that route. Is there a way to get more sexuality content on licensing exams? If that is the case that gives impetus to change curricula to meet the needs of the physicians going in for their boards. It is a hard process to influence.

Renee: (laughter) I am sure it is. Moving on to Clinical Sexologist. What can clinical sexologist do to increase understanding by medical professionals of and use of our services?

Bayer: Sex therapist have to make themselves known to the medical community. A lot of the problem is we tend to preach to the choir. It is easier to present at an ASSECT conference than it is to go to AAMC or a conference in the various medical professions. I think therapist, sex therapists have to work on building bridges whether it is in the community in which you work, call up your local practitioners and this is who I am this is how I can be of benefit. Whether in fact is going in to clinics and doctor offices and doing some education.

I have a colleague who has done lots of outreach to medical schools and different practices to make sexuality better known. It is not something you go to in medical training and hear about. The information is very limited. You certainly are not going to know there are people who are specifically trained. Unless you are a psychiatrist and you know the DSM-5 inside and out, they you are not necessarily going to address sexuality, treat it or recognize it and may not be aware that there are sex therapist to help move that forward. I would say it is about doing the ground work and building the bridges in the local community, making presentations at nursing and medical conferences so that the profession as a whole gets seen and valued.
And I think there is a level of credibility about certification. I am a certified sexuality educator. I think it is about the work that is done rather than the piece of paper. The things that hang on the wall. (laughter).
In my opinion, it is about what kind of work you want to do in the realm of sexual health and see how that parlays into the piece of paper and what the paper on the wall and what it will allow

you to do. I don't know that necessarily that a doctorate in human sexuality is always the path for everyone.

There is a clinical track in Widener's program.

People can present with a masters degree and verification and be involved in that academic discourse without doctoral degrees. One thing I will tell you that degrees from accredited programs can make a difference. Again it depends. If you are not interested in being in academic institutions then accredited degrees don't matter, or as much. But I have seen over and over, people who have gotten doctorate degrees from non-accredited programs that are not able to make headway in academic institutions. One of my students that has graduated from your program has done a lot in her community and went on to start her own practice and she does a lot of events in the community and holds retreats and clinically she has been able to grow in leadership in professional sexuality organizations, but she will be limited if she decides she wants to go in to an academic setting because her degree is not accredited.

Renee: I understand. And it sounds like she has been successful on her own and not depended on the program.

Bayer: Absolutely. She has a thriving practice. You got to take that back and say, "where do I want to go, what am I passionate about?"

Renee: Any advice for me

Bayer: Make your dissertation as manageable as possible and tie all the pieces together. good luck (laughter)

Renee: Thanks you so much for your time for doing this and I will pay it forward when it is my turn

Bayer: No problem. You are welcome. Have a good day.

(End of Interview)

Summary

This chapter has presented the findings obtained from a voluntary survey given to patients, friends and family of patients that have visited a private psychiatric practice in St. Petersburg Fl and Largo Fl. respectively in October 2013. Additionally, is the transcript from an interview conducted in November 2013, by phone with Cary Roth Bayer Ed.D, RN, a sex

educator and assistant professor at Morehouse School of Medicine has been included. In Chapter 5, these findings will be analyzed to provide the climax of this story within the scope of this dissertation hypothesis.

CHAPTER 5

Climax

In the aforementioned chapter, the outcome of the survey and the interview were provided. Towards the end of this encounter, the author presents the climatic analysis of this mixed method approach to answer the question: are medical students prepared to discuss, assess and treat sexual health issues of their patients?

Sexual Health Survey and Interview

Mixed-Method Analysis

Finding #1: Half again as many women answered the survey than men.

This survey was made available in a psychiatric private practice with four psychiatric physicians and three full-time psychotherapists and three part-time therapist. 1) Are there more women utilizing the services than men 2) Are women more interested in their sexual health 3) Are women more comfortable answering questioning about their sexual health 3)Are women more likely to fill out questionnaires?

Finding #2: Age

Again, more women answered the survey than men and of the women that answered the survey, seventeen of forty-nine of those women were of the ages 51-60 which was the highest outcome of surveys answered. The second highest number of surveys answered were women

36-50 with fourteen surveys answered. Men 61-75 had the greatest number of answered survey in the male category. Perhaps from this information can we speculate 1) Are there more women in the age group of 36-60 who utilized psychiatric/psychotherapeutic services 2) Are the women in that age group more interested in their sexual health 3) Are there more men in the age group of 61-75 utilizing the psychiatric/psycho-therapeutic services 4) Are the men in that age group more interest in their sexual health 5) Do more people in the aforementioned age groups have more sexual health problems 6) Are the people in these age groups less inhibited about sex

Finding #3:Sexual health questions or assessments by physicians

Of the women who answered the survey, thirty-three had female physicians and these women reported that twenty-three of the female physicians *did not* ask them about their sexual health or to their knowledge *did not* take a sexual health assessment. The women who had male or both male and female physicians said ten of physicians asked them about their sexual health or did a sexual health assessment. Out of forty-nine women who answered the survey a total of twelve physicians either male or female or both asked their patients about their sexual health. Only 25 % of physicians treating female patients asked about their sexual health.

It is not known for sure why the number is low.

Men reported only six physicians asked them about their sexual health out of twenty-four respondents. Of the six physicians inquiring about their mens's sexual health, four men reported that their physicians were male and two were female. Twenty-five percent of physicians inquired about their sexual health or did a sexual health survey.

1) Could there be time-limitations 2) Could physician lack of comfort in asking sexual questions be relevant to the numbers 3) Do physicians not believe sexual health is important to in a

patients' life 4) Is there a lack of education/knowledge in sexual health by the physician 5) Do the physicians' believe the patient would not be comfortable with the question 6) Do physicians assume all is well unless their patient reports a problem 7) Are male physicians more cognizant of the sexual health of their patients 8) Are male physicians more comfortable asking questions on sexual health?

Finding #4: Sexual health questions by patient and satisfactory responses

Twelve men asked sexual health questions of their physicians and nine of those men felt their physicians answered satisfactorily, five did not. Seventeen female respondents asked their physician sexual health questions and eight did not. Fifteen physicians reported to answer satisfactorily for the women and seven did not. We might be able to say 1) More people want to know about sexual health than physicians think, 2) More people want physicians to ask them about their sexual health or allow them to ask and give a satisfactory answer.

Finding #7: Women only- Painful intercourse

Of the women who said they *sometimes*, *often* or *very often* had painful intercourse, only half of their physicians had asked them about their sexual health. Of the women in this same category, seven reported in the survey that they had asked their physicians sexual health questions. Three had not. Three of the seven women reported they felt as though they received a satisfactory response and three did not and one gave an *I don't know* answer. Fourteen of forty-eight women reported they at sometime had experienced painful intercourse.

The questions of *why* women experienced pain on intercourse was not asked so we cannot with certainty know why they experience pain during intercourse, however this author can offer a theory. 1) Is there a lack of lubrication of these women who answered in this manner 2) Fear of

not being able to accommodate a large male phallus 3) Fear of pregnancy 4) Fear of vaginal penetration 5) Previous sexual trauma 6) Other emotional reason 7) Menopause issues such as thinning of the labia walls, 8) forceful intercourse.

Finding #8: Libido issues

Men reported less libido issues than women and it was not incumbent upon age. Only six out of twenty-four men reported they *often* have libido issues. Eleven women reported they had *never* experienced libido issues. Twelve women reported experiencing libido issues *rarely*. Eight women reported to have experienced libido issues *often* and *very often* respectively. Ten women reported *sometimes* having libido issues.

While there is no way of knowing what causes more women to report problems with libido, we can suggest that 1) more women have more responsibility for childcare and may have a difficult time making time for both *mommy and wife, 2)* more women in the workforce today and if that is coupled with childcare, then they may have more libido issues or at least issues being more tired which could hamper the desire to be sexual 3) libido problems may be dependent upon age or menopause, 4) no longer being attracted to their mate. A through assessment would glean the information needed to provide the women with help in this matter.

Finding #9: Men only- Difficulty getting or maintaining an erection

Three men reported they experienced difficulty getting or maintaing an erection *very often*. The highest number represented was eight in the *sometimes* category. Seven men reported they *never* experience this. 1) medical problems such as coronary, diabetes or prostate health may influence an erection, 2) there may be a psychological component such as no longer being attracted to their

mate, 3)emotional issues, 4) heavy use of alcohol. Men complaining of this malady need to be assessed for primary vs. secondary erectile dysfunction.

Finding #10-Men only- Premature ejaculation

Seven men reported they *never* have premature ejaculation and two men said they had experienced premature ejaculation *very often*. It may be that age may a part in PE but according to Stanley Althof, quoted in text from Principles and Practice of Sex Therapy (2007, p.220), this may be a long-held belief that can be challenged. Low threshold for the amount of stimulation required may be another reason for the problem. According to Altof, this may be acquired or lifelong problem. However, if a patient is having this problem, he may have addressed it with his physician. It is incumbent upon the physician to help the sufferer of PE or to refer him to a professional who can.

Finding #11 *Out of control* sexual behavior

Eight men reported feeling *out of control sexually* at some time in their lives. Sixteen did not. Eleven women reported out of control sexual behavior at some time in their lives. Thirty-six did not and two women did not answer. Can we infer that 1) answers could be dependent upon age and if addressed earlier could have prevented damage to person, persons involved, and health etc, 2) dependent upon early imprinting, 3) sexual addiction/compulsivity's that could have been treated if addressed.

Finding #12 Loss of *spark* in sexual relations

Thirty-two women reported they had lost the *spark* in their relationship and sixteen did not. One women did not answer. The responses were not incumbent upon age or marital status. Thirteen men that answered the survey reported they had lost the spark in their romantic relationship and

eleven reported they had not. The answers were also not incumbent upon age or marital status. 1) age of relationship may play a role in the *loss of spark, 2)* health of a relationship may play a role 3) a physical health problem or emotional problem could cause the *lack of spark 4)*longevity of relationship. An appropriate assessment by a qualified professional would be warranted if the patient is interested in fixing the problem.

Finding #13 Willingness to see a sex therapist upon need

Twenty men of twenty-four (83%) answered affirmatively to this question. Out of forty-nine women who answered the survey, thirty-three said they would see a sex therapist if they needed to and two did not answer the question. Fourteen said they would not see a sex therapist. 1) Can we infer that patients feel that they are inadequately served by their physicians in matters of sexual health and that a specialist such a clinical sexologist is needed 2) People are willing to talk about their sexual problems 3)People feel that clinical sexologist would be more versed in addressing their concerns in a more holistic manner, 4) Some people are still uncomfortable talking about sex, 5) Some people may feel that it is irrelevant 6) Some people deny or cannot see they may have problems in that area.

Conclusion

It is not entirely conclusive that physicians have a lack of education based on the aforementioned findings. However, Dr. Carey Roth Bayer suggests physicians do have a lack of sexual health education coming from most medical colleges. Additionally, she states more should be done to make sexual health an important part of the person as a whole. This author believes that if more sexual health were to be studied in medical colleges by way of mandated curriculum, physicians coming out of medical school will not only have more knowledge about sexual health

but consider it as an important aspect of the whole person when assessing, educating and treating. If in fact, the medical profession as a whole was more knowledgeable about the importance of sexual health to the lives of their patients, they would not only be assessing and educating, but also make appropriate referrals to qualified clinical sexologist and other professionals

CHAPTER 6

RESOLUTION

This dissertation has taken the reader through all of the phases of the story of human sexuality and how it relates to the necessary inclusion of sexual health assessment by physicians in a healthcare setting, including the necessity of an integrated approach to treatment. Chapter One introduced the reader to the import of the hypothesis of medical students lack of knowledge based on limited curriculum in medical colleges and the preliminary assertions of the aforementioned statement. Chapter Two presented the scholarly data to back up the hypothesis. In chapter three, the author presented the mixed method approach to the hypothesis which included a pilot survey to volunteers on their sexual health and an interview with a sexual health educator and assistant professor in a college of medicine. Also, included were the assumptions, limitations and delimitations of the study. Chapter Four continued by listing the findings of the survey as well as the verbatim interview. Chapter Five presented the analysis of the findings of a mixed-method approach, based on the understanding of the authors review of the data and her own judgement of it to fairly represent and communicate what the data reveals in reference to the purpose of this study.

It must be stressed that analyzing and interpreting is

> a highly intuitive process: it is certainly not mechanical or technical. … there is no clear and accepted single set of conversations for the analysis and interpretation of qualitative data. Indeed, many qualitative researchers would resist this were it to come about, viewing the enterprise as more art than science" (Bloomberg and Volpe, 2012.p 172).

Based on the aforementioned description, Chapter Six will result in the resolution which will encompass the shift in the status quo and prescribe a new paradigm for governmental entities, medical colleges, medical boards, physicians, insurance companies, communities and clinical sexologists to include a new approach in promoting education, assessment and treatment of the population on sexual health concerns.

The New Paradigm

Governmental Entities (inclusive, but not limited to CDC, NIH, Surgeon General, WHO

- Research sexual health concerns/illness of the population including but not limited to STI/ STD and teen pregnancy rates
- Develop sexual health policy to be updated bi-annually according to research
- Two minute Radio, TV spot and/or newspaper ad and internet commercials on sexual health illness prevention topics and sexual wellness

Schools of Medicine including but not limited to nursing

- Develop sexual health curriculum or utilize approved curriculum developed by other colleges across all pertaining specialities and general practice with adherence and concern for sexual health policy needs and requirements
- Teach the minimal standards of state medical boards for licensure requirements
- Develop treatment opportunities for medical students affiliated with hospitals/public health departments to treat sexual health medical problems, dysfunction and dysphorias
- Teach a bio-psycho-social approach of interdisciplinary practice options of sexual treatment to medical students
- Provide fiscally within the college of medicine for teaching sexual health curriculum
- Develop a Center of Excellence within all medical colleges to enhance vision and priority in education within sexual health as well as integrated understanding of treatment by developing sexual health fairs yearly free to the public, dissemination of information pamphlets, local hotlines, and a list of local sexual health resources, screening and assessments with follow-up referrals

Medical boards

- Mandate an appropriate number of CME requirements in sexual health bi-annually including but not limited to HIV/AID's to meet the minimal standards of licensure/board certification

Medical Professionals

- Provide sexual health screening/assessment annually with each patient over 14 years of age
- Pediatricians provide parents and adolescents with education annually on child sexual development/prevention-increasing information rather than having providing tertiary care
- Refer patients to other professionals to facilitate an integrated approach to treatment (e.g. clinical sexologist, intra-vaginal physical therapist practitioners)
- Geriatric/internal medicine practitioners provide sexual education by way of pamphlets and/ or waiting room Accent Health Education TV to seniors on prevention of STI/STD's later in life

Insurance companies

- Motivate health care consumers with insurance discounts for annual 2 hour sex education program by approved community providers paid by consumer or insurance company
- Two-minute TV, radio, newspaper and internet commercials on sexual health education and prevention topics
- Include reimbursement to physicians, NP's, sex therapist and clinical sexologist for treatment of dysfunction and/or disease or dysphoria

Communities

- Provide education on sexual health within churches, public health facilities, libraries and schools for adults, children and adolescents as well as parents
- Provide sexual education material in local retail pharmacies, hospitals, public health facilities, schools, colleges/universities in student unions and student health clinics
- Hospitals and pertinent medical specialities office to include sexual health information in waiting areas pertaining to sexual health on Accent Health Education TV, which can include how-to instruction on self-breast exam and testicular self-exam, e.g. gynecologist, internist, urologists

Clinical Sexologists

- Continued self education on sexual health topics to include a minimum of 2 CEU's biennium on the topic of sexual health
- Provide education in hospitals, public health facilities, schools and libraries
- Educate medical professionals post medical school by way of presentations at medical and nursing conferences to increase awareness of sexual health issues as well as making medical professionals aware of the integrated need for treatment by clinical sexologist

- ✦ Research and write articles for mainstream magazines and journals on sexual health to educate the public and increase awareness of sexual health as important part of bio-psycho-social approach to healthcare
- ✦ Team with other types of professionals (PT, Massage therapist etc.) to provide an integrated approach to treatment of sexual health dysfunctions
- ✦ Refer patients to medical professionals as needed for integrated treatment
- ✦ Develop sexual health clinics for individual genders by partnering with other types of healthcare professionals including but not limited to homeopathic/holistic care providers and mental health and pain clinics
- ✦ Become provider of sexual health CEU's for therapists, nurses and other healthcare providers
- ✦ Develop new and/or enhance older modalities of treatment for sexual health dysfunction and intimacy
- ✦ Provide evidenced-based treatment by the use of sexual health questionaries/assessments upon baseline and at termination of treatment (e.g. FSFI, BSFI)
- ✦ Educate clergy on the import of breaking down barriers to a satisfying marriage and relationships.
- ✦ Educate parents on how and when to speak to their children about sex

Conclusion

These ideas of a new paradigm, a shift in thinking about sexual health, were developed by this author from review of the research, data analysis of the findings from the voluntary survey and interview with a sexual health educator in practice in a college of medicine, as well as the information gleaned over the years in private practice with patients, to provide the reader with a comprehensive understanding of the lack of education provided to medical students on sexual health and how it can impact the patient at large regardless of race, ethnicity, sexual orientation, age or gender.

> Sexual health is evidenced in the free and responsible expressions of sexual capabilities that foster harmonious personal and social wellness, enriching individual and social life. It is not merely the absence of dysfunction, disease and/or infirmity" (Pan American Health Organization, 2000 quote in text from New Directions in Sex Therapy, 2012. p.127).

America and beyond, is populated by great minds with zenith vision and brave hearts. These entrepreneurs of thought over the last twenty-five years have created medications to heal and cure the sick, machines that have helped diagnose illness and technology that far exceeds expectation of any science fiction narrative. In the words of Hippocrates, "First, do no harm". These creations have exceeded any harm by doing mostly good. Still, we fall behind in an illustrative view of the whole person, the integrated and bio-psycho-social approach to assessment, education and treatment in the area of sexual health. Education, assessment and treatment need not completely require medications, fancy machines or even technology, but a vision of wholeness of a human life. It begins with an accurate and adequate sexual health education of the health care practitioner, their pen, a piece of paper and an open mind.

APPENDICES

Letter of Informed Consent
and
Instructions to Subjects Completing Research Survey

I am Renee Michaels, a licensed clinical social worker practicing in Pinellas County, FL. and a doctoral student at the American Academy of Clinical Sexology in Orlando FL. As part of my doctoral dissertation I am conducting a survey study with physicians on sexual health of their patients. Your voluntary participation is being requested. Your participation is strictly voluntary and anonymous.

All survey information will be kept in a secure file by this researcher. At no time, will your name be placed on this survey. I thank you in advance for participating in this important study.

Thank you!

Renee Michaels, LCSW,CAP

Figure 1.1 Voluntary Informed Consent

Patient Sexual Health Survey
(Please circle the correct answer)

1. Your gender: M F Differently identified

2. Age 18-24 25-35 36-50 51-60 61-75 76 and over

3. Are you... married single domestic partnership dating

4. How do your identify sexually? Homosexual Heterosexual
Bisexual Transgendered

5. My medical doctor is...
Male Female

6.Has your physician ever asked you about your sexual health or completed a sexual health survey with you?
Yes NoI don't know

7.Have your ever raised questions to any physician about your sexual

health? Yes No What type of physician_____

8. If so, did that physician give you a satisfactory answer?
Yes No

9.If you did not raise sexual health questions to your physician, why not?
Uncomfortable Have not needed to Other_____

10.(**Women only**)How often do you experience any involuntary spasms of your vagina that interferes with intercourse or sexual relations?

Never	Rarely	Sometimes	Often	Very often
1	2	3	4	5

11.(**Women only**)How often do you experience painful intercourse?

Never	Rarely	Sometimes	Often	Very often
1	2	3	4	5

12.How often do you experience libido issues?

Never	Rarely	Sometimes	Often	Very often
1	2	3	4	5

13.(**Men only**)How often do you experience problems getting an erection or maintaining an erection that interferes with intercourse or sexual relations?

Never	Rarely	Sometimes	Often	Very often
1	2	3	4	5

14.(**Men only**)How often have your experienced problems with ejaculating too quickly?

Never	Rarely	Sometimes	Often	Very often
1	2	3	4	5

15.Have you ever felt you have sexual compulsive behavior?
Yes No

16.Have you ever felt the “spark” has gone out of your sexual life?
Yes No

17.Would you be willing to see a sex therapist if you needed to?
Yes No

18. If the answer is no, why not?

Thank you for your participation!
If you feel like you would want to talk to a qualified person about these issues, you may make an appointment with Renee in our office.

Figure 1.2 Voluntary Patient Sexual Health Survey

Interview Questions for Cary Roth Bayer, Ed.D
November 2013

1. What are your thougths on physician/NP's taking sexual assessments? Is it necessary?

2. Do you feel physician/NP's are adequately trained to assess sexual health of their patients?

3. Do you think there is enough attention paid by med professionals on sexual function of their patients?

4. What are the average number of classes on sexual function/dysfunction, disease/dysphoria in Morehouse School of Med for which you are affiliated?

5. Can you give me a list of the classes? Names of the classes?

6. If you believe the med students are adequately trained, what possibly stands in the way of health professionals from addressing these issues with their patients?

7. What are the statistics for STi/'STD/s for teens and adolescents?

8. What are the statistics for late in life sexual diseases?

9. What do physicians need to know about minority sexual health? Stats etc. Are they underserved?

10. Moving to a more global topic, what is the status on a sexual health policy in the US today?

11. What can or should social policy/ medical boards/insurance companies do to increase the chances that med prof will assess sexual health of their patients?

12.. What can clinical sex therapists do to increase understanding by med professionals of and use of our services as clinical sexologists for education, treatment of dysphoria or dysfunctions including but not limited to intimacy issues in couples?

13. What can clinical sexologist do to be more successful in helping their clients?

14. What are your efforts at this time and planned over the next 3 years as a sex educator to educate the public/medical professionals and medical students?

15. What do we need to pay attention to right now?

16. In what direction do you see clinical sex therapy and sex education going forward?

17. Have clinical sex therapist done all they can to make themselves a viable treatment option to physicians and the population?

18. If not, what can we do?

Figure 2.1 Original Questions (Modified in actual Interview) for Cary Roth Bayer, Ed.D
Morehouse School of Medicine

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