

# Recognizing sexual problems masquerading as other medical conditions

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**ABSTRACT** Studies suggest that many clinicians are unaware of the nature and frequency of sexual concerns among their patients, and the ambiguity surrounding sexuality in our society adds to this complexity, often inhibiting both physicians and patients from addressing sexual health routinely. Recognizing that a sexual problem is the patient's real agenda in presenting what may appear to be another medical condition is often difficult and requires a willingness to consider such a scenario in the first place. Focusing on a variety of true patient cases, the authors depict many clinical circumstances in which sexual difficulties or dysfunctions, both in men and in women, were initially thought to be other medical conditions. Different diagnostic strategies highlight approaches for investigating and uncovering the sexual issue that may underlie the overt complaint and help reaching the correct diagnosis early in the investigation.

It is estimated that more than one half of Americans experience sexual difficulties at some point in their lives.<sup>1,2</sup> The sensitivity and ambiguity surrounding sexual subject matters in our society often inhibit patients from candidly presenting sexual concerns to their clinicians, and inhibit clinicians from routinely inquiring about their patients' sexual health.<sup>3-5</sup> In addition, lack of comprehensive sex education and inadequate patient education have led to patients and physicians failing to consider a sexual etiology during the initial evaluation of symptoms. In one study, after asking a set of specific sex-related questions of all new patients attending an outpatient clinic, primary care internists discovered that over one half of patients had one or more sexual concerns.<sup>6</sup> More recent studies suggest that physicians are generally unaware of the nature and frequency of sexual concerns among their patients.<sup>7,8</sup> A proactive approach to discovering and investigating sexual concerns is the key to effective sexual health care.<sup>9</sup> Routinely including a sexual health inquiry in the medical history may prevent missed diagnoses and clarify misdiagnoses.

In addition to underestimation of the sexual health care needs of patients in general, many patients who have sexual difficulties often present with other complaints that mask the underlying sexual problem. This adds a layer of complexity to the clinicians' task of identifying the real problem. The case histories presented here represent actual patients we have managed, illustrating that common complaints in the primary care setting are often somatic or emotional manifestations of underlying sexual health prob-

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**Educational Needs Addressed:** Sexual difficulties are common in patients presenting to the primary care office, but many patients have difficulty identifying and/or discussing sexual issues with their physicians. Much time, money, and many unnecessary tests can be avoided if physicians consider sexual issues in the presenting condition, and if they take the sexual history during the initial visit. From shoulder pain to panic attacks, a sexual problem could be the unsuspected etiology, as shown in the many patient cases.

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lems (Table 1). In presenting these cases we strive to share wisdom gained the hard way—through trial and error. It is humbly acknowledged that in some cases, more detail sooner gleaned could have significantly reduced the duration of the patient’s problems.

### Anxiety and panic attacks

Sexual difficulties may present as anxiety or panic attacks, depression, insomnia, or substance abuse. Sexual trauma, such as abuse or assault, frequently results in anxiety, depression, post-traumatic stress disorder, or difficulties with sexual expression. Patients grappling with issues of sexual orientation, dysfunctional relationships, domestic violence, or impaired sexual function may present with similar symptoms. Anxiety attacks or the effects of substance abuse initially often mimic cardiac or respiratory symptoms. Likewise, emotional and psychological stress can manifest as physical ailments.<sup>10,11</sup> Anxiety often leads to extensive and unnecessary testing; it has become a diagnosis of exclusion, as shown in the following case.

#### CASE 1 *Chest pain, palpitations, and dyspnea*

A 49-year-old woman presented to her physician after several emergency department visits for episodes of chest pain, palpitations, and shortness of breath. These visits resulted in a diagnosis of supraventricular tachycardia and referral for a thorough cardiovascular evaluation. All cardiac diagnostic studies, including electrophysiologic studies, were normal. Anxiety was not considered in the initial differential diagnosis. Her primary care physician diagnosed these episodes as panic attacks and listened as the patient haltingly reflected on the possible sources of her anxiety. Her husband’s erectile dysfunction (ED) of several years’ duration has caused considerable concern. Her husband refused her requests to seek treatment. She wondered if she might be “worried too much” that her husband may be having an extra-marital affair, or that he is no longer interested in or attracted to her. This patient was referred to marital counseling with her husband, who received successful medical treatment for his ED. The woman’s panic attacks improved and eventually resolved.

#### CASE 2 *Anxiety, agoraphobia, and panic attack*

A 65-year-old man with a several-year history of agoraphobia and panic attacks has been undergoing group

**TABLE 1** Symptoms and conditions that may signal underlying sexual problems

<ul style="list-style-type: none"> <li>▫ Depression</li> <li>▫ Drug, alcohol, or tobacco abuse</li> <li>▫ Eating disorders</li> <li>▫ Fibromyalgia or other musculoskeletal complaints</li> <li>▫ Gastrointestinal complaints (eg, irritable bowel)</li> <li>▫ Genitourinary complaints (eg, pelvic pain)</li> <li>▫ Headache</li> <li>▫ Insomnia</li> <li>▫ Obesity</li> <li>▫ Panic, anxiety</li> <li>▫ Reproduction issues: contraception, pregnancy, sterilization, infertility</li> </ul>
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**Musculoskeletal complaints may be caused by sexual activities more often than is commonly appreciated.**

therapy and treatment with a psychotropic agent prescribed by his psychiatrist. When the patient asked why this disabling condition struck so suddenly, his physician responded with an “unloading” question, “Some people who have similar symptoms—difficulty leaving home and panicky feelings—have had a history of sexual abuse. Is it possible that this has happened to you sometime in your life?” After a stunned pause the patient shared what he had “never told anyone before.” A stranger had sexually molested him when he was a young boy. He had been afraid to share this information with anyone, stating that his psychiatrist “would not be interested in this.”

The unloading question indicates to the patient that the experience is not unusual and that others have had similar experiences and symptoms, thereby deflecting the anxiety that the directness of the question might have elicited and reducing the unrealistic belief that the patient’s experience was unique. The discussion with his physician opened up a new area of focus for this patient to explore with his psychotherapist. Soon thereafter, he disclosed this issue to his agoraphobia support group. He was successfully weaned from several of the psychotropic agents that had been required to control his overwhelming anxiety. This case was striking because of the sudden onset of agoraphobia, with no apparent known reason.

Sexual abuse can often be repressed until adult life,<sup>12</sup> and anxiety occurs as memories start surfacing.<sup>13-16</sup> Anx-

ity disorders are commonly recognized by emergency medicine and/or primary care physicians and treated with pharmacologic agents. Underlying causes of panic attacks, which may be ameliorated by behavioral psychotherapy, should be investigated to avoid delay in appropriate treatment. In our first case—a patient with chest pain, shortness of breath, and palpitations—the obvious differential diagnosis included cardiovascular or pulmonary disorders as well as pharmacologic side effects. Recognizing that anxiety disorders (panic attacks) are a component of the differential diagnosis and including the possibility that their etiology can be of a sexual nature may prevent unnecessary tests and costs.

### Musculoskeletal pain

Musculoskeletal complaints may be caused by sexual activities more often than is commonly appreciated. We have had several cases where patients presented with thigh or hip pain, which were historically attributable to strenuous sexual intercourse. Likewise, low back pain in men and women can be caused by exertion during sex, but the association often is not apparent to the patient or the clinician. Unless the clinician makes an inquiry about sexual practices, these connections may be readily overlooked.<sup>17</sup>

#### **CASE 1** *Persistent shoulder pain*

A 32-year-old man presents to the office for the second time, complaining of persistent bilateral shoulder pain of almost 2 months' duration. He was seen 4 weeks ago with the same symptoms and treated with nonsteroidal anti-inflammatory drugs (NSAIDs), with no improvement. Physical exam revealed localization of the pain to the trapezius bilaterally and no signs of impingement. The history indicated no trauma, sports, lifting, or other recalled overuse. When his physician noted that his weight increased from 225 pounds to 235 pounds in the past 2 months (height 6'1"), the patient attributed this to his wife's cooking. Further exploration showed he got married 7 weeks ago and he and his wife enjoyed prolonged intercourse 5 or more times per week, always in the "missionary position." When the couple changed their sexual expression to include other positions, the patient's shoulder discomfort resolved.

### Genitourinary complaints

Genitourinary or pelvic complaints may often mask underlying difficulties with sexual functioning, such as problems with erection, orgasm, vaginismus, or history

of sexual trauma or abuse.<sup>10,18-20</sup> There is also much overlap between these sexual difficulties and relationship or emotional difficulties. Pelvic congestion syndrome is described as dull pain with prolonged sexual arousal that does not lead to orgasm; the cause, however, is controversial and not well established in the literature. In general, pelvic pain is a very common complaint in primary care and can often be associated with sexual problems, although the literature is scant. Table 2 lists pelvic pain complaints that may be misdiagnosed as another problem and possible actual etiologies.

#### **CASE 1** *Patient with "prostate problems"*

A 39-year-old man presents complaining that he is having prostate problems. Review of systems reveals no urinary urgency, frequency, or dribbling, and no decrease in stream. A physical exam and urinalysis are normal. Sexual health inquiry reveals that he is experiencing ED, which began abruptly after his wife of 7 years informed him that she had never found their sexual interactions satisfying. When the ED began, the patient had initially requested and received a prescription for sildenafil, which improved his erectile function. However, he reported that his wife was still dissatisfied, feeling it was not right that a pharmaceutical agent was required for them to have intercourse. They had many areas of marital discord and were referred for marital therapy. After 3 months of therapy, the man was able to achieve and maintain an erection with which they were both pleased.

#### **CASE 2** *Chronic pelvic pain*

A 38-year-old woman married for 6 years presents with a history of chronic pelvic pain. Work-up by a gynecologist and a urologist showed no abnormalities. She denies any history of sexual trauma. When asked about sexual health she verbalizes her frustration with difficulty with orgasm. We provided her information about self-stimulation, to heighten her awareness of the sexual stimulation she needed to reach orgasm. We recommended that she read *Becoming Orgasmic* (by Heiman and LoPiccolo) to help her become more comfortable with her own body and her sexual needs. Her pelvic pain slowly resolved, as she became orgasmic.

#### **CASE 3** *Recurring urinary tract infections*

A 43-year-old woman presents complaining of urinary frequency and urgency and suprapubic heaviness. Physical and pelvic exams are normal. A urinalysis reveals urinary tract infection. As you write the prescription,

**TABLE 2** Sexual problems often presenting as genital or pelvic pain

Patient complaint	Actual problem
Recurrent pain in penis	Pain with ejaculation: stone in prostate, urethra, or bladder
Recurrent pain in groin (with orgasm)	Pain actually occurs in clitoris or labia with orgasm: not well understood, usually temporary, and helped with tricyclics or other antidepressants
Recurrent pelvic pain (with orgasm)	Pain occurs with orgasm: common in estrogen-deficient women
Chronic pelvic pain	Pain in the context of past or present sexual, physical, or emotional abuse; anorgasmia

Personal communication with Rosemary Basson, MD

she asks, “Why does this keep happening?” Further history reveals that she has had six episodes of cystitis in the past 6 months. A sexual health inquiry reveals that she is single and in a long-distance heterosexual relationship that involves intense sexual activity whenever she and her partner are together. Patient education regarding “honeymoon cystitis” alleviates her concern, and a prescription for postcoital nitrofurantoin, or another antimicrobial active against coliforms, prevents recurrence of the infections.

Such urogenital problems related to sexuality are common. “Honeymoon cystitis” is attributed to the short length of the female urethra with proximity to the anus and can be exacerbated by diaphragm use. We need to educate women not to have their partners penetrate vaginally after anal penetration, as cystitis from coliforms, such as *E coli* can result. Recurrent vaginitis, such as bacterial vaginosis or yeast vaginitis, has been attributed to reinfection either by the partner or by the alkalization of vaginal secretions from semen or irritation of the vaginal mucosa by latex condoms or spermicide allergies. The relationship between irritable bowel syndrome and chronic abdominal pain with a history of abuse is slowly becoming established in the literature.<sup>21,22</sup>

### Relationship issues

Relationship issues and mood disorders need to be considered in any sexual concerns. The connection is demonstrated particularly well by our patient with panic

**TABLE 3** Manifestations of childhood sexual abuse in adults

Women	Men
<ul style="list-style-type: none"> <li>▫ Lack of interest in sex</li> <li>▫ Avoid sexual acts that were part of the abuse, even in a loving context</li> <li>▫ Compulsive sexual activity</li> <li>▫ Large number of partners</li> <li>▫ Decreased use of contraceptives; increased unplanned pregnancies, abortions, and sexually transmitted infections</li> <li>▫ Sexual dysfunction (eg, anorgasmia, dyspareunia)</li> </ul>	<ul style="list-style-type: none"> <li>▫ Low interest in sex</li> <li>▫ Erectile difficulties</li> <li>▫ Increased same-sex practices</li> <li>▫ Sexual identity confusion</li> <li>▫ Fear/guilt about sexual pleasure</li> <li>▫ Sexually victimizing others</li> </ul>

Based on Maurice WL. *Sexual Medicine in Primary Care*. New York: Mosby, 1999, p140.

attacks (Case 1, p 25). Interpersonal conflicts because of difficulty with communication contribute to dysfunctional relationships. Past or current abuse illustrates how intrapsychic conflicts can affect sexual health and relationships (Table 3).

Dysfunctional relationships often occur concurrently with mood disorders (eg, depression, anxiety) or substance abuse. It is, however, impossible to distinguish causality from effect when sexual dysfunction coexists with depression, anxiety, relationship dysfunction, and/or substance abuse. Sexual dysfunction is amenable to short-term therapy, whereas couples counseling to enhance the overall relationship requires significantly greater time and effort. Improving sexual function may motivate the couple to work on their other issues. However, if the relationship is significantly dysfunctional, improvement in sexual relationships will only be temporary.

### Sexual minorities: gay, lesbian, bisexual, and transgendered persons

Issues of sexual orientation and gender identity may further complicate relationship and infidelity matters. Relationships aside, concerns over one’s sexual orientation or gender identity may underlie presenting complaints that are confusing or inconsistent. Sexual minorities have a high rate of anxiety, depression, and suicide risk

**TABLE 4** Sexual dysfunction presenting as infertility

Sexual dysfunction	Mechanism of "infertility"
Male orgasmic disorder	Not ejaculating in vagina
Severe premature ejaculation	May regain erection after ejaculating outside vagina, but unable to ejaculate again inside vagina, especially in men age >35
Low sexual desire or aversion in either partner	Frequency of intercourse is very low
Introital dyspareunia (suspect vaginismus as cause)	Vaginal entry precluded; "intercourse" may be interlabial or intercrural; couples slow to admit this or confused about actual intercourse

Personal communication with Rosemary Basson, MD

attributed to negative societal attitudes.<sup>23</sup>

Refer patients who are transsexual or who are experiencing sexual identity confusion to professionals specializing in sexual orientation.

### Nonspecific complaints

Nonspecific complaints, such as malaise, fatigue, or lethargy may also involve sexual functioning; remember to inquire about this possibility when appropriate. Depression must also be a consideration with these symptoms.

Low levels of estrogen, which occur at menopause, can negatively affect a patient's general sense of well-being. This, in turn, may have a negative effect on sexual functioning. New, albeit controversial, evidence suggests that androgens might have a direct effect on sexual desire, with low androgen levels being associated with decreased interest in sexual activity.<sup>24,25</sup>

#### CASE 1 *Lethargy and fatigue*

A 47-year-old woman complains of fatigue and lethargy. She has a history of Graves' disease, treated with thyroid ablation and now levothyroxine sodium tablets. The biggest apparent change is a total loss of her sexual drive, although her close relationship with her husband of 23 years has not changed. Further history reveals mood swings and some irregular menses. Lab work reveals a normal thyroid-stimulating hormone level and very low estradiol. She was put on combination hormone replacement therapy and within 2 weeks

she reported that her interest in sexual activity returned.

### Reproduction issues

Problems related to reproduction, contraception, pregnancy, abortion, sterilization, and infertility are obviously associated with sexual function. The prevalence of sexual dysfunction underlying these conditions is probably not fully realized (Table 4). Nearly 10% of men in the general population report being unable to achieve orgasm at all or with penile-vaginal intercourse.<sup>26</sup> Conversely, men or women who are infertile may experience decreased sexual drive secondary to issues of self-esteem or body image, as the following case demonstrates.

#### CASE 1 *Primary infertility*

A 29-year-old woman presents for a routine examination. She and her husband have been unsuccessfully attempting to conceive for 18 months, despite use of clomiphene citrate and measurement of basal body temperatures. Neither has had any children, surgeries, or sexually transmitted infections. Her periods are regular and his semen analysis is normal. She also had a normal hysterosalpingogram. They use positive ovulation kits to time intercourse. To confirm optimal timing of intercourse, the physician inquires specifically about their sexual practices. The woman expresses concern about their "technique" and mentions that she believes her husband cannot ejaculate inside her. However, she is very satisfied with their sex and is multiorgasmic. When her husband joins you in the exam room, he explains how he enjoys intercourse and satisfying his wife sexually, but has never been able to have an orgasm or ejaculate with intercourse. He has only been able to ejaculate by masturbation while viewing erotic magazines, a habit he carried over from adolescence. The couple was treated with behavioral techniques, such as sensate focus, reintroducing touch, and successive approximation techniques. She gradually joined her husband in his self-stimulation, and then provided most of the stimulation, removing the use of erotic magazines. They were then able to conceive without clomiphene.

**Loss of spontaneity.** Unsuccessful attempts to conceive and subsequent infertility treatments can contribute to decreased sexual interest as sexual activity becomes attached to the goal of conceiving, and spontaneity of sexual activity becomes affected as intercourse requires timing to optimize success at conceiving.<sup>27,28</sup> Couples should be encouraged to set aside time to en-

joy sexual activity outside of the optimal timing required for fertility attempts. This time should be dedicated to themselves and their relationship. Perhaps exploring alternatives to intercourse, such as mutual massage and masturbation and oral-genital sex.

**Stressors.** Anxiety about undesired fertility and lack of confidence or access to adequate contraception may lead to sexual difficulties or frustrations, especially during attempts to reduce unwanted conception via use of the withdrawal technique to prevent intravaginal ejaculation. In nonmonogamous couples, this may also increase the risk of exposure to sexually transmitted infections, including HIV. Correcting the underlying concern regarding undesired ferti-

ility and adequate contraception, as well as safer-sex education, would likely have a positive effect on the sexual relationship. Certainly, undesired pregnancy and decisions about whether to terminate or continue both the pregnancy and the relationship not only affect the woman and her partner's aspirations but also can leave long-term feelings of guilt, particularly in the case of termination. The physical changes and emotional challenges of continuing the pregnancy, particularly with an underlying notion of this being a "mistake," can add significant stressors to the woman and the couple.

Choosing to end fertility via tubal ligation or vasectomy may also cause a sense of anxiety over the procedure, a need to grieve the end of fertility, or significant relief of anxiety as fear of unwanted pregnancy is alleviated. The same issues arise for women in early menopause, especially when children have left the home and a woman is left with an "empty nest."

### Body image and sexual dysfunction

It is likely that sexual side effects of medications are generally well known to patients, becoming apparent to clinicians only when they discover that their patients have stopped taking the medications prescribed. Be sensitive to this when inquiring about a patient's adherence. Take care to differentiate medication side effects from other etiologies involving sexual problems.

#### **CASE 1** Body image, hypertension, and sex

A 60-year-old man presents for a complete physical exam to the physician who has attended to the man and his wife for 7 years. The wife is seen on a regular ba-

sis for several medical problems. The husband often solicitously accompanies his wife, but considers himself healthy. During this visit he initially states that he has no complaints. Upon inquiring about his sexual function, he replies that he "wouldn't have any way of knowing whether it works or not, since you people took away my wife's sex function with that darn blood pressure medicine years ago." He explains that he loves her too much to go outside the marriage for sex, and that he has never complained, nor pushed her on the topic, as he did not want to hurt her feelings. The 58-year-old wife is seen separately and investigation reveals that although she does take hydrochlorothiazide, her avoid-

ance of sexual intercourse stems not from medication side effects but from an altered body image. She had had a radical mastectomy 8 years before. Although she has otherwise done well and always appeared happy and well adjusted to her physician, she has severe body image concerns. She had not al-

lowed her husband to see or touch her "repulsive and disfigured" naked body since her mastectomy. In couple counseling, the husband was able to convince her that it did not matter whether she had one breast or two. They happily reestablished an active and mutually satisfying sex life. This case highlights the need for open communication between patient and physician as much as within the couple themselves.

**Desire.** Problems with body image can affect sexual desire; typically this is tied to issues of self-esteem.<sup>28</sup> Men and women can feel unattractive and experience decreased desire due to changes in their own body images and question how their partners could possibly be attracted to them. Alternatively, they experience decreased desire for their partners who might become less attractive when changes occur due to surgery, weight gain or loss, other changes in body habitus (shifting of weight from one area to another), and/or changes associated with aging.

**Surgery.** An example of surgically induced body change is a colostomy needed for bowel resection. A poorly functioning stoma, perhaps from radiation-induced colitis, makes establishing a routine for stomal functioning difficult. Concerns about being attractive, body odors, and, obviously, worries about mortality can interfere with a previously healthy sexual functioning.

**We need to be aware that our patients may "mask" their underlying reason for seeking health care by presenting other symptomatology.**

**TABLE 5** How to inquire about sexual health

- Allow the patient to feel in control
- Avoid perception of inappropriateness
- Be aware of patient's cultural background
- Defer sensitive questions
- Do not be judgmental
- Ensure confidentiality
- Help the patient to feel less unusual ("unloading" technique)
- Initiate discussion of sensitive subjects
- Offer encouragement
- Provide explanations for questions and alternative answers

Adapted from Basson R. Eliciting the sexual concerns of your patient in primary care. *Med Asp Human Sex* 1(1):13–18, 2000.

### Clinical implications

Sexual concerns and difficulties are fairly common in primary care. We need to be aware that our patients may "mask" their underlying reason for seeking health care by presenting other symptomatology. Basson's framework for eliciting and clarifying sexual concerns of patients (Table 5) can be used in the primary care setting.

Making a thorough sexual health inquiry prevented several of the patients presented here from having unnecessary, costly procedures. It also spared them further discomfort and helped them reestablish sexual pleasure. They remain appreciative of their physician for taking the time and effort to take a sexual history. Regardless of who the patient is, as clinicians we need to be as explicit as necessary, in a sensitive manner, to get the sexual health information needed. We learn from our mistakes. ♀

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