

Group for the Advancement of Psychiatry

A GUIDE TO THE ASSESSMENT OF SEXUAL FUNCTION

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Introduction

Learning to talk to patients about sex is an essential but often anxiety producing educational experience for students. This concise guide is designed to help students in the health care professions gain comfort in assessing their patients' sexual function. It is divided into four sections. Section I covers common problems which students may encounter when learning to conduct sexual assessments of their patients. Section II offers a guide to conducting a sexual history, with particular attention to interviewing children, adolescents, the elderly, the medically ill, gay and lesbian patients, and patients from different cultures. Section III outlines the common sexual dysfunctions which affect men and women. Section IV focuses on the particular problems which may arise when assessing the sexual function of patients who have sexually transmitted diseases, who have been sexually abused, or who have problems surrounding reproduction. Finally, this guide includes a sexual review of systems which outlines all of the important areas which the student should cover in a complete assessment of sexual function. All of the sections are illustrated by vignettes designed to help students relate the issues discussed to actual contacts with patients. We hope that this format will offer students in many different fields a lively, concise, hands-on tool to help allay the misconceptions and anxieties that often accompany learning to talk to patients about sex.

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Section 1
Asking Questions about Sex – Not A Luxury

As we become more aware of the impact each person's sexual life has on his or her physical and emotional health, it becomes clearer that the assessment of sexual functioning is an important component of every medical and psychiatric interview. The AIDS epidemic and the prevalence of a variety of sexually transmitted diseases has made us aware that some types of sexual activity may have life-threatening or lethal consequences.

How do we talk to patients about sex? Despite society's more open attitude generally towards sex and sexuality, individuals are often inhibited about discussing their sexual lives. This is particularly true when a person suspects that he or she has a problem. Patients who think they have problems related to their sexuality or sexual functioning often present with other physical or emotional problems and may only be able to talk about their sexual problems once the subject is broached by the clinician. Some patients may become aware that their presenting problems are related to sexuality or sexual functioning once the clinician has taken a sexual history.

Patients are not the only ones who have difficulty talking about sex. Clinicians are people before they are professionals, and they are subject to the same inhibitions as their patients. Many clinicians who intellectually understand the importance of carefully assessing their patients' sexual functioning still find it difficult to broach this delicate subject. Nevertheless, talking to patients about sex is *not a luxury any more. It is mandatory*. For the patient who is engaged in high risk sexual activity, asking about sexual orientation and sexual behavior may be a matter of life and death. Therefore, clinicians must strive to understand and overcome obstacles that impede their ability to assess their patients' sexual functioning. Any comprehensive patient work-up should contain at least enough of a sexual history to establish an understanding of the patient's general sexual attitudes and functioning. Sexual matters should be explored in depth whenever the initial interview suggests the possibility of problems. An extensive investigation is obviously in order when sexual difficulty is the chief complaint. The astute clinician may suspect the possibility that sexual or relationship problems underlie such physical or psychological symptoms as headache, backache, fatigue, insomnia, menstrual irregularities, dysmenorrhea, anxiety or depression. The clinician should also be attuned to the possibility that sometimes one sexual complaint may mask another.

For example, the patient who complains of not being interested in sex may in fact have questions about his or her sexual orientation, or may have an underlying physical problem such as premature or delayed ejaculation. The clinician that anticipates such associations will ask all the appropriate questions to elicit the necessary history.

There are times when an extensive sexual history may not be appropriate. For example, a routine medical exam may call for a brief sexual review of systems (see Appendix 1) rather than a full sexual history. In a medical emergency, first things are first. The clinician should delay taking a sexual history until the patient is stabilized. If the clinician senses an absence of rapport, the sexual history may be appropriately deferred. With paranoid, manic, or overtly seductive patients, the clinician will generally want to delay asking questions about sex, or may wish to have another person present during the interview. Finally, clinicians should be sensitive when taking a sexual history from patients with multiple personality disorder, as well as from patients who have been traumatized physically or sexually, since they may become highly anxious when talking about sexual matters.

Vignette #1: A young woman who had a history of being sexually abused by her brother presented to an Ob/Gyn clinic with a vaginal infection. The patient was escorted to a small examining room where she was left alone to undress and to put on a gown. A few minutes later, a young male resident came in to take the patient's history. Although he asked questions about the patient's recent sexual activity empathically, the patient began to scream and cry for help. When a female resident came in to assist her colleague, the patient calmed down and revealed that she became acutely frightened when she was enclosed in a small space with a man.

In these and other situations, the clinician should use his/her judgment and carefully tailor the sexual history to the individual clinical situation. Adherence to a short routine outline will not elicit detailed information, yet a basic plan is important. Asking open-ended sexual questions will generally allow the patient to talk explicitly to complete the personal history.

Beginning the Interview

Unless the patient begins the interview with concerns about sex or sexuality, the subject is most appropriately broached after familiar questions about family, education, and health issues have allowed for the establishment of rapport to allow questions about menses, erections, dyspareunia, ejaculation, orgasms, sexual partners, coital frequency, condom use, STDs, and concerns about AIDS. There are a number of ways to introduce the subject, but one routine question in the medical history of every child and teen must

be “Has anything sexually upsetting happened to you?” For every adult, the single question, “How is your sexual function?” will give the patient permission to say “fine” or to begin to discuss problems.

Example #1

Patient: Since I lost my job, I just don’t feel like a man with my girlfriend anymore.

Clinician: What do you mean, you don’t feel like a man?

Patient: Oh, you know.

Clinician: Perhaps you mean that you are having some difficulties in your sexual life....

A brief sex history is also a logical part of a discussion of a woman’s menses or an older man’s increasing nocturnal urinary frequency.

Example #2

Patient: I’m thinking that maybe I should be taking replacement hormones since I started going through the “change” and I’m having hot flashes.

Clinician: OK, let’s talk about that. What types of problems have you noticed since you began menopause?

Patient: My vagina is dry and itchy, and my urine seems to dribble.

Clinician: Have the changes you’re describing in any way affected your interest in having sexual relations or in your comfort during intercourse?

Sexual information may also be elicited while talking about the relationship a patient has with his/her significant other. For example, a patient who is discussing his lover’s illness might be asked, “How has this illness affected your sexual relationship?” while a woman who is discussing the onset of hot flashes might be asked, “What changes, if any, have occurred in your sexual life?” Similarly, the clinician may learn about a patient’s sexual orientation after discussing the patient’s living situation. For example, the female patient who speaks in great detail about her female roommate can easily be asked if this is someone with whom she is romantically or sexually involved.

In general, open-ended questions will elicit more information than closed-ended questions. For example, the clinician will learn more from question “Tell me about your sexual relationship with your

partner” than from the question “How many times per week do you and your wife have sex?” In general, the clinician should move from less sensitive to more sensitive topics, giving the patient the chance to become comfortable with an area of exploration before answering highly sensitive questions. For example, a clinician may first ask a diabetic man with erectile dysfunction about morning erections, frequency of masturbation, and whether he ejaculates with a soft penis, before asking about intercourse with his partner. It is also useful to remember that it is often easier for the patient to talk about anything which the physician suggests is universal, or at least common, than to talk about something that may be unusual or abnormal. For example, the same patient who may be put off by the question “Do you ever masturbate?” may be inclined to talk about it when asked, “Most people normally masturbate. What has your experience been?”

The clinician should also be careful to avoid using popular slang when asking the patient about sexual matters. In certain circumstances, such as when interviewing adolescents, or a non-English speaking patient, the clinician may ask the patient what words he/she uses when describing aspects of his/her sexual functioning. In general, however, clinically appropriate terms are professionally preferable (e.g., penis, vagina, clitoris). The clinician should feel free to ask the patient to clarify words that the clinician finds ambiguous.

Vignette #2: A 45 year old man who has just suffered a heart attack tells his doctor that he and his wife can't “get it on” anymore. The doctor, thinking that this will put the patient at ease, continues to use the patient's phrase, although he doesn't exactly know what the patient means. In a subsequent visit, the doctor realizes that although he had assumed that the patient feared having intercourse because of his heart condition, the patient was actually experiencing erectile dysfunction as a side effect of his anti-hypertension medication. Further questions which would have added more information include “When did this start?” “Do you mean ‘loss of erections?’” “When last have you had intercourse?” “What medications are you taking?” “How were your erections before the pills/heart attack?”.

Several points should always be included in a complete sexual history. Towards the beginning of the interview, the clinician should ask the patient about his/her sexual orientation. This is best done in a professional, non-judgmental way, and should be routinely asked of all patients. For example, the married male patient may have had a homosexual encounter and should be asked, “Have you ever had a sexual experience with a man?” If this is asked in a clinically appropriate way, the patient will feel the least uncomfortable and will understand that the question is part of the clinician's attempt to gain as much information as possible. The clinician should also be sure to obtain a history of sexual trauma, including

rape and sexual abuse, for both male and female patients. Questions such as “Was anyone ever inappropriate with you sexually when you were growing up?” may gently introduce this as a topic.

Clinicians should also be aware that patients may be guarded and are not always entirely truthful about their sexual lives. The clinician should thus maintain a healthy amount of skepticism when talking to patients about their sexual functioning. This may be particularly true when talking to patients about masturbation, sexual abuse, affairs, numbers of sexual partners, homosexuality and bisexuality, sexually transmitted diseases, and “unusual” sexual practices. Just as when we talk to patients about history of drug use/abuse, patients may feel guarded or tense when talking about issues or patterns of behavior of which they are ashamed or uncomfortable. Rather than confronting patients about their tendencies to gloss over details or to fabricate parts of their sexual histories, the clinician should remember these factors to explore a sexual history further at a later time.

Clinicians should always be sensitive to the fact that each patient will react differently to questions about sex. Rather than asking mechanical questions, the clinician should be on the lookout for signs of embarrassment, anger, and anxiety in the patient while taking a sexual history. Explaining the clinician’s rationale for asking such questions may be helpful. For example, rather than saying to a patient, “Tell me about your sex life,” the clinician may instead explain that “The condition which you have often affects different aspects of a person’s sexual life. Therefore, I need to ask you some basic questions about your sexual functioning.” Noticing that a patient is having difficulty answering such questions will be appreciated and may actually help the patient to talk. The clinician may want to say, for example, “This is sometimes difficult to talk about for many people.” The clinician should also be self-observant, and should try to ascertain whether he/she is doing anything that could make the patient more uncomfortable. For example, the clinician should never take a sexual history while performing a physical exam on the patient. The patient may experience this in an eroticized way, and may become uncomfortable, inhibited, or inappropriately stimulated.

Why do we have problems talking to our patients about sex?

There are as many answers to this question as there are clinicians. Just as our patients have individual attitudes towards sex and sexuality, so do we. Understanding these attitudes and the ways they may present obstacles to talking to our patients about sex, is crucial, since the attitude and manner that the

clinician brings to the clinical situation will largely determine whether or not a meaningful and accurate picture of the patient's sexual situation is obtained. The clinician who approaches questions about sex and sexuality in a sensitive, non-judgmental, professional manner communicates to the patient his/her conviction that it is as important to understand the patient's sexual life as it is to understand any other aspect of their life. The fact that the clinician asks questions about sex at all lets the patient know that the clinical situation is a safe and appropriate venue for a discussion of sexual problems and communicates the view that issues about sexuality are a normal aspect of everyday function

The following are some common attitudes and anxieties which may present obstacles for clinicians:

1. *The clinician believes that the patient's sex life is "none of his/her business."* This view is particularly common among students, who often feel that asking about patient's sexual life is intrusive and voyeuristic. The clinician's conviction that the patient's sexual life is "none of his business" may mask anxieties which he/she may have about talking to patients about sex. Students may feel that certain questions, such as whether or not the person is orgasmic, or whether the patient has engaged in anal intercourse are unrelated to the clinical evaluation of the patient. However, in each case, such questions may be crucial to understanding the patient's general physical and emotional functioning. For example, a married woman who presents with a first episode of rectal bleeding should be asked about anal intercourse, while a depressed diabetic man should clearly be asked about capacity for erection and quality of orgasms. These questions are hardly voyeuristic; rather, they are essential to the understanding of the patient's problems.

2. *The clinician feels that talking about sex with patients will embarrass them.* Many clinicians believe that asking about sexual activity, sexual orientation, and sexual function will embarrass their patients. This is particularly common when the patient is much older or much younger than the clinician. Consequently, many elderly patients and adolescents, as well as others, are not given the opportunity to talk about this crucial aspect of their lives. In point of fact, patients are more likely to be embarrassed about discussing sex and sexuality if the clinician *does not* ask questions about their sexual lives. This omission on the part of the interviewer may make the patient feel that the clinician is not interested in his/her sexual problems, or that such issues are not important. When questions about sexual activity and sexuality are

asked in a comfortable professional way, most patients will readily engage in the discussion and will be relieved to be able to talk about this private area of their lives in such a safe situation. The comfort of the physician determines the comfort of the patient. Clearly, some patients may be inhibited when discussing their sexual functioning. The clinician that approaches this subject in a sensitive but matter-of-fact manner will help to reduce the patient's anxiety. Clinicians should question whether their fear of embarrassing their patients might be a projection of their own anxieties.

3. *The clinician feels embarrassed about talking to his/her patient about sex.* Many clinicians refrain from taking thorough sexual histories because they are anxious and embarrassed. This type of initial anxiety is extremely common, and in no way reflects badly on the clinician; rather the clinician should allow him/herself to become aware of the embarrassment so that it does not impose an obstacle to fulfilling his/her responsibilities to the patient. With practice, skill in taking a sexual history greatly reduces the anxiety. If there is an enduring obstacle, the clinician should seek the help of a respected colleague or teacher. If the clinician has difficulty talking about sex with a particular patient, the patient may benefit by referral to another clinician. Familiarization with the physiology of sexual functioning and the common presenting problems may help the beginning interviewer gain confidence in this area. Conducting sexual histories while being observed by an experienced interviewer may also be helpful to the student. The clinician who is consistently unable to talk about sex with his/her patients may be advised to pursue the reasons for this with a trusted advisor or therapist.

4. *Time pressure:* The clinician who is in a hurry may be unable or unwilling to spend the necessary time needed to pursue a complete sexual history or to attend to sexual problems. Clinicians often rationalize their inattention to sexual problems or their incomplete sexual histories by citing their lack of time with patients. While it is true that many clinicians have much less time to spend with individual patients than they used to, this excuse may mask general avoidance of this area. A few brief questions, such as whether the patient is sexually active and whether they practice safe sex, are important even when time is limited.

5. *The clinician fears that talking to patients about sex is seductive.* The interviewer may refrain from talking about sex and sexuality with a patient because he/she fears that the patient will interpret this as being seductive. Simply asking routine questions about a patient's sexuality and sexual functioning will

generally not be interpreted by patients as seductive. The clinician should, under all circumstances, refrain from behaviors that are seductive, such as teasing, flirting, making provocative remarks, or propositioning patients. These behaviors are *never* warranted, and can be viewed as sexual harassment by the patient.

6. *The clinician is attracted to the patient.* Clinicians often become embarrassed and unable to perform a thorough sexual history when they find a patient sexually attractive. The clinician who feels embarrassed or guilty about being attracted to a patient may defensively avoid asking the patient anything about sex and sexuality. Others may overcompensate for their discomfort by overzealously pursuing answers to questions about sexuality. Clearly, these behaviors may deprive the patient of adequate care, and if the clinician is unable to control these feelings it is impossible to proceed with the interview in a professional manner. Though rarely discussed, *these feelings are ubiquitous among clinicians and are not in themselves problematic.* Problems emerge when these feelings impair the clinician's ability to do his/her job, or when the clinician inappropriately acts on them. Flirtatious, seductive, or overtly sexual behavior on the part of a clinician toward a patient is *never* acceptable, and thus the clinician who feels sexually attracted to his/her patient must remain an adept self-observer throughout the interaction with the patient. It is important to bear in mind that patients may misinterpret behaviors such as touching, hugging, patting, and massaging (which the clinician may feel are non-sexual, caring or reassuring) as transgressions of the clinical relationship. Although the clinician may intend for such physical gestures to be non-sexual, the patient may not experience them in that way. Clinicians who have difficulty with this situation are well advised to seek a chaperone (e.g. nurse or other health professional), and to note the name of the chaperone in the progress note. Later consultation with a colleague may assist long-term patient management.

Clinicians should be aware of clues that might indicate that they are attracted to their patient and may be at risk for behaving inappropriately. Spending inordinate amounts of time with a patient, complimenting the patient's clothing or physical features, thinking a lot about a patient outside of the clinical encounter, or giving the patient special treatment (e.g., long phone calls, waiving a fee) may indicate to a clinician that he/she is attracted to a patient.

Vignette #3: A young female podiatrist who generally treated geriatric patients was referred a young male ballet dancer with some minor foot problems. She found the patient to be very attractive. Although his problems could have been treated with one or two treatments, the clinician continued to make follow up appointments for her patient, often as the last appointment of the day. When the patient became irritated that he had to keep coming to appointments, the

podiatrist realized she had been inappropriately keeping the man as a patient because she was attracted to him and looked forward to seeing him.

Again, sooner or later every clinician has the experience of being attracted to his/her patient. This situation only becomes a problem if the clinician fails to recognize that this is happening and/or acts on his/her feelings.

7. *The patient is attracted to the clinician.* The seductive or overtly sexual patient presents a unique challenge. Clinicians may react in a variety of ways to this situation. Some ignore the overture. Other clinicians shy away from discussing sexual issues with a patient, hoping that this will deflect the patient's interest. Others are flattered, drawn into flirtation, or become overly interested in the patient's sexual history. The clinician should continue to conduct the interview in a professional manner. If the patient's overtly sexual behavior prevents adequate clinical care, the patient may have to be seen by a different clinician. The clinician's best tools in this situation are his/her own powers of self-observation, as well as supervision or consultation from teachers and colleagues. As mentioned above, the clinician may also want to enlist the aid of a chaperone.

Vignette #4: A young male doctor was conducting a routine medical interview with a male patient as part of an employment physical. Early on in the interview, the patient revealed that he was gay and asked the physician if he would ever be interested in going out with him and his friends. The physician became so flustered that he completely failed to take a sexual history and to ask about whether the patient practiced unprotected sex.

The clinician should bear in mind that a patient who eroticizes the doctor/patient relationship may have a history of early sexual abuse, with a compulsion to repeat the abuse victimization by enacting a similar scenario in the clinical situation. The seductive overtures on the part of the patient thus may have *nothing to do with the clinician* but rather represent the patient's compulsion to repeat the early abusive situation. The clinician who suspects that sexual abuse may be a factor in the patient's personal history should gently ask about this, (e.g., "Was there any sexual trauma when you were a child?"). Judgment and discretion about the patient's capacity to discuss this difficult topic must be exercised in decided when and how to broach this with the patient.

8. *The clinician disapproves of some aspect of the patient's sexual behavior.* Every clinician has his/her own set of values, and these may clash with those of the patient. Strongly judgmental attitudes

toward aspects of a patient's sexual life, including the patient's sexual orientation, sexual practices, or attitudes toward sex, may impede the clinician's ability to take a sexual history in a neutral, professional manner. Examples might include the clinician who disapproves of abortion interviewing a patient who does not wish to remain pregnant, the clinician who disapproves of pre-marital sex interviewing a pregnant unmarried teenager, or a strongly feminist clinician interviewing a male patient who frequents female prostitutes. Some clinicians may have homophobic feelings and disapprove of homosexual relationships. Clinicians with blindspots or values of this nature may fail to ask questions about those aspects of their patient's sexuality of which they disapprove, or they may ask in a disparaging way which may inhibit the patient's ability to talk about areas central to the problems with which they present. For example, if a young woman who presents to a clinician with depression related to questions about her sexual orientation senses that the clinician disapproves of homosexual relationships, she is unlikely to freely disclose the nature of her problem. Clinicians may communicate such disapproval by omissions (e.g. not asking about sexual orientation, not asking about multiple partners), by asking leading questions (e.g. "You haven't thought you were a homosexual, have you?" or "You're not considering an abortion, are you?"), or with non-verbal cues, such as facial expressions. Open ended questions, designed to make the patient feel comfortable with any answer he/she gives are most likely to make the patient feel that the clinician is non-judgmental.

9. *The patient reminds the clinician of a family member, perhaps a parent, sibling or a child.* This may dramatically alter the clinician's ability to conduct a complete sexual interview. For example, the clinician interviewing a middle aged woman who reminds him of his mother may have difficulty asking her whether she has ever had an STD or unprotected sex, while the male clinician interviewing a young female patient who reminds him of his daughter may have difficulty asking her about her sexual life or a history of sexual abuse.

10. *The clinician is unfamiliar with aspects of the patient's sexuality.* Clinicians may have difficulty taking a sexual history from someone whose attitudes toward sex or sexual behavior are disparate from their own. Examples might include the homosexual clinician interviewing a heterosexual patient, a sexually inhibited clinician interviewing a prostitute, or an older clinician interviewing a much younger indiscriminately sexually active patient. Again, in this situation some clinicians may withdraw from taking

a sexual history, opting to avoid the unfamiliar ground, while others may overcompensate with overly vigorous questioning. If a clinician hears about a sexual practice with which he/she is completely unfamiliar, the best option is to ask the patient for more explicit information. Inexperienced interviewers may pretend that they understand more than they do, for fear that the patient will not trust them or take them seriously if they appear ignorant of some aspect of the patient's sexuality. In reality, most patients will welcome the clinician's interest and provide him/her with the information needed.

11. *The patient is HIV positive or has AIDS.* Many clinicians feel inhibited about asking an HIV positive or AIDS patient about his/her sexual life. They may even assume that the patient's sexual life is over, or that such questions would add insult to injury. On the contrary, these patients often have an active sexual life and many have physical or emotional problems relating to their illness, sexuality and sexual function and activity. All AIDS patients and HIV positive patients, as well as those with chronic illness should be routinely asked about whether they are currently engaging in safe sex. Most will be glad that their clinician realizes that sex continues to be an important part of their lives. Should an HIV positive or AIDS patient reveal deliberate engagement in unprotected sex, the clinician faces an ethical dilemma since there is at present no legal mandate to report AIDS/HIV positive as an infectious disease to public health officials. The clinician should, however, repeatedly discuss with the patient the dangerous consequences of unprotected sex and encourage more responsible sexual behavior as a therapeutic goal.

Many clinicians have difficulties talking to their patients about sex, but few discuss these difficulties with their peers. They may feel that talking about such difficulties will reveal aspects of their own sexuality, for example that they are inhibited sexually, or conversely, that they are overly interested in sex. Some clinicians may imagine that even *thinking* about this topic reflects an overdeveloped sexual interest in their patients. On the contrary, only by discussing these difficulties with peers and seeking out consultation with supervisors will clinicians overcome the anxieties that prevent them from adequately assessing the sexual problems of their patients.

Consultation and Referral

The following guidelines are designed to help the clinician decide when such referrals or consultations may be appropriate.

The clinician may want to seek consultation when:

1. *The patient has frank sexual dysfunction and the clinician does not have the skills to treat the patient.* Referral to an appropriate clinician with specific expertise in this area is appropriate.
2. *The clinician has persistent difficulty in pursuing complete sexual histories.* If the clinician avoids taking a sexual history or alienates patients by probing too aggressively into a history of sexual abuse, he/she should seek supervision (e.g. with a trusted peer or supervisor) or personal therapy to identify blind spots that are interfering with patient care.
3. *Litigation is involved---* The clinician, if uncomfortable, should seek the advice of a colleague or make a referral.
4. *The patient has made allegations of sexual abuse.* If the patient has made allegations of sexual harassment or abuse by the clinician, the clinician should refer the patient and seek legal guidance as to how to proceed.
5. *There is evidence from the history that a child patient has been sexually abused.* State law may require reporting to child protective services. Failure to do so is a criminal violation and endangers the clinician's license to practice. Adults who report having been sexually abused as minors should be appropriately evaluated and treated.
6. *The patient has bizarre sexual ideations.* Consultation with or referral to a mental health professional is appropriate in this situation if the clinician does not feel that he or she can appropriately handle the situation.
7. *The patient reports having had sex with another clinician or therapist.* The patient might require evaluation by a more knowledgeable clinician, experienced with this problem, to assess the emotional, ethical and legal ramifications of this situation.
8. *The clinician experiences intense feelings of love or hate for the patient.* This may make objective treatment untenable, so the clinician should seek supervision or consultation. It may be wise to refer the patient to another clinician.
9. *The clinician commits boundary violations,* such as touching patients, making personal revelations, or beginning romantic/sexual relationships with patients. Such violations have

serious and destructive implications for both the patient and the clinician. Some are manifestly unethical and in some jurisdictions, illegal. The clinician must seek help.

Section 2 **Conducting the Interview**

1. Interviewing Children and Adolescents

Though it is a truism applicable to all of medicine that “children are different,” it is most important when interviewing child and adolescent patients about sexual thoughts and experiences to be especially alert to their unique concerns and modes of expression. Attention given to understanding a child’s circumscribed world of family, school, socio-cultural environment, and developing physical, cognitive and emotional capabilities will be rewarded by a greater richness and usefulness of clinical data gathered about sexuality.

The Child’s Stage of Development

Children of the same chronological age may show a wide difference in their sexual knowledge, interests, experience, curiosities– and in their abilities to share and articulate them. Physical and emotional

development may proceed unevenly so that assessments may be difficult regarding interest, ability and functioning. For example, though a 10 year old girl may have pubertal breast budding and look “adolescent” she may still relate during an interview like a much younger child.

The sensitive clinician will make the effort to be familiar with the general sequence of developmental norms and milestones (e.g. sleeping habits, feeding, toilet training, growth, peer relationships, impulse control) in order to express language and relationship at the level of the individual child. Genital stimulation leads to sexual arousal from infancy and 3-4 year old children have the capacity for orgasm. Pubertal changes from early in the second decade of life– pubic hair growth, breast and genital maturation, and bodily growth– are accompanied by menarche in girls (median age of 12.5) and the capacity for ejaculation in boys (median age 13.7) followed by the onset of spontaneous nocturnal emissions about a year later. A pubertal child may be subjected to an often bewildering bombardment of height and weight changes, penile erections or vaginal secretions, voice deepening, and the onset of acne at the same time that intense sexual preoccupations, fantasies, curiosity and urges dominate his or her thoughts and dreams.

An individual child may experience any of these general age-related developmental milestones unpredictably and out of sequence, and children of the same chronological age may differ radically from each other in developmental and psychosexual status. For example, boys are usually at least one year behind girls in most markers of pubertal maturation, though a particular youngster may have an early height spurt and voice changes as signs that they are sexually precocious.

Organizing Issues

The particular circumstances of the assessment of the young patient should guide the clinician’s approach. A court ordered evaluation in which sexual abuse is suspected cannot be done in an open-ended, “whatever comes up” way, but must focus on specific sexual allegations and issues. Conversely, a mother’s query about a four year old’s occasional nail biting in the course of a clinic visit for an asthmatic attack does not merit a full-scale sexual history. In the course of evaluating and caring for all children, clinicians must help caregivers understand the importance of teaching their children the meaning of privacy. The child should not allow anyone to touch his or her genitals and he should always report such behavior to the responsible adult if this should happen. The clinician can help the caregiver formulate ways of expressing

this to the child, such as “It’s for you only-that’s what private means.” An interview in a well-child setting might focus only on concerns about bodily sexual functions, thus the clinician may want to ask a single question such as, “Has anything happened to your private sex parts?” A psychiatric consultation should inquire into a broader range of feelings, worries, fantasies and behaviors. Confidentiality guidelines and limits– within regional legal constraints on doctor-patient confidentiality– must be clearly established before an interview begins. This will allow the clinician to assure the patient that their privacy will be respected, while simultaneously addressing the interests of parents and other caretakers. Despite this, allegations of sexual abuse will generally necessitate exploration of corroborative data.

Many behaviors can only be evaluated against a background of a family’s values and sociocultural experiences. For example, nudity may be an ordinary part of daily life for some families, while in others it would be considered to be inappropriately seductive behavior. Privacy conventions about parental sexual intercourse, sleep and toileting arrangements and family rules about acceptable TV and speech content all require societally and clinically sensitive scrutiny.

Interview Rapport

When beginning to talk to the young patient about sex, the clinician will benefit from kind, reassuring words, such as: “This is a safe place where we can talk together about any things I can help you with, and then we will go back to where your mother will be waiting for you.” Opening topics can be chosen from school experience, friends, pets, sports, teachers, parents, or other non-threatening, though personally relevant themes. The clinician should keep in mind that most children are easily shamed and, even when they might want to talk about sexual issues, tend to protect themselves from embarrassment by saying nothing. The child’s attention span is also shorter than the adult’s. A child might consider a question such as: “Are you sexually active?” as peculiar, not clear, accusatory or blaming. Instead, consider asking indirect questions such as: “Children make special friends. Do you have a special boy friend (girl friend)?” Or, “Some children kiss and touch each other. Some don’t. What do you think about this?”

When talking to children, some questions about sensitive issues may trigger evasive answers. Examples of such questions include the following: “Has anyone touched your private parts when you didn’t want them to? How did you deal with it? Have you told anyone?” Some children who are abused

are threatened and told not to tell. They may not even tell their parents. Children who live in a climate of furtive or dishonest siblings and adults will, naturally, be suspicious of a strange clinician. There is almost always time pressure, however some essential questions are vital to insure the child's safety.

Conducting the Interview

Though all children experience a great variety of sexual feelings, urges and issues, their developmentally and cognitively limited use of language poses unique challenges to the clinical interviewer. As with adults, the interview must rely on nonverbal clues, sensitivity to developmental stages, the child's sociocultural situation, and clinical experience to decide when to introduce emotionally charged sexual topics. Even an obviously troubled young child will have difficulty speaking about fears, anxieties and worries. Young patients cannot be expected to be open and trusting at the start of a meeting in a strange place, with an unknown adult about issues that few adults can examine with comfort. The clinician will earn a child's trust by making plain, clear statements about the purposes and limits of an interview and by reassuring the young patient about confidentiality. Other facilitating comments may include explanations that:

- 1) sexual feelings, wishes and questions are normal and ubiquitous
- 2) questions will be about seemingly private matters in order to help the child understand more about their sexual function
- 3) symptoms such as anxiety, sleeplessness, and significant embarrassment may relate to sexual experiences, and therefore must be explored in order to treat them

Young children sometimes find it easier to communicate by attributing ideas and concerns to dolls, puppets or other toys. Through discussion of a doll's experiences and worries a child may be led to express personally relevant feelings more easily with less anxiety or tension. Though structured doll play can illuminate reputed traumatic experiences, it is most important to check material gained in fantasy play with firm facts, history data and an assessment of the child's clinical reliability, since confusion and fusion of facts may occur.

Table 1 outlines important topics for the assessment of sexual function in children and adolescents. As above, the setting, purpose of the interview, and developmental stage of the child will guide the clinician's decisions as to which topics are appropriate.

Table 1

Important Topics in the Sexual Assessment of Children and Adolescents

- sexual anatomy and differences
- puberty
- intercourse
- pregnancy and reproductive concerns/information
- masturbation
- sexual function
- history of sexual abuse
- feelings about sex (including, excitement, fear, anxiety)
- medical and interpersonal risks of sexual activities
- safe sex practices

To close an exploratory clinical interview, it is often useful to review the confidentiality and disclosure ground rules agreed upon earlier, point out that further appointments or referrals can be arranged, if needed, and ask: “Do you have any other questions?”

Interviewing the Young Child

The interview of the young child will often focus on the child’s curiosity about sexual functions and the parents’ concerns and lack of understanding about developmentally appropriate behavior.

Vignette #5: A 3-year-old girl is brought in for a well-child clinic visit by her mother, who is pregnant with a second child. Her mother is puzzled about how to reply to Michelle’s repeated statements that: “Mommy is going to poop the baby in the potty and it will be all gone.” She asks the clinician for advice about how much she should tell her daughter about intercourse, conception, and the mechanics of delivery.

In this case, the clinician can help the mother by verbal modeling of developmentally appropriate words and concepts. For example, the clinician could suggest that the mother tell her daughter that she is a big girl for being interested in the new baby, and that, “ the growing baby will eat and sleep and grow securely inside mommy’s body until it is ready to be born, and then it will be delivered through a fine, special opening that all girls and women have inside their bodies-- one that is different from the opening poop comes from.” The clinician could then talk with the young patient about her theories of pregnancy and delivery, as well as her thoughts about having a new sibling. Data and opinions gained in this way can

be the basis for age-appropriate discussion of reproductive physiology and sibling pleasures and rivalries with the child.

Interviewing the Adolescent

The overt sexual activity of this developmental stage of life frequently becomes intertwined with hazardous risk-taking behavior. Adolescents engaging in precocious sexual activity may also have poor school attendance, drug and alcohol use, delinquency, and inadequate adult supervision. Many American adolescents participate in intercourse without the use of birth control, resulting in high rates of teen pregnancy and sexually transmitted diseases. Sexually abused adolescents may be more likely to engage at an early age in high risk sexual behaviors and drug use. Homeless youths are at high risk to participate in what is called “survival sex”—prostitution and the exchange of sex for shelter, money, drugs or food. Although AIDS, due to its long incubation period, is only the sixth leading cause of death in people 15-24, it moves up to second in the 25-34 year old age cohort.

When interviewing patients in this age group, the clinician should ask the following types of questions: What is the adolescent’s sexual orientation and experience with specific sexual partners? How does the patient view pregnancy and impregnation in relationship to experiences of sexual involvement and unprotected sex? Are condoms and other methods of birth control and disease prevention available, understood and used?

Vignette #6: A 13 year old male was brought for a psychiatric consultation by his single mother who was concerned that “he hangs out with a fast group of teenagers” known to be sexually active, although he denies engaging in intercourse. After exploring these issues with mother and teenager together, and later, in a session with the adolescent alone, the adolescent confided that he often felt pressured by his friends to be more sexually active than he might wish to be. In reply to a question about sexual activity with persons who might have AIDS, he said: “I take precautions. I’m not stupid.”

Cases such as this present opportunities for detailed questions and discussion about AIDS prevention and infection modes, as well as reflection on behavior choices, the challenges of peer pressures, and the availability of support groups for teenagers.

Special Considerations

- 1) When uncertain about how to proceed in complex situations involving lawyers and the legal system, seek consultation, legal advice, continuing education or counseling.

2) Patients who produce puzzling sexually colored psychotic ideation should be referred for more detailed psychiatric evaluation.

3) When confronted with a seemingly litigious parent or the possibility of an allegation of sexual harassment, arrange legal advice. Inclusion of a chaperone or patient-sanctioned videotaping may also be appropriate.

2. Interviewing the Older Person

Sex remains an important part of life

The young interviewer who is evaluating an older person may forget– or not even know– that sexual feelings and desires do not disappear in the elderly. In fact, for a number of reasons, they may actually increase in intensity. Any history of the elderly patient, which fails to take his sexual life into account, is incomplete. While the physical status of a patient may justify postponing the taking of a sexual history (e.g., the patient’s physical complaint is so severe that anything else is secondary), this part of the history should not be forgotten. The fact that the patient has a debilitating disease, has outlived his sexual partner, or is tied to a sick or incompetent significant other does not justify the physician’s failure to obtain his sexual history.

Why it may be difficult to ask older people about sex

While interviewers may intellectually understand that it is important to take a sexual history from a patient at any age, they may nevertheless be inhibited when it comes to asking an older person about sex. Some common reasons for this may include:

- *The patient looks like my grandmother* – how can I talk to her about sex? Many people have a difficult time acknowledging the sexual activity of their parents or grandparents. Even if they do, they have most likely never spoken to them about their sexual lives. It may therefore be difficult for these young interviewers to talk about sex with patients who remind them of these important parental figures.

Vignette #7: A 75-year-old woman presented to an OB/GYN clinic with a lesion on her labia. The 25-year-old intern examined her but did not take cultures for sexually transmitted diseases. When the attending asked him why he neglected this important part of the exam, the intern said, “But she’s my grandmother’s age. She’s not sleeping around.” The attending encouraged the intern to call the patient back to the clinic to take a more complete sexual history and to obtain the cultures. He also suggested that the intern tell the patient, “These are routine questions about your sexual activity which will greatly help me in managing your physical problem

The approach originally taken by the young intern will clearly compromise the care of the patient. If it is an ongoing problem, talking with supervisors or peers about this inhibition may help the interviewer.

- *It is disrespectful to talk about sex with older people.* The young interviewer may feel that asking older patients about their sexual activity is rude or insensitive. Some people may also think that because older people were raised in a different time, they are uncomfortable or unwilling to talk about sex. On the

contrary, the older patient is generally pleased and flattered rather than resentful at questions about sexual life. Asking about sexual activity acknowledges that the patient is still a vital, sexual person to whom this remains an important part of life.

- *Sex isn't an important part of the life of the older person.* It is a common misconception that sexual activity is the domain of the young. On the contrary, older patients may have the same range of sexual activity as younger patients, including sex in and out of stable relationships, sex with one or multiple partners, masturbation, homosexual and heterosexual activity. They risk exposure to sexually transmitted diseases, including AIDS, and they are not infrequently the victims of sexual abuse and rape. In addition, older patients continue to have sexual fantasies and may seek new outlets for sexual satisfaction as longtime sexual partners become sick or die.

Vignette #8: An 80-year-old man consulted his doctor for symptoms of listlessness. The doctor found no physical signs of illness in the patient, and he showed no symptoms of major depression. The patient states that his wife of fifty years, who had had chronic heart failures for five years, has recently had an apparent worsening of her physical symptoms. The patient described his wife as being extremely frail, "all skin and bones," and expressed distress that she couldn't be the wife she used to be. When the doctor asked what the patient meant by this, the patient explained that he had become afraid to have sex with his wife because he feared this might kill her. He had consequently begun having sex with prostitutes, about which he felt conflicted and guilty.

Allowing the older person to talk about sexual desires, fantasies, and activity is as important as it is for people of any other age group.

Taking a sexual history from an older person

Along with the questions an interviewer would ask a patient of any age, there are a few topics which are particularly relevant to the older population:

1) *Sexual dysfunction secondary to chronic illness.* The older person with chronic illness may experience actual sexual dysfunction or may fear the inability to perform sexually. It is important to explore these frustrations and fears with older patients, and, when appropriate, to address these concerns with appropriate medications and psychotherapy. Older patients may be reluctant to bring up questions about sexual activity with their doctors, considering this aspect of their lives to be of secondary importance to their physical health, or they may be inhibited about talking about sex at all.

Vignette #9: An orthopedic surgeon received a call from a physical therapist who had been treating one of his patients. The physical therapist asked the surgeon why he had told his patient, a 73 year old woman who had had a total hip replacement six months earlier, that she could no

longer have sex with her husband. The surgeon was mystified and said he never told the woman anything of the kind. Upon seeing his patient, the surgeon asked her why she thought she could not have sex. The woman told him that because the doctor had not told him that it was safe to have sexual relations, she assumed that this was not allowed.

Older people may need reassurance that it is natural for them to be thinking about sex and that it is safe for them to have sex. Patients with various health problems which actually impair sexual function, such as neurological disorders and diabetes, may require help thinking about alternative strategies for sexual gratification. Health professionals should go out of their way to bring up sexual function and activity in this population, since elderly patients may be particularly reluctant to bring these topics up on their own.

2) *Medical problems which present with sexual symptoms.* As with patients of any age group, the first presentation of a physical or mental problem may be sexual dysfunction. With elderly patients, the danger lies in assuming that the sexual dysfunction is a normal result of aging. In addition, the patient may not be aware that sexual dysfunction can be a symptom of underlying medical or emotional problems.

4) *Loss of inhibition* – Patients with organic brain syndromes may experience loss of learned controls and inhibitions with resultant inappropriate sexual behavior. While this may be a difficult topic to discuss with the patient and the patient's family, a frank, non-judgmental approach will relieve those involved. Repeated external verbal controls may be necessary, for example, gently reminding the older person to close the bathroom door.

5) *Medications which may impair sexual function* – The older patient is more likely to be taking one or more medications which can impair sexual function. Among others, these may include medications for high blood pressure and for depression. Any interviewer of the older patient must ask about all medications the person is taking– both prescription and over the counter– and whether any of them have affected sexual function.

Technical considerations

Older patients are likely to present in the company of another person– spouse, child, caregiver, friend. Therefore, finding the privacy necessary for an assessment of sexual function may be a challenge. The interviewer may need to ask the accompanying person to excuse him or herself in order to give the patient some time to talk alone.

As above, the interviewer should assume that the older patient will not be the one to bring up sexual issues. Again, if the interviewer asks questions about sexual activity and function in a professional and empathic way, the older patient is most likely to respond with gratitude and relief.

3. Interviewing the Medically Ill Patient

An individual's sexuality and sexual functioning are aspects of a medical history that are vital to a comprehensive assessment and evaluation of a wide range of medical conditions. In the medically ill patient, inquiry into sexual function is often overlooked. Yet for many ill patients, especially the chronically medically ill, adequate sexual functioning may play a large role in their general sense of well being adjustment and recovery. A common misconception is that patients with medical illness are not sexually active. Although clinicians may not feel comfortable discussing sex and sexual function with these patients, the patients may still consider sex as an integral part of their lives and may have sexual difficulties related to their illnesses that they would like to discuss. Often, complications of illnesses or medications treating both acute and chronic diseases may affect sexual function and patients may be reluctant or embarrassed to bring this to clinicians' attention. Sexual dysfunction warrants careful history taking with an emphasis on premorbid sexual functioning, comorbid diagnosis and current treatment, and the patient's perspective of psychosocial change related to the illness. A clinician's reticence in exploring aspects of human sexuality and function prevents a complete evaluation and ultimately renders suboptimal care. Encouragement of open discussion may have significant impact on a patient's overall functioning. The case vignettes that follow will help illustrate to clinicians the necessity of a comprehensive assessment of sexual functioning, and can help practitioners to inform, educate, and advise patients while advocating the importance of healthy sexual functioning.

Cardiovascular Disease

Vignette #10: A 45-year-old married man had a myocardial infarction six months ago. He had not resumed usual sexual relations with his wife, as he heard once that "you could die if you have sex after a heart attack." He also was taking numerous cardiac medications and was beginning to have difficulty maintaining erections, which he thought was "part of getting old." He was too embarrassed to talk with his doctor about sex, thinking maybe he should just feel lucky to be alive.

Cardiovascular disease, including coronary artery, peripheral vascular disease, and hypertension are typical medical conditions where sexual dysfunction is common. The acute nature of a myocardial infarction abruptly changes a patient's lifestyle, physical and mental health, and sexual relationships. During the course of cardiac rehabilitation, it is critical to discuss issues surrounding sexual function since misinformation and fallacies can persist unless clinicians make it part of a routine review of systems to ask

about sex, specifically after major surgeries or illnesses. One common manifestation of post-myocardial infarction sexual dysfunction is related to anxiety associated with recommencement of sexual activity. An informed clinician can allay many worries patients have about resuming sex and it is important that this information be conveyed to the patient. Pharmacotherapeutic intervention, especially anti-hypertensives, can commonly produce sexual side effects or exacerbate pre-existing ones in both men and women, as can alcohol or illicit substance use. Talking to patients about possible medical sexual effects such as decrease in desire, problems with arousal, or delayed orgasm, allows discussion and can often correct misconceptions and result in change.

Post-Surgical Patients

Vignette #11: A 33-year-old woman underwent a modified radical mastectomy for localized breast cancer. At her follow up visit to her surgeon, she reported persistent tearfulness and worry that her husband will not want to have sex with her if she “only has one breast.” She was so upset that she refused to allow her husband to see the scar, let alone actually try to have sex.

Body changes secondary to surgical intervention can produce substantial physical and emotional changes resulting in sexual uncertainty. This is often occurs with breast and genitourinary surgical procedures, such as hysterectomy, oophorectomy, mastectomy, and orchietomy. In addition to psychological aspects of disfigurement and loss of organs that previously defined fertility and pleasurable sexuality, there are significant hormonal changes that could alter sexual function. Issues of mortality, disfigurement and desirability, fear of rejection, sexual performance and partner satisfaction lead some patients to withdraw from sexual intimacy and activity. It is imperative that the clinician be alert to patients' concerns about the surgery, especially with regard to changes in self-image. Patients may feel inadequate or hopeless with their new physical state which could very likely impact on their desire to have sex. Healing may take up to 6 or 12 months, so patience is necessary. Even if a patient is comfortable with his/her body after surgery, the patient's partner may feel uncertain and awkward about the situation. A clinician should ask about sexual activity in both their pre- and post-surgery care, targeting the feelings patients have about their body image and the impact these feelings may have on sexual function. Surgery and/or chemotherapy may produce changes in sex hormones with resulting sexual difficulties. For example, women who are treated with anti-estrogens may have difficulty with vaginal lubrication. The

clinician should be alert to the potential for such changes and ready to suggest remedies, such non-estrogen topical lubricants.

Chronic Medical Illnesses

Vignette #12: A 65-year-old man with insulin dependent diabetes was seeing a urologist for urinary hesitancy and for prostate evaluation. When the urologist asked about ability to have erections, the patient admitted that he had had difficulties for over five years, but said that had not discussed this topic with his internist. The urologist asked about sexual functioning in a straightforward manner and listened attentively to the patient's answers. The patient felt more comfortable talking with the urologist because the doctor included inquiry into sexual functioning as part of his routine questioning.

Chronic medical illnesses, including diabetes, are often associated with sexual dysfunction. Some clinicians, such as urologists or gynecologists, may be more comfortable discussing sexual function yet not all patients will see a specialist for their care. Patients with diabetes may suffer from impotence but may be reluctant to discuss this. Many patients, though, will openly discuss urinary difficulties. The clinician can therefore use this topic as a stepping stone into asking about potential sexual problems.

Difficulties may arise when the clinician has an illness, which is similar to his or her patients. In such cases, the clinicians may neglect certain areas of inquiry because of personal anxieties. This may also occur if the clinician does not have the disorder, but worries about contracting it. The clinician that finds him/herself in this situation will do well to seek out consultation and advice.

Spinal Cord Injuries

Vignette #13: A young man who has a spinal cord injury and is wheelchair dependent is having a routine physical exam. His doctor always makes a point of asking about urinary and bowel function but has never asked about having an erection. Because his doctor is not asking about sexual function, the patient begins to feel that this aspect of functioning is no longer important.

Patients with spinal cord injuries, particularly when they are young, evoke many feelings in clinicians. The possibility that a young person's sexual function may have been permanently impaired may make some clinicians shy away from asking about sexual functioning at all. However, being wheelchair bound may not necessarily mean that a patient is without any sexual function. For some spinal cord injury patients, sexual activity is fully intact and an integral part of their functioning. Other patients may need help in trying to understand the ways in which sexual functioning may continue despite their capacity, for example, to have erections. The sensitive clinician can help such patients understand the way in which parts of their bodies which they have not focused on can now sustain their sexual functioning. As a rule of thumb, the clinician

is not adding insult to injury by talking about sexual functioning with this population; on the contrary, patients will be relieved that something which is very much on their minds is being addressed.

Partners of the Medically Ill

Vignette #14: A 50-year-old man is dying of AIDS and he and his partner have been unable to have sex. The healthy partner still thinks about sex during this time, feeling both sad at the current loss of his sex life and guilty that he still has a healthy sex drive and that he is thinking about sex while his partner is critically ill.

In addition to addressing issues of sexual function with the medically ill patient, attention should be given to the thoughts and feelings of the partner of the patient. Although the sexual relationship of a couple where one member is ill may be limited, this does not mean that either partner stops thinking about the sexual aspect of the relationship. The clinician should be attuned to the needs of the health partner as well, such as the need express thoughts and feelings about changes in the couples' sexual relationship. As in the above vignette, the healthy partner may feel guilty or selfish about having active sexual thoughts, especially if he/she is thinking about possibly having sex with other people before or after the ill partner dies. The healthy partner may experience the decline in sexual relations as a significant loss in the relationship. Discussions about coping with the illness should thus include both partners in a sensitive inquiry about sexual functioning.

The medically ill patient has many needs, yet the need to discuss sexual function is often not addressed. This may even include the patient's need to expressed grief about the loss of sexual functioning which is now permanently impaired or severely limited. Adequate sexual functioning may make the difference between an illness being tolerable or not. It is imperative that clinicians address issues of sexual functioning with medically ill patients and their partners as an integral part of patients' comprehensive treatment.

4. Interviewing Gay, Lesbian, and Transgendered Patients

When interviewing patients about sexual function, it is important to know about the patient's sexual orientation and sexual practices. Clinicians should never assume to know the patient's sexual orientation, but rather should always ask. It is important to know the patient's sexual orientation and practices in order to fully understand their medical risks, needs and possible social issues. Taking a careful, straightforward, explicit sexual history can be a matter of life or death for patients and their significant others.

Although homosexuality was formally recognized by the American Psychiatric Association in 1973 to be a normal variant of sexual orientation, many clinicians do not feel competent to take a sexual history from patients who are not exclusively heterosexual. In order to be comfortable talking to patients about homosexuality, each clinician must understand his or her own attitudes, preconceived notions, and possible biases about people who are gay, lesbian, bisexual and transgendered. Self-understanding will help the clinician to keep negative attitudes from surfacing during the patient interview. Practice in talking about these issues will soon provide even greater comfort.

The clinician who is respectful and asks questions in a non-judgmental way will enable patients to talk about their experiences, reveal feelings, and ask important questions. The clinician who is unsure of what to ask may say: "In order to care for you I need to know about your sexual history. Please help both of us by telling me what you think that, as your clinician wanting to help you, I should know." On the contrary the judgmental clinician can antagonize patients and make them feel that their access to proper health care is blocked.

Vignette #14: A 32-year-old woman and her female partner present to a fertility clinic to begin exploration of possibilities for having a child. The clinician tells the couple that they should seriously rethink this pursuit because their child will be confused about who his parents are. The couple leaves feeling chastised, disappointed, and angry.

In this case, the clinician allowed personal beliefs to interfere with non-judgmental medical care, causing significant emotional distress. Again, the clinician must be careful not to allow personal biases to interfere with good medical care.

Terminology reflects knowledge and respect. Thus, patients may better accept the terms gay, lesbian, bisexual and transgendered than term *homosexual*. The following is an example of a sequence of open-ended questions, which a clinician might ask a patient about his or her sexual relationships:

Example 1) “Are you currently in a significant love relationship?”

2) “Is this with a man, a woman, or both?”

3) “Are you gay, bisexual or straight?”

Questions like these will enable the patient to give more honest answers, since it will convey that the clinician is making no assumptions and is ready to hear whatever the patient has to say. For example, a gay man, a lesbian, or a bisexual patient in a heterosexual marriage and would need to know that he could tell this to the clinician without fear of negative judgment.

The natural progression of questions should proceed from the general to the specific, from the less sensitive to the more sensitive. For example, the clinician may begin with the question: “Can you tell me about your current significant relationship or relationships and your sexual activities?” and then ask, “Has your partner or have your partners been tested for HIV? Do you know the results?” and, “How many regular and occasional male and female sexual partners have you had during the past two years?”

The clinician may, at some point, also find it relevant to ask about sexual fantasies. When asking about early sexual thoughts, feelings and experiences, questions about any form of sexual abuse and/or sexual assault and consequent trauma must be included for all male as well as females.

Clinicians have the responsibility to be knowledgeable, respectful and empathic in taking a sensitive and complete sexual history from gay, lesbian, bisexual and transgendered patients, as from all patients. They must communicate clearly and quickly, with a professional and respectful demeanor so that the patients can respond honestly and in appropriate detail. Only then can the patient be in the best position to obtain appropriate medical care.

5. Cultural Considerations in Interviewing

The clinician should be especially attuned to the ways in which taking a sexual history may differ when interviewing patients from different cultures. The interviewer should be aware of the fact that a given patient’s cultural beliefs and attitudes about sex may be different from those of the majority culture. In

some groups, sex is often a forbidden subject, not to be discussed with strangers. Patients from these groups may not feel as free to disclose information about their sexual histories as are patients from other groups. As above, patients from cultures in which sexuality is rarely addressed may present with other physical problems, rather than with overtly sexual problems. Different cultural values and practices, such as the commonality of extramarital sexual relations or homosexual encounters, should be explored with patients. Religious beliefs, which contend that certain sexual practices, such as premarital sex and homosexual sex, are “sinful”, should also be understood, since such beliefs can have a tremendous impact on the psychological and sexual health of the individual. Care should also be taken when talking to members of some ethnic and religious groups about contraceptives and abortion. In some cultures, men who regularly have sexual encounters with other men will not identify themselves as bisexual – thus, exploration of this topic should always be specific. The place of origin of each patient should also be carefully pursued, since some geographic areas have particularly high rates of certain types of STD’s.

The clinician who regularly works with members of a particular ethnic or religious group which is different from his or her own will do well do educate him or herself about the sexual mores of that particular group. This luxury may not be possible, of course, for busy clinicians who find themselves interviewing patients from groups about which they know very little. In this situation, the clinician should make as few assumptions as possible, and should be alert for the possibility of different ways of thinking about sexuality.

Vignette #16: A 20-year-old woman from a religious Catholic background presents to an emergency room with vaginal bleeding. She is accompanied by her mother who refuses to leave the room. The busy resident who comes to examine her begins by asking, “So, when’s the last time you had sex?” The patient begins to cry and the patient’s mother starts screaming at her. The patient is unable to give any further information.

In this vignette, the doctor’s insensitivity to potential differences in the sexual mores of the patient’s religious group grossly compromised the adequacy of the interview. The question needed to be asked, however, the resident would have done well to arrange an interview alone with the patient and to have preceded the question with a statement like, “When a patient presents with a problem, I have to ask about all of the possible causes, even if some of them might be hard to talk about. Some of them might relate to your case, and some may not. Since the bleeding is from your vagina, I have to ask about whether any sexual activity occurred

which could have contributed to this problem.” Asking in this way prepares the patient for the discussion, and makes no assumptions about the way in which the patient will experience the topic.

The following guidelines can be used when interviewing patients of disparate religious and ethnic groups. The clinician should:

- Make no assumptions about the group’s sexual mores
- Always ask questions in the most respectful way
- When in doubt about a group’s beliefs or practices, ask the patient. Patients would much rather be asked than become victims of erroneous assumptions.
- Examine his/her own beliefs and attitudes about sex in order to be best prepared to not impose them on others.

Difficulties with translation can also present challenges to the clinician taking a sexual history. If the translator is a friend or family member, the patient may not feel comfortable discussing intimate aspects of his or her sexual history. The clinician should be particularly attuned to this difficulty and should arrange for an appropriate translator when pursuing the sexual history.

Section 3
Common Sexual Dysfunction in Men and Women

In order to take a comprehensive sexual history, the interviewer must have a working understanding of the common sexual dysfunctions in men and women. Such an understanding will help the interviewer ask appropriate questions to follow-up on problems. This chapter is an outline of common problems and will suggest interviewing technique.

Human sexual response occurs in predictable phases, and in order to correctly diagnose a sexual dysfunction it is critical to understand which phase is impaired. For example, if a patient says, “I have problems having sex,” the clinician does not know what aspect of the patient’s sexual functioning is involved. For the purposes of this chapter, the common sexual dysfunctions are broken down into three phases and those involving pain:

1. Sexual desire disorders
2. Sexual arousal disorders
1. Orgasmic disorders
2. Sexual pain disorders

Once the phase of the problem is determined, the clinician must ascertain whether the problem is global or situational. Thus, a male patient’s comment that, “I have no interest in sex anymore,” may actually mean, “I don’t want to have sex with my wife anymore but I’m very turned on by women I see in the street.” Finally, the clinician needs to investigate whether the patient’s difficulty is physiologic , psychological or a combination of the two.

Sexual Desire Disorders

Both men and women may experience a low level of sexual desire. The patient or the patient’s partner will usually classify this as a “problem” when it represents a change from a previous level of functioning. It should be ascertained whether this does in fact represent a change or whether the patient has always had a low level of sexual desire. It is also important to ask the patient whether this is a global problem, or whether it exists only in certain situations. The clinician may ask the patient whether he/she still masturbates, or whether the patient experiences sexual desire in response to attractive people or when stimulated by erotica in print, movies, TV, or the internet. Some common causes of global impairment of sexual desire are listed in Table 2:

Table 2

Causes of sexual desire disorders

1. Affective disorder
 - Depression
 - Dysthymia
2. Endocrine disorders
 - Cushing's syndrome
 - pituitary adenoma
 - disorders which affect testicular functions (e.g. hypogonadism)
3. Substance abuse
 - alcohol
 - cannabis
 - narcotics
4. Surgical interventions
 - hysterectomy
 - oophorectomy
 - orchiectomy
 - prostatectomy
5. Medication
 - antihypertensives (e.g. Beta blockers; digoxin; Anti-cholesterol drugs; diuretics, anti-ulcer drugs (cimetidine)
 - antidepressants (e.g. specific serotonin reuptake inhibitors)
 - anti-anxiety agents
 - anti-psychotic agents
 - antihistamines
 - methadone
6. sexual trauma/exploitation
7. anxiety about sexual consequences (e.g., pregnancy, pain, disease, death)
8. anger, recurrent conflict.

Patients may also have a sexual desire disorders after myocardial infarction or during pregnancy due to fear of sexual activity.

Vignette #17 : A patient presents to a psychiatrist stating that although she felt that she was happy with her husband, they have recently begun to fight continuously. Further exploration reveals that

their fights center on her lack of interest in sex. She is sure that her lack of sexual desire for her husband means that she no longer loves him and that she should leave him. When questioned, she states that she no longer masturbates and has “just not felt sexual recently.” When the interviewer asks her what medications she is taking, she states that she has been taking fluoxetine for 4 months for a depression which followed her mother’s death. A careful look at her symptoms indicates that her decrease in sexual desire closely parallels her use of fluoxetine.

Low sexual desire which is situational in nature is commonly related to a psychological problem such as a problem in a relationship or a fear of intimacy. A person with this type of problem may continue to masturbate and to have his/her sexual interest aroused by other stimuli, but has little or no interest in a particular situation or with a particular person. Anger, frustration, and disappointment with a partner may manifest as a lack of desire and coital avoidance. In addition, increasing intimacy may provoke lack of sexual desire in an anxious person for whom this is threatening. In this situation, it is helpful to take a more detailed sexual history to see whether a pattern emerges.

Vignette 18: A man who is about to move into an apartment with his lover presents to his internist asking to have his thyroid checked. Although he has been very sexually active in his life, and has had no problems with sexual desire, he suddenly does not want to have sex with his partner and he fears that this represents the symptoms of a physiologic problem. Further exploration reveals that the man has recently become very aroused around a co-worker, and that he continues to masturbate frequently. A discussion of his relationship with his lover reveals that he has never lived with someone before and that he fears that he will be trapped with this partner, unable to ever make love to another man again.

Sexual Arousal Disorders

In both men and women, sexual arousal is produced by an influx of blood into the genitalia caused by reflex vasodilatation of these organs. In men, penile erection is produced, while in women the clitoris dilates and the vagina becomes swollen and lubricated.

Impotence, defined as the partial or complete failure to attain or maintain an erection, is one of the most common sexual complaints in men. In the case of impotence, which can often be caused by an organic problem, it is of the utmost importance that the clinician obtain a complete history, including information about the patient’s medical status, substance use history, and medication history, as well as detailed information about whether the problem is global or situational.

Vignette #19: A 55 year old man presents to a psychotherapist with depression. In the course of the evaluation, the therapist learns that the man is particularly depressed because he cannot maintain an erection long enough to have intercourse with his wife. He and the therapist work for 6 months in psychotherapy on his feelings about himself as a man and his fears of aging. During this time, his impotence worsens to the point where he can no longer attain an erection at all. Although he is too embarrassed to mention this to his internist at his next yearly physical, he is

discovered on blood testing to have elevated glucose suggestive of adult onset diabetes. Upon further questioning by the internist, it becomes clear that the man cannot have an erection under any circumstances, including morning erections.

In this example, it is likely that the man's impotence was affected by his diabetes. Potential physical problems should be foremost in the clinician's mind when evaluating impotence, particularly in the patient over 40 years old. Nevertheless, it is important to remember that sexual problems that arise from medical conditions may also be contributed to by psychological components.

Vignette #20: A 23 year old man presents to his internist with fears that something is wrong with his penis. He fears that his marijuana smoking has interfered with his erectile function. He states that although he awakens each morning with an erection, he rapidly loses his erection when beginning to have sex with his girlfriend. When asked about masturbation, he shyly states that he masturbates frequently and without difficulty, but that he often thinks of male friends to achieve sexual excitement.

In this case, although drug use can clearly affect erectile function, the capacity for morning erections and the patient's frequent masturbatory activity clearly point to a situational problem. This young man may be struggling with his sexual preference and may not in fact be adequately sexually excited by women; conversely, conflicts about women may be affecting his ability to have sex with his girlfriend. In this situation, referral to a mental health professional would be appropriate.

New medications, such as sildenafil are currently available to treat erectile dysfunction. This medication can be used hours before intercourse to allow men with difficulties having and sustaining erection to be able to have more satisfactory sexual experiences. Patients often have misconceptions about the mechanism of action of this drug, as well as its indications, side effects, and contraindications. Sildenafil is not an aphrodisiac; rather it enhances the impact of natural nitric oxide on the penis which allows erection to occur. The risk of serious side effects are greatest in patients with severe cardiovascular disease, in particular past history of coronary artery disease, and should be used with caution in patients with hypertension, hypotension, and diabetes. Clinicians should ask their patients about use of these types of medications, both prescription and over the counter preparations.

Women with sexual arousal disorders complain of a lack of lubrication during sexual activity. They are interested in sex and may be able to have orgasms but have pain upon intercourse because of inadequate lubrication. In contrast to male impotence, impaired female excitement is much less frequently attributable to an organic problem. The one organic cause of this problem is a measurable estrogen

deficiency, such as may occur in menopausal women. Consequently all patients presenting with this problem should be asked about their menstrual histories, since the presence of a normal menstrual cycle is evidence of adequate estrogen levels.

Orgasmic Disorders

Although these disorders are found in both men and women, they are quite distinct in the sexes and will be discussed separately. In women, anorgasmia is one of the most common sexual complaints presented to clinicians. Some women may never be able to have orgasms, or they may be unable to reach orgasm in certain situations. Although physiological causes of this problem are rare, the clinician should ascertain whether the problem is in fact global and should refer all patients with this complaint for a full medical evaluation. Of particular importance are those patients who present with new onset anorgasmia after a period of normal functioning. In addition, women using various antidepressants, such as monoamine oxidase inhibitors and specific serotonin re-uptake inhibitors may present with secondary anorgasmia or with new onset of delayed orgasm.

Most cases of anorgasmia in women, however, stem from psychological causes. The clinician should ascertain whether the patient is able to achieve orgasm at all, if so, under what circumstances. Often, a patient is able to achieve orgasm while masturbating alone but not together with a partner. Causes of this may include problems with the relationship, body-image, self-consciousness with another person, inability to use fantasy when having sexual relations with a partner, or underlying psychological problems that lead the patient to misperceive the partner as a parent or early caretaker. Experiences of sexual abuse or trauma may also factor into the equation. Many women have never masturbated, while others may have inhibitions or unrealistic ideas about what they “should” be capable of experiencing. For example, many women believe they are abnormal if they are unable to achieve orgasm via intercourse alone, while in fact only a small percentage of women are able to achieve this without some measure of clitoral stimulation. The clinician should be sensitive to the pervasiveness of these assumptions, and should ask about them.

Vignette #21: A 24 year old woman presented to a psychiatrist after breaking up with her boyfriend. She stated that she realized that she must not be attracted to him because he always wanted to have sex and she never did. Although she focused exclusively on the relationship, the psychiatrist asked about her former relationships and discovered that she had never particularly enjoyed sex because, although she was attracted to men and became excited during foreplay, she could never achieve orgasm. Further treatment revealed that she had never masturbated, and that

she felt that her vagina was a dirty place that she didn't want to touch. She consequently had little idea about what stimulated her and what a partner could do to help her to achieve orgasm during sexual activity. She also wrongly believed that fantasizing during sex was evidence that one was not interested in one's current partner.

In this case, the young woman had many false assumptions that inhibited her sexual activity and capacity for orgasm. Continued psychotherapy and/or treatment with a sex therapist both have good possibilities for helping such a patient.

In men, orgasmic disorders take the form of disorders of ejaculation. Men may have absent ejaculation, delayed ejaculation, "dry" orgasm (orgasm without ejaculate), and premature ejaculation. Of these, orgasm without ejaculation is always caused by organic causes, such as various medications, urological surgery, or neurological problems, and should always be evaluated medically.

Delayed or absent ejaculation is similar to inhibited female orgasm in that the primary form in young men is usually psychologically based, while the secondary form is often attributable to an organic/physical cause. It is important to whether this is in fact a new condition or whether it has always been a problem. In men over 50 presenting with new onset of delayed ejaculation, the clinician should be sure to ask a full medical and surgical history, including history of vasectomy and medication use, as well as a history of alcohol or substance abuse. Physical examination is generally appropriate in these cases, since medical illnesses, such as diabetes and neurological problems may include delayed ejaculation as a symptom. Primary delayed orgasm, particularly in men under 50 years old, is generally due to a psychological problem. Clinicians should ask about whether this is a situational or a global problem, and where it is situational, the clinician should learn as much as possible about the specifics of the situation. Appropriate questions might include whether the patient is able to ejaculate when masturbating, whether the patient is only unable to ejaculate during intercourse, and whether sexual fantasy affects the patient's ability to ejaculate. Psychological interventions, such as psychotherapy and/or sex therapy, are most appropriate here.

Premature ejaculation is one of the most common sexual complaints with which men present. In this disorder, the man is unable to control when he ejaculates, and therefore often achieves orgasm almost immediately upon becoming excited or entering his partner. This is usually due to anxiety, and thus it rarely has an organic cause. Common causes include performance anxiety and the man's inability to

accurately assess the state of his sexual excitement. Performance anxiety is worsened when the man focuses on his ejaculation, heightening his tension and excitement. The clinician should ask about the details of the problem, such as when it occurs (e.g., immediately before penetration), how long it takes for the man to ejaculate, and what techniques the man has tried to prevent it. The clinician should be sensitive to the psychological distress this can cause the patient and his partner. Sex therapy has a high rate of success with this problem.

Vignette #22: A woman presents to a sex therapist complaining of inability to achieve orgasm during intercourse. A thorough evaluation reveals that she is able to achieve orgasm when masturbating, and that she has been able to achieve orgasm during intercourse with former partners. She states that although she loves her fiancé, she has been consistently unable to achieve orgasm during sex with him. Although she faults herself, the sex therapist learns that the woman's fiancé ejaculates almost immediately upon entering her, and that the woman subsequently becomes dejected and disinterested in further sexual activity. The therapist urges the woman to bring in her fiancé for the next visit. The man reveals that this has been a long-standing problem that he has been loath to discuss with anyone because it was so embarrassing.

Sexual pain disorders

Patients who present with pain during sex, namely dyspareunia, should also be evaluated for phimosis in men and in women, vaginismus. Dyspareunia, which may occur in men and women, refers to genital pain during any phase of sexual activity. The clinician evaluating a patient with this complaint should carefully obtain a detailed description of the pain, such as the quality of the pain, when it occurs, where it occurs, whether it always occurs in the same pattern. Organic causes, such as genital infections and inflammations, are important here in both men and women; patients should therefore be carefully questioned about recent infections as well as any abnormalities in urination or (in women) menstruation. Once organic causes are ruled out, psychological causes may be explored, but these are rare. In particular, the clinician should ask the patient about other pain syndromes, since genital pain is a common complaint of patients with somatization disorder.

Vaginismus is caused by an involuntary spasm of the muscles of the outer third of the vagina. This impairs penetration and may lead to painful sexual intercourse. This may be a global problem, with spasm occurring in response to any penetration (such as with a tampon or speculum), or situational, occurring only with sexual intercourse. This reflexive involuntary spasm may arise secondary to a gynecological condition, such as an infection (vaginitis) or endometriosis, which makes sexual activity painful, or the contraction may be secondary to rape or other sexual trauma causing a psychological

problem. Complaints of global or pervasive vaginal spasm should always lead to a referral to a gynecologist for a complete physical evaluation.

Vignette #23: A newly married couple in their 20s presents to a couples' counselor. The husband is very upset, complaining that his wife doesn't like to have sex. The wife states that although she finds her husband very attractive and becomes sexually excited during foreplay, intercourse is very painful and she would rather avoid it. The counselor finds them to be otherwise compatible. The husband further states that the wife always seems to be having one type of gynecological complaint or another-- her periods are very irregular and she is completely incapacitated with menstrual cramping for several days of every month. The counselor recommends consultation with a gynecologist, who diagnoses severe endometriosis with secondary dyspareunia.

Other Issues To Be Considered In The Assessment of Sexual Dysfunction

- **Substance-Induced Sexual Dysfunction**

The clinician who is evaluating a patient with sexual dysfunction should be aware that many substances may induce sexual dysfunction. These include substances of abuse, as well as medications of all kinds. Of the substances of abuse, alcohol is the most common agent to affect sexual function. Intoxication, as well as long term use, may cause the sexual dysfunction. Other substances which may impair sexual function include cocaine, opioids, sedatives and anxiolytics. Intoxication may decrease sexual desire as well as cause problems with arousal in both sexes. The clinician should be attuned to the presence of sexual problems in patients who present for difficulties with substance abuse of all kinds.

Prescribed medications have also been implicated in the same disorders, as well as orgasmic dysfunction in men (see Table 1, page 16.). Medications such as antihypertensives, H2 receptor antagonists, antidepressants, neuroleptics, anxiolytics, anabolic steroids, and anti-seizure medications all are known to cause sexual dysfunction.

- **Masked Sexual Problems**

Because of a number of factors including education, culture, and the use of language to describe physical phenomena, patients will sometimes perceive an underlying sexual problem as a physical one. Patients may present with vague physical complaints such as fatigue, malaise, appetite disturbance and the like that cover the basic sexual disorder from which the person suffers. The patient may be embarrassed or ashamed to mention the sexual problem overtly because of a restricted upbringing or a cultural taboo. A physical complaint can be a ticket of admission to the clinician's office.

Vignette #24: A 54-year old married man presented to the internist with vague complaints of fatigue and lassitude. Physical and laboratory evaluation was unremarkable. The patient had recently visited relatives overseas and had not felt well since returning. The internist ruled out parasitic infections and other tropical diseases, but it was not until he took a careful sexual history that he learned that the patient was concerned about having contracted AIDS during his visit. The patient reported that he had sex with a prostitute and had become concerned that he had become infected with HIV. Upon returning home he was so anxious and guilty that he was unable to have sex with his wife. He was afraid he would infect her with the virus. HIV testing was negative after six months, but the patient remained unable to obtain an erection. Referral to a psychiatrist was made.

In this case, careful history taking enabled the patient to reveal his true complaint and to obtain the proper management.

Complaints of pain for which no physiologic cause can be found can also be frequently associated with underlying sexual complaints. When a patient complains of pain associated with sex, the diagnosis is less difficult. However, when the complaint is about pain in another anatomical location and not associated in time with sex, the physician has a more difficult diagnostic task. The symptoms may not meet all of the criteria for the diagnosis of a pain disorder such as significant impairment, but is similar to the presentation of this disorder because the symptom is clearly related to psychological factors.

Vignette #25: A 30-year old married woman complains of severe headaches that are unrelieved by medication, including narcotics. Physical and laboratory examination does not reveal a cause for her headaches. In reviewing her social history the physician learns that the patient is considering a divorce because her husband is too demanding of sex. Careful sexual history reveals that the patient was raised in a strict and repressive environment in which sex was both evil and dangerous. Her older sister had rebelled and become sexually active as an adolescent. One evening, while on a date, her sister had been killed in an auto accident. This confirmed for the patient the dangers of sex (and freedom). During her marriage of 3 years she had only had sexual intercourse during the honeymoon and for a few months after. She had never had orgasm. She was only partially aware of the psychogenic cause of her headaches. She avoided sex by telling her husband she was in pain but had experienced the pain in non-sexual situations as well. The patient was very distressed about her inability to have a normal sex life. The patient was referred for psychotherapy to deal with her sexual aversion.

- **Sexual Problems Masking Other Conditions**

In contrast to patients who present with physical symptoms as a cover for underlying sexual dysfunction, some patients may present with symptoms of sexual dysfunction that are due to another primary medical or psychiatric disorder. Any symptom may be seen from decreased desire to male erectile dysfunction. Proper diagnosis of the underlying medical condition is paramount. Among the medical causes of sexual dysfunction are several of the most common conditions of adult life. These include diabetes melitis, hypertension, coronary artery disease, hypothyroidism, pelvic infections and endometriosis. Less common conditions such as multiple sclerosis, hyperprolactinemia, hyper-and hypoadrenocorticism and spinal cord trauma are also known to be causes of dysfunction.

Vignette #26: A sixty-year old married man saw his physician for problems maintaining an erection. The patient had noticed a gradual increase in difficulty in achieving an erection over the previous six months. In the past several weeks he had been unable to maintain his erection for more than a few minutes. He had been married for 33 years and at first denied any marital stress. The patient then admitted that he had recently had a brief affair with a younger woman and had had no difficulty in performing sexually. There was no other history of infidelity and the patient reported no earlier sexual problems. Physical exam revealed a mildly obese 60-year-old with hypertension of 145/95. Clinical labs showed an elevated fasting blood glucose. This was followed by a workup for diabetes that indicated the patient suffered from type II diabetes. Nocturnal penile tumescence studies were abnormal and consistent with diabetic neuropathy.

In this case, despite the presence of a medical illness, the novel sexual stimulus associated with the illicit affair was sufficient to overcome the physical impairment. This common phenomenon demonstrates the complexity of mind/body relationships and illustrates the need to attend to all aspects of the history when evaluating a sexual complaint.

The sexual complaint may also be secondary to a primary psychiatric disorder. A primary diagnosis of another mental disorder should be made when the sexual dysfunction is secondary to and only one of the symptoms of a psychiatric disorder. For example, major depression is often associated with a lack of desire for sex as well as problems with arousal. Many speculate that there must be a pathophysiological process involved, but as yet this is unknown. Other psychiatric conditions associated with sexual dysfunction include the anxiety disorders, psychotic disorders, and some of the personality disorders.

Section 4

Special Clinical Considerations

1. Sexually Transmitted Diseases

In order to comprehensively assess the sexual function of all patients, understand their sexual practices, and refer them for appropriate treatment, clinicians must evaluate all patients for the presence or history of sexually transmitted diseases (STD's). The presence of STD's may be a marker for unprotected sex, alerting the clinician to the need to discuss this important health topic with the patient. STD's are a cofactor in HIV transmission, and thus the occurrence of STD's may indicate that a given patient may be at risk for HIV. Patients with and without STD's have concerns about their own risk of infection and the risk to others. And finally, patients with STD's need appropriate medical referrals and information about preventative measures. Talking to patients about this extremely personal aspect of their lives may be difficult, however most patients with STD's will be relieved to be discussing a subject which is so often on their minds. The practitioner should set the tone of the discussion – if he/she is at ease and asks matter of fact questions in a sensitive way, the patient will usually be comfortable answering questions in a straightforward way. The clinician will want to understand the patient's response to having an STD, as well as their coping mechanisms and the way in which the STD has impacted on their life. In addition, the clinician will also want to explore the ways in which the patient with an STD may be putting others in danger of infection.

Sexual Risk Taking

Examples of risk taking behaviors include vaginal intercourse without a condom, anal intercourse, sex with multiple partners, sex with partners known to be intravenous drug abusers, and sex associated with substance abuse. Substance abuse may impair judgment and therefore place participants in riskier situations than they would ordinarily choose to be in. It is important for the clinician to remember that anyone is potentially at risk for these types of behaviors, regardless of their gender, sexual orientation, marital status, age, ethnic or socio-economic group.

Vignette #27: A 50 year old man company vice president presented to the executive medical clinic of his firm with pain on urination. The clinician, whom he had known for many years, knew that the patient was married, well respected in the community, and generally considered to be a family man.

He therefore prescribed antibiotics for him without questioning his sexual activity. He did not, therefore, learn that the patient had been having sex with men he did not know without using a condom.

This clinician, in the spirit of protecting his patient from unnecessary and embarrassing questions, unwittingly sent his patient back into a potentially life threatening situation. Adolescents should be particularly questioned about these activities, since this group is developmentally prone to risk-taking behaviors of all kinds.

Making a Diagnosis

Many patients with STD's may not be aware that they have them. The interviewer should ask about any unusual sores or discharges from the genitals, as well as about any unusual lumps or areas of irritation. Many STD's, such as herpes, can present in protean ways, so the interviewer should ask about any physical irregularities, even if the patient is inclined to write them off as "nothing to worry about". Important questions include the nature of the lesion, when outbreaks occur, the frequency of outbreaks, what brings them on, whether the outbreak is constant or whether it comes and goes, relationship to the menstrual cycle, if it causes pain, and all of the places on the body where it appears. In addition, the clinician should ask the patient if their sexual partner (s) have any history of STD's, or if they have noticed any unusual sores, discharges, etc. on the genitals/anus/mouth of their partner. This last point is important, since STD's may not be limited in locale to the genitals alone. Any patient who presents with any genital irregularity should be questioned about a history of STD's as well as the partner's history of STD's. In the assessment of risk for HIV, the clinician must also ask about whether the patient or the patient's partner uses intravenous drugs, since this also predisposes to HIV infection. This discussion should also include information about whether the patient (or the patient's sexual partner) has multiple partners, and about whether the patient (or partner) uses condoms during sexual activity. Even if the patient says that he/she uses condoms, the clinician should be specific about whether condoms are *always* used.

In diagnosing and treating sexually transmitted diseases, some, like gonorrhea and syphilis, are often missed in because gonorrhea is often asymptomatic in the pharynx, rectum and even urethra, and a primary chancre of syphilis may not be sought or seen if it is in the rectum or throat. Clinicians should ask about symptoms such as discharge, the color and amount, burning, etc. A number of diseases such as hepatitis B, amebiasis, giardia, salmonella and shigella have been found in gay men as sexually transmitted

by oral-anal contact. Less is known about woman to woman transmission of STDs and vaginitis, but physicians must inquire about every woman's and man's sexual practices and symptoms and past diagnoses of disease and vaccines administered. It may help the clinician to ask the patient about his or her sexual practices in order to learn as much as possible about where an infection may reside. For example, a clinician could explain to the patient, "Gonorrhea germs can live in many different places within you. Whatever parts of your body have been involved in sexual contact will need to be cultured, so let's discuss each activity and which parts of your body were exposed." In this way the clinician enlists the patient's help and minimizes the chances of missing exposed areas. Newer testing methods now make the diagnoses of STD's even easier, further enhancing the need to make this assessment a routine part of the medical review of systems.

The tremendous morbidity and mortality caused by HIV infection and AIDS makes the assessment of risk for HIV of paramount importance. Clinicians should remember that this virus does not discriminate among socio-economic, racial, or ethnic groups and that any patient may be at risk for HIV infection. All patients should be asked about intravenous drug use (which may predispose patient to HIV as well as to many types of hepatitis), multiple partners and homosexual activity.

Vignette #28: A housewife with two children presented to her internist with lethargy, weight loss, and loss of appetite. On the first two visits, the internist prescribed iron and vitamins. On a subsequent visit, thyroid function was tested with normal results. After six months of no improvement, the internist finally questioned the woman about what was happening in her life. The woman reported that she was on the verge of divorce because her husband was chronically unfaithful. HIV testing was positive.

Although patients may be frightened by the topic of HIV, the responsible clinician will always ask about risk factors and will do HIV testing when appropriate and consented to by the patient. HIV infection has a long asymptomatic period and is most effectively treated if it is diagnosed before clinical signs and symptoms of illness appear.

Risk factors for HIV infection

- Injection drug use (present/past)
- Receipt of blood products or organ transplant between 1978 and 1985
- Multiple sexual partners

- Unsafe sexual practices (e.g. unprotected anal or vaginal intercourse, prostitution or sexual involvement with prostitutes, sexual activity with partners known to be injection drug users)
- Presence of other STD's
- Use of noninjection drugs through association with high-risk sexual activity

Impact on the patient

Aside from the all important task of diagnosing an STD, the clinician will want to assess the impact that the STD has had on the patient. The presence of an STD can affect the patient's sense of their body, their sense of being physically attractive, their willingness to enter into a sexual relationship, and their understanding about whether they are able to have children. Common misconceptions about STD's may cause patients to incorrectly believe that they can no longer have sex with a partner or that they will no longer be able to have children.

Vignette #29: A 31-year-old woman presented to a psychiatrist with symptoms of depression. She reported that after many unsuccessful relationships, she had finally met someone whom was really nice to her and to whom she was attracted. However, as the relationship became more intimate, she began to pull away. Over the course of several weeks, the patient and the psychiatrist explored her history of relationships, in an effort to better understand why the patient was distancing herself from her boyfriend just as the relationship was deepening. The patient finally said that she had been omitting the fact that she had herpes and was afraid to be in a sexual situation with this man for fear that he would reject her.

Many patients with STD's which involve recurrent outbreaks, such as Herpes and genital warts, have inadequate information about the ways in which they can continue to have satisfying sexual relationships and the ways in which they can protect themselves and their partners from further infection. Frank and empathic discussion of these topics with patients can greatly relieve them of their feelings of shame and isolation. Patients may also have ideas about the ways in which their STD's are punishment for being sexual or for poor choices they made. Clinicians should attend to these feelings, which can plague patients and ultimately affect their treatment.

Vignette #30: A 21 year old woman who was 9 months pregnant was brought in by ambulance when she went into premature labor in a supermarket. On pelvic exam, the patient was found to have a lesion which was strongly suggestive of vaginal herpes. When the OB/GYN resident explained to the patient the risk that herpes posed to her baby, the woman began to cry. She said that she was too ashamed to have it looked at, fearing her partner would beat her if he learned that she had an STD.

Assessing Risk to Others

In addition to assessing the patient, the clinician also needs to assess whether others may be at risk because of the patient's behavior. In this way, the clinician can help the patient to better understand the ways in which he or she can continue to have a satisfying sexual life without endangering the health of others. Many patients may have inadequate information about safer sex practices. Clinicians should ask all patients, not just those with STD's, about use of condoms and about unprotected sexual behavior of all kinds (vaginal intercourse, anal intercourse, and oral sex). In this way, the clinician uncovers unsafe sexual practices that could potentially jeopardize the health of the patient and of others. Clinicians may shy away from this type of questioning, however in the wake of the AIDS epidemic inquiring about sexual practices may be a matter of life and death.

Risk taking behavior regarding sex has in earlier times concerned unwanted pregnancy and sexually transmitted diseases that might be embarrassing but not usually medically serious unless untreated. With the onset of HIV and AIDS, risk taking involving sex has become a life-threatening issue. Examples of risk taking behaviors include vaginal intercourse without a condom, anal intercourse, sex with multiple partners, sex with partners known to be intravenous drug abusers, and sex associated with substance abuse. Substance abuse may impair judgment and therefore place participants in riskier situations than they would ordinarily choose to be in. It is important for the clinician to remember that anyone is potentially at risk for these types of behaviors, regardless of their gender, sexual orientation, marital status, age, ethnic or socio-economic group

Vignette #31: A 50 year old man company vice president presented to the executive medical clinic of his firm with pain on urination. The clinician, whom he had known for many years, knew that the patient was married, well respected in the community, and generally considered to be a family man. He therefore prescribed antibiotics for him without questioning his sexual activity. He did not, therefore, learn that the patient had been having sex with men he did not know without using a condom.

This clinician, in the spirit of protecting his patient from unnecessary and embarrassing questions, unwittingly sent his patient back into a potentially life threatening situation. Adolescents should be particularly questioned about these activities, since this group is developmentally prone to risk-taking behaviors of all kinds.

2. Sexual Abuse

In the initial patient evaluation, busy clinicians may omit asking about a history of sexual abuse unless the patient initiates the discussion. However, the need to obtain a sexual abuse history is essential for all patients. Before discussing the ways in which sexual abuse should be addressed with patients, it is important for the clinician to be clear about how to define this sometimes elusive topic. Sexual abuse may be defined as:

- (A) the employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or stimulation of such conduct for the purpose of producing a visual depiction of such conduct; or
- (B) the rape, molestation, prostitution, or other form of sexual exploitation of children, or incest with children.

Sexual abuse may consist of behaviors which occur over a protracted period or may be limited to a single incident.

In beginning to evaluate every patient for a possible history of sexual abuse, clinicians must acknowledge that such a history may exist and may be related to the patient's presenting symptoms.

Vignette #32: A 23-year-old single woman presented with symptoms of depression. She was disheveled, mildly obese, withdrawn, and had a paucity of speech. She stated that she had a good relationship with her parents and that her father had severe cardiac disease. She denied a history of sexual abuse. In the course of treatment, she did not respond well to antidepressants or psychotherapy. Several years later, she called and asked to see the same clinician. She was thinner, cheerful, attractively attired, and, for the first time, appropriately verbal. She reported that now that her father has died, she could admit that, because of concerns about her father's health, she had not revealed that an older brother sexually abused her. She says that she is now ready to discuss this.

Before asking specific questions, clinicians should tactfully introduce the topic of sexual abuse.

The clinician may do this by reassuring the patient that questions about sexual abuse are an important and usual part of the clinician's questions about the medical history of every patient. Certain symptoms may give a clinician a high index of suspicion that a patient has been a victim of sexual abuse. These include the symptoms of post-traumatic stress disorder, including: insomnia, hypervigilance, exaggerated startle response, excessive irritability, anger outbursts, concentration difficulties, intrusive nightmares and memories when exposed to triggers, avoidant behaviors, a sense of no future, amnesia about the trauma, dulling of emotional responsivity or recurring feelings of suffocation. In addition, the memories of an adult

who experienced sexual abuse as a child may remain childlike, i.e., with sensations and feelings rather than as a complete recall of an event.

Vignette #33: A 30 year old woman, 5 months pregnant with her third child, presents to the emergency room with a black eye, bleeding nose, abdominal cramping, and vaginal bleeding. The clinician checks her fundi, stops the nasal bleeding, listens to abdominal heart sounds to ensure the baby's status and does a vaginal exam. When the clinician asks how the battering occurred and whether the patient had ever had similar experiences before, the patient cries more and says that it happens every time she's pregnant; she gets beaten and raped. The clinician states he will refer the woman for further counseling after the interview is completed. He then asks if she ever had been abused sexually prior to her first pregnancy. The patient appeared startled, hesitated for several moments and then confessed blurts that her grandfather, "did bad things to her when he baby-sat with her while her parents were at work." He warned her that no would believe her if she talked about it, so she had never discussed this.

Asking about these topics may be difficult for both clinicians and patients. Once again, clinicians must put aside preconceived cultural or personal assumptions in order to ask questions, which may make patients initially uncomfortable or upset. The clinician must be prepared for all types of answers and must not foreclose further revelations by rushing the questioning. Clinicians will be further aided by observing nonverbal responses, and listening empathically. The following outline will aid the clinician who is talking to patients about sexual abuse.

The clinician should:

- (1) Reassure the patient that they are not responsible for what happened to them as children.
- (2) Talk to the patient without family members or significant others present
- (3) Ensure confidentiality within the limits of the law

As with many other aspects of the sexual interview, the clinician may find it helpful to begin with the most general and least threatening topics, such as general questions about sexual function, symptoms of PTSD, depression, anxiety, and substance abuse. Questions about sexual abuse should be asked chronologically.

The following series of questions may provide a template for interviewing:

- (1) Did you have a bad experience you have never told anyone about?
- (2) Do you recall any sexual experiences with an adult or with someone older than you, man or woman, before you started first grade, middle school, or high school?

- (3) Did anyone ever try or succeed in putting their penis in your mouth or vagina when you were young?
- (4) Were you sexually abused by more than one person?
- (5) Who were they?
- (6) Did you tell anyone?
- (7) What happened?
- (8) Did the police get involved?
- (9) Were the circumstances of these forced, and associated with any other violent activities?

If necessary the clinician should attempt to define sexual abuse for the patient by saying, for example, “Someone may have exposed their genitals to you, touched your genitals, or had sexual intercourse with you with or without your consent. Even if at the time you consented, it may be that, in looking back, you now realize that you had no choice but to consent.” It is also important for the clinician to assess what the patient thinks the effects of the abuse have been. Questions such as, “What do you think were the early effects?” “What do you think are the lasting, ongoing effects of that/those experience(s) for you?” can be particularly important in this regard. The clinician should also try to ascertain whether behaviors occurred which the patient might not classify as sexual abuse, but which may have significantly impacted the patient. Examples of these include family nudity or exposure to adult sexual activity in the home.

Vignette #34: A 10-year old girl presents to a pediatric clinic with recurrent nightmares and enuresis. Upon questioning, she reveals that for two months on her way home from school, she had to pass a man who exposed his genitals to her. She also states that he repeatedly asked her to get in his car so he could hold and touch her. She never responded. She finally told her grandmother who called the police. The man was arrested and the child had to tell the police the details. She is now afraid that the man will return and harm her.

Vignette #35: A 15 year old boy, arrested for stealing hubcaps, and on another occasion a car, is evaluated. During the course of the evaluation, the clinician asks the child if he has ever been the victim of sexual abuse. The boy hesitates and then haltingly admits that, when he was between five and seven, his stepfather made him submit to anal intercourse with the threat that he would beat his mother if the boy told her or anyone else. He never told anyone but has had difficulty with authorities ever since.

A detailed review of a patient’s history of sexual abuse will clearly not be appropriate for every interview. The clinician must decide whether it is important to ask about this in an initial interview, for example when a patient is presenting with injuries inflicted by an abuser, or whether the history will unfold

over time, as in psychotherapy. When it is not medically necessary, the clinician should not insist that the patient go into great detail about sexual abuse until the patient develops sufficient trust in the clinician. In addition, clinicians should try whenever possible to be as validating of the patient's experience as possible.

Vignette #36: A 26-year-old female patient presented with symptoms of sleeplessness and phobias two months before her wedding. She revealed to the interviewer that she had been gang raped three years earlier by three men in a bar. The interviewer said, "Really? That sounds rather odd." The patient did not return for her follow-up appointment.

Discussing sexual abuse is a great challenge for both patients and clinicians. Patience, empathy, active listening and non-judgmental attitude will help both parties negotiate this difficult but important topic.

3. Problems Surrounding Reproduction

Many reproductive problems, affecting both men and women, lead to problems in sexual functioning. When interviewing patients about these problems, clinicians should be prepared to ask about and discuss their effects on sexual functioning.

Contraception

Questions about contraception are appropriate to the interview of all sexually active persons. Interviewers should not assume that adolescents are not sexually active. In fact, they may be the most in need of information about appropriate contraceptives, including such topics as types of contraceptives, method of use, and effectiveness. Providing this information should not necessarily be left to the obstetrician-gynecologist. A pregnant woman should also be questioned about her contraceptive practices, since she may be pregnant because she is not informed about proper use of contraceptive measures, and she may want to prevent a future pregnancy.

Vignette #37: An 18 year old woman presented to a clinic when she was four months pregnant. She was confused and angry, saying that she did not know how she could have gotten pregnant since she had been using a diaphragm. Further questioning revealed that she had only used the diaphragm around the time she thought she might be ovulating and she was not aware that she needed to use spermicidal jelly with the diaphragm.

Before asking about contraceptive practices, the interviewer should ask the patient about her attitudes and beliefs about birth control, since religious and cultural values are an important aspect of contraceptive use. For example, Catholic and Muslim patients may not use contraceptives because of their religious beliefs. The interviewer should then ask if any other method of birth control is being used. Birth control methods include such practices as abstinence, the rhythm method, and withdrawal. The interviewer will want to ascertain whether the patient is using his/her chosen method to minimize the risk of unwanted pregnancy. In addition, it is important to determine whether the patient is satisfied with the current method of birth control and what the patient's partner feels about the chosen method of contraception. For example, it is possible that a certain contraceptive reduces the couple's sexual gratification, or that one member of the couple objects to the method of contraception. This might decrease the likelihood that the contraceptive will actually be used. Some patients may even fear using certain methods of birth control, such as condoms, because they fear that their partner will object and the relationship may be threatened.

The interviewer who is asked about a proposed change in contraceptive method should be able to explain the advantages and disadvantages of the various methods and to comment on the effectiveness of each. He/she will be interested in the reasons underlying the proposal for change, for example, whether the couple hopes for improvement in sexual gratification or for more trustworthy prevention of pregnancy. Questions about contraception may mask concerns about sexuality, and vice versa. In addition, a couples' decisions about contraception may be part of a psychological struggle in which one partner is trying to get the other to assume the responsibility for contraception or to bear the burden of it.

Vignette #38: A young woman presents stating that she wants to switch from using a diaphragm to the contraceptive pill. When questioned, she states that she feels inhibited sexually and hopes that once she no longer has to put in her diaphragm she will feel freer in sexual situations. Finally, she admits that her sexual partner has been pressuring her to switch to the pill so that she will be more amenable to sex.

The interviewer should also question the patient about the ways in which he/she is using contraceptive methods in the service of safe sex. For example, a young woman who chooses to use the pill for contraception may not understand that this will not protect her from sexually transmitted diseases.

Vignette #39: A young man complains that he is unable to maintain an erection with his current girlfriend. He finds himself attracted to her but persistently loses his erection prior to intercourse. When asked about contraception he admits that his girlfriend has herpes and that he is afraid of catching it, however he objects to using a condom because he fears that it will impede his sexual pleasure during intercourse.

Pregnancy

The interviewer should ask all patients about their obstetrical histories. Again, this includes adolescents and older persons. After asking a female patient if she has ever been pregnant, the next question should be, "How many times have you been pregnant?" rather than "How many children do you have?" so that the woman's history of abortions/miscarriages can be obtained and explored. Men should be asked about their partner's obstetrical history as well, since this may impact on their sexual life as well.

Vignette 40: A depressed 35 year old married man presented with dissatisfaction with his sexual life. He focused on guilt for having sexual fantasies about a co-worker. When asked about the couples' obstetrical history, the patient described how the family already had five children and his

wife, refusing to use contraception on religious grounds, has decided that they should abstain from all sexual activity.

When interviewing the pregnant patient, the interviewer will want to ascertain how she found out that she was pregnant, how far advanced the pregnancy is, her partner's attitude towards it as well as her own, and whether it was planned or unplanned. The interviewer should not make the mistake of forgetting to ask the pregnant woman about her sexual life. Although pregnant women usually continue to be sexually active, pregnancy will invariably affect their sexual lives. The woman's partner may feel awkward or unsure around her and may tend to shy away from her, making the woman feel unattractive and unsexual. The partner may turn away from the pregnant woman because he/she finds her less sexually appealing or because he/she believes it wrong, inappropriate or unwise for her to have sexual intercourse during her pregnancy. Physical discomfort during pregnancy or changing attitudes about her body may decrease the pregnant woman's sexual interest during pregnancy. The woman who has struggled with infertility problems or who has suffered multiple miscarriages may fear that sexual intercourse may induce miscarriage and may thus be fearful about engaging in sexual activity with her partner. If a couples' sexual activity diminishes during the woman's pregnancy, the pregnant woman may fear that her partner is having sexual relations with someone else. The pregnant woman will most likely not express such concerns unless given the opportunity to do so and asked the appropriate questions.

The interviewer should be prepared to answer common questions on the basis of knowledge rather than on the basis of prejudice, hearsay or folklore. If the interviewer is asked a question about which he/she is not well-informed, he/she should confess the limitations of his/her knowledge and should follow through by obtaining an answer from an informed source " I'm not sure but I can find out for you." Such questions might include those about breast-feeding or the advisability of intercourse during different stages of the pregnancy and the postpartum period. It is important to know how the woman feels about breast-feeding, and to prepare her for its erotic possibilities, since these provide pleasure for the accepting woman but distress the one taken by surprise with a reaction which she regards as wrong or distasteful on moral grounds.

Interviewers must guard against revealing prejudices and negative attitudes when interviewing single women who have become pregnant. A patient who perceives a negative reaction may not return for necessary care.

Vignette #41: A 17 year old woman presented to an emergency room with her frightened boyfriend complaining of dizziness, nausea and fainting. Halfway through taking the history, the resident told the young couple, "No need to tell me more. You're pregnant. We see this everyday. Don't you people know how babies are made?" The humiliated young woman ran crying into the waiting room, unwilling to proceed with the exam and blood tests. Only after a nurse spoke reassuringly to her could she return to the examination area for her physical exam and discussion of important information about her medical condition.

Termination of Pregnancy

The issue of abortion is rife with conflicts for both clinicians and patients. When a young woman wants to terminate her pregnancy, or asks for help in deciding whether or not to do so, the interviewer will be wise to approach the matter objectively, obtaining all possible information which will be most helpful in discussing this option with the patient. The clinician who is opposed to abortion may wish to refer the patient to a colleague for assessment. The interviewer must ascertain why the patient seeks an abortion and whether there are medical indications or contraindications for this procedure. Equally important are questions about the patient's understanding about alternatives to abortion such as adoption, and whether these have been considered. As indicated earlier, the interviewer should know whether the abortion is the patient's idea or whether it is being advocated by someone else. For example, a patient's partner may be the one who is insisting on the abortion, or the patient may be seeking the abortion without informing her partner of this decision. It is particularly important to understand the patient's psychological state and the ways in which she feels that an abortion will affect her relationship. For example, a patient may fear that she will lose her partner if she *has* an abortion, while another patient may fear that she will lose her partner if she *doesn't* have an abortion.

Patients often have poor understanding about abortion, including fears that they may be permanently damaged or that abortion is illegal. Questions about abortion are appropriate for women who are actively seeking abortion as well as for women who may have had abortions in the past. These women often feel guilty or fear that they have damaged their reproductive systems.

Vignette #42: A 42 year old married woman who was undergoing treatment for infertility presented to a psychiatrist with symptoms of anxiety and depression. After many sessions which

focused on the woman's disappointment at not being able to conceive a child, the psychiatrist asked about whether the woman had had an abortion in the past. The woman revealed that she had become pregnant at the age of 36 but that her husband had not felt emotionally ready to have a child and had pressured her into having an abortion. She remembered that the obstetrician who had performed the abortion had wondered why she was having it and warned her that she might regret it later. She realized how angry she was at her husband and how this unexplored anger about her abortion was affecting her current mood and anxiety level.

The clinician needs to appreciate that despite the fact that the abortion was elective, patients will still need to grieve the loss of the pregnancy. Feelings about this loss may impact the patient at the time of the abortion, as well as many years later. Whether discussing a pending abortion or one that occurred in the past, the interviewer should remain sensitive to the fact that many patients and their families hold very strong views about abortion.

Miscarriage or Spontaneous Abortion

Pregnancy loss through miscarriage may also affect a woman's sexual functioning. Sustained grief may require brief counseling. Clinicians may not appreciate the need to grieve the loss of the pregnancy through spontaneous abortion. In addition, some patients may have the mistaken notion that sexual activity caused a miscarriage, and may thus be inhibited sexually during subsequent pregnancies. Clinicians should be sensitive to these fears and should address them straightforwardly with both members of the couple.

Birth

The event of birth itself and its after-effects may dramatically affect a couple's sexual functioning. Couples are generally advised to abstain from sexual activity for several weeks after parturition, and this may lead to frustration and a feeling of alienation in one or both partners. This may be compounded by the couple's exhaustion from sleep deprivation if the newborn is restless. One or both members of the couple may have feelings that their intimacy has been intruded upon by the new baby. In addition, new fathers and partners who have not given birth often feel excluded from the mother-child bond during the post-partum period, and may feel neglected. Women who have had a Cesarean section, as well as women who have had other complications of birth may even have more difficult post-part periods, requiring longer periods of sexual abstinence. Clinicians should remember to attend to these issues in single mothers, as well as those who are members of a committed couple.

Women frequently experience emotional changes after birth. These range from emotional lability to post-partum depression. Such feelings may decrease libido and further affect the couple's sexual life. Women who are experiencing mild post-partum blues or frank major depressions should be asked about changes in libido, and the woman's partner may also need help in sorting out feelings about the couple's altered sexual life. As suggested above, some women also feel that breast feeding alters libidinal desire.

Vignette #43: A man presents to his internist with the fear that he has contracted herpes and could pass it on to his wife. He is extremely anxious, and although no lesions are found, he cannot be reassured by the clinician. Further inquiry on the part of the doctor reveals that the couple has not had intercourse since the man's wife gave birth to their first child five months ago. Although the man had never been unfaithful in the past, in the last month he had been very flirtatious with a woman at work and had intercourse with her once. His guilt about this affair, his resentful feelings toward his wife and their child, and his sexual frustration were very difficult for him to talk about, however he felt very relieved to have someone ask about his feelings.

Infertility

The experience of infertility can have a dramatic effect on a couple's sexual function. One or both partners may feel inadequate, or one partner may blame the other for infertility problems. Such dynamics will almost certainly impact on the couple's sexual life. The emotional stress of undergoing a work-up for infertility, as well as the constant disappointment of not being able to become pregnant may distance the partners from one another and diminish their capacity for sexual intimacy. The many high-tech maneuvers to which couples may turn in their quest to become pregnant, such as temperature charts, oral and injectable medication, and artificial insemination, may invade the couple's intimate life, disrupting their usual interest in sexual activity. The interviewer will want to explore the couple's response to having sex go from being a "treat" to a "treatment." Men and women frequently react differently to infertility, and their individual reactions should be explored. The interviewer will want to obtain a full history of the couple's infertility problems, including any medications or procedures which the couple has undergone. Some of the medications which are used for infertility may physiologically affect libido, with obvious effects on sexual life. It is important for the interviewer to remember that not only married people have infertility problems: many single men and women, as well as gay and lesbian couples, may seek help with fertility through artificial insemination. Couples who seek sperm and/or egg donation may also have feelings about their participation in the process of having a baby which may affect their sexual function.

Vignette #44: A man in his forties whose sexual partner has been undergoing a work-up for infertility presented to a sex therapist with complaints of impotence. He stated that he felt guilty

because he was not able to produce the sperm specimens that his partner needed for insemination, nor could he have an erection so that they can have intercourse during her fertile periods. He ultimately realizes that he feels depressed after learning that his sperm count was very low, and that he resents being used as a “sperm bank.”

Many men and women feel that their doctors are not sensitive to the emotional problems which may accompany the experience of infertility. On the other hand, some doctors may mistakenly attribute all emotional changes to reactions to infertility, rather than realizing that the extreme hormonal changes which are induced in women may dramatically affect their moods.

Vignette #45: A 38-year-old woman who was undergoing treatment for infertility with injected hormones was referred to a psychiatrist by her gynecologist. She had symptoms of insomnia, irritability, and mood lability which the gynecologist attributed to upset about the infertility work-up. On further investigation, the psychiatrist discovered that these symptoms only occurred during the days when the patient was injecting herself with the hormones. The intervention included patient education about the physiologic effects of hormone therapy, as well as a call to the gynecologist to discuss the ways in which the treatments themselves were affecting her patient.

Menopause

The physiologic changes accompanying menopause often have important effects on a woman's sexual function. The interviewer should ask women over the age of 45 whether they have had any symptoms of menopause, and about the ways in which these symptoms may have affected their sexual activity. Many symptoms of hormonal changes, such as vaginal dryness, may affect the experience of intercourse because of pain or discomfort. Depression or mood changes during this time should also be investigated, and their impact on sexual functioning should be discussed.

Vignette #46: A 55 year old woman presents with the chief complaint that she thinks that she is having a “mid-life crisis.” She feels no interest in having sex with her husband and wonders if after thirty years of marriage she has fallen out of love with him. Further questioning reveals that her sex drive has diminished and she has recently begun to have hot flashes, which she neglected to tell the interviewer at first because she is upset at the prospect of beginning menopause. Once she has broached the topic, she reveals that she has noticed changes in her external genitalia which have made intercourse painful.

Women may have questions about hormone replacement, or, on the other hand, they may not be aware that oral hormone replacement or topical hormone therapy may alleviate many unpleasant symptoms. Patients may also have concerns and misconceptions about hormonal therapy, including questions about efficacy, side effects, and possible linkages to cancer.

Concluding Comments

Talking to patients about sex is often a matter of life and death. The student who approaches each patient as a human being with a sexual life will always remember to attend to the patient's sexual function. This assessment should be as non-judgmental as possible, and the clinician should try as much as possible to gear the interview to the particular situation and to the demographics of the individual patient. We hope that this guide has demonstrated ways to approach this all important assessment in a variety of circumstances. We also hope that this guide helps students to acknowledge the anxieties which attend to talking to patients about sex, and that it may make them more inclined to seek help from others when having difficulties in this area.

Appendix 1

The Sexual Review of Systems (A Brief Sexual History)

I. General Information about Sexual Activity and Sexual History

- A. Is the patient sexually active?
- B. Patient's sexual orientation
- C. Multiple Partners– present and/or past
- D. Practice of “safe sex practices”
- E. History of sexual abuse, rape, or other trauma
- F. History of sexually transmitted diseases, including HIV, herpes, syphilis, venereal warts, or gonorrhea
- G. Medications– over the counter and prescriptions
- H. History of alcohol and drug use
- I. General medical history

II. Sexual function

- A. Men– ask about change in functioning or problems in the following areas:
 - 1. Libido– Interest in Sexual Activity, Sexual Excitement
 - 2. Erectile Function (if problem exists ask about the following):
 - a. premature ejaculation
 - b. retrograde ejaculation
- B. Women– ask about change in functioning or problems in the following areas:
 - 1. Libido– Interest in Sexual Activity, Sexual Excitement
 - 2. Physiologic Signs of Excitement, such as lubrication
 - 3. Capacity for Orgasm (if problem exists ask about the following):
 - a. primary anorgasmia– patient has never had an orgasm
 - b. capacity for orgasm during masturbation
 - c. capacity for orgasm during sexual activity with a partner
 - d. vaginismus– pain during intercourse

4. Menopausal changes, if applicable

III. Contraception– applicable for men and women

- A. Type of contraceptive used (include rhythm method and abstinence) and others used in the past
- B. Patients' understanding of how to use the method
- C. Satisfaction with the method
- D. Understanding of condom use for “safe sex practices”

IV. Reproductive History– applicable for men and women

- A. History and number of pregnancies (including miscarriages, abortions)
- B. Number of children
- C. History of fertility problems

Glossary

Amebiasis	A disease caused by a one-celled parasite called <i>Entamoeba histolytica</i> . May be contracted via contact with contaminated stool through contaminated water or food. May be contracted during sex which involves contact with contaminated stool (such as mouth to anus contact). Symptoms include diarrhea, stomach pain, and stomach cramping.
Anorgasmia	One of the orgasm disorders: The inability to achieve orgasm
Antidepressants	Drugs used to treat depressive disorders
Anxiolytics	Drugs that have an antianxiety effect and are used widely to relieve emotional tension. The most commonly used antianxiety drugs are the benzodiazepines
Aphrodesiac	Something which is thought to arouse or increase sexual desire
Contraceptive	Any device or drug used for the intentional prevention of fertilization of the ovum.
Dyspareunia	One of the sexual pain disorders: refers to genital pain, in either a male or a female, before, during, or after sexual intercourse that is not due to a general medical condition, drugs or medication
Endometriosis	The growth of endometrial tissue in abnormal locations, as on the ovaries or within the peritoneal cavity. It can result in pain and infertility.
Estrogen	any of several female sex hormones
Giardiasis	Illness caused by <i>giardia lamblia</i> , a one celled parasite. Usually contracted through contaminated food or water. May be contacted via sexual activity involving mouth to anus contact. Symptoms include diarrhea, abdominal cramping, and nausea.
Gonorrhea	A sexually transmitted disease caused by gonococci, characterized by inflammation of the mucous membrane of the genitourinary tract
Hepatitis B	Inflammation of the liver caused by the Hepatitis B Virus (HBV). May cause lifelong infection, cirrhosis, liver cancer and liver failure. May be contracted via sexual contact. A vaccine is available.
Herpes	

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Hysterectomy	The surgical removal of all or part of the uterus
Impotence	The inability to achieve or maintain a penile erection of sufficient quality to engage in successful sexual intercourse; male erectile disorder. Two types are described by Masters and Johnson: in primary impotence, there has never been a successful sexual coupling; in secondary impotence, failure occurs following at least one successful union.
Lesbian	Homosexual woman
Major Depression	A depressive disorder characterized by significant lowering of the mood tone and loss of interest or pleasure in daily activities, plus a range of other symptoms that may include significant weight or appetite changes, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue or loss

of energy, feelings of worthlessness or excessive and inappropriate guilt, diminished ability to think or concentrate, indecisiveness and recurrent thoughts of death or suicide.

Multiple personality Disorder

renamed Dissociative Identity Disorder in DSM-IV. It consists of the existence within one person of two or more distinct personalities or personality states. Each personality state has its own relatively enduring pattern of perceiving relating to, and thinking about the environment and the self, and at least two of them alternate in taking control of the person's behavior. Characteristically, there is an amnesic barrier between personalities, which may be absolute or, more commonly, unilateral, denying one personality access to the memories of the other, but allowing the other personality full access to the memory systems of both.

Neuroleptic

An antipsychotic drug

Oophorectomy

The removal of one or both ovaries

Organic Brain Syndrome

Renamed organic mental disorder in DSM-IV. A condition showing behavioral or psychological symptoms that is secondary to or based upon detectable disturbances in brain tissue functioning. These include delirium, dementia, and amnesic disorders.

Orchiectomy

The surgical removal of one or both testicles: castration

Orgasm

Sexual climax; peak psychophysiological response to sexual stimulation

Personality Disorder

Enduring patterns of perceiving, relating to, and thinking about the environment and oneself that begin by early adulthood and are exhibited in a wide range of important social and personal contexts. These patterns are inflexible and maladaptive, causing either significant functional impairment or subjective distress.

Posttraumatic Stress Disorder (PTSD)

An anxiety disorder in which exposure to an exceptional mental or physical stressor is followed, sometimes immediately and sometimes not until 3 months or more after the stress, by persistent reexperiencing of the event, avoidance of stimuli associated with the trauma or numbing of general responsiveness, and manifestations of increased arousal. The trauma typically includes experiencing, witnessing, or confronting an event that involves actual or threatened death or injury, or a threat to the physical integrity of oneself or others, with an immediate reaction of intense fear, helplessness, or horror.

Reexperiencing the trauma may take several forms: recurrent, intrusive, and distressing recollections (images, thoughts, or perceptions) of the event; recurrent distressing dreams of the event; sudden feeling as if the event were recurring or being relived (including dissociative flashback episodes); or intense psychological distress or physiological reactivity if exposed to internal or external cues that symbolize or resemble some part of the event.

The affected person tries to avoid thoughts or feelings associated with the event and anything that might arouse recollection of it. There may be amnesia for an important aspect of the trauma. The person may lose interest in

significant activities, feel detached or estranged from others, or have a sense of a foreshortened future.

The person may have difficulty falling or staying asleep, be irritable or have angry outbursts, experience problems concentrating, and have an exaggerated startle response.

Premature ejaculation	One of the orgasm disorders: Undesired ejaculation occurring immediately before or very early in sexual intercourse.
Prostatectomy	The surgical removal of all or part of the prostate gland
Salmonellosis	A bacterial infection caused by the bacteria <i>salmonella</i> . Contracted via contact with contaminated feces. May be contracted via sexual activity which involves mouth to anus contact. Symptoms include diarrhea, fever, and abdominal cramping.
Sexually transmitted Disease (STD)	Any illness which can be contracted via sexual contact. Common examples include gonorrhea, syphilis, AIDS, Herpes, and Hepatitis B.
Shigellosis	A bacterial infection caused by the bacteria <i>shigella</i> . Contracted via contact with contaminated feces. May be contracted via sexual activity that involves mouth to anus contact. Symptoms include diarrhea (which can be bloody), fever, and abdominal cramping
Spermicide	A substance that kills sperm: often used with a barrier method of contraception (such as a condom or diaphragm)
Substance Abuse	Impairment in social and occupational functioning resulting from the pathological and compulsive use of a substance. The concept is closely related to the definition of substance dependence, which has similar symptoms of impairment but may include evidence of physiological tolerance or withdrawal. Typical symptoms of abuse include failure to fulfill major role obligations at work, school or home; recurrent use of the substance in situations where such use is physically hazardous; substance related legal problems; and continued use even though it causes or exaggerates interpersonal problems.
Syphilis	A sexually transmitted disease caused by the spirochete <i>Treponema pallidum</i> ; if untreated, it can ultimately lead to the degeneration of bones, heart, and nervous tissue.
Vaginismus	One of the sexual pain disorders: refers to recurrent or persistent involuntary spasm of the musculature of the outer third of the vagina severe enough to interfere with coitus
Vaginitis	Inflammation of the vagina
Vasectomy	Surgical removal of all or part of the vas deferens, the duct which conveys sperm from the testicle to the ejaculatory duct of the penis. When successful, this operation renders the man infertile.

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