

# Beyond the bedroom:

## Advocating for pleasure-centered sexual health education in medicine



Blue Flower (Detail), Georgia O'Keeffe, 1918. Public domain, via Wikimedia Commons

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**L.S.** was a woman who, at 80, still wore her vibrant personality like the clashing floral patterns she adored, with aplomb. In comparison, notes from her prior annual health exams were bland. However, this year something was different.

She was quieter, less verbose, and hesitated when asked about her husband of 60 years. “He wants to have sex all the time,” she remarked, her eyes downcast from a mixture of embarrassment and fatigue. “I know it’s supposed to be somewhat painful, but after so long I’m just not interested. Us older folks aren’t supposed to be doing that as much.” Beneath these words were decades of expectations, disappointments, and difficult-to-articulate emotions. L.S. had been taught that sex meant pain and that aging meant an escape from the obligation to bear it. Her pain at this point was not only physical, but emotional. The intimacy she had once experienced

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with her husband based on their shared expectations had shifted, leaving a gap she was unsure how to bridge.

J.T. was a 16-year-old whose life felt under control, until it didn't. After years of struggling with depression but remaining largely stable, he was admitted to the psychiatric inpatient unit after a weekend that included waving a knife around at his parents while threatening to kill himself. During his largely monosyllabic intake interview, we happened to stumble upon some yet undisclosed information while discussing his sudden change in behavior; namely, that he had stopped taking his psychiatric medications for several months, a secret that he had kept from his family and outpatient psychiatrist. His gaze burned a hole in his dancing-pizza socks as he said, "They just made me feel like a zombie. Plus, with my girlfriend ... you know ... it made doing stuff harder. It was freaking me out but then I read online that it was probably because of my meds." J.T. had never been told about the potential sexual side effects of his treatment plan; nor had his psychiatrist ever asked if he was experiencing them. In this vacuum, he had elected to stop treatment altogether rather than bring something up he felt his providers did not care about.

C.A., a 24-year-old transwoman, had been seeing her primary-care provider for gender-affirming hormone therapy for several years. Chatting at the beginning of her annual check-in, her face lit up when she mentioned a new boyfriend who would bring her a bouquet of different flowers each week for her kitchen table. "I never thought I'd find someone like him," she sighed. When asked if she had any questions or concerns about sex, she hesitated for a beat, but then voiced, "I've been considering a vaginoplasty for a few years now, but I don't want to lose the ability to cum. I want to be able to have that kind of sex with him, but not if it means I'll never enjoy it again." Upon further discussion, it became clear that her fear was due to the fact that her teachers and health care providers had never educated her on the fact that ejaculation and orgasm are distinct, non-mutually exclusive events. In the absence of answers to counter this confusion, she delayed making decisions she felt were vital to her future.

These patients were of three different ages, had three different gender identities, and were seen in three different clinical settings. However, all three had questions related to sex that were never addressed in prior visits. The underlying health concerns of each remained untreated because no health care provider had ever

asked about them before. These concerns may not seem life altering to others, but for these three patients, they were. These concerns caused the patients additional stress, impacted their physical and mental health, and affected their relationships—both with others and their own bodies.

Sexuality is a part of everyone's life. This is true regardless of age, race, ethnicity, ability, income, or any other marker of identity or behavior. Patients and providers each bring their own experiences and expertise to every encounter, creating space for bidirectional teaching. However, for too long when it comes to sexuality, provider knowledge and comfort have constrained this exchange, placing an undue onus on patients to raise the issue. The health care community, to ensure comprehensive and effective patient care, must improve its understanding of and education on sexuality and pleasure, and their relationship to overall health and well-being.

### An introduction to sexuality

Sexuality is a complex phenomenon extending across psychological, physiological, behavioral, and sociocultural realms. According to a recent abstract calling for a more comprehensive definition of sexuality:

Sexuality is a multifaceted concept that is uniquely experienced and expressed.... Sexuality is primarily psychological, reflecting one's emotions, mental state, attractions, desires, fantasies, and identity....Sexuality is also a social concept, reflected in people's interactions, relationships, and connections...[and] is influenced by one's society and culture, both historically and in present day.<sup>1</sup>

Sexuality, while often conflated with sexual behavior, is not reducible to it. Sexual behavior nonetheless also has multiple definitions depending on the discipline. From a psychological perspective, sexual behavior is generally understood to encompass actions related to pleasurable satisfaction (e.g., arousal) and/or reproduction. These actions may involve direct physical stimulation with another person, or they may not (e.g., sexting or masturbation).

When one hears the word "sex," certain images, often involving genitals in some way or another, typically pop into the mind's eye. However, the word can also refer to what is sometimes called "biological sex," or sex

assigned at birth, a label that people base on anatomy, hormones, genes, and/or physical attributes. For the sake of readability, this essay will use “sex” exclusively to refer to sexual behavior, not to assigned sex or sexuality more broadly.

Another important concept related to both sex and sexuality is that of pleasure. The World Association for Sexual Health (WAS) in its “Declaration on Sexual Pleasure” defined sexual pleasure as “the physical and/or psychological satisfaction and enjoyment derived from shared or solitary erotic experiences, including thoughts, fantasies, dreams, emotions, and feelings.”<sup>2</sup> WAS declared sexual pleasure to be a “fundamental part of sexual health and sexual rights,” and argued for the guarantee that it be “integral to sexual health care services provision.”<sup>2</sup>

### **Sex and sexuality in the United States**

For centuries, the U.S. has fostered a stigmatizing relationship to most, if not all, topics related to sex and sexuality. While historically many Indigenous and pre-colonial cultures across the world have embraced open expressions of sexuality (and continue to do so), the dominant narrative in the U.S. and other colonial cultures treats such expressions as taboo, a matter of repression, fear, and disgust.<sup>3</sup>

There are many examples of this taboo throughout U.S. history, such as the Comstock Act of 1873, a federal statute that made illegal and punishable the sending through the postal system of any kind of “obscene, lewd, or lascivious” material.<sup>4</sup> This act, beyond the obvious prohibition on erotica and sex toys, also made illegal and punishable mailing anything related to abortion and contraception, including information.<sup>4</sup> In many cases, this prohibition extended to all written sex-education materials.<sup>4</sup>

Another notable example of this taboo is how homosexuality was criminalized, classified as a mental illness, and heavily stigmatized in the U.S. through most of the 1900s.<sup>5</sup> In fact, health care professionals only removed this classification from the Diagnostic and Statistical Manual of Mental Disorders (DSM), the handbook used to diagnose mental disorders, in 1973 (other diagnoses related to sexual orientation remained in the DSM for many years afterwards).<sup>5</sup> However, continuing stigmatization, both of people who identify as LGBTQ+ and of topics related to sex and sexuality, has led to significant discrimination and neglect in public health response and

treatment for affected groups, most conspicuously during the HIV epidemic in the 1980s.<sup>5</sup> Since then, U.S. cultural perspectives on sex and sexuality have progressed, but deep-seated societal norms and taboos about them persist throughout the country.

### **Sex education**

The legacy of this zeitgeist is evident to this day, highlighted by current controversies over access to comprehensive sexual health education, gender-affirming care, and abortion. Perhaps the most blatant evidence of this persistent taboo is the dearth of comprehensive, accurate, and non-stigmatizing sex education in the U.S. While most states (41 of 50) and Washington, DC, require sex education in public schools, only a fraction of them (26 of 41) require that information to be medically accurate as of May 2025.<sup>6</sup> This deficiency in essential knowledge not only deprives young people of their right to education and autonomy, but also has multiple negative downstream effects, including increased rates of unwanted pregnancy, sexually transmitted infections (STIs), and gender-based violence.<sup>7</sup>

Another negative downstream effect is that many students enter medical school with limited or biased exposure to sexual health topics, having received no, or at most abstinence-only, sex education in high school and then little formal sex education as undergraduates. Depending on the cultural, political, and physical context in which students were raised, they may also have had little exposure to various expressions of sexuality, further affecting their understanding and comfort when providing sexual health-related care. Once these students enter medical school, their main exposure to sexual health education, if it exists, tends to revolve primarily around STIs and contraception,<sup>8</sup> missing many other important sexual health topics about which patients commonly have concerns.<sup>9</sup>

Consequently, health care trainees often feel ill-equipped to competently and confidently address sexual health issues.<sup>8,9</sup> Medical students and residents are aware of, and have expressed their dissatisfaction about, these gaps in their education. Steve Criniti et al. highlight multiple studies showing that around half of medical students and residents report dissatisfaction with the sexual health education that they received and feel inadequately prepared to address patients’ sexual concerns.<sup>8</sup> These studies are in line with that of Sarah Beebe et al., who found that, on average, medical students and

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residents rated their preparedness to treat patients with sexual health concerns as 2.7 out of 5 (equivalent to 54 percent).<sup>9</sup> Beyond these subjective assessments is the objective evidence of knowledge gaps. Criniti et al. discuss one study showing that two-thirds of fourth-year OB-GYN residents had little knowledge of how to administer or interpret screening questionnaires for sexual function,<sup>8</sup> which is notable given that OB-GYN and urology residents tend to receive the most training in sexual medicine and report higher comfort levels with the topic than other residents.<sup>9</sup>

### Implications for providers

Unsurprisingly, the low confidence and competence of medical students and residents does not magically resolve after they transition from trainees to independent providers. Some providers, depending on their specialty, may not feel this educational gap is a cause for concern. However, it affects health care professionals across all specialties, not just primary-care providers or reproductive-health experts. Sexual health is intimately connected to a wide range of physical, mental, and emotional states, and has bearing on a wide range of clinical specialties.

Specialists like endocrinologists regularly encounter sexual health concerns, such as erectile dysfunction or changes in libido, whether as sequelae of endocrinological conditions or as side effects of their treatment.<sup>10</sup> Dermatologists who have patients with conditions such as psoriasis or eczema need to be able to discuss how those conditions affect self-esteem and intimacy, especially if they appear in areas of a patient's body directly involved in sexual activity. Neurologists frequently care for patients with conditions that lead to changes in sexual function (e.g., multiple sclerosis, spinal-cord injury, or movement disorders).<sup>11</sup> Similarly, oncologists commonly care for patients who experience sexual health concerns related to treatment.<sup>12</sup> However, while 84 percent of oncology providers surveyed believe discussing sexual health is part of their job, only 17.4 percent of them reported discussing sexual health often or always and a majority of them, 62 percent, reported never or rarely giving their patients a referral to professionals specializing in sexual health.<sup>12</sup>

Other surgeons operating on areas of the body unrelated to reproductive organs are no exception. Orthopedic surgeons rarely have open discussions about safe sexual positions upon resumption of sexual activity post-arthroplasty.<sup>13</sup> Colorectal surgeons, who should be aware that

post-colorectal surgery patients report substantial alterations in preferences related to sexual positions, sexual activity, and body confidence, seldom refer those patients to health care professionals for advice about sex.<sup>14</sup>

By integrating comprehensive sexual health education into the medical training of all specialists, the health care community can better prepare providers to engage in these important conversations, to recognize sexual health issues early, and to provide timely and appropriate care. Ultimately, these skills should be a part of every physician's toolkit, for they can lead to enhanced quality of life for patients across the lifespan, regardless of chronic illness or comorbidities. True excellence in health care means treating sexual health not as an area of specialization for only some providers, but as a standard of practice for all.

### Implications for patient care

Educational gaps in sexual health have repercussions on how providers communicate, directly affecting patients. Research suggests that many patients want their health care provider to initiate discussions about sex.<sup>8</sup> Many think that if they raise the topic themselves, their provider will dismiss them or become uncomfortable.<sup>8</sup> This hesitancy can prevent patients from receiving the education and resources necessary for safer and more pleasurable sex.

As societal norms shift, and opinions around sex and sexuality become more open, especially among younger generations, the need for accurate and accessible sexual health information becomes increasingly urgent. Social media has not only amplified opportunities for sex education, but provided platforms for rampant misinformation about it, both of which can affect people's health. While greater cultural openness to and acceptance of a broader range of sexual interests is encouraging, it also intensifies the need for health care providers who can understand and be comfortable discussing sexual health with patients. This need has been underscored in recent research cataloging the rise of "rough sex" in U.S. college students. Debby Herbenick et al. have found that while definitions of rough sex were diverse among this population, they often included choking (more accurately referred to as "strangulation").<sup>15</sup> As Herbenick et al. note, the frequency of strangulation raises critical safety concerns (even if consensual),<sup>15</sup> concerns that necessitate educational, fact-based discussions between providers and patients to allow patients to make informed choices.

Ultimately, to provide patients with the best, most-comprehensive health care possible, providers must increase their comfort with and competence in topics related to sex, sexuality, and sexual health.

### **Implications for medicine and public health**

The dearth of sexual health topics covered in individual patient-provider interactions and in medical education generally is indicative of a larger systemic issue: much of medicine, both clinical- and research-oriented, remains deeply rooted in a problem-based approach. This approach, which emphasizes identifying and addressing specific health issues based on their symptoms, has served as a cornerstone for medical practice for centuries. While the approach is useful in managing certain acute conditions, such as infections and injuries, it presents significant challenges for and has negative repercussions on contemporary health care.<sup>16</sup> It often reduces the complex health concerns of individuals to an isolated problem, neglecting the broader context of their lives and personal goals. As James W. Mold has said, “The result is great disease management but poor doctoring.”<sup>16</sup> The reductionism of this approach, in addition to lessening the quality of patient care, has contributed to clinician burnout, inertia, patient dissatisfaction, and rising health care costs.<sup>16</sup> These limitations have led to a growing call for a paradigm shift in health care provision towards person-centered, goal-oriented care that better aligns with individual patients’ values and needs, and offers a more holistic and humane approach to health management.

The same limitations are found in sexual health care, which likewise tends to focus on the prevention of negative outcomes, or problems, such as STIs, unwanted pregnancies, and sexual violence. That focus, in turn, leads to an overemphasis on the risk of certain behaviors and, occasionally, patient characteristics that may increase the likelihood of what we consider to be adverse outcomes. Though this and other risk-based approaches aim to prevent harm, they often oversimplify complex issues to the detriment of the emotional and physical dimensions of sexuality that contribute to well-being. Moreover, fear-based messaging, often used in counseling related to sex, is most likely ineffective in motivating change in health behaviors.<sup>17</sup> It also contributes to such negative consequences as the stigmatization of certain populations. Sarit A. Golub examines how damaging the “high-risk” label has been, specifically when used in the

context of HIV prevention, contributing to both stigma and exaggerated fears of risk-compensation behavior.<sup>17</sup> She argues that the theory of risk compensation—the belief that prescribing pre-exposure prophylaxis (PrEP) to “high risk” HIV patients encourages unprotected sex, sex viewed as inherently negative—has hindered the broad implementation of PrEP as a preventive measure.<sup>17</sup>

Just as Mold<sup>16</sup> argues that modern medicine should shift from a problem-based framework to a goal-based framework, educators, advocates, and researchers in sexual medicine have begun to call for a shift from risk- to pleasure-based sexual health care.<sup>16</sup> A pleasure-based approach places more emphasis on the positive aspects of sexuality and sexual health, and on the enhancement of individuals’ sexual experiences, desires, and overall well-being. This approach, rather than concentrating solely on what individuals should avoid, invites them to explore and understand their sexuality and sexual preferences, promoting self-awareness, autonomy, and open communication with partners. It allows for a more inclusive and holistic relation to sexual health that comprehends the diverse ways in which people experience sexual pleasure and connection.<sup>18</sup> Sexual pleasure, as international bodies such as WAS recognize,<sup>2</sup> is not just a crucial component of health, but a human right. Ignoring that kind of pleasure contributes to a limited and paternalistic view of sexual health.

A pleasure-centered approach also offers health care providers an opportunity to dismantle harmful stigmas surrounding sexual health. By moving the focus of conversations with patients away from risk to what enhances sexual well-being and intimacy, providers can help reduce shame, foster trust, and support patients in cultivating healthy sexual lives. For example, providers can reframe STI- and HIV- prevention tools like condoms and PrEP as not merely a means to avoid infection, but as a means to increase the capacity for experiencing pleasure. In a meta-analysis of sexual- and reproductive-health interventions, Mirela Zaneva et al. have found that those incorporating the concept of pleasure had more successful outcomes (e.g. increased rates of condom use) than those that did not.<sup>18</sup>

### **Steps forward**

There is substantial evidence that the current state of medical education across all stages of training is inadequate with regards to sex and sexuality. To resolve this problem, standardized and pleasure-centered sexual

health education must be integrated into the medical-student, medical-resident, and continuing-education curriculum to enhance the willingness, comfort, and competence of providers in addressing patients' sexual concerns. Medical professionals should work to transition from a risk-based to a pleasure-centered paradigm to ensure more holistic care and ultimately improved outcomes for patients.

Efforts to reform sex education in medical training are promising yet nascent. A few medical schools have started developing strong sexual-education curricula that can serve as foundational examples.<sup>8</sup> For currently practicing providers, new models like the GOALS Framework for Sexual History Taking in Primary Care ([goalsapproach.org](http://goalsapproach.org)) show potential for enhancing provider comfort, patient-provider rapport, and such measurable outcomes as STI testing.<sup>19</sup> On a global level, organizations like The Pleasure Project ([thepleasureproject.org](http://thepleasureproject.org)) are working to promote systemic change through education, research, and advocacy on pleasure-based safe sex.

Despite these efforts, challenges remain. Stigmatization and active resistance to the inclusion of sexual health topics persist in all educational contexts, and medical schools in particular face the difficulty of prioritizing this curricular content amidst an already crowded syllabus. There is limited evidence-based research on certain sexual health topics, often due to a historic or an ongoing lack of funding. There is also a shortage of educators with expertise in sexuality since many health care professionals currently lack the training to teach competently on these critical topics themselves.

Failing to overcome these barriers will, however, result in continued stagnation and another generation of ill-equipped physicians. Greater interdisciplinary collaboration among sexuality educators, researchers, health care professionals, community organizations, and patient advocates can help facilitate the necessary reform. Medicine must evolve or the world, and patients themselves, will move on, leaving providers and the health care profession behind.

The experiences that L.S., J.T., and C.A. had with the health care system highlight the profound impact that the neglect of sexuality and sexual health can have on people's lives. For L.S., she felt trapped in a relationship where intimacy was synonymous with discomfort and had been for decades. Her current struggles with desire discrepancy left her feeling isolated and frustrated with her husband, but also with herself. If earlier health care

providers had asked about her sexual health, they could have offered her simple solutions to reduce her discomfort, both physical and emotional.

J.T.'s silent discontinuation of his medications is regrettably common and speaks to a deep systemic failure in patient-provider communication about sexual side effects. The decision to stop treatment, made in isolation, was particularly unfortunate in J.T.'s case as it contributed to a newfound distrust of health care providers and, more than likely, his hospitalization. An earlier conversation with J.T., however brief, could have provided him with an alternative treatment plan, one that spared him from encroachment on his autonomy and perhaps further deterioration of his mental health.

The absence of space provided to C.A. to discuss her sexual health in relation to surgical options delayed critical decisions about her body and future. Had her providers normalized and welcomed questions on that topic without embarrassment, she might have had the information that she needed to make an informed decision sooner and avoided the unnecessary burden of fear. This type of delay is particularly notable given the quickly changing political and legal landscape regarding people's ability to access gender-affirming care.

Ultimately, the goal is to envision a world where people have access to pleasurable, safer sex without stigma or fear. As William A. Anthony, a former Executive Director of the Center for Psychiatric Rehabilitation at Boston University, has said:

A vision pulls the field of services into the future. A vision is not reflective of what we are currently achieving, but of what we hope for and dream of achieving. Visionary thinking does not raise unrealistic expectations. A vision begets not false promises but a passion for what we are doing.<sup>20</sup>

Visionary thinking should be understood as part of a broader commitment to enhancing patients' overall well-being. A pleasure-centered health care system goes beyond simply addressing symptoms or risks to helping individuals achieve more fulfilling lives, including more fulfilling sexual lives. In such a system, each service—whether it be sexual history-taking, treatment, or counseling—is designed not only to reduce negative health impacts, but also to create opportunities for greater pleasure, autonomy, and well-being. Providers would not merely manage sexual health issues as they

arise, but actively foster positive sexual health outcomes for patients by enhancing their sense of agency, encouraging open dialogue about their desires and concerns, and supporting their pursuit of sexual fulfillment. The objective, then, is not just to resolve specific problems, but to promote vibrant and rewarding sexual lives. Health care providers, by adopting this approach, can help create an empowering, supportive, and respectful environment where patients can pursue healthier, more pleasurable sexual lives, free from stigma or fear.

This transformation starts with health care providers who understand the importance of sexual health and pleasure in overall well-being, and feel comfortable addressing patient concerns related to sexuality. While improving medical education on sex and sexuality may not be simple, it is a vital first step to achieve the necessary changes. The medical profession, by advocating for enhanced and pleasure-centered sexual health education, can prioritize patients' sexual health, well-being, and rights within the broader scope of holistic care. Truly excellent providers caring for their patients as humans will recognize the importance of bringing sex and sexuality outside the bedroom and into the clinic.

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