20 Sexuality and Sexual Disorders

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- What are the phases of the human sexual response?
- What is the most common sexual concern patients discuss with their physician?
- How do specific health situations affect sexuality?
- How do age and sexual orientation affect sexual health?
- How are sexual orientation and sexual identity defined?
- What are the major sexual disorders?

Sexual Health

Sexual health is defined as a state of physical, mental, and social well-being in relation to sexuality. It implies a positive and respectful approach to sexuality, the enhancement of life and personal relationships, and the possibility of having pleasurable and safe sexual experiences that are free of coercion, discrimination, and violence. Reproductive or sexual health services should provide basic information about biological and psychological aspects of sexual development, human reproduction, and the variety of sexual behaviors, dysfunctions and disorders. The provision of such services requires health care professionals who possess positive attitudes toward sexuality, provide opportunities for discussion of sexual matters, and who show understanding and objectivity in providing advice, information, and treatment.

Human Sexual Response

What are the phases of the human sexual response?

The human **sexual response** includes a cycle of *desire*, *excitement*, *plateau*, *orgasm*, and *resolution* phases.

- The *desire phase* involves spontaneous thoughts, fantasies, and biological urges to self-stimulate or initiate sexual activities with a partner.
- The *excitement (arousal) phase* is induced by sensory stimuli or mental imagery. Physical response includes male penile erection and female vaginal lubrication, erect nipples in both genders, and engorged clitoris and testicles. Respiration increases up to 60 breaths per minute, heart rate up to 180 beats per minute, and blood pressure may rise 40–80 mm Hg systolic and 20–50 mm Hg diastolic. In males, arteriolar dilation causes penile engorgement and obstruction of venous outflow. Engorgement is limited by the fascial sheath, causing rigidity. Other responses include scrotal engorgement, testicle retraction, and pre-ejaculatory secretion by the Cowper's glands. In females, vasoconstriction elevates the uterus, and increases the depth of the vagina, the upper two thirds of which expands while the lower third becomes engorged and narrowed.
- With the *plateau phase*, arousal levels off and may be of varying time span depending on the experience of the individual.
- The *orgasmic phase* is a brief physiologic response involving involuntary motor activity. Ejaculation occurs in males, as muscular contractions of the prostate, urethra, and perineum propel seminal fluid through the urethral opening. Up to 15 vaginal and perineal muscular contractions occur in females.

- In the *resolution phase*, physiologic parameters return to normal. In males, orgasm is impossible until after completion of the *refractory period*, which lasts minutes to hours depending on various factors, including age.

Common Sexual Concerns of Patients

What is the most common sexual concern patients discuss with their physician?

While patients may present their concerns and problems explicitly, in many cases these concerns may arise only when an astute clinician listens to the subtext of the patient's dialogue. Common concerns include:

- Am I normal? How do I compare?
- Sexualyidentity: lifestyle, orientation, preference
- Psychosexual development: over the life cycle
- Reproduction: infertility, family planning, contraception, pregnancy, abortion
- Sexual desire, satisfaction, and dysfunctions; couple's differences in desire; problems with vaginal lubrication, erections, orgasm, pain
- Sexual changes due to age, physical disability, medical illness, treatment
- Sexual trauma resulting from molestation, incest, rape
- Safe sex practices: AIDS, STIs
- Paraphilias and sexual compulsions

Situation-Specific Sexuality Issues

Contraception

Determining a method of contraception depends upon (a) type and frequency of intercourse (a woman having infrequent intercourse may prefer a barrier to a continuous method); (b) number and type of partners (a woman with several partners is better protected using condoms and sper-

Table 20.X: Advantages and disadvantages of different types ofncontraception

Type of Contraception	Examples/Class	Advantages	Disadvantages
Hormonal	Progesterone implants/injections	Long Lasting Safer in hypertension and diabetes	Delayed return of fertility Irregular bleeding
Combined Pill	Estrogen/Progesterone	Protects against cancers and osteoporosis Regulates period No long-term effects	Contraindicated in women >35 with smoking, hypertension or diabetes Side effects
Mini Pill	Progesterone only	Good for women with contraindications to combined pill	Must be taken at the same time each day
Condom (Male or Female)	Barrier	Easy to use Helps prevent STI's	Dulling of sensation Potential for failure
Intrauterine Device (IUD)	Barrier	No effect on hormones Works immediately	Risk of pelvic inflammatory disease
Diaphragm/Cap	Barrier	Inserted prior to sex No hormones	Can cause cystitis Can have failure
Rhythm/Fertility Awareness	Natural	No side effects	Restrictions on timing of sex

micide with oral contraceptives than oral contraceptives alone); (c) health history of the partner (the female partner of a man with genital herpes should use condoms rather than a diaphragm); (d) timing of a future desired pregnancy (a barrier method may be preferred to a long-term method such as injectable progesterone); (e) number of previous pregnancies (an IUD or relatively permanent contraception such as tubal ligation may be appropriate for a female in a mutually monogamous relationship); (f) degree of discomfort with touching one's body (oral contraceptives may be preferred to a diaphragm); and (g) concurrent medical conditions (oral contraceptives may be contraindicated).

Pregnancy

During early pregnancy, *fatigue, nausea, or breast tenderness* may interfere with sexual desire. In the second trimester, bothersome symptoms decrease, but issues of *body image* often arise. Some women feel unattractive, others feel more sexual. Some men are concerned about "hurting the baby" and avoid intercourse. Late in pregnancy, conditions may require abstaining from vaginal intercourse. However, in most cases, other forms of sexual intimacy are possible.

The discomfort of the healing perineum after episiotomy can interfere with resumption of sexual activity after childbirth. Sleep deprivation caused by an infant who awakens during the night can decrease libido.

Some women find breastfeeding to be sexually stimulating; others feel ambivalent about their partner touching or stimulating their lactating breasts. Marital strain can occur when a husband feels replaced by an infant who receives much of the mother's attention. Conflict can arise over the distribution of infant-related chores or financial pressures of an expanded family.

Chronic Illness

How do specific health situations affect sexuality?

Medical conditions associated with changes in sexual functioning include: arthritis/joint disease, diabetes mellitus, endocrine problems, injury to the autonomic nervous system by surgery or radiation, liver or renal failure, mood disorders (including depression, anxiety, and panic), multiple sclerosis, peripheral neuropathy, radical pelvic surgery, respiratory disorders (e.g., COPD), spinal cord injury, and vascular disease.

Supportive therapy may be needed for patients experiencing physical limitations, changes in physical appearance or sexual functioning. Information about reproductive options such as electro-ejaculation is important for men with spinal cord injury. Patients may be embarrassed about appliances such as catheters, ostomies, artificial limbs, or about surgical scars. A postmastectomy patient's body image and relationship with her partner help determine whether reconstruction or a prosthesis should be considered. Antihypertensive drugs frequently cause erectile dysfunction, and although alcohol, sedatives, and narcotic analgesics may reduce inhibitions, they may also interfere with normal physiologic functioning.

Infertility

Infertility and difficulty getting pregnant can cause conflict and concern. Monitoring, scheduling intercourse, taking medications, and undergoing testing are stressful. Respecting concerns, informing, counseling, and minimizing blame and guilt are essential components of managing infertility. Most couples have success using "low tech" options with a minority requiring *in vitro* fertilization. Success rates depend on type of therapy and age of the partners. Two thirds of couples being treated for infertility will conceive a baby.

Fertility treatment options include:

- *Fertility Drugs*: Clomiphene, letrozol (ovulation induction), anastrozol (ovulation induction) and gonadotropins.
- *Surgical Infertility Treatments*: Hysterosalpinogram (HSG) to determine blockage of the fallopian tubes followed by laproscopic surgery, if needed.
- *Intrauterine Insemination*: Artificial insemination, where sperm are placed into the uterus.
- *In Vitro Fertilization (IVF):* Fertility drugs are used to produce eggs. Eggs are removed, inseminated outside of the female body until fertilization occurs, and then placed back into the uterus.

Termination of Pregnancy

Unplanned pregnancy is most common at the extremes of a woman's reproductive life. While political, religious, and ethical controversy surrounds this issue, providing information about alternatives is essential, even if that means referral to another provider. Familiarity with community resources and separating personal bias from the care of the patient are fundamental to good care. Current options include the "*morning after pill*," a high dose of oral contraceptives taken within 72 hours after sexual intercourse; an *abortifacient* like mifepristone, methotrexate, or misoprosol (to induce spontaneous abortion), and *vacuum aspiration*. *Adoption* should be considered as well.

Sexually Transmitted Infections (STI)

Common **sexually transmitted infections (STIs),** usually treatable with antibiotics, include gonorrhea, syphilis, and chlamydia. *Viruses* that cause STIs include human immunodeficiency virus (HIV), human papillomavirus (HPV), cytomegalovirus (CMV), and herpes virus (SV). Some strains of human papillomavirus have been associated with genital warts and with cervical cancer. Currently, it is recommended that the HPV vaccine be administered to all women between the ages of 9 and 26. For optimal results, the vaccine should be administered before the individual becomes sexually active. Public debate about immunizing young, prepubescent girls against an STI is ongoing as a primarily social rather than medical issue, especially in states like Texas where immunization has been mandated. Other sexually transmitted conditions such as trichomonas, molluscum contagiosum, pubic lice, scabies, and monilial vaginitis are bothersome, but rarely cause serious long-term problems. *Bacterial vaginosis*, frequently caused by Gardnerella, Haemophilus, or group B streptococcus, has been implicated in premature labor and small-for-gestational-age infants.

Prevention of STI requires candid communication between patient and partner and effective protection. Condoms, although not perfect, provide the best mechanical protection when combined with an appropriate spermicide. Latex gloves, finger cots, or condoms can be used for manual stimulation. Dental dams can be used during oral sex. In cases of latex allergy, non-latex skins can be applied over or under other coverings depending on which partner is allergic.

Least risky behaviors include gentle kissing, mutual masturbation, fellatio with a condom, and non-shared sex toys. *More risky behaviors* include oral sex on a male (fellatio) without a condom; oral sex on a female (cunnilingus) without a dental dam; and vaginal or anal intercourse using a condom and spermicide and withdrawing prior to ejaculation. *Most risky behaviors* include anal or vaginal intercourse without a condom, with or without ejaculation, and fellatio without a condom and with ejaculation. Correct techniques for condom use should be taught and reasons for not using condoms discussed. Role playing situations in which patients find themselves confronted by a partner who does not want to use a condom is helpful, particularly for adolescents.

Post-Exposure Prophylaxis (PEP) may be available for individuals exposed to HIV. Candidates are individuals who are HIV-negative, but have been in contact with a HIV positive individual, or an individual of unknown status in high prevalence areas. Such individuals must have engaged in a high risk sexual behavior and present for treatment within 72 hours of exposure. The course of therapy, lasting 28 days, usually involves 2 or 3 classes of anti-retroviral therapy. Individuals who repeatedly engage in high risk behaviors are not good candidates for this treatment.

Age and Culture Specific Sexuality Issues

How do age and sexual orientation affect sexual health?

Childhood and Adolescence

Adolescent sexual behavior often includes masturbation and non-coital stimulation with partners of the same or opposite gender. Adolescents today engage in intercourse at an earlier age than their parents. By age 15, a majority of African American males and more than a quarter of African American females and Caucasian males and females have had coitus. By age 18, most ado-

lescents have had sexual experiences including intercourse. Same-sex behavior in adolescence is not uncommon and does not necessarily predict future sexual orientation or behavior.

Adolescents know little about the risks of not using contraceptives or the types of contraceptives available. About 35% do not use contraceptives during their first sexual experience. Unfortunately, 20% of all pregnancies occur during the first two months of sexual activity. Adolescents are also at increased risk for STIs for biologic (lower estrogen, immature lining of the cervix) or psychosocial reasons (risky behaviors, embarrassment about contraception).

Many adolescents avoid consultation on sexual issues for fear of parental disapproval. Some states require parental permission while others allow treatment of minors for possible STIs without parental permission.

When interviewing adolescents, use language/terms appropriate to their developmental age and provide a safe, non-judgmental environment to talk about sexual issues. This may involve time without a parent present.

Aging

Although sexual desire does not necessarily diminish with age, physiologic function does change (see Chapter 22 Geriatric Health and Successful Aging). Postmenopausal women not taking *hormone replacement therapy* experience decreased vaginal lubrication, mucosal thinning, diminished vaginal expansion, and vasocongestion. Older men require longer to achieve penile erection and, if interrupted, may not gain full tumescence; ejaculation is less intense and forceful. Women typically cease to reproduce at *menopause*, but men have been reported to reproduce into their 90s. While older couples do not necessarily have less satisfaction from intimate experiences, perceived diminution in function may inhibit activity. Medical conditions, medications, and physiological change can interfere with sexual functioning at any age, but these problems become more prevalent with age. Other issues for older persons include embarrassment, family disapproval, lack of privacy, and the illness or death of a partner.

Social and Cultural Expectations

Every culture has *norms* regarding sexual behavior. Sex may be acceptable only for procreation or only after a postmenstrual ritual cleansing bath. Extramarital sex or polygamy may/may not be acceptable. Some religions prohibit contraception unless the mother's life is at risk. In some cultures, unwed mothers are accepted; in other cultures, they are ostracized or killed. In 1999, the World Association of Sexual Health adopted a Declaration of Sexual Health that included:

- the right to sexual freedom, excluding all forms of sexual coercion, exploitation and abuse;
- the right to sexual autonomy and safety of the sexual body;
- the right to sexual pleasure, which is a source of physical, psychological, and spiritual well-being;
- the right to sexual information – generated through unencumbered yet scientifically ethical inquiry;
- the right to comprehensive sexuality education; and
- the right to sexual health care, which should be available for prevention and treatment of all sexual concerns, problems and disorders.

The declaration is not meant to impose upon cultural traditions, but certain customs, such as female genital circumcision, may be challenged under such a declaration.

Sexual Orientation and Identity

How are sexual orientation and sexual identity defined?

Sex is the designation given at birth based on observed anatomy (genitalia) or biology (e.g., chromosomes).

Gender denotes the role assigned by society based on behavior and expression. **Sexual orientation** denotes the physical, romantic, or emotional attraction to another person (homosexuality, heterosexuality, bisexuality). **Sexual identity** describes the person's subjective experience of sexual orientation. Sexual behavior does not always indicate orientation or identity since indi-

viduals may be involved in same-sex activity, but not identify themselves as homosexual. However, the majority of people are consistent with self-identification, behavior, and attraction throughout their adult lives.

Homosexuality and Bisexuality

Most individuals develop a behavioral preference for the same or opposite sex partners during adolescence. While neuroscience and genetic research suggest a role for genes and neurobiological factors in determining sexual orientation, the actual determinants of sexual orientation remain unclear.

About 40% of males will have at least one *homosexual experience* leading to orgasm in their lifetime, but only about 10% of men practice homosexuality at any given time, and about 4% are exclusively homosexual for >10 years. Homosexuality appears to be less prevalent in women than men, but women are less genitally focused than men, and definitions related to the number of homosexually induced orgasms may not accurately reflect a person's perception of his or her own sexual orientation. Although 10–13% of women have had sexual experiences with other women, only 3% of all women describe themselves as lesbian.

Persons who identify themselves as *bisexual* are sexually attracted to members of both sexes. Although only a few people describe themselves as bisexual, many members of both genders have had sexual experiences with members of the same and the opposite sex in their lifetime.

Transgender

Transgender individuals feel an incongruity between their anatomic gender and their gender identity, often describing their problem as being "trapped in the wrong body." For some, this realization occurs during childhood; for others, it occurs during adolescence or later. **Gender dysphoria** refers to the discomfort or unhappiness experienced in the biologically assigned gender role. Some individuals choose to undergo hormone replacement or surgical correction; others live their lives in the opposite role without any anatomic changes. The term, **transsexual**, has been used to refer to an individual who desires gender-changing procedures to acquire a physical appearance consistent with their gender identity (see Chapter 21, Health Care Issues Facing Gay, Lesbian, Bisexual, and Transgender Individuals).

Sexual Disorders

What are the major sexual disorders?

There are five categories of sexual disturbance**:** sexual response dysfunction; sexual pain; gender identity disturbances; paraphilia; and disorders due to a medical condition (see Table 20.2).

Disorders of Desire

Decreased libido (**hypoactive sexual desire**) is the most common complaint of women and may also be experienced by men. Decreased libido may be person-specific (a particular partner) or global, or reflect a discrepancy between partners' expectations of frequency or activity. Etiologies include dissatisfaction with a relationship, underlying medical or psychiatric problems, medications, substance abuse, stressors, and normal differences in desire. Sudden change in desire unrelated to a specific stress suggests an underlying medical or psychiatric problem. **Sexual aversion** is characterized by fear or repulsion of engaging in sexual activity in excess of normal fluctuations in sexual desire.

Disorders of Arousal

Erectile dysfunction is the inability to attain and maintain a penile erection sufficient to permit satisfactory intercourse. Up to 30% of men with erectile dysfunction have no identifiable organic basis for the problem. Differentiation of *psychogenically* based erectile dysfunction from *organically* based erectile dysfunction is critical to appropriate treatment. Individuals with psychogenic erectile dysfunction often have spontaneous nocturnal erections whereas those with organic etiologies do not. History and physical examination should identify medications (e.g., antihypertensive or antidepressant agents) or medical conditions (e.g.,

Table 20.2. Sexual and gender identity disorders: Definitions and estimated frequency

Disorder	Estimated frequency	Definition
Sexual desire disorders		
Hypoactive desire disorder	20% of adults	Reduced desire for sexual contact or total aversion to sexual activity
Sexual aversion disorder	Unknown	
Sexual arousal disorders		
Female sexual arousal disorder	33% married females	Inability to attain or maintain sexual arousal sufficient to initiate or complete sexual acts
Male erectile disorder	2–4% < 35 years old 75% > 80 years old	
Orgasmic disorders		
Female orgasmic disorder	5% adult females	Excessive orgasmic delay, absence of orgasmic response, or premature orgasm
Male orgasmic disorder	4% adult males	
Premature ejaculation	30% adult males	
Sexual pain disorders		
Dyspareunia	Unknown	Pain in sexual organs during sexual activity that interferes with or prevents sexual activity
Vaginismus	Unknown	
Paraphilia		
Exhibitionism	Unknown	Deviant arousal patterns and object choices
Fetishism		
Frotteurism		
Pedophilia		
Masochism/sadism		
Transvestic fetishism		
Voyeurism		
Gender identity disorders	Unknown	Discomfort with or nonacceptance of primary sexual identification and desire to change sexual identification to the opposite gender
Sexual dysfunction due to medical conditions	Common	Variable sexual dysfunction resulting from identified medical conditions or treatment

Source: Sadock VA. Normal Sexuality and Sexual Dysfunction. In Sadock BJ, Sadock VA (Eds.), *Kaplan and Sadock's Comprehensive Textbook of Psychiatry,* 7th ed. Philadelphia, PA: Lippincott Williams and Wilkins; 2000.

diabetes) that might cause dysfunction. Vascular studies can uncover arterial or venous outflow problems. Oral medications that increase blood flow provide effective treatment in many cases. Surgical intervention may be necessary in more severe cases. Phosphodiesterase inhibitors such as sildenafil (tradename Viagra®) are usually effective. Endocrinologic evaluation may indicate that administration of testosterone or alpha adrenergic receptor antagonists, penile self-injections, or

use of urethral suppositories containing a vasodilator would be helpful. Vacuum pumps that provide negative pressure to obtain an erection that is maintained by an elastic band at the base of the penis, and various malleable or rigid penile implants are other options.

Non-organically based, or combined, erectile dysfunction in the male and disorders of arousal in the female often benefit from **sensate focus therapy**. This therapy includes having couples engage in progressive, sensual touching exercises with focus on the patient's sexual sensations. *Performance anxiety* is removed by initially excluding intercourse from the exercises.

Disorders of Orgasm

Rapid ejaculation (RE) is defined as ejaculation without sufficient voluntary influence over timing. For some men, ejaculation is considered rapid if it occurs within the first 2 minutes of vaginal intercourse; for others, it may be defined as ejaculation before 10 or more minutes of vaginal intercourse. Treatments to control the timing of ejaculation include the "stop and start" technique (repeated cycles of withdrawal of stimulation before ejaculation becomes inevitable) and the "squeeze technique" (application of pressure below the coronal ridge or at the base of the penis for 5 to 10 seconds until the urge to ejaculate ceases).

Men generally find vaginal intercourse an effective method of stimulation. Intercourse, however, is not the most effective means of stimulation for the female because the vagina is less sensitive to stimulation than the clitoris. Consultation for women who cannot achieve satisfactory orgasm includes learning direct methods of clitoral stimulation either by the patient or the partner, or use of appliances such as vibrators.

Psychological issues contributing to disorders of arousal include conflicts between an individual's level of sexual interest and perceived social "norms" (e.g., "nice girls don't have sex for orgasm"). Sometimes couples describe a change in their ability to "let go" when their role changes from date to spouse or from partner to parent. Sensate focus exercises may have the benefit of increasing the frequency of orgasm since less emphasis is placed on achieving it.

Sexual Pain Disorders

The sexual pain disorders affect women primarily. Common disorders are vaginismus and dyspareunia. Onset may follow sexual trauma or gynecological surgery, or have other physical or psychological origins. Discomfort during intercourse, **dyspareunia**, can occur at all times or only in certain situations or with certain partners. Discomfort due to inadequate foreplay, causing pain because of insufficient lubrication, must be differentiated from pain on deep penetration, or overt **vaginismus** (the inability to allow any object into the vagina due to involuntary muscular contractions).

Pain on intromission may be due to vaginal infection, irritation, anatomic abnormalities, changes resulting from irradiation, inelasticity, or trauma. Pain on deep penetration can be caused by infection or other conditions such as endometriosis. True vaginismus, or involuntary spasm of the perineal muscles, can be treated with graduated vaginal accommodators to a point where intercourse is possible. **Sexual trauma** must be ruled out as an etiologic factor in any case of dyspareunia, but especially in suspected vaginismus.

Paraphilias

Paraphilia is the need for recurrent, intense sexually arousing fantasies or sexual urges or behaviors to induce sexual excitement that occur over at least 6 months (see Table 20.3 for a list of common paraphilias). Many individuals who have thoughts or fantasies involving unusual settings, different partners, or bondage are concerned about being "abnormal in addition to differentiating between action and thought." It is also essential to distinguish between occasional behaviors and behavior that is repetitive/necessary for sexual arousal, and between consent versus non-consent by the partner.

Hypersexuality has been described as an addiction to sexual activity that temporarily alleviates anxiety, loneliness, and depression. According to some authorities, when the need to have sexual experiences interferes with normal activities and relationships, the condition should be viewed as similar to any addiction. Hypersexual individuals often feel unworthy and ashamed. Hypersexuality can present within the context of a committed relationship, as extramarital activity, or as a primary mode of sexual relations.

Table 20.3. Common paraphilias

Paraphilia	Behavior
Exhibitionism	Genital exposure of to an unsuspecting person or stranger
Fetishism	Use of non-living objects (e.g., pieces of apparrel of the other sex) for arousal
Frotteurism	Touching and rubbing against a non-consenting person
Pedophilia	Attraction to or behavior involving a prepubescent boy or girl
Masochism	Intense fantasies, urges, or behaviors, whether real or simulated, of being humiliated or made to suffer
Sadism	Arousal is achieved from the real psychological or physical suffering of the victim
Transvestic fetishism	Cross-dressing by a male in women's attire that produces sexual arousal
Voyeurism	Arousal while viewing nudity or sexual activity by others who have not given permission.

Potential Changes in Classification of Sexual Disorders – DSM-5

Definitions of "normal" vs. "abnormal" sexual behavior change across cultures and time. For example, homosexuality was considered a sexual disorder until 1973 when it was eliminated from the Diagnostic and Statistical Manual (DSM) of Mental Disorders. The American Psychiatric Association is considering the following changes to the classification of sexual disorders for DSM-5:

- The DSM-5 may distinguish *Paraphilia* from *Paraphilic Disorder*. Paraphilic Disorder will be reserved for individuals who present with distress/impairment related to a specific paraphilia.
- The DSM-5 will distinguish those paraphilias that involve non-consenting individuals (voyeurism, exhibitionism, and sexual sadism). Diverse sexual practices that do not cause distress, impairment, or harm, will not be considered mental disorders, but, rather, normal variants of sexual practice.
- Pedophilia is expected to be reclassified as *Pedohebophilic Disorder* with a distinction between pedophilic and hebophilic type. Pedophilia describes an individual with sexual attraction to prepubescent children (≤ age 10). Hebophilia refers to individuals with sexual attraction to pubescent children (age 11 to 14). The term Pedohebophilia will refer to individuals attracted to both prepubescent and pubescent children.
- A new diagnosis, *Hypersexual Disorder*, is expected to replace the diagnosis of sexual addiction. *Sexual Aversion Disorder* may be removed from the new DSM and reclassified under anxiety disorders as a specific phobia.
- Gender Identity Disorder may be replaced with *Gender Incongruence*. Transgender advocates have argued that gender identity is more biological than psychological and that the term "Gender Identity Disorder" is stigmatizing.

Sexual Exploitation

Rape is a legal rather than medical term. It is defined as penile penetration of the vagina without mutual consent or with a person who is less than a certain age (**statutory rape**). Although rape involves a sexual act, it is primarily an expression of violence or power (see Chapter 26 Interpersonal Violence).

Incest

It is estimated that one in four girls and one in five boys experience sexual abuse. Most perpetrators

are known to the victim. **Incest** between siblings or child relatives is more common but less often reported than incest perpetrated by an adult relative. In some families, only one child may be victimized; in other families, many children may be abused. Although most sexually abused children are between 8 and 12 years of age, younger children, including infants, have been assaulted. Some children experience incest as a one time event; others may experience it on an ongoing basis for years.

Long-term *sequelae of incest* include difficulty establishing intimate relationships, sexual dysfunction during adulthood, and increased genitourinary complaints in later life. *Dissociation* is a common coping mechanism used by children while being assaulted. As a result, some victims never have memories of the events; others remember them years later either spontaneously or during the course of psychotherapy.

Sexual Harassment

The legal definition of **sexual harassment** in the workplace includes sexual advances or conduct that interferes with the employee's working environment, performance, or conditions of employment. A study of federal employees found that 44% of women and 19% of men had felt sexually harassed at work during the preceding 24 months. Although regulations exist to prevent sexual harassment in the workplace, it is often subtle and difficult to prove. Most cases involve male perpetrators and female victims, although successful suits have been brought by men against women. Recent court cases have broadened the definition of sexual harassment to include unwanted sexual contact between members of the same sex.

Sexual Abuse in Intimate Relationships

Women who experience physical violence in an intimate relationship often experience being forced to have sex against their wishes. Before age 15, a majority of girls report that their first intercourse experiences were non-voluntary. Women in such situations may be at risk if they leave the relationship precipitously. Although reported less commonly, men can have similar experiences and are also at risk. Couples in a violent relationship should not be referred for conjoint counseling since the victim may not disclose information at all or the batterer may retaliate physically or emotionally if the victim does disclose. Referring the victim and the perpetrator individually to counseling services is imperative.

Prostitution

Prostitution involves the exchange of sex with another person for the explicit purpose of receiving immediate payment. Female prostitution for heterosexual activity is more prevalent than male prostitution, which is usually homosexual. Prostitution puts the individual at risk of sexually transmitted disease, assault or injury by customers, exploitation by pimps or other agents of organized crime, involvement of minors, and arrest for illegal activity.

Recommended Reading

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Sadock VA. Normal Sexuality and Sexual Dysfunction. In BJ Sadock, VA Sadock (Eds). *Kaplan and Sadock's Comprehensive Textbook of Psychiatry,* 7th ed. Philadelphia, PA: Lippincott Williams and Wilkins; 2000.

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Review Questions

1. Among the general population, the percent of males who have had at least one homosexual experience leading to orgasm is closest to
   A. 20%.
   B. 30%.
   C. 40%.
   D. 50%.
   E. 60%.

2. A man reveals that he sometimes rubs his chest with his wife's underwear in order to feel sexually aroused. This behavior is consistent with
   A. exhibitionism.
   B. fetishism.

C. frotteurism.
D. gender identity disorder.
E. voyeurism.

3. Pedophilia is an example of which of the following sexual disorders?
   A. Gender identity disorder
   B. Obsessive-compulsive disorder
   C. Paraphilia
   D. Sexual arousal disorder
   E. Sexual desire disorder

Key to review questions: p. XXX