

Let's Get Personal: Intimacy And Sexuality After Breast Cancer

**National Teleconference Transcript
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Presented By:



Linking Young Jewish Women in Their Fight Against Breast Cancer

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I. Introduction

Shera Dubitsky, M.Ed., M.A., Clinical Supervisor, Sharsheret

Shera Dubitsky: Shera Dubitsky: Thank you for joining us this evening for Sharsheret's National Teleconference, "Let's Get Personal: Intimacy and Sexuality after Breast Cancer." We welcome all of tonight's participants who, by the way, represent over 15 states across the country.

My name is Shera Dubitsky and I am the Clinical Supervisor at Sharsheret, a national organization supporting Jewish women facing breast cancer.

Momentarily, I will have the pleasure of introducing our distinguished speakers who will be sharing their insights and wisdoms into what is often a difficult enough subject discussing with your partner or close friends, let alone in a public forum. I assure you that tonight's program is designed to explore this topic in a sensitive, modest, and confidential forum.

I would like to briefly thank Sharsheret's staff and volunteers who have spent many hours researching and coordinating logistics in order to make this an invaluable and successful event.

Throughout my years of working with people living with cancer, I have had many conversations concerning intimacy and sexuality. Issues have focused on premature menopause, decreased libido, painful intercourse, altered self-esteem and body image, only to be complicated by issues that arise when there is a spouse or partner involved. One particular woman I spoke with summarized her feelings saying, "My sex drive is in the freezer and I don't even feel attractive enough to take it out to defrost." In this brief statement, this caller captured the physical and emotional issues facing many women who have faced or are facing breast cancer.

Jewish women face a litany of other ritual and spiritual issues that further complicate the issues of intimacy and sexuality, including fulfilling the mitzvah of sexual intimacy at a time when you do not want to engage physically for multiple reasons and the difficulty of being intimate because it may be a reminder of not being able to bear children naturally, a value deeply embedded in Jewish life. This teleconference is for anyone who has been touched by breast cancer and is seeking sexual well-being in the context of living as a Jewish woman.

It is now my pleasure to introduce Dr. Elizabeth Poynor. Dr. Poynor is a gynecologic oncologist and pelvic surgeon who focuses on a comprehensive surgical management of gynecologic cancers and works with medical and radiation oncologists to facilitate a compassionate, multidisciplinary approach to the management of women's cancers. She has special expertise in the complex management of women and their families who have a genetic predisposition to

developing breast cancer and gynecologic malignancy. As a surgeon-scientist, Dr. Poynor's work focuses on translating basic science principles into clinically meaningful treatment and she serves as Director of translational research for the gynecology service at Memorial Sloan-Kettering Cancer Center. She has also served as an investigator in numerous clinical trials relating to surgical, medical and biological treatment of gynecologic cancers. Dr. Poynor has graciously spoken at a previous Sharsheret symposium, "Breast Cancer and Ovarian Cancer: Exploring the Connection." Her words of wisdom continue to be available on our website under transcripts. Without further ado, please join me in welcoming Dr. Poynor.

II. Physical Side Effects and Medical Intervention

Presentation by Elizabeth Poynor, M.D., Ph.D., FACOG

Dr. Elizabeth Poynor: I'd like to thank Shera and the organizers of this important conference for allowing me to participate this evening.

Sexuality after a cancer diagnosis is an important topic that is now beginning to get the attention that it deserves. Sexuality is an important quality of life issue for women and sexual function/dysfunction can affect individual mental health, relationship satisfaction, quality of life, and family functioning.

Approximately 43% of American women are experiencing problems with sexual functioning and this number is much larger for women who have undergone or who are currently undergoing treatment for breast cancer. Women's sexuality is a complex dynamic between a number of factors and an individual's life which include those related to emotion, relationships, and physical health. Any of these components can be affected by a cancer diagnosis. This evening, I will focus mainly on the physical side effects of breast cancer treatment and my colleagues will focus on the relationship emotional issues.

In order to understand how breast cancer can affect a woman's sexuality, it is important to understand the female sexual response cycle. The most recently developed model describes the circular set of events in which women will have multiple sexual and non-sexual reasons for engaging in sex such as: emotional intimacy, sexual stimuli, and spontaneous sexual drive. This model also includes psychological and biological influences on arousability and the subjective feeling of arousal and desire. The pleasurable outcomes, including emotional and physical satisfaction, affect the seeking out of subsequent sexual encounters. Within this model, there are many factors that may instigate sex and a variety of potential outcomes. Factors that may interfere with the satisfactory sexual cycle for a woman include: lack of emotional intimacy, lack of appropriate sexual stimuli, negative psychological factors, fatigue, depression or medications that reduce arousability.

Any assessment of sexual dysfunction should include a clarification of the sexual problem including the length of time that the problem has been present. Is it acute or has it been going on for before a cancer diagnosis? Is it always present or is it situational? How is it affecting the relationship with your partner?, should be an important question and does your partner have any sexual problems, that may also contribute to your sexual dysfunction, have there been any prior assessment or treatment. Then, a thorough medical, surgical, and psychological history should be taken.

Female sexual dysfunction can be attributed to any or a combination of the following factors as these rarely act in isolation to affect the woman. They include deficit in sexual desire, arousal difficulties, orgasmic difficulties, and sexual pain disorders.

Hypoactive sexual desire disorder is characterized by a persistent or recurring deficiency of sexual fantasy, thoughts and/or receptivity to sexual activity that causes personal distress. The causes can be physiologic including hormonal deficiencies of androgens and estrogen. They can be secondary due to other problems in a sexual response cycle such as poor arousal and response or pain. They can also be psychological including depression and associated treatments for depression.

Female sexual arousal disorder has been characterized by persistent or recurring inability to attain or maintain adequate sexual excitement causing personal distress. This can be due to vaginal dryness, low sensation of the clitoris and labia, decreased engorgement of the clitoris and labia, or lack of vaginal smooth muscle relaxation. The causes again can be physiologic including, medications and hormonal deficiencies, secondary to other problems in the sexual response cycle, and psychological due to low self-esteem, poor body image, depression, and anxiety.

The female orgasmic disorder has been characterized by a persistent or recurrent difficulty, delayed and/or absence of attaining an orgasm following sufficient sexual stimulation and arousal that causes personal distress. Causes again can be physiologic including medications which are used to treat depression such as SSRIs (Selective Serotonin Reuptake Inhibitors – antidepressants) or hormonal deficiencies, secondary again to other problems in the sexual response cycle and psychological stressors including emotional stressors and relationship conflicts.

Sexual pain disorders include vulvodynia, which is chronic vulvar pain, or vaginismus, which is involuntary spasm of the outer one third of the vagina interfering with vaginal penetration.

Medical and psychological causes of sexual dysfunction can be due to the following possible medical conditions. They include vasculogenic causes including high blood pressure, high cholesterol, smoking, and heart disease which can damage the small vessel - blood vessels leading to the clitoris and the labia. They can be musculogenic due to deficits in the pelvic floor and nerve injury to the pelvic floor during the increased intra-abdominal pressure of pregnancy and pushing during child birth. They can also be due to neurogenic causes or damages to the nerves due to central or peripheral nerve disease such as diabetes. Causes of female sexual dysfunction can be hormonal including menopause induced by either chemotherapy or oophorectomy. And of course

psychogenic including emotional and relationship issues, depression, and associated medications, anxiety, poor self-esteem and body image, stress, and fatigue.

Sexual challenges during and after treatment for breast cancer include body image issues related either to lumpectomy, mastectomy, or lymphedema after surgery, relationship issues in which stressors can occur after a partner has been diagnosed with cancer, depression which is a normal reactive response to a cancer diagnosis, hormonal issues including chemotherapy induced menopause, surgically induced menopause when oophorectomy is used to treat breast cancer or to prevent ovarian cancer, and those related to the selective estrogen receptive modulators such as Tamoxifen and the aromatase inhibitors such as Femara.

Hormonal changes which lead to sexual dysfunction include decreased estrogen which results in adverse effects on the structure and function of the clitoris and the vagina with resulting decreased blood flow and scarring or fibrosis of the clitoris, decreased blood flow and vaginal thinning. This results in vaginal dryness, lack of sexual arousal, and decreased libido probably due to the previous two problems.

A lack of estrogen may also affect a woman's mood so that she is not receptive to sex. Androgen insufficiency has also been linked to libido problems. The risk of menopause during chemotherapy treatment is related to the type of treatment and the age of treatment.

There are multiple mechanisms by which chemotherapy can cause ovarian damage and alkylating agents such as Cyclophosphamide or Cytosan are caused the most damage to the ovary and this is a drug which is commonly employed in the treatment of breast cancer. The degree of damage to the ovary is determined by whether a woman loses her period during chemotherapy, called amenorrhea is permanent and she goes on to a permanent menopause or whether it's temporary and she regains her hormonal function. Standard endocrine therapy such as Tamoxifen or the GNRH agonists do not damage ovaries but they may be used during the years in which ovarian function is naturally declining such that a woman will go through menopause after she completes her endocrine therapy. Many young women with breast cancer will remain premenopausal after adjuvant treatments for breast cancer with chemotherapy. However the duration of their premenopausal status and associated fertility may be shortened due to ovarian damage.

Vaginal atrophy or vaginal thinning is the major and universal change related to estrogen deprivation. Up to 70% of women with breast cancer will report symptomatic vaginal dryness. This leads to painful intercourse and may interfere with sexual responsiveness. Vaginal atrophy occurring as a result of treatment

related estrogen deprivation either due to chemotherapy or surgery is often more severe and develops more rapidly than with the onset of natural menopause so that these problems may be more difficult to deal with.

Tamoxifen can also affect vaginal atrophy because it blocks estrogen combining to the receptors in the vaginal mucosa leading to vaginal symptoms and 19% to 48% of women on Tamoxifen. Women taking aromatase inhibitors may also experience more severe vaginal dryness when compared to women taking Tamoxifen. And ovarian ablation with GnRH agonist also causes vaginal dryness and up to 26% of premenopausal women who are treated.

Vaginal atrophy treatments by non-hormonal treatments including vaginal moisturizers actually may be very effective when used properly on a regular basis. Regular sexual activity may also help to prevent vaginal atrophy by improving blood flow to the vaginal tissue and dilators may also be used to increase vaginal capacity to overcome the lack of elasticity in the atrophic vagina. Hormonal treatments can also be employed at the discretion of the treating oncologist and topical estrogens may be very effective when there is low systemic absorption. In one very small study of topical estrogen they actually appear to be relatively safe for a well selected group of individuals with breast cancer.

Treatments for women with sexual dysfunction and a diagnosis of breast cancer, of course, include psychosexual treatments, pharmacologic including hormonal treatments, non-hormonal treatments and some herbal remedies. Non-pharmacologic treatments include, Eros therapy which is a clitoral stimulator, sexual aids, and physical therapy to increase pelvic floor musculature.

Of course, there is always a combination of therapies which will be employed for each patient and a treatment plan which will be individualized. There's interaction of various factors leading to sexual dysfunction and treatments must therefore be individualized and multidisciplinary. Treatment also includes psychology as well as medical therapies and oncologic therapies.

Pharmacologic treatments include estrogens to improve clitoral sensitivity, increased libido, and decreased pain during intercourse. Systemic estrogens are usually contraindicated in women with breast cancer except in exceptional situations. Topical estrogens, however, may be considered at the discretion of the treating oncologist.

- Androgens may also be in use. They may improve libido. An individual may opt to use topical testosterone. However the studies (there are no studies in women with breast cancer and the safety has not been proven) have not shown proof yet. It's very important to realize that testosterone may also be converted to estrogen in a woman's body.

- Pharmacologic treatments include vasodilators such as Viagra. This may help with arousal disorders in women. However, results are not consistent and use again must be individualized. L-Arginine is very effective in men however it has not been yet studied in women.
- Phentolamine is another vasodilator which may enhance vaginal blood flow and subjective arousal, and prostaglandin E1 may be delivered intravaginally and is currently being investigated in women.
- Wellbutrin may also be a drug which maybe used to improve libido in a woman with breast cancer and one small study has been reported in literature to demonstrate that Wellbutrin does have a positive effect on women who have a diagnosis of breast cancer.
- Herbal treatments include Zestra which is a topical botanical formation which results in increased clitoral and vaginal warmth, heightened arousal, and increased sexual pleasure. It increases blood flow and nerve conduction. In a small clinical trial involving 20 women, Zestra was shown to benefit both normal women and those with female sexual arousal disorders.
- ArginMax is another nutritional supplement which is composed of a number of herbs. It is thought to enhance blood circulation and muscle relaxation resulting in increased arousal. It was also shown in a pilot study to improve sexual function in women with sexual dysfunction. This product however contains ginseng which has been shown to have estrogenic effects and has not been studied in women with breast cancer or with other cancers.

In conclusion, sexual dysfunction is common in women with breast cancer with at least 60% reporting some level of sexual dysfunction. Attention to women's sexual concerns has recently moved into the forefront of clinical medicine. Women's sexuality is complex and requires a multidisciplinary approach which should include attention to psychological, physiologic, and oncologic issues. Sexual dysfunction may involve painful intercourse, loss of libido, difficulty in maintaining arousal, or difficulty in achieving orgasm. This may result from treatment related events such as medically or surgically induced menopause, specific effects of medical treatments, and body image issues secondary to surgical treatment including lumpectomy and mastectomy.

Patients should be given the opportunity to discuss openly and freely their sexual health issues with their healthcare professional in a kind, professional, and compassionate manner. A multidisciplinary approach is necessary which must include the treating medical oncologist as well as a healthcare professional comfortable in managing sexual health concern.

Once again thank you very much for allowing me to talk at this important conference this evening.

Shera Dubitsky: Thank you Dr. Poynor. You have given us a wonderful overview of the medical issues affecting intimacy and sexuality and I think that you shared a lot of information.

I just want to say to our participants that this transcript will be on our website at www.sharsheret.org so that you can have the information available to you the second time. I certainly encourage our participants to explore the options that you suggested.

It is now my pleasure to introduce Sage Bolte. Sage works for Life With Cancer and Inova Health System non-for-profit program in Northern Virginia where she has helped develop a program that addresses the needs of people impacted by advanced breast cancer. She also provides individual and family counseling, facilitates cancer support groups and partner support groups, and also presents educational seminars on sexuality and intimacy. Sage has presented at local, regional, and national conferences on the impact of chronic illness on sexuality, intimacy, and sexual function and ways that people are affected by a cancer and the healthcare professionals to address common problems. Upon completion of her PhD, she hopes to further the training of oncology social workers in the area of sexuality and utilize her training in an oncology clinical practice and at the university level. Finally, I want to mention that Sage was generous of her time and insights in helping Sharsheret develop the Empower teleconference on dating and disclosure. Sage, the proverbial floor is yours.

III. Psychological and Interpersonal Issues

Presentation by Sage Bolte, MSW, LCSW, OSW-C

Sage Bolte: Thank you so much and it's such a pleasure to be with you all this evening and I look forward to hopefully being able to answer questions in the question and answer time if I don't cover the topic here you're most interested in.

As Dr. Poynor pointed out, I know there are a lot of physiological implications of the treatments that you all have undergone. All of that is complicated by the psychosocial implications and sometimes the psychosocial implications complicate the sexual function issues as well as the treatment issues.

I want to talk just briefly about some of the psychosocial implications that impact both intimacy and sexuality. I want to first say that loss is a huge part of being diagnosed with cancer. It can affect the way you feel about yourself as a woman, the way you feel about your partner, the way you feel about your marriage or your relationship, and your future. It's important to start by acknowledging the loss - acknowledging the possible loss of fertility, again, the changes in body image and sexual drive and sometimes grieving that loss helps us move forward. Then grab on the hope, because there are always things that can improve, there is always a way to find a way to enhance your sexuality and your intimacy, to enhance the way you feel about yourself.

It's important to maintain an open mind, be open to the possibility that maybe your new normal, and I'm going to use that term a lot throughout this talk, may look different than your old normal. It's important to remember, again, that what may have worked last year as far as your relationship or dating or in your marriage, in your sexual self may not work now because of the treatments that you've undergone. We need to give ourselves permission to reestablish a new normal, to reestablish what may work for us today and maybe that will change tomorrow. Keeping an open mind is going to be an important part of really healing your sexual self.

I want to start briefly by just introducing how you might talk about some of the sexual concerns that you might have with your partner. I will also talk briefly about a single person as well but right now I'm going to focus on talking to your partner.

How do you talk to your partner about sex after cancer treatment? The National Cancer Institute has some great tips on it so I'm taking from their information and it really talks about how to talk to your partner to avoid blame, to stay positive, and to give your significant other a better sense about how you're feeling.

You want to start with describing what's happening with your sex life and then give your thoughts and beliefs about why your sex life is the way it is, how it

makes you feel: for example, it if makes you feel scared, lonely, sad, angry, feeling isolated. And then, what would please you or what would make you feel better.

One of the things we definitely know about coupleship is that we can tell them how we're feeling. But, if we don't give them a path to correct or a path on how they might fix it and make it better, we're just kind of turning water. Here's an example of what you might be able to say to your partner, "We've made love only a few times since my cancer treatment," that's stating a fact. Then you might say, "I think it may be because my scars are a problem for you or because I don't have a breast." That's your belief so again you're avoiding blame. Then you state your feelings. "When we don't have sex, I feel very lonely and I miss being close to you. Sometimes I also feel angry that cancer affects are sex life too." You're stating your feelings after your belief and your act. And then give them something to go with, how can they create change. Maybe also in the suggestion that I feel much better if we have sex more often or if it was your idea more often. You've offered them a fact of how you feel, your belief about why there is concern or problems in your sex life. Then you're giving them suggestions on your feelings and then how they can correct the problem or how you can work together as a couple.

Then when they respond, make sure that you listen to what they say. Don't assume that you know what they're going to say. Repeat what he or she says in your words so that you show that you understand and show support saying things like, "You seem worried," or "I'm sure this is hard for you too." Listen and focus on your partner's comments, not on what you plan to say in response. It's important to keep an open mind.

If you are experiencing sexual difficulties within your coupleship, beyond just talking about the problem, there are some things you can do to help enhance it. Some of it is just simply finding different sexual positions that maybe more comfortable for you. As Dr. Poynor said earlier, some of the changes - the vaginal changes that are caused by cancer and its treatments may impact the comfort level of certain positions. You may need to experiment with different positions to decrease both of your anxiety. If you recently had a mastectomy you may want to try a different position to feel like you're protecting your breast area. Sometimes even placing a pillow over your chest eases the anxiety around causing any pain. Utilizing vaginal lubricants to assist with increasing comfort, I usually tell patients that about water-based lubricants if you have any concerns. There are also products that help enhance sensations that are helpful, some clitoral enhancement aids that are creams or ointments that you can use to help enhance that response.

Remember that the change in libido is a significant loss and I know I hear that from women all the time. But there is a way even without adding any lubricants or

enhancements aids to help improve your libido. Some of that is just being willing to change the thought of a libido comes from the body or physiological response to maybe thinking that now it moves to the head, that the libido really starts from the head. We need to talk to ourselves and get ourselves in the mood by saying some self-talk. It may need to start very early in the day. If you plan on being intimate with your partner later in the evening, you may need to start with just offering yourself some statements saying, "I will feel sexual this evening," or "I'm feeling sexual today." Offer yourself statements that help enhance your sexual self. Even just offering yourself positive statements about how you feel or look can help you get in the mood. We all need more time to kind of get revved up for that. Give yourself time and patience and give yourself all day to get ready if you need to. But remember that it goes from changing from just a physiological response to a head response and we can create that change with practice.

We need to remember to communicate. Our partners don't read our minds. They may have no idea that you're frustrated or scared or anxious. We need to make sure we communicate that. If you still feel stuck in your communication or in some of your sexual response, you may need to see a therapist together to help work through your road blocks or talk to your spiritual leader for assistance and advice.

If you are a couple with children - one of the things I really talk about with couples is the importance of maintaining intimacy within the marriage because in the midst of cancer treatment, life gets turned upside down and as you're trying to maintain this normal feat for your kids - you may forget that the two of you are still a couple and not just going to cancer together. Remember that marriages don't work if you don't take time out for each other. It's important to schedule the night out for the kids on a regular basis or for yourself on a regular basis. Remember to be honest with your kids because intimacy is also with your children, not just with your partner. They may have a lot of questions, so be honest with them. Express yourself in front of your children as you feel comfortable and in a loving way. Find a way, as a couple, to connect with each child if you find that your activity level is limited. Some women experience such fatigue that intimacy is really challenged, both physical intimacy with their partners as well as intimacy with friends and their children. You may need to get down on the floor and play a board game or change some of the normal dynamics to accommodate your new normal.

The next part again of maintaining intimacy is really thinking about all of your relationships, not just your partner relationships. Part of maintaining intimacy is making sure that you have a close-knit circle who are really giving to you as much as you are giving to them. Cancer can provide us with an opportunity to really reevaluate any relationships that we have in our life that may not be as healthy as we'd hoped. That may be what I would call a "toxic" relationship. These relationships are really not helpful for your physical or your emotional

health. It's important to surround yourself with individuals who are able to be honest with you and who provide you with the support you need. If your needs, your emotional needs and your physical needs, aren't being met, it's important that you ask.

If a friend says something to you, you may need to say, "You know, it's not helpful when you say to me that everything is going to be okay or everything happens for a reason. What I need from you is for you to listen to me and tell me that this frustrates you too." You're giving them language to use with you. And, again, telling them what you need and asking for your needs to be met.

With maintaining intimacy you need to get to know your new body and it's important for you to take time to do that. There are going to be sensation changes whether you've had a lumpectomy or mastectomy or radiation to your breast area. You need to start with some self pleasuring exercises, first on your own in the privacy of your own time. This can be done in the shower or the bath or when you're lying down. Figure out what feels good. Maybe there are certain parts around your breast or above that are extra sensitive that you don't want them touched or sensitive enough that they feel good to be touched. You may want to explore the use of massage to help with increasing your libidic response or using vibrator aids to assist you in getting to know your sexual response again or to enhance your response within your relationship.

Provide yourself with daily affirmations. You know, so often in the middle of a crisis or when we're feeling down, we begin to tell ourselves negative things. "Oh, I look so awful today," "Look at those bags under my eyes," "No one will ever want me," "I can't believe he's attracted to me." All those negative thoughts we start to latch on to. What would happen if we actually started saying positive things to ourselves in the morning? Providing a daily affirmation to ourselves, waking up in the morning and looking in the mirror and even if we don't believe it at first, telling ourselves something positive, "You'll have a great day," "You'll feel beautiful." "I am good to my body and I will do all that I can to help enhance how it feels."

You can also choose a friend who will help lift you up and who you can talk to about some of these issues. All of us usually have one friend that we feel really safe with and then others we don't. Choose that friend to kind of talk through some of these issues. You may be surprised whether they are survivors or not. But they have the same issues.

Then as you're getting to know your body again, take some time to really pamper yourself and reconnect to yourself. Maybe that's just taking a day out to go to a day spa or finding something feminine for yourself that enhances how you feel about yourself.

Some other ways in maintaining sexual and intimate moments is to really find other ways to be sexual. Remembering, that sometimes being naked together is the most intimate experience. If sex isn't an option right now, you can have a wonderful sex life without the actual act of sex.

If body image is a concern, if you've had a mastectomy, and you've chosen not to have reconstruction, or if you're in the midst of having reconstruction, or you've had reconstruction and are not pleased the way it looked, then you may want to look at wearing silk lingerie. If you're using a prosthetic, wear the prosthetic with a pretty bra or a silky camisole that would enhance how you feel about yourself. You can still feel sexual and modestly clothed.

You can redefine your new normal. Be patient that this may change on a daily basis. Maybe tomorrow your libido is higher than it is the next day. That's okay, be patient with the process. Go slowly at first. Allow yourself time to get used to the scars and spend time touching, both yourself as well as allowing your partner to touch any scars or areas that are of concern. You're going to need to give them permission to touch because a lot times partners are very scared to initiate out of fear of hurting the woman. Or out of fear of not knowing what feels good anymore. You're going to have to direct them or give them permission to touch. With libidic changes, you may just need to ask for more foreplay. You may need to spend more time kissing or touching. You may need to find ways to feel more sexual and sensual, enhancing the areas that you feel confident about.

Maybe you feel really confident about the way your eyes and your face look so enhance them so that you take time to feel more sensual or sexual. Take more time to set the mode or make yourself feel beautiful before you're going to engage. Again, you go in confident and feeling confident.

You may feel as far as your intimate life goes or your social life has drastically changed. You may need to find ways to connect with your friends or loved ones in a setting that you enjoy. Maybe that means they come over for a half hour in the evening when you're most refreshed, at 7:00 or 7:30 instead of 9:30.

You may also want to think, in a partnership, about creating a sensual mood. Some of the simple things that we go back to, maybe when you were first married, lighting, music or lighting or candles, creating a special scent, a romantic meal, some of the simple things that get lost when you are married for a while or even if you have dated for a while. Creating a sensual mood is going to be an important part of helping your response - your sexual response as well as your sensual response. Maybe you need to take a long weekend trip to celebrate being done with the treatment or to celebrate just being ready to redefine your new normal and kind of re-embrace who you are now as a survivor.

Remember to stay positive, that's one of the biggest things you can do for your self and your partner. Even when you're feeling discouraged, always be positive that there is a way out. There is always hope especially in areas of sexuality.

One important thing to remember is the appropriate timing of activity may increase enjoyment effects. If you found that your energy level has changed, if you find yourself very tired at 7:30, then you and your partner may need to get creative around the time that works for you. Maybe it's 11:00 in the morning and the two of you need to schedule an early lunch together to meet at home. There are a lot of creative ways to work around what may be best for you.

Remember that you have control over who you surround yourself with. Be careful. Surround yourself with people who uplift you and encourage you. Communicating your needs is such an important part of intimacy whether it's with your friends or your sexual intimacy with your partner.

We are given permission to really communicate what our sexual needs are. Really and truly this can help enhance how you feel about yourself and feeling a little bit more in control as well as helping your partner because most partners are scared after cancer about what they can and what can't do.

Remember to take a break, if you are engaging in sexual intercourse again, rest. The goal is not to have an orgasm. The goal is just to enjoy that physical intimacy and so rest. The rest is that will come. Remember, again, that sex is not the only form of intimacy. Patience and a sense of humor are an absolute must. If we don't laugh we get lost in the sadness sometimes. Sometimes humor can really bring us together closer. The one thing I really want you to hear is that skin is the largest sex organ and the brain is the most important sex organ. The possibilities are limitless. There are lots of ways to be sexually satisfied in spite of cancer and its treatments and in spite of losing a breast or having changes to the breast.

I want to end with a quote from the Mayo Clinic, "Intimacy need not end with cancer." You may need to redefine your ways of expressing intimacy and you many need to experiment because what worked before may no longer work after cancer. Remember again there are a lot of options. There are a lot options to enhance the libidic response. There are a lot of options for regaining control of your intimacy and sex life. The biggest keys could be patience, communication, and asking for help if you need it.

Thanks so much for your time this evening I look forward to talking to you further.

Shera Dubitsky: Thanks Sage. I found your presentation to be very hopeful and I believe that you have shared with our participants important insights and suggestions that they can implement in order to change how they approach themselves and their significant relationships.

Our final presenter, Rachel Lerner, presents weekly and monthly Torah classes and records many classes for the OU radio. Additionally, Rachel writes a “psalm thought of the day” that reaches over 300 subscribers. She is a psychotherapist whose approach to Bible study integrates her passion for textual analysis with a psychological mindset. In addition to teaching, she maintains a private psychotherapy practice. I also want to note that Rachel has led truly moving and spiritual discussions for previous Sharsheret events. It’s my privilege to introduce Rachel Lerner. Rachel.

IV. Jewish Ritual and Spirituality Presentation by Rachel Lerner, MS

Rachel Lerner: Thank you Shera. I'm really honored to be doing this panel with Dr. Poynor and Sage Bolte. I really want to take you back on some of what they said from a religious advantage point.

As Jews, we know that there is an enormous priority placed on intimacy within a relationship, on sexuality and we know that there is a tremendous drive to have children. Women who are in premature menopause, who are kind of precluded from having children naturally, or women who are in the midst of feeling sexually disconnected are not only battling with physical issues but they're also battling spiritual issues.

What I want to do is highlight some things that may be not as well known. The first is what is really the Jewish conception of sexuality and intimacy? Is it really intercourse? Does it mean we have to have sex when we are not in the mood to do so? Is it only about the pleasuring of a man? Is it only about sexual procreation? And I'd like to say the answer is no and yes. And let me clarify.

The idea of Jewish sexuality is about the fact that God created man with pleasure organs and man can use those organs to bring new life into the world. But if sex was exclusively for the benefit of procreation, then how do you make sense of your entire history?

Three out of four of the Matriarchs, Sarah, Rachel and Rebecca were all barren women who could not conceive. It took literally an act of God to make that happen. Wouldn't it have been the case that Abraham would have to separate from his wife if the entire purpose of sex was for procreation? The woman did not get pregnant till her 90s! We need to re-emphasize and understand the entire Judaic idea of what sexuality is and what it isn't.

Sexuality is about the fact that we are physical creatures given physical pleasure centers and those centers seek and find a fulfillment within a committed relationship. Within a marriage, one of the bottom lines in marriage is intimacy. Therefore, we have a lot of family purity where women would go through her menstrual cycle followed by seven (free) days and she would immerse herself and go home and be expected to be sexually active with her husband. But what you may not realize is the burden of being sexually active and sexually pleased falls to the husband in the Judaic system. The husband has an obligation, spelled out clearly in the Ketubah to pleasure and satisfy his wife.

If a woman is post breast cancer and she is not feeling up to intercourse as Sage said so eloquently, intimacy is about skin and brain, the possibilities are limitless. A woman does not have to be forced to have sexual intercourse. It's about

sexual pleasure and if her pleasure comes from snuggling and cuddling and being connected to her partner then that meets the Judaic criterion of sexual intimacy. In fact, in the Jewish halachic system, in the Jewish system of law, a woman cannot be coerced to have sex against her will. She cannot be compelled. We need to rethink our definitions and broaden our definition of what sex is. The application to pleasure a woman is fundamental. It's one of her three rights. If so, she can dictate what gives her pleasure. For a woman who is post-chemo treatment, who is post-surgical treatment, who is in the middle of a very difficult and toxic regimen, perhaps sexual for her is defined as a snuggle or perhaps sexual is sitting down and eating a box of chocolates with her husband in bed. But, it doesn't have to be defined as intercourse per se. With that being said, it takes some pressure off of women in terms of feeling compelled or absolutely guilty for not wanting to be sexually intimate or engaged physically.

The Torah, the Jewish book of law, is not unaware of the fact that sexual arousal goes in cycles and that there are times in one's life that sexual morale relaxes and wanes. Therefore, it is clear that the Torah understood and even made allowances for women in menopause. Men do not divorce women in menopause because they can't procreate. Men do not have to leave a marriage if their wives are not giving them sex every week and night. It's just not the case.

Sexual intimacy within the context of Judaism is a much broader, richer, deeper concept than what we have thought of previously. A woman may go to the Mikvah (ritual bath). She spends a lot of time preparing herself for the experience. She has to cleanse herself, she has to get ready. She has to do a lot of preparation. That is already setting a mindset in a woman that tonight I can, and I will be sexual. Not I must be sexual because that's what the burden of having to do something and all of us hate to do what we're told. The reality is that the mitzvah itself can be a conduit for enhancing and expressing one's sexuality because there are quite a few hours given over to preparation for that Mikvah experience.

The other question that comes up so profoundly when one addresses the spiritual issues surrounding sexuality and intimacy is the issue about children. This goes not just to married individuals but to people who are single and who are looking forward to the future. Is there an issue? How does one resolve the issue of intimacy when one knows that they cannot have any more children. There's one thing that they're cheating their partner, that it feel like there's something wrong with moving toward marriage of one can't have children naturally. The answer, once again, is found in Jewish history. It is a common thread throughout our history, in the history of our forefathers, actually in our foremothers, that barrenness and difficulty in having children was a common scene.

To have a child is not just the biological experience of producing a child in Judaism. Judaism admits that a person can be considered a parent if they foster

a child, if they adopt a child, if they teach a child. We know that anybody who is engaged in education is considered to have the same status as a parent for that child. The child owes the same respect to him or her as he owes his natural father and mother according to the fifth commandment.

In Judaism, the fullest and overriding configuration in Judaism is always the value of the human beings. That is the number one absolutely central value that we carry in Judaism, that human beings matter independent of whatever abilities or inabilities that they have. A woman who is not able to bear children is not considered lesser than any other person. God has not granted her the physical capacity to fulfill that particular Torah commandment. But she is no less a valuable human being.

It's very important for us to broaden the definition of what we mean by intimacy and spirituality, what we understand about Jewish ritual. It's confusing sometimes because we live in communities with children and not having children can be so desperately painful. One must remember that when God gave us any task that he gave us, he created us in his image. Since we're not all the same, we have to assume that God is multifaceted and multi-imaged. Therefore, each of us has a task that we fulfill given whatever skills and weaknesses, pluses and minuses, abilities and inabilities that we possess. The task and the challenge is to find one's answer that is specific to yourself. The answer for you is not the answer for someone else. But there is an answer and that answer may mean to clarify for one's spouse that I'm not ready to be fully intimate. Let's just snuggle. This is what would give me pleasure. This is how you would make me happy. Since I agree that most partners are hesitant to do anything painful, they certainly would be glad to do something that would be positive and pleasure producing.

I also want to touch on the single piece for just a moment. That is to take a look at the fact that being a single person and knowing that one is not able to bear children can make one feel like a sexually damaged person. It becomes critical to clarify that from a Jewish point of view. The ability to have children and the ability to be sexual are not one and the same. They are totally separate issues. One of the nice things about sex is that you can get pregnant. And, one of the not so nice things, depending on your circumstances, is that you can get pregnant, it all is circumstantial, it's situational. Sex and the ability to procreate are not one and the same. Sexual pleasure is not equated in Judaism with procreative ability.

A woman is entitled to the same obligation from her husband for sexual pleasure whether or not she is able to conceive or not able to conceive. The Torah admits to every possibility and allows one to be fully realized in that sense and sexuality is part of that realization.

I invite your questions and I look Shera to hear any word from you and thank you again for allowing me to participate.

Shera Dubitsky: Thank you Rachel. As always, you have presented challenging material in a manner that lifts the spirit and encourages us to approach issues with a sense of renewal.

Before we begin the question and answer portion of tonight's teleconference, I want to ensure you that your identity will remain anonymous should you decide to ask a question. Please feel free to dial "Star 1" to submit a question.

V. Question and Answer Session

Moderated by Shera Dubitsky, M.Ed., M.A., Clinical Supervisor,
Sharsheret

Shera Dubitsky: Without further ado, the first question that we have is for Dr. Poyner. The question is a little bit off of something that you presented before but simply, Is it safe to have sexual intercourse while receiving chemo.?

Elizabeth Poyner: First I would just tell you that you should always discuss everything with your medical oncologist because every chemotherapy treatment is different. Some treatments will have side effects where the white blood cell count will drop down more significantly than other treatments. Some treatments don't drop your white blood cell count. With some treatments you really do drop your white blood cell count. In general, it is safe to have sex during chemotherapy but you probably don't want to have intercourse if your white counts are dangerously low or your platelets are dangerously low. Always discuss these issues with your medical oncologist. In general, it's safe to have sex during chemotherapy as long as your white blood cells count is adequate and your platelet count is adequate.

Shera Dubitsky: Sage, a question came in, "My husband doesn't seem to mind touching the area where my breast used to be but I find it upsetting. How do I communicate this to him without him pulling away from me?"

Sage Bolte: That's a great question. I think coming forward and saying I'm not yet comfortable with it. I think the way to start is just being honest by saying, "I'm not yet comfortable with that. I appreciate how open you are and how accepting you are. I have not yet been able to accept or feel comfortable with that." Maybe find another place that he could touch or maybe in a non-sexual way can he spend time. He's doing it because it may be that he's really just appreciating your life. In fact some men, I've heard, just look at that scar and find it amazing and beautiful to see what their wife has sacrificed to be present with them today. It may be an emotional connection with you. It's important to open a dialogue about that. There may not be a quick answer or quick fix but the first place you can start is just opening a dialogue and just expressing your own insecurity or discomfort about it, and maybe directing him to something that does feel comfortable to you.

Shera Dubitsky: This is a question for Dr. Poyner and Sage. If you both can briefly share your thoughts on it, that would be great. The question is, "How do I know if my lack of libido is physically or emotionally related?" Dr. Poyner?

Elizabeth Poynor: I'd like to say that because I think always when we investigate sexual dysfunction, it's always multidisciplinary and always emotional issues should be discussed before medical issues. I like to talk to people about their relationships but I'm going to let Sage start first and then we can talk about the medical issues after that.

Sage Bolte: Yes, I agree. It's usually hard to decipher. Usually if the patient was coming to me I might ask some questions that might tell me if that person was experiencing depression. There are some key questions we might ask like, Are you losing joy in life? Can you find things that still bring you joy? If you can't, you might be looking at depression which would definitely impact your libidic response or the way you feel sexually. Some other complications again would be just your own body image. If you're constantly concerned or consumed with the way you feel or the way you look, it's absolutely going to impact your libido. That would be where you first start enhancing how you feel about yourself. When you feel comfortable with yourself and comfortable with your sexual self, and there is still no libidic response, then you may want to look at other medical interventions that are possible. But, I agree with Dr. Poynor that really it's complicated to separate the two. I think starting with talking with someone you trust, whether that's your oncologist or your oncology nurse or one of the social workers in your team to ask that exact question and see if they might be able to help you rule out. The other question I would ask is, Has this been an ongoing issue for you prior to cancer? If so, then you'd want to talk about that too, was it emotional or physical.

Elizabeth Poynor: I do have some people who come in to my office and say, "Look, I'm in a great relationship. I really want to be sexually active but I just don't have any libido." We rule out those emotional and psychologic issues and then I begin to ask if sex is painful. Do we need to work on vaginal dryness to make it more pleasurable? We need to talk. Do we need to enhance the vagina with maybe some topical estrogen to it and enhance responsiveness. Then, going on to more other significant medical interventions and intra-testosterone therapies. Wellbutrin is another medication that has the side effect of increasing libido. After the psychologic and emotional concerns are ruled out, I try to start with the simplest and least invasive in terms of medical intervention and least harmful. With the risk and benefit analysis, start with the non-hormonal things first and then moving forward after that.

Sage Bolte: The other thing I want to add is with some of the other responses, physiological responses for libido, sometimes even if I ask a woman to try to use an arousal cream, which I would call clitoris sensation cream, that even just using that if they notice there is a physiological response sometimes it just triggering the body memory and the mind memory of, "Oh right. This is what it feels like to be aroused." And the woman can get very comfortable. For some women though, it sends them a little bit into a panic and they're not as comfortable and that again

would indicate to me that there might be psychosocial issues going around and not just the physical response.

Shera Dubitsky: Rachel, somebody was asking, first the statement was that they found your presentation very helpful and that you touched on issues that they had thought about. Their question was, when they were having some of these thoughts that this particular caller had gone to the rabbi and the rabbi essentially said, "You know, you need to be there for your husband." Clearly she didn't feel fine with that answer but she doesn't really know where to turn.

Rachel Lerner: I'm first going to say I hope the rabbi can give you a prescription specifically of how often you need to be there for your husband. That's the number one thing. And that being said, what I mean by that in a serious note is that being there for one's husband can take many forms. Generally, the whole idea of not masturbating somebody is the idea that you don't want to have spilled seed for no reason. That leads to a loss of potential life. As a woman is going to be menopausal, and she does not have the potential for life because it is impossible anymore, she can be with her husband without having to allow herself to determine how close and how intimate she would like to become. And that's a very important factor. So you can modulate.

I think the rabbi is probably perhaps not understanding - this is where it goes into Sage's territory. The particular dynamics of a marriage, your husband may well be able to handle not having full fledged intimacy if he feels that the relationship that you were engaged in is sexually satisfying or sexually meaningful to him. Sex is not just about orgasm. It is about meeting the other partner's needs. It's about giving gratification. As I stressed before from a Judaic law point of view, the partner within the marriage who has the obligation to satisfy is the husband, not the wife. It may require you to seek a rabbi who perhaps can be more open to a more nuanced discussion about sexuality and about pleasure than someone who gives you the straight line and said, "You have to accommodate your husband."

I certainly would look perhaps to a more psychologically interested or sensitive individual, rabbi or spiritual mentor to seek answers to those questions.

Shera Dubitsky: Dr. Poynor, a question came in about discussing current research on birth control and its effect on hormone positive cancers for young women.

Elizabeth Poynor: I would assume that the question is induction of hormone positive breast cancers in young women. The newer preparations of oral contraceptive have a relatively low dose of estrogen. We do know that prolonged use of birth control pills may increase the woman's chance of developing breast cancer. There is one study that demonstrated that women who use birth control

pills or at a younger age before delivery, may have an elevated risk of developing breast cancer. That's controversial.

There have also been studies that have demonstrated that there is no increased risk for developing breast cancer while on oral contraceptive. What may be true in all of the data is that for a brief period of time while a woman is using oral contraceptives, she may be at slightly elevated risk to develop breast cancer which drops back down to a population based risk after she stops using birth control pills. It's been very difficult to evaluate. The studies are not straightforward in their findings, not every study has demonstrated this. Certainly our newer preparations of birth control pills, with lower doses of estrogen, have not been out for a prolonged period of time in order to completely evaluate them.

Shera Dubitsky: On the heels of all this discussion about whether it's lubricants or whether it's birth control with the hormone, do the same rules apply for women who have had a prophylactic oophorectomy without diagnosis but because they were carriers of the BRCA1 or BRCA2 genes?

Elizabeth Poynor: The rules I think are a little bit different because systemic hormone replacement therapy is contraindicated in a woman with breast cancer only under insinuating circumstances. But for women who don't have a history of breast cancer who are BRCA1 or BRCA2 positive and premenopausal, we will many times, discuss going on systemic hormone replacement therapy with these women if they are symptomatic from their surgically-induced menopause. Indeed, data from a couple of studies have demonstrated that women who are younger and who have prophylactic oophorectomies decreased their risk of developing breast cancer. Now a length of time for that is not well-defined but we know that they can decrease the risk of breast cancer by 50%. That decreased risk is not negated by hormone replacement therapy. That's in the younger woman and the premenopausal woman who has undergone oophorectomy. I don't think that necessarily applies to the older woman who has undergone prophylactic BSO (Bilateral Salpingo – oophorectomy).

Usually what many people would do in their practice is they will discuss hormone replacement therapy with the patient, review the risks, benefits, and alternatives and then - at by the age of 50, the natural age of menopause begin to taper off and stop hormone replacement therapy. The rules are a little bit different.

Shera Dubitsky: When you were talking about the testosterone cream, we have one caller who said that her doctor put her on a 2% testosterone cream twice a week, and it has helped with the libido, and that she is very active in terms of exercise and weight training and yoga. But she has noticed a little bit of a weight gain. Is this to be expected?

Elizabeth Poynor: Women will go through downshifts in their metabolism during different parts of their lives. It's always hard to know what to attribute weight gain to. Is it due to hormonal issues? Is it due to a natural downshift in metabolism? I think that it is a little bit difficult to decipher what the inciting event to the weight gain is. As always, increased activity, work with a nutritionist, low-fat diet, adjust the carbohydrates in your diet, no processed food, kind of good nutritional, principles apply. At different points of a woman's life she may need to adjust her diet to control her weight. What you can attribute it to is very difficult, it is factorial many times.

Shera Dubitsky: Here is an interesting question that came in that was not addressed in any of the presentations and that is, Is there a connection between breast cancer and increased arousal?

Elizabeth Poynor: There are the triggers of persistent arousal and there are a few case reports in a literature of this. But the link to breast cancer and an increased arousal, I'm not aware of.

Sage Bolte: No, I haven't heard of that either. In fact I don't think biologically that would make much sense unless they're trying to connect it to high estrogen levels increasing libido. But, really what we know about libidic response is it's not just estrogen. That really is driven by the androgen levels. I have not heard that before.

Shera Dubitsky: Are there any drugs to increase the libido that can be prescribed to women who are HER2-negative?

Elizabeth Poynor: Libido is linked to androgen so the medications that we can discuss with women after a thorough discussion of risks and benefits, can be testosterone. However, I'm always very hesitant to use testosterone without the oncologist's approval because androgens are converted into estrogens by the aromatases in the body. You are using testosterone but you're going to potentially have an elevated estrogen level. We look to those non-hormonal medications first, and there are a number of those that you may use to increase libido including the ones we spoke about, and also vasodilators and that type of thing to help with arousal. All of those, though, are under investigation and all of them are used off-label currently.

Shera Dubitsky: Another question just came in and I want to make sure that we're getting everybody.

This is for Dr. Poynor, for estrogen positive women, would pregnancy make another breast cancer - or would it put somebody at risk for another breast cancer?

Elizabeth Poynor: That's a very controversial topic. There have been a number of investigators that have addressed this in their studies of young women with breast cancer. There is a theoretical risk that you can increase your risk of occurrence. It's dependent on the stage of your breast cancer. Certainly there should be a waiting time before you do get pregnant after breast cancer treatment to assure that there is no recurrence present or is not yet developing in the near future because you would not want to be pregnant in that situation and have the estrogen drive the tumor.

As always I would suggest that the breast medical oncologists who is taking care of the patient address this issue with them, the particular risk and the timing of a potentially planned pregnancy.

That has been controversial in the medical literature.

Shera Dubitsky: One more question: How does a single person tell a date that they had breast cancer?

Sage Bolte: Briefly, what you need to do is find out what your comfort level is. Everybody finds their own comfort level as far as how many dates until you tell someone you disclose that you're a survivor. My best friend who is a survivor decides by the end of date 3 that she is going to disclose to him that she is a survivor. For her, she knows that date 4 she's going to really want date 5 and she finds that her interest level rises in that person. To avoid her own feelings of getting hurt or feeling rejected and to really provide an out or an in for the person she is interested in, she decides by date 3. It's going to be a personal call for you. The one thing I'd recommended is that you really practice with one of your girlfriends or a friend who you trust or maybe a script you feel comfortable using. Some people use humor with it. Some people just come right out and say it. But find something that you're comfortable with so that when you're disclosing you display the comfort level. Also, it's important to be educated about it so that when they have questions you can respond. Most people will have questions.

Rachel Lerner: I'm going to agree with you, Sage, to that part. The first thing has to be a level of comfort. Particularly when it comes to the Jewish spiritual piece, the religious piece, there may not be an easy level of comfort attainable because there is a sense of, "Well, how can I go on and date and disclose? I'm a damaged one, unable to fulfill one of the commandments which is to have children?"

What you need to do first and foremost is sort it out in your head and come to a kind of peace, a place of peace which says, "This is who I am. This is who God made me to be. I didn't choose this illness, it chose me. One of the byproducts of this illness is perhaps the inability to have children naturally." Then, when one has a level of comfort with that, and I agree with you Sage that perhaps role

playing it, even writing a particular script for it can help make him clear. Then say to the person, “Well, this is an important discussion. I really care about you. You need to know that this is my plus and minus list. One of the things on this list is that I’m unable or it’s risky for me to have children naturally, et cetera, et cetera.”

First and foremost, you need to arrive internally at your own place of peace and that will require some practice and some work to understand spiritually how to process this entire experience. For that, I would direct you really to talk to a spiritual mentor. It doesn’t have to be a rabbi. It could be a friend or someone in the community that you look toward that can sort of help you and guide you to find the words you need to amplify your sense of self so that there is no guilt or shame that’s attached to that disclosure.

VI. Teleconference Conclusion

Closing Remarks by Shera Dubitsky, M.Ed., M.A., Clinical Supervisor, Sharsheret

Shera Dubitsky: Thank you all for submitting very thoughtful questions. I want to make a point that tonight's topic was spurred on by the many women who requested that we address this issue. It reinforces the idea that Sharsheret is indeed powered by our callers. I encourage each of you to complete the evaluation forms that are included in your information pocket. Your feedback is critical in helping us tailor our services and programs to better meet your needs.

I also wanted to remind you to visit our website at www.sharsheret.org for resources and transcripts from previous symposia. Coming soon to our online Forum, we will be offering an opportunity to "Ask the Experts." We will be alternating members of Sharsheret's Medical Advisory Board to respond to your general questions.

You will also be receiving an announcement of a new project that we are launching called, *"Our Voices: Insights and Wisdom from Jewish Women Living with Breast Cancer."* Time and again, women have shared memorable anecdotes and wisdom with Sharsheret's staff or with their links or callers. The time has come for Jewish women across the country to benefit collectively from one another. I encourage you to submit as many anecdotes or words of wisdom that you think would help other women navigate the world of breast cancer treatment and survivorship, or perhaps just to lift the spirit. This is an opportunity for all the women of Sharsheret to serve as links.

Finally, please remember that you can reach us any time toll-free at (866) 474-2774.

Thank you to our speakers and to all of you who participated this evening. Good night.

VI. Speakers' Bios

Sage Bolte, MSW, LCSW, OSW-C, works for Life with Cancer, an Inova Health System not-for-profit program in Northern Virginia, where she has helped develop a program that addresses the needs of people impacted by advanced (metastatic) breast cancer. She also provides individual and family counseling, facilitates cancer support groups and partner support groups and offers educational seminars on sexuality and intimacy. Ms. Bolte has presented at local, regional, and national conferences on the impact of chronic illness on sexuality, intimacy, and sexual function and ways that people affected by cancer and healthcare professionals can address common problems. Upon completion of her PhD, she hopes to further the training of oncology social workers in the area of sexuality and utilize her training in an oncology clinical practice and at the university level.

Shera Dubitsky, MEd, MA is Sharsheret's Clinical Supervisor. Ms. Dubitsky served as a Psychology Resident and Fellow at the Bronx Psychiatric Center of the Albert Einstein School of Medicine, and an Associate Psychologist for the Jewish Board of Family and Children's Services. She has also worked as a Researcher at Memorial Sloan-Kettering Cancer Center. As Sharsheret's Clinical Supervisor, Ms. Dubitsky assists women newly diagnosed and at high risk of developing breast cancer, and provides supportive counseling to women living with metastatic breast cancer. She also assists in the advancement and development of programs addressing the needs of the women of Sharsheret.

Rachel Lerner, MS is a psychotherapist in private practice. Ms. Lerner attended Yavne Teachers College in Cleveland Heights, Ohio. She has taught adult education classes for the past 30 years including women's Rosh Chodesh and Psalms/Tehillim classes in her home. Ms. Lerner's approach to Bible study integrates her passion for textual analysis with a psychological mindset.

Elizabeth Poynor, MD, PhD, FACOG is a gynecologic oncologist and pelvic surgeon who focuses on the comprehensive surgical management of gynecologic cancers and works with medical and radiation oncologists to facilitate a compassionate, multidisciplinary approach to the management of women's cancers. She has special expertise in the complex management of women and their families who have a genetic predisposition to developing breast cancer and gynecologic malignancies. As a surgeon scientist, Dr. Poynor's work focused on translating basic science principles into clinically meaningful treatments and she served as Director of Translational Research for the Gynecology Service at Memorial Sloan-Kettering Cancer Center. She has also served as an investigator in numerous clinical trials relating to surgical, medical, and biological treatment of gynecologic cancers.

VIII. About Sharsheret

Sharsheret is a national not-for-profit organization linking young Jewish women in their fight against breast cancer. Sharsheret (Hebrew for chain) pairs young women facing breast cancer with volunteers who can share their experiences, both personal and medical.

Sharsheret's programs respond to the needs of the women we serve and include:

- **The Link Program**, a peer support network connecting young women newly diagnosed or at high risk of developing breast cancer with others who share similar diagnoses and experiences.
- **Education and Outreach Programs**, including health care symposia addressing the concerns of young women facing breast cancer. Recent events addressed the subjects of breast cancer and fertility, parenting through breast cancer, breast cancer genetics, and surviving breast cancer. Transcripts of all symposia are available on Sharsheret's website, www.sharsheret.org.
- **Quality of Life Programs**, including the Busy Box for young parents facing breast cancer, Best Face Forward to address the cosmetic side effects of treatment, Embrace, a support program for young women living with advanced breast cancer, and Empower, a teleconference support program for single women.

For more information about participating in Sharsheret's programs, please call toll-free (866) 474-2774. All phone calls are confidential.

IX. Disclaimer

The information contained in this document is presented in summary form only and is intended to provide broad understanding and knowledge of the topics. The information should not be considered complete and should not be used in place of a visit, call, consultation, or advice of your physician or other health care professional. The document does not recommend the self-management of health problems. Should you have any health care related questions, please call or see your physician or other health care provider promptly. You should never disregard medical advice or delay in seeking it because of something you have read here.

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