
Enhancing the Sexual Connection in Midlife Women: The Clinician's Role

Lana L. Holstein, MD

The “seven dimensions of sexual connection” is a conceptual framework that can help primary care clinicians begin to assist their patients in pinpointing and addressing problems that can compromise sexual well-being.

Women should expect to have pleasurable, fulfilling and meaningful sexual connections with their partners throughout their lives, but many do not simply because they don't know how to address problems and are hesitant to ask for help. Clinicians can help these women by providing an opening for discussion, help in assessing the nature of the difficulties and appropriate treatment or referral.

Women in menopause are in particular need of information and expert advice; they face significant physical and emotional changes as they begin what is essentially a new phase of life. Many midlife women experience changes in sexual function at this time, and such patients need clinicians who can help them understand this vital aspect of their health and well-being, and who will help them find solutions to whatever problems arise.

This article offers suggestions to help clinicians broach the important topic of sexual function with midlife women, and describes a conceptual framework that can be used to pinpoint and begin to address problems that can compromise patients' sexual well-being.

Broaching the Subject

Ideally, clinicians should be asking their

patients if they have questions or concerns about sexual function throughout their adult lives. If, however, such questions haven't been asked previously, perimenopause is a logical time to broach the subject. Most patients are anxious to discuss the changes they are beginning to experience, and the annual well-patient examination is the perfect opportunity to broach the subject. To this end, a simple, forthright question about sexual function can, and should, be included in the routine review of systems. The question should be a broad, wide-open one, with follow-up questions determined by the patient's responses, as illustrated in the example below.

Clinician: “Do you have any questions or concerns about your sexual function at this point in your life?”

Patient: “We're not really having sex very much anymore because of my husband's problems.”

Clinician: “Is that all right with you?”

Patient: “No, but my husband is having trouble with impotence.”

Clinician: “Do you feel as if he needs some help? Has he seen a urologist?”

This type of brief, straightforward questioning opens the door to discussion

and tacitly gives the patient “permission” to talk frankly with a trusted healthcare professional; it also lets the patient know that the clinician views her sexual function as part of her total health profile, and as a subject that can and should be addressed with as much candor as any other aspect of her health. Since patients tend to take their cues from what they perceive to be their clinician's attitude, it is up to the practitioner to let patients know that the subject is a valid and important one.

It has been my experience that direct, professional questions about sexual function are greatly appreciated by most patients. If, however, a woman indicates that she isn't clear about the reason for such a query, a brief explanation of menopause as a time when many women experience changes in this, and other, aspects of their lives is useful and reassuring. Women who prefer not to discuss their sex lives will usually say so. This is, of course, perfectly acceptable, and the patient should not be pressured in any way; the clinician should, however, close the topic with an assurance that he or she will be available should the patient have concerns at a later date. It is, in fact, quite common for a woman who initially tells her practitioner that “everything is fine,” or that she doesn't care to discuss her sex

life, to refer back to the original conversation during a subsequent visit several months, or even years, later (e.g., “Do you remember asking me about my sex life? Well, actually, I’ve been having some pain during intercourse.”).

Time is, of course, at such a premium in today’s healthcare environment that some clinicians might fear that broaching the subject of sex will lead to lengthy discussion. It is, however, a mistake to choose not to raise the subject for reasons related to time constraints; most sex-related problems acknowledged during an initial discussion need not (and cannot) be addressed in their entirety right then and there. An effective strategy for dealing with time constraints, while still giving sufficient attention to this vital aspect of well-being, is to suggest that the patient schedule a return visit. If the woman’s concerns seem to have a biologic dimension (e.g., hormonal changes or difficulties after pelvic surgery), appropriate laboratory tests can be ordered and a follow-up visit scheduled. It also is frequently useful to refer patients to accurate, helpful books and other resources that can help them sort through the issues with which they are dealing. A short list of such materials is provided in Table 1.

The Seven Dimensions Construct as an Assessment Tool

Time constraints notwithstanding, lack of confidence in their ability to help is likely the most common reason that clinicians don’t ask about their patients’ sexual function. In reality, primary care practitioners need not be sex therapists to help their patients continue to have pleasurable and fulfilling sex lives through menopause and beyond. Primary care clinicians can, in fact, be enormously helpful to their patients in this regard, by permitting them to discuss problems and helping them to home in on the causes of those problems and address difficulties appropriately, whether in the primary care office setting or through referral.

Pinpointing the source of a sex-related problem is easiest when the cli-

Table 1.
Selected References for Patients*

Books

The Art of Sexual Ecstasy. Margo Anand. Los Angeles: Jeremy P. Tarcher, Inc., 1989.
Authoritative book about sexuality and spirituality.

Divine Sex. Caroline Aldred. London: Carroll & Brown Limited, 1996.
Sexuality book on the Eastern approaches to loving.

How to Have Magnificent Sex: The 7 Dimensions of a Vital Sexual Connection. Lana L. Holstein, MD. New York: Harmony Books, 2001.
Detailed view of the multidimensional aspects of sexual connection.

The New Male Sexuality. B. Zilbergeld. New York: Bantam, 1992.
Useful information about men’s sexuality.

Sexual Healing. Paul Pearsall, PhD. New York: Crown, 1994.
Using the power of an intimate, loving relationship to heal the body and soul.

Tantra, the Art of Conscious Loving. Charles and Carolyn Muir. San Francisco: Mercury House, 1989.
Tantra and its application to Western love relationships.

What to Do When He Has a Headache. Janet L. Wolfe, PhD. New York: Penguin Books, 1992.
Discussion of what can be a common problem in midlife.

Videos

Tantra: Ancient Secrets of Sexual Ecstasy for Modern Lovers and Multiorgasmic Response Ecstasy Training for Women and Their Lovers. Anand Margo, et al.
Guide to the erotic arts of the East, and instructional video. (800/9-TANTRA)

Tantra: The Art of Conscious Loving. Charles Muir and Carolyn Muir. Hawaiian Goddess Video.
A modern approach to the sacred Indian art of love. (808/572-8364)

Tantric Massage Video. Kenneth R. Stubbs.
Comprehensive guide to the erotic arts of the East. (800/9-TANTRA)

Resources/Organizations

The Kinsey Institute
Indiana University, Morrison Hall 313
Bloomfield, IN 47401-7686
812/855-7686
Fax: 812/855-8277

SIECUS
130 W. 42nd St., Suite 350
New York, NY 10036
Phone: 212/819-9770
Fax: 212/819-9776

www.tantra.com

Web site for sexuality and spirituality books, tapes and music.

*This table lists only a few of the many resources that patients have found useful in enhancing their sexual connection. A more extensive list of resources appears in Holstein L.¹

Editor’s note: The books, videos and Web sites included in this list are recommended by Dr. Holstein and have not been reviewed by The North American Menopause Society.

Table 2.
Seven Dimensions of Sexual Connection

Dimension	Poles		
	Positive	Middle	Negative
Body/ Biologic	Function	Ignoring problem	Dysfunction
Sensual	Pleasure from all 5 senses + kinesthetic "6 th sense" (knowing where body is in space)	Numbness	Pain
Desire	Feeling of sexual power/energy	Celibacy/no sexual desire	Humiliation, shame or feeling sex is repulsive (past teachings)
Heart	Commitment/attachment to partner	"Stingy heart" (keeping score)	Fear of abandonment
Intimacy	Can be truthful/authentic with partner	Silence (not sharing truth)	Betrayal (affair, emotional betrayal)
Aesthetic	Beauty/radiance ability to "light up" partner	Blind to beauty/radiance	Judgment/criticism/loss of touch with inner beauty
Transpersonal	Feeling involved/blended with partner (sex is sacred/spiritual)	Disbelief	Ego (fear of letting go, blending); feeling sex is profane, not sacred

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nician and patient understand that sexuality is a complex aspect of life that involves a range of issues. Human beings are more than a set of biologic facts; satisfying connection with a partner extends beyond biology to encompass emotional, sensual, aesthetic and spiritual aspects of sexuality. There are many dimensions of sexual connection, whether pleasurable and fulfilling or marred by physical or emotional pain, fear or lack of desire.

Once the practitioner knows which questions to ask, determining the sources of the problem and the best course of action becomes straightforward. To this end, I have found my seven-dimensions model of sexual connection¹ to be a useful construct for assessing sexual problems. In clinical practice the seven dimensions provide a framework that enables both clinician and patient to clarify where a

problem "resides," after which they can focus on the areas in need of change and formulate a plan that might involve medical treatment, simple discussion, formal counseling or a combination of modalities.

Each of the seven dimensions has a positive (function) and negative (dysfunction) pole, as well as a middle space, in which people can become "stalled" (Table 2). Each dimension is described below, along with the most common reasons for dysfunction, cues the clinician can use to determine whether a particular dimension is a problem area and, finally, the appropriate courses of action. Because primary care clinicians tend to be most familiar with the biologic aspects of sexual function, the other dimensions of sexual connection (sensual, desire, heart, intimacy, aesthetic, transpersonal) will re-

ceive the primary emphasis in the remainder of this article.

Body. This dimension is the most familiar to primary care clinicians, as it involves the biologic aspects of sexual function. Many common features of menopause can affect sexual function. During early menopause, for example, many women experience night sweats and difficulty sleeping, both of which can affect their sense of well-being and can begin to encroach upon their perceived sexual energy. In addition, testosterone levels—which affect desire—can change during perimenopause, menopause or even postmenopause.² Such hormone changes are unpredictable and make the sexual effects of estrogen replacement uncertain. Some women have small increases in testosterone because of declining levels of sex-hormone-binding globulin (SHBG),³ which preferentially binds testosterone. If such a woman is put on estrogen replacement, SHBG increases and binds more testosterone which, in turn, then drops more precipitously.⁴ Consequently, in my experience,

beginning estrogen replacement actually reduces libido in some women.

For women with menopause- or perimenopause-related symptoms I strongly recommend obtaining not only testosterone levels, but free testosterone levels, as well; I tend to rely on the free testosterone levels with respect to decisions about the need for testosterone replacement. The starting dose is 1 mg/day, which can be adjusted after free testosterone levels are checked in 6-8 weeks.

For women who report that their sexual desire has changed or shifted dramatically in the few months prior to an office visit, investigation of potential sleep disturbances and, possibly, relationship issues is in order; hormones might not be the "whole story."

Once women are fully menopausal they can begin to experience vaginal dryness

and, sometimes, vaginal atrophy, along with discomfort during intercourse. Menopausal women also can experience a decrease in orgasmic potential, which can be related to decreased blood supply to the vagina and clitoris.⁵ These physical problems can be treated. Some studies on the use of sildenafil (Viagra) in women show a possible increased sexual responsiveness, both in pleasurable sensation and ability to be orgasmic.⁶ Studies have also described the usefulness of sildenafil in women experiencing decreased sexual function while taking antidepressants.⁷ In addition, women have reported improved sexual responsiveness with the use of a recently approved vacuum device that draws blood into the clitoral body.^{8,9}

It is also important to keep the anatomic perspective in mind when considering the biology of sexual dysfunction. Pelvic surgery (bladder suspension, hysterectomy, etc.), pelvic radiation and blood supply interruption often contribute to sexual problems.

Because human sexuality is complex, it is important to remember that problems with the body (biologic) dimension of sexuality, even when confirmed, are frequently only part of the picture; problems in other dimensions of sexuality typically contribute to whatever difficulties the woman is experiencing.¹⁰

While, as stated above, the biologic aspects of sexual function are usually the most familiar to primary care clinicians, sorting out biologic problems from those related to other aspects of sexual connection can be somewhat unfamiliar territory. A basic understanding of the remaining six dimensions, as described below, can help clinicians to make such needed distinctions.

Sensual. The sensual dimension involves the pleasure derived from the sexual relationship or, conversely, the absence of such pleasure. The woman whose problems are rooted in the sensual dimension might report that she simply doesn't feel anything during sex; she has detached from her body and its sensations. Questions about whether the patient responds sexually, and whether sex is pleasurable or

irritating to her, are useful in determining whether difficulties lie in this dimension.

Asking when this absence of feeling began, or whether the patient has always felt "absent" during sex, is a useful follow-up in such cases. The clinician might want to investigate the possibility of an unhealed emotional or physical trauma, or negative associations that make sex difficult or frightening for the patient.

For the woman who relates past abuse or rape, the clinician can suggest referral to a counselor. In the absence of such a history, the clinician can point out that the patient might simply have gotten into the habit of detaching during lovemaking. Such patients typically have difficulties in some of the other areas of sexual connection (e.g., the heart dimension), as well. The clinician can help the patient understand that this sort of problem is usually the physical expression of emotional detachment from her partner (e.g., a sense of being unloved, feelings of hurt and anger over an affair or resentment related to a lack of commitment). The clinician also can reassure the patient that help for such problems is available in the form of counseling or work that she and her partner can do on their own.

Desire. Central to the desire dimension is the feeling of sexual power or energy that is partly a function of hormonal support and partly a function of the interaction between the woman and her partner. Women with problems in this area experience a lack of sexual desire and commonly state that they simply don't have "the same feeling" anymore.

Lack of desire is usually connected with feelings of humiliation or shame. Such feelings can stem from early training or painful sexual and romantic humiliations (commonly in adolescence) or can relate to the woman's body image. Humiliation in the workplace or a sense of failure related to family troubles can also deplete sexual energy. It is important to differentiate between these potentially problematic areas and to encourage the patient to identify the specific source of these feelings, while assuring her that they need not poison every aspect of her

sexual connection. It is also useful to try to determine whether the patient's lack of desire began after some sort of trauma in the relationship or after a family-related trauma, such as the death of a loved one. Identifying the point at which the patient "closed up" often helps the healing to begin.

When women present with decreased or nonexistent libido it is, of course, important to rule out hormone levels as a cause. If, however, hormones are found to be a problem, the clinician should not consider the case "closed." This is an especially important point in light of the increasing numbers of midlife women who, usually after hearing about a friend's experience with testosterone replacement, are asking their clinicians for testosterone to solve libido problems. In such cases measuring testosterone levels is an appropriate first step, but further investigation is needed to reveal whether other issues are contributing to the difficulty. Referral to a qualified therapist is appropriate when feelings of humiliation or shame prevent a woman from moving forward and reclaiming her libido.

Heart. The heart dimension refers to feelings of commitment and attachment to the partner. A patient with problems in this area might tell her clinician that her sexual relationship isn't like it used to be, that she'd rather be doing other things or that she doesn't feel secure in her partner's commitment and love. The woman with heart difficulties often fears abandonment. While most primary care practitioners wouldn't feel comfortable addressing these issues in detail, the clinician can certainly ask a patient if she has the sense of being in love and feeling loved by her partner; in other words, is she truly making love or is she just having sex? An ambivalent response often suggests difficulties in the heart dimension. Patients are reassured to hear that such problems are quite common and that therapy can be helpful.

Intimacy. Trust is an essential component of satisfying sexual connection, and the woman who enjoys intimacy in her sexual relationship feels she can be truth-

ful and authentic with her partner. Problems in this dimension often stem from betrayal—typically an affair. A woman who feels betrayed can become extremely passive, putting her sexuality “on the shelf.” The inability to get beyond the adolescent/early adulthood fear of “getting into trouble” is another common cause of intimacy failure in some women. Other women feel obligated to “go along with” sex and come to view sex as servicing their partner; they have essentially abrogated their power, and intimacy is lost.

In most cases, problems with sexual intimacy fall beyond the scope of the primary care clinician’s expertise, and referral to a qualified therapist is appropriate. The clinician can, however, help the patient begin to think about the problem in a new way. The key question in such cases is whether the woman’s physical connection reflects the depth of her emotional commitment or is mechanical in nature. Considering this question challenges the woman to begin thinking about whether she is actually making love or just having sex.

The primary care practitioner can tell such women that everyone deserves something better and that, at least sometimes, sex ought to take one’s breath away. These words can be quite powerful when they come from a trusted healthcare professional.

Aesthetic. Central to the aesthetic dimension is beauty (especially inner beauty), radiance and the ability to “light up” one’s partner. A woman with a problem in this area is likely to be very self-critical and judgmental; she might also have an extremely judgmental partner.

The idea that true personal beauty lies within is an especially valuable one as women’s bodies change during menopause. If a patient with sexual problems indicates dissatisfaction with her looks, it might be helpful to ask her who, among the people she loves, she considers to be beautiful. The response to this question is frequently “my mother” or “my grandmother,” at which point the clinician can stress that no one remains physically perfect forever, and lovers make love to and

Sex and Menopause: Dispelling the Myths

Despite the increasing level of sophistication with respect to women’s knowledge of and willingness to talk about sex, many myths about sexual function (especially sex and aging) persist. Once the channels of communication have been opened, primary care clinicians can do a great deal to dispel these myths by validating patients’ well-founded concerns while allaying any misconceptions, as illustrated below.

Myth: “Once I’m menopausal, I’m no longer sexual; I’m not fertile or attractive and can no longer expect to have great sex.”

Reality: Despite the fact that, today, discussing sexuality has become acceptable in many social circles, and many older women refer to menopause as a time of “coming into their own” sexually, the idea that we somehow become asexual beyond a certain age still persists among some women, and even some of their clinicians.

While it might be difficult to believe, many women have told me that their attempts to broach the subject of sexuality with their healthcare practitioners have been met with responses such as, “You’re not interested in that anymore, are you?” and “Why would you bring that up at your age?” Fortunately, the vast majority of clinicians realize that, in addition to demonstrating ignorance, such comments shame the patient and ensure that she will never again bring her questions or concerns to that practitioner.

Women’s attitudes are changing; most are neither willing nor content to give up their sex lives at menopause and realize that they don’t have to—far from it. Many older, and even elderly, couples have extremely fulfilling, rewarding and active sex lives.

Another important consideration for patient and clinician is that many midlife women find themselves newly single at a time of other changes (i.e., menopause) and are venturing out into the dating world for the first time in years, or even decades. These women are dealing with a range of issues, and the prospect of new relationships can be at once exciting and daunting. Concerns or fears related to sexually transmitted diseases (STDs) need to be validated and put into perspective, and appropriate information about protection against STDs provided. At the same time, midlife women should not feel as they need to “compete” with 20- and 30-year-old single women; they should, instead, be encouraged to value the unique qualities they can bring to a relationship and look for a partner who will appreciate those qualities.

Myth: If sex throughout life isn’t just as it was in the beginning, it’s a failure.

Reality: Sex, like everything else, changes over time. Older couples with a vital sexual connection probably aren’t doing exactly what they did when they were 20 or 30, but that doesn’t mean their sexual connection is not as good and, perhaps in some ways, even better than it was when they were very young. Energy can continue to flow between a woman and her partner very late in life, and both women and men should be encouraged to add to and take care of their sexual

relationship, and to continually infuse it with energy in any way that works for them.

As realities and changes encroach upon relationships, couples need to develop the ability to put their concerns aside when the bedroom door closes and focus on one another and what their partners mean to them; with attention, sexual relationships expand and deepen. Primary care clinicians need not delve into intensive therapy in order to help; they need only remain available for questions or concerns, and to direct their patients to the resources they need.

Midlife women also are reassured to hear that other women in their peer group often find menopause a liberating experience with respect to their sex lives. With no more worries about pregnancy, increasing confidence in themselves as individuals and, in many cases, the intimacy that comes with a loving, long-term relationship, sex can take on a new and deeper dimension than ever before.

Myth: There are sexual standards that apply to everyone with regard to “how much, how great and how often.”

Reality: Both women and men in our society are bombarded with sexual misinformation that encourages unrealistic expectations. In books and magazines and on television talk shows, supposed experts pontificate about “normal” frequency of sexual intercourse for couples in various age groups. As a result, some perfectly happy, healthy men and women begin to feel that something is wrong with them, and that they’re not “measuring up.”

Women and their partners should be reassured that variation in frequency of sexual encounters is extremely wide and that it is the quality, rather than the quantity, of sex that matters. Having merely mechanical sexual intercourse every day likely won’t add anything to a couple’s quality of life, while true, meaningful lovemaking every 2 weeks can fill the heart and soul.

While it is probably wise to avoid numbers in discussions about sex, when lovemaking is as infrequent as once every few months, there might well be a gulf between the woman and her partner that makes it difficult to initiate sexual relations. An appropriate intervention might be indicated once the cause of the difficulty is established. In such a case, however, the emphasis should remain on the energy and focus, and the emotional, physical and spiritual experience of sex, rather than on the frequency of the act.

It also is important to realize that a tremendous number of woman who complain about their sex lives are really complaining about their partner’s inability to initiate sexual relations and, frequently, reluctance to seek help. The clinician can assist in such situations by making the woman aware of the range of help that exists for such problems; the patient can then pass the information along to her partner.

Whether newly single or in a committed relationship, midlife women need clinicians who will validate their realistic concerns, allay misconceptions and encourage them to find and revel in the opportunity that this new stage of life can afford.

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with their partner’s *inner* beauty.

Many women truly mourn the loss of their youthful looks. These women need to be encouraged to dig; they can start by adopting some simple strategies, such as accepting, rather than shrugging off, compliments from their partners. It is helpful to point out to midlife women that this time of life could be an opportunity to find greater depth of love and sexual connection. Indeed, in my experience, the couples having the best, most fulfilling sex are those who have been together for a long time.

Transpersonal. The transpersonal dimension relates to the spiritual aspect of sexual connection, the feeling of being blended with the partner’s soul or the understanding of that possibility. Women with problems in this area often don’t believe such a connection is possible and might have been taught that sex is profane, rather than potentially sacred and spiritual. They might also simply be overwhelmed by the realities of daily life, such as “the four Ds” (deadlines, dishes, diapers and duty).

In order to experience the transpersonal dimension, the patient and her partner need to possess strength in the other dimensions, as well as the courage to open up their hearts and souls to this deeper experience. There are belief systems that discuss this aspect of sexuality quite openly; tantra, a type of yoga, teaches techniques to approach this type of lovemaking.^{1,11,12} It has been my experience that women and their partners are curious about this perspective and are usually willing to give it a try, even if there is some natural skepticism about a different approach to sex.

Follow-up

After an initial discussion of sex-related problems has taken place and the causes have been explored, follow-up becomes extremely important. Depending on the nature of the problem, a return visit in 1 or 2 months is generally appropriate. During the interim there might have been an intervention, either with respect to purely physical function or regarding the patient’s

perception of herself as a sexual person (e.g., through counseling).

The clinician can anticipate some changes that will be evident at the follow-up visit; once the topic of sex is broached, people think about it and usually begin to shift their ideas or come to a new understanding of the choices they've made. By scheduling a follow-up visit for all patients who have revealed difficulties in this area, the clinician underscores both the validity of the woman's desire for a vital sexual connection and his or her concern for the patient's total well-being.

Conclusions

Many adults believe that sex is simply a natural function, that we should all know what to do intuitively and that—without investing any attention or effort—sex should be wonderful and passionate forever. In reality, enhancement of sexual connection is an ongoing, if pleasurable, project. Patients should be encouraged to pay attention to their sex lives, acknowl-

edge any problem areas and invest the time and energy needed to enhance their sexual connection. As clinicians talk about sexuality a bit more with their patients, they will likely be astounded by the number of patients who are anxious to discuss these issues with them. ■

Lana L. Holstein, MD, is Assistant Clinical Professor, Department of Family Medicine, University of Arizona Health Sciences Center; and Director of Women's Health, Canyon Ranch Health Resort, Tucson, AZ. Dr. Holstein is the author of *How to Have Magnificent Sex: The 7 Dimensions of a Vital Sexual Connection*, New York: Harmony Books, 2001.

References

1. Holstein LL. *How to Have Magnificent Sex: The 7 Dimensions of a Vital Sexual Connection*. New York: Harmony Books, 2001.
 2. Davis S, Burger H. Androgens and the postmenopausal woman. *J Clin Endocrinol Metab* 1996;81:2759-63.
 3. Rannevik G, Jeppson S, Johnell O, et al. A longitudinal study of the perimenopausal transition: Altered profiles of steroid and pituitary hormones, SHBG and bone mineral density. *Maturitas* 1995;21:103-13.
 4. Shifren JL, Braunstein GD, Simon JA, et al. Transdermal testosterone treatment in women with impaired sexual function after oophorectomy [see comments]. *N Engl J Med* 2000;343:682-8.
 5. Rubio E, Lopez M, Lipezeker M, et al. Alpha blockade and vaginal blood flow response in postmenopausal women with female sexual arousal disorder. *Proceedings of the Female Sexual Function Forum*; Oct 26-29, 2000; Boston.
 6. Caruso S, Intelisano G, Lupo L, et al. Premenopausal women affected by sexual arousal disorder treated with sildenafil: A double-blind, cross-over, placebo-controlled study. *British Journal of Obstetrics and Gynaecology* 2001;108:623-8.
 7. Nurnberg HG, Hensley PL, Lauriello J, et al. Sildenafil for women patients with antidepressant-induced sexual dysfunction. *Psychiatr Serv* 1998;50:1076-8.
 8. Billups KL, Berman L, Berman J, et al. A new non-pharmacological vacuum device for female sexual dysfunction. *Journal of Sex and Marital Therapy* 2001;27:1-7.
 9. Wilson SK, Delk JR II, Billups KL. Treating symptoms of female sexual arousal disorder with the Eros-Clitoral Therapy Device. *Journal of Gender-Specific Medicine* 2001;4:1-6.
 10. Dennerstein L, Leher P, Burger H, et al. Factors affecting sexual functioning of women in the mid-life years. *Climacteric* 1999;2:254-69.
 11. Anand M. *The art of sexual ecstasy*. Los Angeles: Jeremy P. Tarcher, Inc., 1989.
 12. Muir C, Muir C. *Tantra, the art of conscious loving*. San Francisco: Mercury House, 1989.
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