CHAPTER 8

TALKING ABOUT SEXUAL ISSUES: MEDICAL, PSYCHIATRIC, AND SEXUAL DISORDERS (Apart From Dysfunctions)

The nature of [a patient's response to the presence of a sexual difficulty] is influenced by cultural background, personality characteristics, the individual's prior experiences, and the dynamics of [the] marital relationship . . . It seems important to use a multi-factorial model . . . that integrates psychological variables with biological processes in order to better understand the effect of . . . medical illness on human sexuality.

SCHIAVI, 1990[1]

MEDICAL DISORDERS

Physcial Illnesses and Disability in Adults: Sexual Issues and Questions

Avoidance of sexual issues that partly results from the gloomy attitude of some health professionals is contraindicated by clinical experience and research findings that emphasize the benefit that patients can derive when intervention is offered.[3]

While a wide variety of sexual problems exist in those with a chronic medical illness, a "pessimistic stereotype" on the part of a health care provider about the sexual potential of patients can result in professional inactivity.[2] From a biological point of view, the appearance of sexual problems is hardly surprising when body systems that contribute to sexual function (hormonal, gynecological, urological, neurological, and cardiovascular) are affected. Yet the avoidance of sexual issues, which partly results from the gloomy attitude of some health professionals, is contraindicated by clinical experience and research findings that emphasize the benefit patients can derive when intervention is offered.[3]

Sexual dysfunctions that occur in the desire and arousal phases of the sex response cycle (see Chapter 3) seem more common than others in the context of chronic medical disorders.[4] The orgasm phase appears less vulnerable to disruption by illness (apart from neurological disorders and side effects of some medications—see Appendix V). Observations about the vulnerability of different parts of the sex response cycle seem equally valid in men and women. A common finding in various studies is the appearance of multiple sexual problems, rather than any one in particular.

Over 70% of 384 patients referred to a sexual rehabilitation service were seen only once or twice, but 50% of the patients who were followed up had a positive view of the consultation and their present sexual status.

"Numerous studies have documented that patients with disabilities related to diabetes, myocardial infarctions, or strokes . . . want information about sexual function from their primary-care team but rarely solicit or receive sex education relevant to their medical problems"[4] (p. 320). Findings from one study of cancer patients state the same conclusions and are revealing from a primary care perspective.[5] Over 70% of 384 patients referred to a sexual rehabilitation service were seen only once or twice, but almost 50% of the patients who were followed-up had a positive view of the consultation and their present sexual status. "Patients . . . who are distressed enough about sexual issues to ask for

help usually want *education* and *crisis intervention* rather than conventional sex therapy."[5] In a needs study of cancer patients, over 50% indicated they would feel most comfortable discussing sexual and social concerns with their physician.[6] In response to the sexual and fertility needs of patients with cancer, Schover has written an informative and sensitive self-help book.[7]

The focus of attention in this section of the book is on adults with acquired illnesses and disability, but one must remember that individuals with congenital disorders grow into adulthood with sexual consequences to their disorders that are, in some respects, quite different from those that develop later in life. Overprotective behavior by parents, personal devaluation, desexualization by others, deficits in knowledge about sexual anatomy and physiology, lack of knowledge of sexual practices, lack of experience in relationships, and social isolation are only some of the elements identified as being influential factors in such a child[8] (p. 244).

In addition to the issues and questions outlined in previous chapters and in the section on Psychiatric Disorders below in this Chapter, some particular issues and questions

Table 8-1 Sexual Issues in a Medical and Psychiatric Examination

EXAMINATION SECTION	SEXUAL ISSUES
Identifying information (II)	• Relationship status • Sexual orientation (possibly)
History of present illness (HPI)	Sexual symptom(s) of disorder
Personal and social history (P and SHx)	• Childhood sexual experiences with adults • Sexual orientation • Past romantic and sexual experiences
Review of systems (ROS)	Sexual Disorders • Sexual dysfunctions • Paraphilias • Gender identity
Past medical history (PMHx)	• STDs (past and present) • Reproduction Birth control Effect of pregnancy on illness Effect of illness on pregnancy and child care Abortion • Bowel and bladder problems • Motor difficulties
Physical Examination (Px)	Signs of disease affecting sexual function
Mental status (MS)	Thoughts of sexual violence
Treatment (Rx)	Sexual side effects of drugs

arise around the topic of sexuality associated with medical illness and disability in adults with acquired disorders. Table 8-1 outlines one approach to considering sexual issues in a conventional medical and psychiatric history. In this structure, the interviewer asks about sexual and sex-related issues that might be relevant to each stage of the history. As an alternative, the health professional might also consider specific areas of inquiry. Szasz outlined seven such areas in patients with a severe physical disability[9] as follows:

1. Sexual response
2. Fertility
3. Motor functions
4. Urinary/bowel/gas control
5. Partnership
6. Sexual self-view
7. Sexual interest.

Some of these areas are discussed elsewhere in this book (e.g., symptoms of sexual dysfunction in Chapter 4 and Part II); others are addressed below.

ISSUE #1: What was the Sexual Status of the Patient *Before* the Onset of the Illness or Disability?

When sexual function is apparently disrupted at the time of the onset of an illness or disability, the assumption is often made that the latter was the cause of the sexual problem. This is not always so. Only a thorough history reveals the accuracy of this supposition.

A 44-year-old man was referred because of erectile difficulties. One year before, he was diagnosed with diabetes mellitus. Since erectile problems are well known to be a symptom of diabetes, the referring physician assumed that the two were related and suggested that the patient receive intracavernosal injections as the then preferred form of treatment.[10]

The patient and his wife wanted to explore other forms of treatment, hence the referral. History revealed that the patient, indeed, had erectile difficulties with his wife but had full and prolonged erections with masturbation (which took place about once per month) and in the morning upon awakening. Furthermore, when questioned about his previous sexual function, it became apparent that he had experienced erectile problems from time-to-time since he married 18 years ago at the age of 26. The diagnosis of a situational erectile disorder (see Chapter 11) was made and he was reassured about the lack of connection between his erection function and his diabetes. The suggestion of intracavernosal injections was not accepted and a talk-oriented form of treatment was initiated with the patient and his wife. While the patient continued to have erectile difficulties after treatment, they occurred far less frequently and the wife and the husband were more satisfied with their sexual relationship.

Suggested Question to be Asked in the Context of the History of the Present Illness (HPI) or Review of Systems (ROS): "**TELL ME ABOUT YOUR SEXUAL RELATIONSHIP WITH YOUR WIFE (HUSBAND, PARTNER) BEFORE YOU DEVELOPED (FOR EXAMPLE) DIABETES.**"

ISSUE #2: What is the Patient's *Mood* and How Does it Influence His or Her *Attitude* Toward Sexual Activity With a Partner?

Physical illness or disability can result in someone feeling undesirable and undesired as a partner generally and a sexual partner specifically. Other professionals use the terms *devaluation* and *desexualization* to refer to these phenomena[8] (p. 243). (These attitudes should be distinguished from an acute depressive disorder when a person may feel self-deprecatory). Family members, friends, and the community may reinforce thoughts of "devaluation" and "desexualization." The question may be heard: "Why can't people see me as someone who has a handicap rather than someone who *is* handicapped?"[11]

A 37-year-old woman was diagnosed with multiple sclerosis four years before referral. She worked full-time as a secretary and her symptoms were, so far, invisible. She was married for ten years but left her husband because of his involvement with another woman. In her past sexual experiences (alone and with a partner), she came to orgasm easily and regularly but this ceased altogether about two years before.

To her surprise, men asked her out on dates, and some continued to be interested in her "even" after they discovered her illness. She was fearful about resuming a sexual relationship with a man because she viewed herself as undesirable. When she did resume a sexual relationship, her (current) male partner wondered why she did not come to orgasm and whether he was somehow at fault. She wondered if there was some way that her problem with orgasm could be reversed. Knowing that the "stimulus" intensity provided by a vibrator would be much greater when compared to her usual sexual experiences and being aware through history-taking that she had never used one in the past, her family doctor suggested this approach to her. With her persistence in the length of time she used the vibrator (over one half hour) and in the number of times she tried (many), she eventually came to orgasm again—initially when alone and then with her partner.

Suggested Questions to be Asked in the Context of the History of the Present Illness (HPI) or Review of Systems (ROS): "**HOW HAS (FOR EXAMPLE) MULTIPLE SCLEROSIS INFLUENCED THE WAY YOU FEEL ABOUT YOURSELF GENERALLY AND HAS IT INFLUENCED OTHERS ROMANTICALLY INTERESTED IN YOU?**"

Additional Question: "**HOW HAS (FOR EXAMPLE) MULTIPLE SCLEROSIS INFLUENCED THE WAY YOU FEEL ABOUT YOURSELF SEXUALLY?**"

ISSUE #3: Does the Patient have any *Symptoms* (e.g., Pain or Motor Problems) that would Interfere with being Affectionate or with Sexual Experiences?

Intimacy does not require sexual intercourse. Virtually no disability precludes some form, of physical closeness in bed.[9]

Some kinds of illnesses (e.g., rheumatoid arthritis) might significantly interfere with being affectionate and with sexual activities. The same might be said of disabilities that result in the need for a wheelchair. Movements that entail hugging or holding may be a problem, quite apart from more complex actions which involve, for example, transfer from a wheelchair to a bed or undressing. However, "intimacy does not require sexual intercourse. Virtually no disability precludes some form of physical closeness in bed."[9]

A 45-year-old married woman developed rheumatoid arthritis 20 years before. It now affects joints, including her hands, hips, knees, and ankles. She walks with a cane and, much of the time, uses a motorscooter. She and her husband were always very affectionate with one another and although less sexually interested compared to the early part of her marriage, she felt that a sexual relationship was important to a couple and that every effort should be made for it to continue. Among other problems, intercourse became progressively difficult because she could not easily spread her legs. As a result, she and her husband gradually focused their sexual/genital experiences on him stimulating her clitoris with his fingers and she stimulating him orally. These sexual practices were familiar to them since before their marriage and remained greatly satisfying to both.

Suggested Question to be Asked in the Context of the History of the Present Illness (HPI) or Review of Systems (ROS): "**HOW HAVE YOUR PROBLEMS (FOR EXAMPLE) WITH YOUR JOINTS AFFECTED YOUR SEXUAL EXPERIENCES OR LOVEMAKING?**"

ISSUE #4: Has the Patient's Sexual Function been Affected by *Treatment for the* Disorder?

Medications (see Appendix V) and surgical procedures, especially those affecting body systems described at the beginning of this chapter, can have profound and direct effects on sexual function.

The 35-year-old wife of a 55-year-old man phoned for an appointment because of her husband's relative sexual inactivity. They were married for four years, she for the first time and he for the second. Their sexual activity was satisfying to both

until his prostate surgery (TURP) two years before. Since then, his erections were partial:

- During sexual activity with his wife
- On awakening in the morning
- During masturbation

Moreover, his ejaculation was retrograde (which to him, was like not ejaculating at all) and his orgasm was much less intense.

He was angry about not having been alerted before surgery that these phenomena might occur and said that, had he known, he would have at least obtained a second opinion. His wife was chagrined at his apparent loss of sexual desire. Because of his great difficulty in adjusting to this new situation, they were referred to a sex-specialist, who was also a mental health professional. After a period in which the husband was seen alone in psychotherapy, his anger diminished and his sexual desire returned, much to the pleasure of his wife. Sildenafil (viagra) was successfully used to treat his generalized erectile dysfunction. However, much to their disappointment, attempts at becoming pregnant were unsuccessful.

Suggested Question to be Asked in the Context of Reviewing the Patient's Treatment Course: **HAVE THERE BEEN ANY SEXUAL SIDE EFFECTS FROM THE MEDICATIONS THAT YOU'RE TAKING (OR SURGERY THAT OCCURRED)?"**

Additional Question if the Answer is, "yes": **"WHAT KIND OF CHANGES HAVE YOU NOTICED?"**

ISSUE #5: Are there *Reproductive Consequences* to the Patient's Illness or Disability?

When considering reproductive consequences, illnesses and disabilities that most affect people in their childbearing and childrearing years are of greatest concern. Included are, for example, spinal-cord injuries and autoimmune diseases such as multiple sclerosis and rheumatoid arthritis. Reproductive consequences involve the ability to conceive and include factors such as genetics, prenatal care, childbirth and postnatal childcare.

A 23-year-old man fractured several vertebrae in a motorcycle accident. His spinal cord was severely injured at the mid-thoracic level. As a result, he was unable to walk and required a wheelchair. His girlfriend with whom he had been living for six months (and intended to marry) could not continue to live with someone who was paraplegic and, as a result, they separated. He seemed depressed but was unwilling to talk with a health professional about his reaction to the disrupted relationship.

In the course of his rehabilitation program, he was informed that if he wished, someone was available for him to talk with about sexual issues. Approximately two

years later, he was interested in seeing a health professional after he became romantically involved with another woman. At that time, he also stated his great desire to father a child. His genital function was such that he was able to have reflex erections but could not ejaculate. However, he knew from other men in similar situations that intercourse was possible and that obtaining semen to impregnate a woman might also be possible through the process of electroejaculation or vibratory stimulation.[12] He was referred to a urologist who specialized in this form of care to obtain more information.

Question to be Asked in the Context of Rehabilitation: "**WHAT IS YOUR OPINION ABOUT SOMEONE IN YOUR SITUATION HAVING CHILDREN?**"

Addition Question: "**IS THIS SOMETHING YOU WANT SOME MEDICAL ASSISTANCE WITH NOW OR POSSIBLY SOMETIME IN THE FUTURE?**"

PSYCHIATRIC DISORDERS

In 1972, Pinderhughes, Grace, and Reyna, surveyed 18 psychiatrists in a Boston Veterans Administration Hospital. Not only did physicians believe that the great majority of psychiatric disorders could be caused by sexual anxiety, but two thirds agreed that sexual activity could slow recovery from an acute episode of psychiatric illness. In the same hospital, however, only 40% of patients surveyed recalled discussing sexual issues with their psychiatrists.

SCHOVER AND JENSEN, 1988[13]

Psychiatric Disorders: Sexual Issues and Questions

Some health professionals (particularly nonpsychiatric physicians) and many people in the community believe that psychiatrists and others who work in the mental health field are especially knowledgeable about sexual issues (if not inordinately interested in this area). In truth in talking to patients about sexual problems, psychiatrists, for example, seem no more and no less knowledgeable and skilled than other physicians.[14]

As indicated above, Table 8-1 outlines one approach to considering sexual issues in a conventional medical and psychiatric history. In this structure, the interviewer asks about sexual and sex-related issues that might be relevant to *each* stage of the history.

Alternatively, the interviewer could focus on specific sexual and sex-related issues. There are at least seven topics that should be addressed in the course of a conventional psychiatric history. While it may not be appropriate to ask about all of these issues during the first visit, they should be included sometime during the first few meetings with the patient. The seven areas are described below, with brief case histories and suggested questions.

ISSUE #1: Does the Patient have a Sexual *Symptom of a* Psychiatric Disorder?

Psychiatric disorders are generally so pervasive that they interfere with all aspects of a patient's day-to-day function, so much so that it is difficult to conceive of "sex" not being

affected in some way or other. In other words, "sex" is almost always disrupted when a psychiatric illness develops and therefore is almost always evident as a symptom. In treating people with psychiatric disorders, one is reminded of Freud's appeal to other clinicians to think about love and work when considering the impact of a mental disorder on a patient.

When thinking about sexual symptoms of a psychiatric disorder, depression is a handy example, partly because it is so common. While DSM-IV outlines The Diagnostic Criteria for a Major Depressive Episode, disrupted sexual function is not specifically included.[15] Yet it seems to be conventional wisdom that sexual interest or desire is diminished when a person is depressed. Paradoxically, at the same time that diminished sexual desire in depression is assumed, a question about this may not even be asked.

A 29-year-old woman with a bipolar disorder was admitted to hospital because of depression. Her chief worry was difficulty in finding a boyfriend. Questions asked included those related to sleep, energy, appetite for food, present mood, and thoughts of suicide. No sex-related questions were included in her history despite the fact that in a previous episode of mania and unlike her usual behavior she was sexually indiscriminate, had five different sexual partners in a two-week period, and, as a result, became pregnant and subsequently had a therapeutic abortion.

When seen as an outpatient some months later, the psychiatrist to whom she was referred included questions about her present sexual status in his initial interview. She felt that her sexual desire changed radically in that there was a complete absence of interest. She attributed this change to her medications. Her psychiatrist thought that medication side effects could be an explanation but also wondered whether her persistent depression was the principal cause. His belief was confirmed when the patient's sexual desire level again increased during an episode of elevated mood three months later. However, since the connection between her mood and sexual behavior was discussed in recent visits, the patient became amenable to continuing the birth control measures she had recently begun.

Suggested Question to be Asked in the Context of the History of the Present Illness (HPI): "**SOME PEOPLE FIND THAT WHEN THEY ARE DEPRESSED, SEXUAL THOUGHTS OR EXPERIENCES CHANGE. HAS THIS HAPPENED TO YOU?**"

Alternative Question: "**HAVE YOU NOTICED ANY CHANGE IN YOURSELF SEXUALLY?**"

ISSUE #2: Is there any Sex-related Facet of the Patient's *Personal and Social (developmental) History* that Might Help Explain the Present Episode of Psychiatric Illness?

In the assessment of a psychiatric disorder, the interviewer considers the symptoms of the disease and the patient's life history in an attempt to understand (1) why the patient is ill and (2) why the patient is ill at this time. Since love and sex are part of individual development, it becomes important to understand how these two issues evolved over the lifetime of a patient. The interviewer particularly wants to know about significant negative events, including possible sexual assault as a child or as an adult. On a psychiatry inpatient service, over 80% of patients describe a history of sexual or physical assault as a child or an adult.[16]

A 44-year-old woman was in hospital because of depression. Early in the initial interview and in the course of a developmental history, she talked about her father having been sexually involved with her when she was a child. The interviewer inquired sensitively into some of the details. In response to specific questions, she talked about the following:

- Having been raped repeatedly from about the age of six to eleven
- Not having discussed this with anyone prior to the current admission
- The impact of these events on her relationships with others (she found trusting others to be difficult)
- The impact on her personal development (she blamed herself).

In subsequent months, she began to come to terms with her childhood sexual experiences, and her periods of depression seemed to diminish in frequency and intensity. While sexual activity with a partner was not always pleasurable in the present, the "flashbacks" that had regularly been associated with such experience in the past occurred appreciably less often and represented considerable less interference.

Suggested Question to be Asked in the Context of a Personal and Social (developmental) History: "**WHEN YOU WERE A CHILD, DID YOU HAVE ANY SEXUAL EXPERIENCE WITH AN ADULT?**

Additional Question: "**AS AN ADULT, HAS ANYONE EVER FORCED YOU INTO A SEXUAL EXPERIENCE?**"

ISSUE #3: Are There *Rep roductive* Consequences to Women Patients that are Apparent in the Review of Systems?

A serious mental illness in a woman can have enormous repercussions from a reproductive viewpoint, including:

1. The effect of pregnancy and child care on the course of the illness
2. The effect of the illness on the developing fetus
3. Postnatal care of the child
4. Genetic considerations

Despite the importance of reproductive issues, questions about the topic seem infrequent in mental health histories. A survey of 94 psychotic women (ages 18-45) found that 75% of the patients never talked about family planning with a professional.[17]

A 25-year-old pregnant woman with schizophrenia was seen in the emergency room of a general hospital because of a recent worsening of symptoms, including auditory hallucinations and the thought that her fetus was actually the devil. She was seen previously in the same emergency room on four occasions over the same number of years and was hospitalized once. Her background history disclosed that:

1. She was presently in the second trimester of pregnancy
2. Did not have a family physician
3. Was not on any antipsychotic medication
4. Had been living on the street
5. Had not been using any form of contraception

She was seen every few months by a community psychiatric outreach service. That clinic was unaware that she was pregnant and had no information concerning her sexual or reproductive history. Also, no related information was included in the recorded history from her previous hospital admission. With antipsychotic medication, careful communication with the community psychiatric service, and regular care by a family physician attached to the clinic, she gave birth some months later to an apparently healthy baby. At that time, and with her consent, a tubal ligation was performed.

Suggested Questions to be Asked of Women in the Context of a Review of Systems (ROS):
"HAVE YOU EVER BEEN PREGNANT?"
"WHAT HAPPENED TO THE PREGNANCY?"

"WHAT HAPPENED TO YOUR (FOR EXAMPLE) DEPRESSION WHEN YOU WERE PREGNANT BEFORE?
"ARE YOU HAVING INTERCOURSE WITH OTHER PEOPLE?"

"ARE YOU USING ANY KIND OF BIRTH CONTROL?"
"IS THIS SOMETHING YOU WOULD LIKE TO DO?"

ISSUE #4: Are there *STD-related* Consequences to the Patient's Illness that are also Apparent in the Review of Systems?

Individuals with chronic mental illness were, in the past, often thought to be sexually stagnant, and therefore concerns about the consequences of sexual experiences were relatively few. While restrictive policies of mental hospitals allowed little sexual activ-

ity to occur, the process of "deinstitutionalization" has provided patients with opportunity for greater sexual spontaneity. The result of this freedom is the recognition that many patients with a chronic mental illness are far from sexually inactive. However, such patients "are likely to exhibit problem-solving, planning, and judgmental deficits that increase vulnerability to casual, transient, coercive, or exploitative sexual relationships".[18] In one study, 44% patients with the diagnosis of schizophrenia who were sexually active in the preceding six months infrequently used condoms on a consistent basis in spite of substantial risk of HIV transmission.[19] It seems evident that those with chronic mental illness represent a high-risk population for HIV/AIDS infection.

A 23-year-old man was brought to an emergency room by police because he threatened others as a result of believing that his thoughts were being electronically monitored. He had been living on the street for over one year and was occasionally followed by a community mental health team because of his schizophrenia. His symptoms diminished over several days and it became apparent that part of his present symptoms resulted from his use of intravenous amphetamines on many occasions in the previous several months. Needles were usually reused and obtained from others.

In addition, he engaged in intercourse with three different women (also on the street) in the past month, and never used a condom. He tested negative for HIV but positive for Hepatitis C. The mental health service had not known previously about his use of IV drugs (and therefore, sharing needles) and assumed him to be sexually inactive. Both issues became an immediate focus of his care. He agreed to participate in a needle exchange program but thought that condoms were unnecessary because of his low level of sexual desire. He was, however, willing to continue talk about condom use.

Suggested Question to be Asked the Initial History, or ROS: "**HOW MANY MEN OR WOMEN HAVE YOU BEEN SEXUALLY ACTIVE WITH IN THE PAST SEVERAL MONTHS?**"

Additional Question: "**DID YOUR SEXUAL EXPERIENCES INCLUDE HAVING INTERCOURSE?**"

Additional Question: "**WHEN YOU HAD INTERCOURSE (ANAL OR VAGINAL), WERE THERE TIMES WHEN YOU DIDN'T USE A CONDOM?**"

ISSUE #5: Is there any Other Sex-related Aspect of the Patient's Review of Systems (such as a sexual disorder in addition to the current psychiatric disorder)?

DSM-IV contains a category of illness titled: "Sexual and Gender Identity Disorders"[15] One of these disorders might coexist with the psychiatric illness being considered.

A 19-year-old single male was admitted to hospital because of depression. He was interviewed by a resident who could talk easily with patients about sexual problems because of a recent and special educational experience in a clinic that focused on patients with sexual disorders. The patient identified problems in a relationship with a woman as an important reason for his present mood state. He was asked specifically about the sexual part of that relationship and answered that it was "not quite satisfactory." He was then asked specifically about having desire, erection, or ejaculation difficulties before the current episode of illness. He said none of these problems occurred but that what was sexually "unsatisfactory" was her disinterest and their virtual absence of sexual experiences together. In asking him about other sexual issues, the patient described the following:

- Unknown to his partner he would wear women's clothes approximately once each week when alone
- Cross-dressing was part of his sexual life since he was 14
- He became sexually excited when cross-dressed and would masturbate

He also indicated that he often had such fantasies when with his girlfriend and (contrary to what he had previously reported) that they would interfere with his erections when he attempted to engage in sexual intercourse. He was referred to a sex-specialist for consultation while in hospital who saw him in continuing care after discharge.

Suggested Question to be Asked in the Context of a Review of Systems (ROS) or Personal and Social (developmental) History: "**DO YOU HAVE ANY SEXUAL CONCERNS (PROBLEMS OR DIFFICULTIES) THAT EXISTED BEFORE THE DEVELOPMENT OF THIS CURRENT PROBLEM AND THAT WE HAVEN'T YET TALKED ABOUT?**"

Alternatively, One Might Ask Specific Questions:

- About Sexual Dysfunctions): "**DO YOU HAVE SEXUAL DIFFICULTIES WHEN YOU ARE ACTIVE (OR INVOLVED) WITH A PARTNER (OR ALONE)?**"
- (About Gender Disorders) see below in this Chapter
- (About Paraphilias) see below in this Chapter

ISSUE #6: Is there any Sex-related Facet of the Patient's Mental Status (such as thoughts of sexual *aggression or violence*)?

Residents in Psychiatry are usually taught to ask questions of patients concerning thoughts of homicide. Yet, judging by newspaper reports, acts (and presumably thoughts) of sexual violence seem far more common. Given the propensity of men to act aggressively or even violently when disinhibited and the fact that acts of sexual violence by women are much less usual, a question on this subject should be directed toward male patients.

A 26-year-old man was admitted to hospital with the diagnosis of schizophrenia. When asked, he admitted to thoughts about injuring himself and others with a knife in response to voices telling him to do this. He felt he had the potential to act violently, although he had never done so in the past. He spontaneously described himself as "gay." No questions were asked about any sexual matters (including his sexual orientation), or about any possible connection between sexual thoughts or hallucinations and violence.

He responded quickly to antipsychotic medication and was discharged from hospital. When asked about the content of his hallucinations some months later as an outpatient, he described his previous thoughts of sexual violence and said that they had almost disappeared. He was sure that other people currently conothers could be assured.

Suggested Question to be Asked in the Context of a Mental Status Examination of a Man: "**HAVE YOU EVER HAD THOUGHTS ABOUT BEING SEXUALLY AGGRESSIVE OR VIOLENT TOWARD A WOMAN OR ANOTHER MAN? (OR YOURSELF)?**"

Issue #7: Is The Patient Receiving Any Form Of Treatment That Might Interfere With Sexual Function?

Since symptoms of psychiatric disorders are so widespread in their manifestations, any form of treatment that is successful will likely be sexually beneficial. In fact, asking about current sexual and interpersonal function may be one way of gauging therapeutic progress. However, some kinds of treatment (especially psychotropic drugs) are notorious for having a negative effect on sexual function (see Appendix V).[20,21] Men may have problems with erection or ejaculation. Women may have problems related to orgasm. Both may find that sexual desire has changed. Infrequently, patients complain about sexual side-effects of drugs spontaneously. More likely, they will not talk about this unless specifically asked.

A 36-year-old divorced man was admitted to hospital because of depression. In his opinion, his divorce was the precipitating factor in this current episode of illness. Questions included the following topics:

- Sleep
- Energy

- Suicide thoughts
- Weight change
- Interests

No questions about "sex" were asked throughout the hospitalization in spite of his concerns about his past relationship with his former wife. His treatment had involved various drugs, including

- Fluoxetine
- Desyrel
- Pimozide

No questions were ever asked about any sexual side-effects of these substances despite, for example, the frequent reports of sexual side-effects with the use of SSRIs. When seen some months later as an outpatient, his depression had markedly improved. Sex-related questions were asked at that time and he revealed that he was distressed about not ejaculating. A "drug holiday" (see Chapter 10) was suggested and ejaculation was successfully accomplished on the following weekend.

Suggested Question to be Asked in the Context of an Inquiry into Previous or Current Treatment(s): "**HAVE YOU NOTICED ANY SEXUAL SIDE-EFFECTS OF THE MEDICATION(S) YOU ARE USING?**"

A More Specific Alternative Question is: "**HAVE YOU NOTICED ANY EFFECT OF THE MEDICATION YOU ARE USING ON YOUR SEXUAL DESIRE, ERECTIONS, OR EJACULATION (IN MEN) OR SEXUAL DESIRE, VAGINAL LUBRICATION, COMING TO ORGASM, OR INTERCOURSE PAIN (IN WOMEN)?**"

SEXUAL DISORDERS (APART FROM SEXUAL DYSFUNCTIONS)

Sexual Sequelae of Child Sexual Abuse in Adults: Sexual Issues and Questions

Epidemiology of Child Sexual Abuse

Childhood sexual experiences with adults seem to be extraordinarily common. Prevalence rates vary according to the following parameters:

1. Definition used, which, in turn, reflects such factors as the sample studied (college students, clinical, or community populations—each progressively higher in prevalence)
2. Types of sexual incidents ('hands-on' or 'hands-off')
3. Age limit of "childhood"
4. Interviewing methods

Rates of child sexual abuse range from 6% to 62% for women and 3% to 31% for men.[22] Wyatt's definition used in her research as it related to the issues of age and consent seems particularly sensible: "incidents involving a victim 12 years or younger are included as sexually abusive, regardless of the victim's consent, because children cannot understand sex-related incidents in which they are being asked to participate.

Incidents occurring with victims ages 13 to 17 that were nonconsensual and involved coercion, regardless of the age of the perpetrator were also included. . .".[22]

Long-term Sexual Consequences of Child Sexual Abuse

While the general outcome of child sexual abuse on adults is well reviewed, a relatively small amount of attention seems to have been specifically given to long-term sexual sequelae.[23] Many observations on the sexual impact are from uncontrolled studies. Reported effects on adult women include the following phenomena[22]:

1. Avoidance of the sexual act that was forced on the person as a child
2. Extremes in sexual activity (lack of interest or a compulsive desire)
3. A high number of sexual partners
4. Less use of birth control, with more unplanned pregnancies, more abortions, and increased risk of acquiring a sexually transmitted disease
5. Specific sexual dysfunctions (anorgasmia, dyspareunia, vaginismus)

Reported effects on adult men include the following[24]:

1. Low sexual interest
2. Erectile difficulties
3. Increased homosexual practices
4. Sexual identity confusion
5. Fear and guilt about sexual pleasure
6. Sexually victimizing others

Child Sexual Abuse and History-taking in the Adult Patient in Primary Care

The clinical identification of child sexual abuse in a primary care setting requires asking a screening question that is descriptive, has no implication of judgment and does not include an opinion about consent. The term *sexual abuse* in a screening question does *not* fulfill any of these criteria, in contrast to the question suggested in Chapter 5 and repeated here.

The majority of sexually abusive experiences in childhood are remembered in adult life so that the primary care clinician does not need to contend with the issue of whether the events are "repressed" or whether they are, in fact, "recovered memories."[25]

Suggested Question to be Asked in the Context of a Review of Systems (ROS) or Developmental History: "**CHILDREN SOMETIMES HAVE SEXUAL EXPERIENCES WITH OTHER CHILDREN OR WITH ADULTS. WAS THIS PART OF YOUR EXPERIENCE WHEN YOU WERE A CHILD?**"

Acquiring details of a childhood sexual experience with an adult is important to understanding the personal meaning of child sexual abuse but women and men both attest to the infrequency of such questions from health professionals.

The majority of sexually abusive experiences in childhood are remembered in adult life so that the primary care clinician need not contend with the issue of whether the events are "represssed" or whether they are, in fact, "recovered memories."[25] That is, primary care health professionals should consider as "sexually abused," patients who recall the childhood sexual experiences. The concepts of "recovered memories" and the False Memory Syndrome provokes immensely strong feelings and tremendous

antagonism.[26] Sorting out conflicts over memory as it pertains to any particular patient should be left to specialists in the field of child sexual abuse.

Acquiring the details of the childhood sexual experience(s) with an adult is important to understanding the personal meaning of child sexual abuse but women and men both often attest to the infrequency of such questions from health professionals.

A 27-year-old nurse was referred to a sex specialist from a psychiatrist. She described a history of child sexual abuse with the deep and repellent concern that she could become sexually aroused only when she had fantasies of being sexually assaulted by a man. As a child from age five to eleven, she was repeatedly stimulated orally by her uncle and several of his friends and was also regularly coerced into stimulating them orally to the point of them ejaculating in her mouth. Intercourse never took place. Typically, she was threatened with the disruption of the family if the secret was revealed.

The details of these sexual events were discussed with her after some initial reluctance. She acknowledged that the process of describing her childhood sexual experiences was painful and that she had never described them before. She said with gratitude that it was a relief to put the memories into words and added that, as a result, she was convinced that the interviewer was the first health professional who truly understood what she experienced as a child. As she was able to reveal these events, her fantasies of being assaulted diminished in frequency and intensity.

A 24-year-old law student was referred with his wife because of his inability to consummate his marriage of two years. During sexual activity alone or with his wife, he had no difficulty obtaining and maintaining full erections. However, whenever vaginal intercourse was attempted, he continually experienced erectile loss. This same sequence of sexual events occurred regularly in his few previous relationships and, as a result, he had never experienced intercourse. His wife experienced no vaginal pain during pelvic examinations and described no fear of intercourse. In fact, she was distressed at the absence of intercourse because she wanted to become pregnant. When seen alone and during the course of obtaining a sexual-developmental history, the husband revealed having been anally raped by a male cousin on several occasions when he (the patient) was about eleven years old. The patient did not see a connection between the past and present sexual events and, as a consequence, had never raised this issue before with a health professional, including the psychiatrist he had seen because of repeated episodes of depression.

The treatment plan was to initially see him alone in individual psychotherapy, after which both partners would be seen together in sex therapy. At the beginning, the husband questioned whether his sexual inclinations were toward men, since he had never had intercourse with a woman. In fact, his sexual fantasies involved men

and women, a fact that he revealed with a sense of shame. He gradually became more accepting of having bisexual fantasies but was adamant about not wanting sexual experiences with other men.

When he and his wife were seen together, he revealed his childhood experiences to her and, much to his surprise, she remained quite supportive and loving. While continuing to be apprehensive about losing his erections, they completed a sex therapy program together and several months later were regularly including intercourse in their sexual experiences.

A health professional should not be satisfied with simply knowing that "child sexual abuse" had occurred and repeating this phrase to other professionals as if its meaning was self-evident. The rationale for obtaining details extends to the following:

Questioning about details should avoid anything that may appear as a repetition of the sexual assault.

1. Not conveying the idea that what took place is so horrible that it is, in fact, unspeakable
2. Understanding the context in which the events occurred (where, with whom, ages of the participants, the relationship with the other person)
3. Becoming aware of the possible connections between past and present (the nature of sexual activities, and response both then and now)

Questioning about details should avoid anything that may appear as a repetition of the sexual assault. Asking about details should not be done precipitously but rather with a signal to the patient that, if OK from their point of view, this aspect of their experience will be discussed on another occasion in the near future. Wyatt provided a list of detailed and explicit questions.[22]

Child Sexual Abuse and Primary Care Intervention

When primary care clinicians encounter a patient who had sexual experiences in childhood with an adult, several initial approaches are possible. The extent of care often depends on what the patient wants at that time. For example, some patients feel that the experience is far behind them and has little or no relevance to present concerns. However, the fact that the childhood sexual experiences are inquired about and discussed (even briefly) in the present indicates to the patient that he or she can return at some time in the future to discuss this topic again if so desired. Other patients may want to consider their childhood sexual experiences further in a preliminary way before embarking on any serious examination with a health professional. In this circumstance, informative reading materials can be helpful, particularly first-person accounts—some of which are especially powerful.[27] When the patient wants in-depth dissection, referral to a mental health professional is warranted, especially a mental health professional who has clinical experience in this area.

Sometimes treatment for nonsexual issues relating to child sexual abuse simply ends without any attention to sexual concerns. "It's almost as though we don't see the word *sex* in sexual abuse. But sexual abuse does cause *sexual* harm" (italics added).[28] Some patients who are reluctant to focus on these sexual issues might benefit by reading a

self-help book that highlights this area.[28] When more extensive care is necessary, referral to a sex therapist may be required.

Nonparaphilic and Paraphilic Compulsive Sexual Behaviors: Sexual Issues and Questions

Compulsive sexual behaviors (CSBs) include nonparaphilic and paraphilic actions.

Definition of Nonparaphilic Compulsive Sexual Behaviors

In a review of CSBs, Travin, defined nonparaphilic compulsive sexual behaviors "as normative behavior carried to extremes".[29] Examples include:

- Compulsive use of erotic videos, magazines and computer programs
- Uncontrolled masturbation
- Unrestrained use of prostitutes
- Numerous, brief, and emotionally superficial sexual liaisons (previously referred to as Satyriasis in men and Nymphomania in women)

Nonparaphilic sexual behaviors usually involve repetitive actions over many years, the expenditure of large amounts of time and money, and interference with personal and family responsibilities. The uncontrolled nature of the activity robs the person of pleasure. Nonparaphilic behaviors usually involve men but include women as well. Judging by referrals to sex-specialty clinics, nonparaphilic CSBs are common.

Terminology and Nonparaphilic Compulsive Sexual Behaviors

Phrases used to describe CSBs that are nonparaphilic include *sexual addictions*[30] and *obsessive-compulsive disorder.*[31] Both terms elicit objections: "addiction" because no substance is ingested and there are no physiological consequences to the behavior or its cessation, and "obsessive-compulsive disorder" because obsessions and compulsions are usually considered by patients to be intrusive, senseless, and distressing, whereas CSBs are regarded by patients (at least initially) as pleasurable.[32]

Definition of Paraphilias

Paraphilias are defined in DSM-IV as "recurrent, intense sexual urges, fantasies, or behaviors that involve unusual objects, activities, or situations and cause clinically significant distress or impairment in social, occupational or other important areas of functioning"[15] (p. 493). The DSM-III-R definition of paraphilias was slightly different: "response to sexual objects or situations that are not part of normative arousal-activity patterns and that in varying degrees may interfere with the capacity for reciprocal affectionate activity"[33] (p. 279). The most visible and dramatic paraphilic actions are illegal in most jurisdictions and range in severity from sexual behavior that affects other people indirectly (e.g., exhibitionism: displaying one's genitalia in public) to those that are direct and violent (e.g., sexual sadism: becoming sexually aroused by causing pain to others). Not surprisingly, individuals who display illegal sexual behavior often first come to the attention of others after being arrested by the police.

Terminology and Epidemiology of Paraphilias

The word "paraphilia" replaces the older word "perversion" and the more recent phrase, "sexual deviation." The frequency of paraphilic behavior in the community is not known, partly because individuals with paraphilias are extremely secretive about their sexual activities. DSM-IV, however, deduces that paraphilias are far from rare, given the "large commercial market in paraphilic pornography and paraphernalia"[15] (p. 524). An additional reason for the mystery about the prevalence of paraphilias is because researchers tend to omit questions about such practices in sexology[34-36] or psychiatric[37,38] surveys.

Some paraphilic and most nonparaphilic behaviors do not result in legal problems. Thus primary care clinicians are becoming increasingly involved with such patients

In a clinical context (and, perhaps, in a research context as well), most people with paraphilias will not spontaneously reveal this aspect of their behavior. Because of the illegality of many paraphilic actions and the great impact of these (and nonparaphilic behavior) on close relationships, people may not even admit to such actions when questioned. The majority of individuals who demonstrate paraphilias are men, for reasons that are a matter of debate. The degree to which paraphilic and nonparaphilic behavior are separate or on a continuum is unclear, as is the extent of overlap.

Compulsive Sexual Behaviors: Initial Evaluation

Primary care clinicians generally have little to do therapeutically with sexual offenders, since they are quickly diverted to the legal system and thence to the mental health system. However, given the fact that some paraphilic and most nonparaphilic behaviors do not ordinarily result in legal problems, primary care clinicians are becoming increasingly involved with such patients, at least in their identification, if not their care. Health professionals may be asked to talk with such patients by a distraught partner who may have just discovered what is occurring. Although there may be a strong professional temptation to immediately refer the patient to a psychiatrist or psychologist, a thorough assessment should be conducted first. Individuals reporting CSBs have been described as representing a heterogeneous group[32], as follows:

1. Typically a man in his late 20s who has had the CSB for almost nine years
2. Impairment that was psychological (subjective distress), relationship (marital discord), or occupational
3. Comorbidity with several psychiatric disorders, including:
   - Substance abuse (64%)
   - Major depression or dysthymia (39%)
   - Phobic disorder (42%)

Maintaining a nonjudgmental attitude becomes particularly important for the health professional if the relationship with the patient is to survive. The interviewer must remain dispassionate. Doing so may be difficult, since many CSBs represent sexual behavior that is foreign (and sometimes repellent) to many health professionals.

Suggested Screening-type of Question Concerning Nonparaphilic CSBs to be Asked in the Context of a Review of Systems (ROS): "**DO YOU EVER FEEL THAT YOUR USUAL SEXUAL EXPERIENCES ARE OUT OF CONTROL?**"

Suggested Screening-type of Question Concerning Paraphilic CSBs to be Asked in the Context of a Rreview of Systems (ROS): "**WHEN YOU WANT TO BE SEXUAL, DO YOU ENGAGE IN SEXUAL ACTIVITIES THAT OTHER PEOPLE FIND UNUSUAL?**"

Creating a screening question about paraphilic CSBs without sounding judgmental is difficult. There is less likelihood that the word "unusual" would be interpreted as judgmental if the question is phrased so that any judgment is attributed to others rather than the interviewer. Maintaining a nonjudgemental attitude becomes particularly important for the health professional if the relationship with the patient is to survive. For that to happen, the interviewer must remain dispassionate. Doing so may be difficult since many CSBs represent sexual behavior that is quite foreign (and sometimes repellent) to many health professionals.

When talking to a patient about CSBs, and for reasons discussed in Chapter 6 (see "Interviewing a Couple"), it is best to meet with that person alone rather than with a partner, since the information revealed may be damaging to the couple relationship. In addition, patients will likely be much more candid when seen alone. Given the embarrassment and sense of shame that usually accompanies atypical sexual behavior, the patient is not likely to have previously discussed this subject with anyone.

Health professionals working in a specific jurisdiction must be aware of the legal context in which their practice takes place in order to provide optimal care to their patients and to protect themselves.

Confidentiality (see "Privacy, Confidentiality, and Security" in Chapter 2) are usually serious issues in the evaluation of CSBs. Laws regarding confidentiality are determined by individual states and provinces in North America, so that the possibility of making generalized recommendations to health professionals on a country-wide basis is limited. Thus, health professionals working in a specific jurisdiction must be aware of the legal contexts in which their practice takes place in order to provide optimal care to their patients and to protect themselves. Health professionals are usually not lawyers and therefore are unschooled in legal interpretations involved in reporting. State and provincial health professional organizations should provide guidance to their members.

Most jurisdictions in North America (state and provincial) will breach confidentiality laws in certain circumstances. For example, most have laws that require a health professional to inform others concerning children in need of protection (which generally include those who are sexually abused).

When, for example, talking to a patient about sexual experiences with children, the health professional should alert the patient *beforehand* of legal reporting requirements. If the particular jurisdiction requires the health professional to report on a child in need of protection because of *current* vulnerability (laws vary on the issue of current and past), one might ask relevant questions of a patient in the following manner (deliberately moving from fantasy to behavior):

When atypical sexual behavior is discovered, the answers to two questions should be immediately determined: (1) Is this person a physical danger to himself or someone else and (2) is anything occurring that is illegal?

Question: "**Do you have sexual fantasies involving children?**"
Answer: "**Yes**"
Statement: "**I'd like to ask you more about this topic but if you tell me about any current experiences with children (rather than fantasies or experiences in the distant past), I have a legal obligation to report them to _____ (often a government agency).**"

Behavior that is not illegal or harmful should remain private between the health professional and the patient. However, the presence of a major secret might well inhibit any existing relationship between the health professional and the patient's *part-*

ner, since the former becomes, in effect, an ally of the person with the secret. Under these circumstances, it is best that the two people not be seen as a couple until such time as the patient decides to reveal what is hidden.

When atypical sexual behavior is discovered, the answers to two questions should be immediately determined:

1. Is this person a physical danger to himself or someone else?
2. Is anything occurring that is illegal?

Obtaining the answers requires that the clinician obtain a detailed description of the problem.

A 47-year-old car salesman, married for 21 years, was referred to a psychiatrist/sex- specialist by his family physician because of a five-year history of sexual involvement with prostitutes at an average frequency of several times each week. The patient was personally distressed by this and wanted to stop. Efforts to do so had so far been unsuccessful. He read about *sexual addiction* and was convinced that the term applied to him.

About once each month, he would have intercourse with his wife. She was unaware of his visits to prostitutes. He never wore a condom with his wife and only did so on about 80% of occasions when he had intercourse with a prostitute. He was never asked the details of his sexual behavior by his family doctor, or the two psychiatrists he saw in the previous two years. He never had a blood test for HIV/AIDS, nor had this been discussed with him by any of the physicians that he consulted. His HIV test was, in fact, negative (a result that he greeted with relief). When he continued to visit prostitutes in the following months (although much less frequently), he regularly used condoms (partly as a result of discussion about the risks to his wife).

A 42-year-old university professor, married for 14 years, was seen together with his wife because of erection problems. When talking with him alone, it became evident that his erection difficulties were situational in that, when alone and occasionally with his wife, he would be fully erect. With some trepidation, he talked of becoming sexually aroused when his wife dressed as a dominatrix in a costume that he purchased for her. She also pretended to whip him (he explicitly disliked pain and viewed the entire sexual process as the acting out of a fantasy). He was embarrassed at asking his wife to engage in this activity and, as a result, did so rarely. After talking with the health professional, he decided to speak more candidly with his wife about the true frequency of his desire for the implementation of his fantasy. While her own sexual preferences were relatively conventional, the two quickly worked out an arrangement whereby they would alternate sexual experiences: one time, "his way," and the next time, "her way." His erectile difficulties

disappeared.

If any one form of atypical sexual behavior is discovered, it is obligatory to ask about others.

Paraphilic Sexual Behaviors: Beyond Screening

The evaluation of paraphilic sexual behavior owes much to the research of Abel and his colleagues.[39] They interviewed convicted sex offenders under conditions that allowed the offenders to talk freely about their experiences without fear of further legal consequence. Two crucial discoveries were made.

First, offenders tend to have a wide variety of atypical sexual experiences, in contrast to the previously held belief that atypical sexual behavior was specific and consistent (e.g., that exhibitionists were not also privately cross-dressing). The clinical application of the finding is that *after any one form of atypical sexual behavior is discovered, it becomes obligatory to ask about others.* Since the varieties of paraphilias seem almost endless, it is obviously necessary to focus questions on those that are more common and more serious (to life and limb).[40]

Suggested Question Regarding Exhibitionism: "**HAVE YOU EVER SHOWN YOUR PENIS TO OTHERS IN A PUBLIC PLACE?**"

Suggested Question Regarding Pedophilia: "**HAVE YOU HAD SEXUAL THOUGHTS OR EXPERIENCES INVOLVING CHILDREN?**"

Suggested Question Regarding Voyeurism: "**HAVE YOU WATCHED OTHER PEOPLE HAVE SEXUAL EXPERIENCES WITHOUT THEM KNOWING?**"

Suggested Question Regarding Fetishism in a Man: "**HAVE YOU DRESSED UP IN WOMEN'S CLOTHES TO BECOME SEXUALLY AROUSED?**"

Suggested Question Regarding Rape: "**HAVE YOU EVER FORCED SOMEONE TO DO SOMETHING SEXUAL WITH YOU?**" (Rape is not listed as a paraphilia in DSM-IV because objections were raised to using rape as a medical diagnosis, which, in turn, could be used to justify this behavior as a legal defense).

One should assume that what one knows about the frequency of a patient's atypical sexual behavior represents a minimum.

Suggested Question Regarding Sexual Asphyxia (tying a ligature around one's neck to lessen the amount of oxygen to the brain and thereby become more sexually aroused): "**HAVE YOU EVER TIED ANYTHING AROUND YOUR NECK TO BECOME MORE SEXUALLY AROUSED?**" (This is also not listed as a paraphilia in DSM-IV, presumably because it appears to be uncommon. It is included here because it may constitute a lifesaving emergency that requires immediate hospitalization).

Health professionals should maintain a substantial degree of skepticism about having the whole story, or even one that is entirely accurate, when considering paraphilic behavior.

Second, through the research conducted by Abel and his colleagues, it became apparent that many more sexual offenses occurred than previously were known by legal authorities.[39] The clinical appli-

cation of this finding is to *assume that what one knows about the frequency of a patient's atypical sexual behavior represents a minimum.* What was said about truth-telling in a sexual history in Chapter 2 was generally accurate (that patients do not usually lie about sexual experiences but rather may not be forthcoming with the truth unless asked). The one exception to this rule is what one might hear from patients who experience paraphilic sexual behavior that could be considered illegal or personally harmful if discovered by others. Such patients will falsify information to conceal it. As a consequence, health professionals should maintain a substantial degree of skepticism about having the whole story, or even one that is entirely accurate, when considering paraphilic behavior.

Gender Identity Disorders: Sexual Issues and Questions

Definition and Epidemiology of Gender Identity Disorders

Gender identity disorders represent confusion by a person about whether they really belong to the anatomic sex into which they were born, that is, the sex manifested by their secondary sexual characteristics and written on their birth certificate. DSM-IV defines Gender Identity Disorder as requiring "a strong and persistent cross-gender identification" and "persistent discomfort with" one's "sex or sense of appropriateness in the gender role of that sex."[15] The term *transgendered* was introduced recently. It describes "individuals (who) live full- or part-time in the gender role opposite to the one in which they were born. They often seek medical assistance (including hormonal therapy and cosmetic surgery) to more completely approximate the appearance of the gender in which they choose to live. This is especially true of transsexuals, who also usually seek genital reassignment surgery."[41]

When considering only the strictly-defined disorder of Transsexualism, the incidence of such difficulties is quite uncommon among biological males (1:37,000).[42] However, when considering the more liberal term of Gender Dysphoria, which refers to "the whole gamut of individuals who, at one time or another, experience sufficient discomfort with their biological sex to form the wish for sex reassignment"[43] (p.5), the prevalence is estimated to be at least 10 times higher.[40] In contrast to males, the incidence of female-to-male transsexualism is estimated to be 1:100,000.[44] Although the care of such patients tends to be highly specialized, the initial identification may occur on a primary care level, and for this reason the subject is included here.

Gender Identity Disorders and History-taking in Primary Care

Sometimes the presentation of a disorder of gender identity is more subtle than, for example, a man explicitly asking for surgery to change his appearance to that of a woman, and requires a more detailed history. In a man, a gender problem may appear, for example, as a difficulty with sexual function, and in a woman, for example, as an eating disorder.

A 32-year-old single man told his family doctor about a four year history of erectile problems. As a result and with little further information, the patient was referred to

a specialist in sexual dysfunctions. The patient described erectile problems in the absence of desire or ejaculatory difficulties. His erections were about 5/10 when awakening, were no different when masturbating, and on the occasional time when he was with a female sexual partner. During the assessment and in response to a question about his reaction to having erectile problems, he commented that he didn't "feel like a man." When the interviewer inquired further into this remark, it became apparent that the patient's meaning was literal (rather than the figurative feelings of demasculinization that plague many men with erectile troubles). He related that since his early teens, he was unhappy about being a male and at times wondered if his life would be easier as a woman.

He previously obtained extensive psychiatric care over several years with several psychiatrists because of substance and child sexual abuse but had never volunteered information about his gender concerns with any health professional. In addition, no such question had ever been asked. He was subsequently referred to a gender clinic for assessment.

A 15-year-old girl appeared with her mother who was concerned about her weight loss. The daughter's intake of food during the past two years was meager, and her weight had drastically decreased from 120 pounds at the age of 12 to 85 pounds at the time of referral. She had been seeing a child psychiatrist for the past one and one half years and her mother was told that her daughter had anorexia nervosa. When seen privately and asked, among other things, about sexual matters (the patient did not discussed this topic with the child psychiatrist), she indicated that her sexual interest was in other girls but added that in her sexual fantasies she thought of herself as a boy. Indeed, for many years she considered herself to be male and to have been born into the wrong body. She said that she lost weight for two reasons:

- To shrink the size of her breasts
- To stop her menstrual periods

She convincingly said that her weight would cease to be a problem after she obtained surgery to become a male. She was referred to a specialist in gender identity disorders.

Suggested Question to be Asked of a Woman (man) in the Context of the History of the Present Illness, a Personal and Social History, or a Review of Systems (ROS): **"SOMETIMES AS A CHILD, A GIRL (BOY) IS UNHAPPY ABOUT BEING A GIRL (BOY) AND WANTS TO BE A BOY (GIRL) INSTEAD. DID THIS EVER HAPPEN TO YOU?"**

SUMMARY

Questions about sexual issues that appear in the context of medical and psychiatric disorders usually are not asked unless required by the patient's symptoms. The absence of information exists despite public and professional perceptions that physicians and mental health professionals have expertise in this area. In addition to the reasons outlined in previous chapters, one also encounters explanations that relate to the appropriateness of such questions given a patient's current status. An omission is, in fact, reasonable under some circumstances. In the beginning stages of almost any illness, many areas of the history are dropped, since the focus is properly on controlling the acute symptoms. However, after management of the disorder results in some lessening of the patient's symptomatology, the professional returns to completing the history, and, in this context, it is reasonable and fitting to include some sex-related questions. The following seven questions can sensibly be asked in the context of medical and psychiatric illnesses:

1. Has something changed sexually for the patient that would constitute a symptom of the disorder?
2. Is there something related to sexual matters in the patient's developmental history that might help to explain why that person is (1) ill altogether and (2) ill at this particular time?
3. What, if any, relationship is there between the patient's illness and reproduction (e.g., birth control, sexual activity, genetics, maternal and child care)?
4. Is there any relationship between the patient's illness and exposure to STDs.
5. In addition to the medical or psychiatric disorder manifested by the patient, does that person also have a sexual disorder?
6. Has the patient demonstrated any sexual violence in thought or behavior?
7. Is there any aspect of the treatment of the medical or psychiatric disorder that may have some sexual impact on the patient?

Once identified by generalists in the health system, individuals with sexual disorders (apart from sexual dysfunctions), including paraphilias and gender identity disorders, as well as victims of child sexual abuse, are usually cared for by mental health professionals. The identification of such patients requires asking questions that, in context, are neither many nor difficult.

Screening for child sexual abuse should be done in a clear and descriptive way by simply asking if the patient, as a child, had sexual experiences with an adult. This question could be asked without using the phrase "sexual abuse," which so often substitutes for understanding the details of what actually occurred, at what age, and with whom.

Information about paraphilic and nonparaphilic compulsive sexual behaviors (CSBs) is usually not volunteered by patients. Such behavior is disclosed only when discovered by family members or the police. This situation may well involve a primary care health professional, at least for identification and clarification of the problem. When a paraphilia is encountered, the health professional must ensure that no one is at risk of harm (the patient, a family member, or a stranger), and that nothing illegal has occurred. Nonparaphilic CSBs can be enormously disruptive to a patient and his or her family but, since they usually are not illegal, they involve the health (rather then the

justice) system. Referral to a mental health professional is justified but should follow a through evaluation at the primary care level. The same can be said of individuals with Gender Identity Disorders. Both disorders can appear in different guises and require careful initial scrutiny.

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