# Sexual Problems in Adolescents and Young Adults

(Chapter 22)

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## Author Note

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## Introduction

**Overview of sexual problems among adolescents and young adults.** Despite the wealth of research on the sexual lives of adolescents and young adults, it is surprising how little is known about the sexual functioning of young people. “Adolescence” refers here to the period of development between childhood and adulthood, and captures the teenage years. “Young adulthood” typically refers to the period between late adolescence through the mid-20s, or 24 years of age (CDC, 2012; UN Population Information Network, 1997). The gap in this literature is also notable in light of the high rates of sexual dysfunctions among adults. Sexual experiences in adolescence and young adulthood are the foundation upon which adult sexual lives are based. Positive sexual functioning is clearly an essential component of sexual health; however, there is a dearth of research on the sexual functioning of young adult populations and almost none among adolescents. Although their sexual lives have garnered considerable research attention, it has been through a very selective prism focusing on high-risk behaviors and problem outcomes, such as early onset of partnered activity, unwanted pregnancy, sexually transmitted infections, and coercion. In some respects, the same sexual problems that are considered to be indicative of dysfunction among adults, such as lack of pleasure, rapid ejaculation, anorgasmia and pain, are viewed as normative conditions among young people.

Society fosters a deep and abiding distrust and discomfort around issues related to sexual development, privileging sexual experience to the realm of adulthood. Thus, sexually active young people are viewed with some disdain, their sexual behaviors referred to as irresponsible or problems in themselves, and they are not viewed as having rights to sexual pleasure (or absence of pain). Sexual problems that arise are in some respects viewed as if they are deserved or to be expected (“the wages of sin”). This period of life is replete with many related psychosocial and

relational challenges, including establishing one's sexual orientation, learning to negotiate contraceptive access and use, fear of pregnancy or contraceptive/condom failure, use and exposure to sexually explicit media and changes in dating norms. Problems in sexual functioning may compromise young people's romantic and sexual relationships, and exacerbate questions relating to gender identity, body image, and fertility—all factors central to positive development, identity and adjustment in this period of life. We use a developmental focus and sexual rights perspective to address issues relevant to sexual functioning among adolescents and young adults and explore the challenges and limitations to advancing treatment among this population.

**Epidemiology.** Several large-scale studies of sexual functioning have included late adolescents or young adults. However, they tend to be small in number and include rates that are obscured in the analyses of older adults (e.g., Mercer et al., 2003). For example, a U.S. national probability sample analyzed rates from men and women 18-29 years of age (Laumann, Paik & Rosen, 1999). These rates combine those of late adolescents, young adults, and adults. Even so, the rates for men and women for the preceding year were: lacked interest in sex (14%, 32%), unable to orgasm (7%, 26%), experienced pain during sex (30%, 21%), found sex not pleasurable (10%, 27%), anxious about performance (19%, 16%), trouble lubricating (19%, women only) and trouble maintaining/achieving an erection (7%, men only). Sexual difficulties were more prevalent among women (43%) than among men (31%).

In an analysis of data from the National Longitudinal Study of Adolescent Health, researchers examined the regularity of orgasm among 3,237 respondents aged 18-26 years, who reported being in a heterosexual relationship of at least three months' duration (Galinsky & Sonenstein, 2011). Ages, again, were not separated for adolescents and young adults alone as the range includes those up to 26 years of age. Sex was defined as including vaginal, oral or anal

sex. Fifteen percent of the young women reported having orgasms less than half the time or never compared to 2.6% of the young men. A survey of 18-24 year old women found that 31% were unable to have an orgasm during intercourse, 33% reported low sexual desire and 22% reported physical pain during intercourse (Fisher & Boroditsky, 2000). No data on men were available. Although unclear, these studies suggest moderate to high rates of problems in sexual functioning among young people and possibly rates that are comparable to those of adults.

In one of the few known studies addressing sexual problems among young people directly, 171 late adolescent men and women (17-21 years) were surveyed regarding lifetime experiences of sexual difficulties (O'Sullivan & Majerovich, 2008). The prevalence of difficulties among men that occurred "sometimes" or "always" included: climaxing too quickly (41.9%), anxiety about performing sexually (32.6%), difficulty maintaining an erection (23.1%), engaging in unwanted sexual activity (18.7%), and inability to climax (16.3%). Chronic difficulties were uncommon in this sample of men, although occasional experiences of sexual difficulties, such as rapid ejaculation and performance anxiety, were fairly common. Problems reported "sometimes" or "always" for women were: inability to climax (53.1%) or climaxing too quickly (23.2%), insufficient lubrication (31.3%), performance anxiety (31.2%), painful intercourse (25.8%), unwanted sexual activity (23.5%), lacking interest (22.9%) or pleasure (11.2%). Like the young men, few young women reported "always" experiencing a given sexual problem. The most common persistent difficulty was inability to have an orgasm.

Follow-up qualitative interviews with 30 of these individuals revealed that (1) pleasure increased with sexual experience; (2) sexual difficulties frequently led to sex avoidance; (3) sexual activity may be high even when sexual interest is low; and (4) pain was often linked to low arousal. A female participant said, *"If we don't do it for a couple days it'll hurt sometimes,*

*just starting off... or actually on the inside wall sometimes it hurts after I've reached orgasm. I don't know why... I just work through it."* A man explained, *"Her sex drive is still very, um, high and mine's falling off. Which is kind of ironic, since the guy's supposed to be the sexual animal... It's a point of stress, which makes it worse so I'm beginning to hide out, avoid even touching her."* A young woman explained, *"Uh, one of the reasons why I believe I can't orgasm during sex is because I haven't… there's not much to it. I don't feel a whole lot during sex."* Another young woman told us: *"He has [laughs] a very large penis. And it hurt... It wasn't enjoyable. I thought he hit an organ for god's sake. [Laughs] So, we only had sex twice. I..I..I just wasn't happy with the relationship in many ways and that was one of them."* Additional research is needed to explore further the impact of sexual problems on the psychological and relationship functioning of young people.

An ongoing longitudinal study of 319 youth (16-21 years) is underway to help track the onset and progression of sexual problems among adolescents and young adults (O'Sullivan, Brotto, Byers, Majerovich & Wuest, 2012). Analyses of baseline data for sexually active youth revealed that 15% reported distress associated with a sexual problem. Using a standard measure of sexual dysfunction (Rosen et al., 2000), young women's scores revealed problems in desire, arousal and satisfaction, lubrication, orgasm, and genital pain that more closely resembled those of women with sexual dysfunction than those of controls. Likewise, the young men's scores more closely resembled those of in the development sample of patients than of the adult controls (Rosen, Riley, Wagner, Osterloh, Kirkpatrick & Mishra, 1997). Overall, 18% of the young men were classified as having symptoms of premature ejaculation (PE) or possible PE. No other studies that address a range of sexual problems among adolescents and young adults were found.

Finally, there are several studies linking specific sexual dysfunctions among young people to medical disorders, gynaecological or genitourinary problems or abnormalities (e.g., pelvic inflammatory disease, testicular cancer, endometriosis), conditions requiring surgical treatments, such as congenital anomalies, ovarian cysts or tumors (Greydanus & Matytsina, 2010), complications of medications, such as selective serotonin reuptake inhibitors (SSRIs), antipsychotic medication, and long-term oral contraceptive use. Other studies provide less direct evidence of sexual dysfunctions, such as sildenafil use among late adolescent males (Peters, Johnson, Kelder, Meschack, & Jefferson, 2007).

**Assessment and diagnostic issues.** A sexually active adolescent female who feels no desire, has never had an orgasm, and experiences no pleasure from her sexual life is unlikely to be viewed as experiencing sexual problems. Tolman argues, “Female adolescent sexual dysfunction is an oxymoron” (Tolman, 2001; pg. 197). Sexual problems among adolescent males are frequently the object of ridicule or depicted humorously in popular books or movies, such as American Pie and Fast Times at Ridgemont High. Adolescence is viewed as a period in which young people transform from sexually inexperienced to sexually inept to sexually competent. Upon reaching adulthood, they are expected to have sexual experience, expertise, even prowess (for men at least), perhaps contributing in part to the high rates of adult sexual dysfunctions.

These assumptions are particularly clear when reviewing the diagnostic criteria of the DSM. There are no age criteria for any of the sexual dysfunctions included in the revised DSM-5 or its predecessors. As we have argued above, many of the hallmark features of the dysfunctions appear to be typical of many young people, especially early in their sexual lives, such as “marked delay in, marked infrequency, or absence of orgasm” (Female Orgasmic Disorder); “persistent or recurrent pattern of ejaculation occurring during partnered sexual activity within approximately

one minute of beginning sexual activity and before the person wishes it" (Early Ejaculation); "absent/reduced frequency or intensity of interest in sexual activity" (Sexual Interest/Arousal Disorder in Women); "persistently or recurrently deficient (or absent) sexual fantasies and desire for sexual activity" (Hypoactive Sexual Desire Disorder in Men); and "inability to have vaginal intercourse/penetration" or "marked vulvovaginal or pelvic pain during vaginal intercourse/penetration attempts" (Genito-pelvic Pain/Penetration Disorder). Even if there were age-related specifiers (e.g., age at onset), underlying assumptions within the DSM criterion-based diagnostic system present challenges to the case of adolescence and/or early adulthood.

The DSM diagnoses require that an individual experience the symptoms for at least six months for a diagnosis to be warranted, with the exception of Hypoactive Sexual Desire Disorder in Men which does not specify a time period at all. Thus, many adolescents and young adults in their first half year following the onset of sexual activity could meet this requirement for diagnosis of a sexual dysfunction. We recommend that clinicians not be put off by the lack of specificity, and review presenting symptoms in the context of an individual's broader sexual and relationship life. Particularly important in the case of young people is to take into account patterns of sexual functioning from the onset of their sexual lives, across partners, if applicable, while bearing in mind that many young people have little consistency in sexual frequency and experience long periods of often abstinence at first. The six-month criterion assumes regular sexual activity to assess frequency of symptoms, which is much less likely in young adolescents. It may be a year or two once activity has commenced before there is a sustained period across which one may judge the course of the complaint. Thus, clinicians should apply that criterion cautiously. It is likely that some problems are encountered in the course of learning how to control timing, communicate effectively to a partner in order to maximize pleasure, and while

developing preferences for positions and activities in general. We recommend that clinicians always be cognizant of the potentially strong, stigmatizing or inhibiting impact of applying diagnostic labels at this (early) point of life. Clinicians should communicate these labels cautiously, if communicated at all.

Central to the diagnostic system is an assessment in each case that an individual has experienced "clinically significant distress or impairment" as a result of the problem. This feature likely ensures that many young people who are learning "how sex works," developing skills, learning how to communicate about sexual matters with a partner, and overcoming various sexual problems across partners, activities and time are unlikely to report the high level of distress that warrants diagnosis. This is only an assumption based on our own research, however, as there is scant research to indicate whether distress is characteristic of their early sexual lives and certainly no discourse on this matter in the field. A challenge to clinicians is to assess the nature and severity of distress related to established problems in sexual functioning among adolescents and young adults.

We recommend that clinicians employ existing measures designed for adults with few changes (e.g., wording to reflect the knowledge or lexicon of a teenager) as necessary. We like the comprehensiveness of the *Golombok-Rust Inventory of Sexual Satisfaction* (Rust & Golombok, 1985), but it has a strong relationship focus, which may not always be appropriate. We have also used successfully the *Female Sexual Functioning Inventory* (Rosen et al., 2000), and the *Brief Index of Sexual Functioning for Women* (Taylor, Rosen & Leiblum, 1994). For young men, we recommend the *International Index of Erectile Function* (Rosen, Riley, Wagner, Osterloh, Kirkpatrick, & Mishra, 1997), the *Premature Ejaculation Diagnostic Tool* (Symonds et al., 2007) or the *Brief Sexual Function Questionnaire* (Reynolds et al., 1988). The *Female Sexual*

*Distress Scale* (Derogatis, Rosen, Leiblum, Burnett, & Heiman, 2002) measures sexual functioning distress in both young women and men.

The potential impact of revised DSM-5 diagnostic proposals on adolescents and young adults is likely minimal given that the dysfunctions have unknown applicability. However, in the case of the new diagnoses for Female Orgasmic Disorder and Sexual Interest/Arousal Disorder in Women, changes recognizing the substantial variation across women in sexual response cycles will likely benefit young women who may have response cycles that look quite different from adult women's. There is also now greater recognition of variation in the expression of interest and desire, especially in the form of fantasy/erotic thought. Researchers find both overlap in interest, arousal, and desire, inconsistent sequencing, and variation in spontaneity/responsive (Graham et al., 2004). The new Genito-pelvic Pain/Penetration Disorder is far more expansive and descriptive than before and now may capture young people experiences, given the high rates of sexual pain (O'Sullivan & Majerovich, 2008). The new Other Specified Sexual Dysfunction category addresses fear and anxiety related to sexual contact, rather than loss of sexual feelings despite "otherwise-normal" arousal and orgasm. Once again, there is no comparative model to capture "normal" response cycles in young people, but fear and anxiety are known components of early sexual expression and avoidance for adolescents, if not young adults.

**Etiology/theories/models of the sexual problem.** Young people face a host of age-related factors that appear to be linked to the experience of sexual problems. These include inadequate sex education and family communication around issues pertaining to sexual functioning, lack of experience across time and partners, less sophisticated communication and intimacy/relationship skills, and high rates of compromising health factors, such as STIs, and anxiety and depression. Compared to adults, sexual problems among young people might be less

attributable to organic breakdown associated with long-term medical conditions, although we simply do not yet know.

Important to understanding etiology are the host of psychosocial factors central to the experience of youth, including the sexual objectification of girls to represent targets of male desire, socialization with heavy emphasis on a range of romantic myths surrounding sex, such as sex should always be perfect, spontaneous, and fulfilling, and the myriad messages that young people receive through the media equating sex with personal value. There continues to be strong endorsement of what Simon and Gagnon (1986) have termed the traditional sexual script, which positions men as adversarial sexual agents in heterosexual encounters with girls, and positions girls as sexual ascetics, targets of male sexual attention, or negotiators of sex for love and security. Endorsing such scripts has negative consequences for both young women and men , such as agreeing to unwanted or painful sex, silencing the self around sexual interests and needs, abuse and coercion, poor body image, guilt, resignation, resentment and anxiety (Dworkin & O'Sullivan, 2005; Elmerstig, Mijma, & Berterö, 2008).

Dysfunctions may also be the result of biomedical factors such as inherent pathophysiological abnormalities. These would include mild congenital defects such as hypospadias in males or the more complex case of abnormalities of the urogenital tract due to a disorder of sex development (DSD) (Pasterski et al., 2010). Genetic impairments may also result in the inability to reduce inflammatory responses, or variations in pain-regulatory mechanisms or thresholds (Landry & Bergeron, 2011).

**Approaches to Treatment**

Young people are not expected to have a sexual life, so if it is undesired or painful that is to be expected, if not subtly reinforced. Standard approaches to the treatment of sexual problems

among young people are often medical ones and health care providers are the first (and often only) to know of sexual problems (Brown & Brown, 2006). Although desire and arousal are important components of a healthy sexual life, the focus with youth tends to be on issues of contraception and reproductive health. Young people require assurances that the care they receive is confidential, yet clinicians typically request that a parent leave the room, offer time alone, or assure an adolescent or young person that the information that they provide is kept private only when the provider suspects that the individual has a sexual problem to discuss (McKee, Rubin, Campos, & O'Sullivan, 2011).

Because youth may not present with sexual problems, clinicians need to ask the essential questions that can uncover problems in sexual functioning. An excellent approach is to incorporate this line of questioning into inquiries for related presenting issues, backed by more random and comprehensive inquiries into all areas of medical or psychosocial functioning that include sexuality. Parental consent is not required to talk to or counsel an individual below the age of majority about sexual problems. Nor do clinicians require consent from a partner to talk about their relationship in therapy. Clinicians need to be aware of age of consent laws relevant to sexual activity as they vary regionally (e.g., 16 in Canada and the UK; 16-18 in the US) and clarify the limitations of their privacy assurances with the youth that they counsel. Similarly, the issue of parental involvement for adolescents can be a difficult one. We recommend encouraging open communication with a parent or other trusted family member or offering to facilitate communication about sexual problems that require more serious intervention or treatment.

Without a body of literature upon which to draw, it is exceedingly difficult to outline treatment approaches. Tailoring standard psychological therapies that are used with adults with dysfunction to address the unique issues faced by adolescents and young adults (described

above) is a sound staring point. Therapy might best be combined with pharmacologic management of cases, but we know of no medications that are approved for treatment of sexual dysfunctions among young people and recommend again that clinicians take a longer-term perspective to truly understand the sexual problem in the context of a young person's developing sexual life. In the absence of a literature on which to refer, treatment protocols may be developed drawing on other related bodies of literature or by developing theoretical models. In the case of structural anomalies in sexual functioning, there is a growing consensus on psychological treatment relating to psychosexual health in young patients (Hughes et al., 2006). The approach is one of full disclosure (with the permission of parents where necessary), and openness regarding sexual functioning. Talk-based therapy is often used to address psychological sequelae of these dysfunctions (e.g., Hughes, et al., *in press).* Interestingly, in this context, sexual activity is generally seen as a healthy and natural part of early adult life. The goal of the health care provider is to promote healthy sexual functioning. In the absence of structural abnormality, frank discussion regarding sexual functioning, treatment options and general sexual health apply.

Although there are as yet no reports of outcomes specific to psychological therapeutic approaches in counselling adolescents and young adults with possible sexual dysfunction secondary to DSD, one successful approach has incorporated cognitive theory. According to cognitive theory, general positive beliefs about the self are central to healthy psychological functioning and should be considered in parallel with treatments aimed at specific sexual problems. Open communication with one's partner(s) may be difficult or impossible for a young person experiencing dysfunction. Improving the self- and body-image by restructuring beliefs and underlying assumptions may be valuable here. In many cases, sex therapy requires that both partners participate and work together toward solving sexual functioning problems. Although

such an approach requires trust and a degree of stability in the relationship, we recommend incorporating partners wherever possible.

Some useful resources include books, such as “Sex, Therapy, and Kids: Addressing Their Concerns through Talk and Play” (Sharon Lamb), “It’s Perfectly Normal: Changing Bodies, Growing Up, Sex & Sexual Health” (Robie H. Harris & Michael Emberley), “Nurturing Queer Youth: Family Therapy Transformed” (Linda Stone Fish & Rebecca Harvey). Excellent web resources include those of the College of Sexual and Relationship Therapists, the Sex Information and Education Council of Canada, the Sex Information and Education Council of the United States, American Association of Sexuality Educators, Counselors and Therapists, sexualityandU.ca, and Advocates for Youth.

**Case Discussion**

We reiterate here that there is no systematic report of sexual dysfunction or its treatment in adults younger than 17 years old. We present two cases and outcomes here, but these are only examples and not evidence of treatment success. Larger samples and systematic implementation of treatment protocols are needed to establish guidelines beyond our recommendations.

**Case discussion #1.** Here we present a case of a 17-year-old female, JL, who presented upon referral from her GP and at her mother’s insistence. The primary complaint was that, for about 8 weeks, JL had been exhibiting symptoms of what her mother feared may be depression. JL had withdrawn from most activities with her family, spent much of her free time by herself in her bedroom, had fallen behind in her homework and showed no outward signs of distress at her failing grades. Most notably, however, was that she had cut off contact with her boyfriend who also expressed concern to her family. In JL’s first meeting with the psychologist, she calmly and quietly confirmed what her mother had reported. In this case, a standard psychological

assessment was administered, confirming clinical depression. However, upon hearing the results of the assessment, JL broke down in tears and revealed that, contrary to her presentation heretofore, she was keenly aware of the factors contributing to her withdrawal and low mood.

In the prior 4-5 months, JL had become sexually active with the boyfriend she had been dating for 2 years. She was clear that she had consented and that the two loved each other. The problem was that JL was left with severe abrasions after each episode. The psychologist quickly assessed that the abrasions were likely due to lack of lubrication and began a line of questioning about JL's sexual response from the desire to arousal to orgasm. Not surprisingly, JL reported that most encounters began quickly and passionately, but without sufficient arousal (or time for arousal) to allow for lubrication. JL was unaware of the relationship between arousal and lubrication, nor did she report experiencing orgasm during intercourse. In any case, the abrasions became infected and intercourse became incredibly painful for JL. Not wanting to disappoint her boyfriend, she gave excuses for withdrawal from him that lead to feelings of sadness and despair. JL's mood lifted very quickly upon realisation that there was nothing mysteriously wrong with her, as she had tested negative for STI.

This case illustrates several points critical to the conceptualization of sexual dysfunction in adolescents and young adults. First, JL would not meet the standard criterion which suggests that the "dysfunction" should be noted in comparison to previous satisfactory functioning. JL had only been sexually active for a very short time. Second, JL, as with many young women, may not have been exposed to features of healthy sexual functioning. In fact, she was unaware of the necessity for lubrication to facilitate coitus. She was also seemingly unaware that her own sexual response is critical to her sexual satisfaction. She seemed to be under the impression that women should "have sex" with their partners because that is what the partner desires. Finally, this case

illustrates the fragility of the sexual response in the context of depressed mood, or, in this case, apparent clinical depression. In many cases, the clinician has trouble discerning which factors lead to the other, i.e., does low arousal contribute to relationship difficulties and/or depression or can depression completely unrelated to relationships decrease desire/arousal. In this case, confusion, pain, and fear of disappointing her partner clearly lead to the depressed mood. Once this cascade of events had set in motion, it likely turned to a cycle difficult to break.

JL was a bright and insightful young woman. She was visibly affected by the short course of sexual education she received in the therapist's office. She took on board advice with respect to taking some control of the sexual encounters. She, surprisingly, was also open to having a discussion with her boyfriend explaining what she had kept secret for several months. At follow-up, JL reported that she had taken some time for the abrasions to heal though she very quickly became romantically engaged with her boyfriend again. The reunion had a very positive effect on her mood and self-esteem. Once she and her partner resumed sexual relations, she felt more in control and better understood her own sexuality. Her report suggested that she now had what appeared to be a healthy sexual relationship. One final point should be noted: Without the education JL received from the psychologist, she may well have gone on to have further difficulty in other areas of her life in addition to romantic/sexual relationships. This, again, illustrates the importance of education for healthy beginning to sexual life.

**Case discussion #2.** Our second case is that of a 16-year-old male, TM, who presented to a community mental health clinic with complaints of erectile dysfunction. This young man presented of his own accord without hesitation regarding his inability to maintain an erection during heterosexual encounters. He reported that he has never suffered from psychological disorder and neither was there any such history in his family. TM reported that he comes from an

intact family including 3 children, two boys and one girl. TM is the oldest. There was no history of sexual abuse and his parents appeared to him to have a loving relationship. TM's family was of middle income that afforded him the ability to focus on his studies and social affairs. He planned at the time to go to university to study art history. TM presented with no obvious personality or psychological dysfunction. He was engaged and measured with regard to the frank discussion about his sexual failings.

When asked to describe the problem specifically, TM said that on several occasions he has been unable to maintain an erection to the point of climax and has had to end the encounters with attractive young women prematurely. He has found this embarrassing, although he has been able to attribute the dysfunction to alcohol consumption, allowing him to save face. It became clear that he had a tight circle of friends and these episodes occurred with girls in his social network. He had asked for help as he felt he could no longer engage sexually in his network without solving this problem first. While he recognized, from popular culture, that young males need to find their way about sexual relations, he believed that the problems he was experiencing reflected something more than inexperience. At the completion of the general assessment, TM was offered a referral to a sex therapy centre. TM expressed that the couples-oriented nature of sex therapy did not appeal as he had no regular partner and no one with whom he might comfortably implement treatment strategies. It was at this point that TM offered his impression that there was a psychological conflict at the root of his problem and suggested that he would like to further explore his sense of self as a sexual person.

It later came to light that TM had concerns regarding his sexual orientation, but had yet to explore them for fear of a homosexual orientation. He was not bigoted toward homosexuality nor did he maintain beliefs about the superiority of heterosexuals. He said that the thought of letting

his parents down when it came to having a family of his own someday had caused him some concern. It also came to light that TM perceived his network of male friends were engaging completely successfully in sexual relations. This apparently had become a topic of discussion amongst the young men on a regular basis. It was also the case that the sought after girls were in the same network and gossip travelled quickly. TM had put immense pressure on himself to perform before he had even begun his sexual life in full.

Although there was no clear evidence of anxiety disorder, this preoccupation had become a type of obsession for TM. The therapist proposed a combination of schema therapy and cognitive behavioural therapy. The aim was for TM to first explore his relationship with his parents and his sense of self in that context. Next steps involved assessing TM's beliefs about himself in his cohort as a successful male. Both therapist and patient agreed that to relieve the pressure may alleviate the problem. Twelve sessions were proposed.

Given TM's general intelligence and insight, the case took clear form and resolved. He re-evaluated his parents' expectations, which were clearly that he grow into a happy, healthy adult. He also had the insight that his male companions were likely presenting as socially desirable in competing for females. The greatest relief came with the insight that he could if he wanted explore his sexual orientation, albeit in a context outside his social set. TM's dysfunction abated in the sense that he was no longer felt pressured to perform nor distressed about the prospects of maintaining an erection during intercourse with women. He carried on with his goals toward becoming an art historian. In this case, we were able to watch this young man's sexuality as it first developed. This likely will have provided a healthy foundation for a healthy sex life, although no follow-up has been completed. While in this case, the therapist was confronted with the inability to apply traditional couples or sex therapy, we can see that the

application of schema and cognitive theories were successful, at least in the short term. TM was never diagnosed with ED, which, in our view, was to his benefit.

**Summary and Conclusions**

Our current understanding about sexual problems in adolescents and young adults is based on a small, but growing, body of research and to some extent extrapolation from the adult literature on dysfunctions. Many sexual problems among young people likely reflect a steep learning curve emanating from a dearth of information about how sex works; however, rates of sexual problems appear high. Our strongest recommendation is to provide extensive, comprehensive, and explicit information about healthy, pleasurable sexual functioning, with an emphasis on effective and clear partner communication and negotiation, as well as strategies for seeking treatment. Connecting with health care providers, who are likely to learn first of any problems that emerge, and encouraging frank discussions about sexual matters among youth in one's practice are also recommended. Until intervention research has advanced, clinicians must adapt standard approaches for adults to the unique contexts of young people's lives. We also strongly suggest that clinicians treating young people connect to organizations aimed at improving the sexual lives of youth for resources, support, and continued education.

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