majority (80%) said that they switched because withdrawal is healthier and safer, or because they did not like the side effects of the previous method.

It was found that withdrawal is negotiated and agreed to, not imposed. There was a mutual recognition of the need to limit childbearing, an analysis of the contraceptive options, discussion and possibly negotiation, and then, the practice of a method that by most accounts is not perfect.

"We think it is vital for more nuanced research on sexual relationships, particularly in areas of the world where powerful stereotypes - traditional families, women's low status, oppressive religion, early marriage, high fertility, male dominance, vulnerability of women to divorce, need to produce sons - influence the questions we ask and the interpretations of what we see and hear," concluded Myntti et al. "While acknowledging the complexity of people's sexual lives, our modest research suggests that it might be useful to credit women with some measure of agency, and men some measure of altruism and humanity."

The corresponding author for this study is Cynthia Myntti, Yale University, New Haven, CT.

Sexual Desire in Women

Rethinking the Traditional View of Women's Sexual Response and Desire

Researcher Rosemary Basson of Vancouver, Canada questioned the traditional view of women's sexual response and the nature of their sexual desire and presented an alternative model of human sexual response.

"The new model illustrates the difficulty experienced by most women in distinguishing between desire and arousal and the common lack of both," wrote Basson. "There are implications for the management of low desire in the context of chronic dyspareunia, chronic infertility, gradual reduction of ovarian androgen from midlife onwards, and for the management of sudden complete loss of ovarian androgen in premature, surgical or medical menopause" ("Rethinking Low Sexual Desire in Women," British Journal of Obstetrics and Gynaecology, 2002;109:357-363).

Studies indicate a 33 to 39% rate of self-diagnosed low sexual desire in women (Laumann et al., 1999; Fisher et al., 1999). "Rather than concluding that some one-third of women have a disorder, the reasons for this apparently common perception of failing to meet some sexual standard must be sought," wrote Basson. "The apparent high prevalence of low sexual desire in women leads to a questioning of the traditional view of women's sexual response and the nature of their sexual desire. Is the traditional model of sexual arousal and potential orgasmic release, initiated by sexual desire (as manifested by sexual thinking, fantasizing and conscious sexual neediness), actually true for women? Are other cycles of response more common and would their acknowledgement clarify causes of apparent low desire and thereby facilitate management?"

Management of low sexual desire is reported to be highly challenging. "The medical response has been largely to clarify medical, including psychiatric and gynecological history, confirm normal genital and pelvic anatomy and state that nothing organic is amiss," stated Basson. "Often the woman is then dismissed with the conclusion: 'your problem must be psychological'. Indeed, being an emotion, sexual desire is a psychological entity, but it also has a biological and interpersonal basis and women expect their gynecologist to accept their sexual difficulties as a legitimate women's health issue and be prepared and able to address it."

An intimacy-based model of women's sexual response (Basson, 2000) has recently been presented as an alternative to the traditional human sex response cycle of Masters, Johnson and Kaplan. A woman frequently begins a sexual experience sexually neutral. She, for intimacy-based reasons (to be emotionally close, to show love and affection, to share physical pleasure for the sake of sharing, to increase a sense of attractiveness and attraction, to increase a sense of commitment and bonding), deliberately finds or receives sexual stimuli that potentially could move her from neutrality to a state of sexual arousal. Although psychological and biological factors may potentially preclude arousal, if arousal is experienced, further arousal follows and in time, in addition to her original intimacy-based motivation, she achieves definite desire in order to continue the experience for the sake of sexual tension and sexual enjoyment. "In this cycle, departing from the traditional one, sexual stimuli are integral; arousal is experienced before desire and orgasm is not mandatory for a normal or healthy response," wrote Basson. "The power behind the cycle is
the couples emotional intimacy and this power or 'motor' may be enhanced or diminished by the experience itself."

A potential break in women's alternative cycle is lack of emotional intimacy. Emotional intimacy may be so minimal that the woman is not motivated to find or receive sexual stimuli that could allow her sexual response. "If the partners are motivated to improve their emotional intimacy, professional counseling can be suggested: the problem is not inherently sexual but has to do with the non-sexual interpersonal relationship," wrote the authors.

Another potential break in women's alternative cycle is lack of sexual stimuli. Heterosexual women recently expressed a wish for both more non-genital and genitally penetrative stimuli, without sexual intercourse. "When sexual stimuli and context are minimal," wrote the author, "gynecologists can clarify their 'normal' necessity especially in the longer term monogamous relationship."

Many psychological factors can negatively influence the processing of sexual cues, including non-sexual distractions, past negative or painful experiences, fears of infertility, pregnancy, and sexually transmitted disease, or fear for emotional or physical safety.

Biological factors may also cause a break in women's alternative cycle and are only beginning to be explored. Chronic dyspareunia, partner's sexual dysfunction, effects of medication, anorgasmic disorder, or deficient estrogen or testosterone may cause a woman's cycle to be broken.

While for men physical tumescence itself constitutes an additive or compounding second level sexual stimulus, women typically under-rate their physical response (Laan, 1998). Data of objective increase in the vaginal blood low in response to erotic stimulation repeatedly shows lack of correlation with the woman's subjective arousal (Laan, 1998; Laan et al., 1995; Wouda et al., 1998). "Clearly, the subject of sexual arousal and any lack thereof is highly complex, with the result that the role of genital vasoactive medication in women complaining of arousal difficulty is far from clear (Basson, 2000, 2001; Andersen and Cyranowski, 1995)," wrote Basson. "The traditional view that vaginal lubrication constitutes sexual arousal in women is...not only restrictive but misleading when arousal disorder is under discussion. Women tend to focus mostly on how mentally exciting they find the stimulus when they rate their sexual arousal (Laan et al., 1995)."

Women with chronic infertility require special consideration. "Emotional intimacy frequently suffers due to the stressors of multiple medical appointments, investigations, adverse effects of fertility drugs, failed cycles, and failed IVF," Basson stated. "The experience of intercourse being required on certain days can lead to mechanical emotionally unrewarding experiences. The women's sense of sexual self-confidence and attractiveness may suffer, thereby inhibit the processing of any stimuli. The outcome can remain unrewarding owing to the limited psychosexual interaction, the focus for so long begin the mechanical act of intercourse, dispensing with erotic play."

"Understanding her sexual response cycles and identifying faulty or absent components motivates the woman to address them," Basson concluded. "Her difficulties are explicable, stemming not only from herself but from her general circumstances, including her partner and her past experiences. She may also see the fallacy of the idea that a medical solution in the form of a pill (hormonal or otherwise) will suffice. Even when biological factors are strong, she can see that focusing only on them without addressing the rest of her cycle will be ineffectual."

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**Asthenozoospermia**

**Relation of Seminal Plasma NO Concentration to Varicocele**

Plasma nitric oxide (NO) concentration is probably not related to infertility in general, but explicitly to varicocele, according to researchers in Turkey, because NO production is less in oligo- and/or asthenozoospermic patients that do not have varicocele.

"NO production could be specifically related to the varicocele, since NO production in oligo- and/or asthenozoospermia cases without varicocele is not increased," wrote the authors ("Seminal
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