Communications

Heterosexual Anal Intercourse – An Illustrative Case History

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Little is written in medical literature of sexual, medical, social, and emotional responses or complications of heterosexual anal intercourse or anal sexual stimulation. Several authors estimate its incidence from one percent to 25 percent in selected populations,[1-4] but the failure to request information on this topic[6-11] is apparent. The frequency of heterosexual anal intercourse appears to have increased in today's society from an acknowledged, but uncalculated incidence in 1953[1] to 25 percent in 1974.[2,4] The following case history should help the practicing physician better understand some aspects of heterosexual anal sexual activity.

Case History

A middle class, divorced, 27-year-old Anglo-Saxon woman, para 1-0-0-1, without medical illness or sexual dysfunction, had begun sexual petting at age 19 and intercourse at age 20, with marriage. This woman, with three years of post-college education, had since participated in four episodes of serial monogomy (including the three-year marriage) with satisfying emotional and sexual (orgastic) responses, limited only to oral-genital and penile-vaginal activity. At age 24, a new monogamous relationship was begun and active sexual activity was continued, with the addition of masturbation, mutual masturbation, and anal stimulation to augment sexual gratification. Over a six-month period, occasional digital anal stimulation before and during orgasm gradually heightened sexual response. Thereafter, anal lubrication and gentle, gradual (fingers to penis) anal dilatation was associated with labial and clitoral stimulation; during the fourth episode, orgasm occurred with anal intercourse. Anal intercourse now occurs regularly (every one to two weeks) in the same sexual relationship that allows penile-vaginal, oral-genital, and masturbatory sexual activity (every one to two days). Mutual anilingus is also used for increased sexual stimulation. In both vaginal and anal intercourse, orgasm occurs about 75 percent of the time. Direct labial, vulvar, and clitoral stimulation may or may not accompany orgastic anal intercourse.

The patient has noted no vaginal irritation or itching, although the only precautions taken are those of normal lower bowel evacuation and external washing. No special hygiene (enemas, douching, cleansing of the penis between vaginal and anal activity) is used. On two of her approximately 70 episodes, pain has occurred: (1) accidental sudden anal entry during active vaginal intercourse resulting in two days of anal discomfort similar to "hemorrhoidal" (no history of hemorrhoids except with pregnancy) pain, (2) rapid, prolonged anal activity which occurred under the influence of oral alcohol ingestion and resulted in post-coital anal mucosal swelling and tenderness of eight hours' duration. Vaginal culture has not changed from that of normal flora[5] and no mucosal or sphincter damage is noted on rectal exam. The only incontinence she has experienced has been that of infrequent flatus incontinence immediately following anal intercourse, which is completely controlled with concentration or approximately five minutes of resolution. Her sexual partner has a normal genital and rectal exam, has noted no urinary or urethral symptoms, and receives anal sexual stimulation without complication also. The patient and her male partner have been followed regularly for two years. The patient's subjective evaluation of orgasmic response is vulvo-vaginal-penile intercourse orgasm > ano-rectal-penile intercourse orgasm > masturbatory orgasm.

Discussion

Eleven other cases with similar goals and lack of complications have been seen personally. In two of these, there was a history, in the male, of recurrent non-specific urethritis occurring only with anal intercourse. These cases were effectively managed with condom use similar to that previously reported.[12] The medical complications associated with the insertee – fissure, abscess, fistula, cryptitis, and hemorrhoids – in homosexual anal sexual activity are related to trauma, communicable disease (classic venereal disease and other infectious diseases), and pre-existing ano-rectal pathology.[13,14] Although primarily dependent on the same factors, these complications do not appear to be as frequent in the cooperative heterosexual set.

These cases and others with associated questions led to a non-productive search of the medical literature (medline – Index Medicus) for a guide for the physician managing questions and possible complications of heterosexual anal sexual activity in cooperative relationships. A recent survey by personal letter to the gynecologists and psychiatrists in this geographical area was done. The respondents acknowledged asking no questions relating to anal intercourse in their routine evaluation, routine sexual counseling, or intensive sexual therapy.

Survey reports show that it is a middle class, sexually active population that most likely participates in heterosexual anal sexual activity.[1,2] There are increasing letters and articles

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in magazines with a growing readership, ie, *Playboy, Playgirl, Viva, Penthouse,* and *Cosmopolitan,* relating to satisfying heterosexual anal sexual activity. Therefore, primary care physicians (gynecologists, family physicians, internists, and others) in private practice are those most likely to be confronted by this selected population, now encouraged by the testimonials in their day-to-day magazines. These physicians must have the information available to intelligently address the subject without prejudice, shock and disbelief, or misinformation. A study of the prevalence, goals, and complications of this sexual activity has been initiated to collect this information.

Anal intercourse is not just a practice of homosexuals; it can be a form of heterosexual sexual gratification. The prevalence of cooperative, heterosexual anal sexual activity and intercourse in the middle class, sexually active population is apparently increasing. A case history reveals the development of sexual gratification without apparent medical injury with anal intercourse in a healthy female and 11 additional, similar cases are cited. The physician's need for more information about incidence, goals, and complications related to this activity is apparent from the paucity of data in the medical literature.

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Incidence of Psychiatric Problems in One Family Physician's Practice

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Although many family physicians are playing an increasingly active role in the treatment of patients with psychiatric problems, there remains sparse documentation of the distribution of psychiatric disorders in family practice and the profiles of patients presenting with these kinds of problems. This brief paper summarizes the major findings of a retrospective study of psychiatric problems from among a total of almost 5,000 patients in one family practice.

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Methods

This study involved reviewing and coding the charts of the author's entire medical practice of 4,801 patients who were seen between September 1, 1964, and August 1, 1968. As a result, 394 patients were classified as "psychiatric" and those remaining as "nonpsychiatric." A patient was designated "psychiatric" based upon his having had psychological problems which were significant enough to him or to society to warrant his seeking a doctor's help. Patients with somatic complaints caused by psychological determinants were also classified "psychiatric." Those with gastrointestinal complaints, however, were purposely excluded from this category, since it would have been impossible, even with GI series and barium enema studies, to definitively control for such anatomical variants as hiatal hernias and diverticulitis, which have no known psychological determinants. Similarly, those patients with bronchial asthma and dermatitis were categorized "nonpsychiatric," since confusion among infectious, allergic, and psychological factors as determinants of such diseases is possible. Each patient was given a complete physical examination, and work-up sometimes included a skull x-ray, spinal tap, electroencephalogram, blood count, urinalysis or electrocardiogram, before a decision was made as to whether or not a specific symptom was psychosomatic.

A psychiatric diagnosis was designated for each patient in accordance with the American Psychiatric Association guide (Diagnostic and Statistical Manual, II). In addition, a practicing, psychoanalytically-oriented psychiatrist was provided pertinent data which included symptomatology, functional impairment, and mental status of the patients. A high positive correlation between her diagnoses and mine was noted.

Results

As noted in Table 1, the diagnoses of the "psychiatric" group were as follows: 74 percent of the group (290 patients) were classified as neurotic