Appendix II

First Assessment Interview With A Solo Patient

(The following is a compilation of several taped and edited interviews with different patients, together with comments on what was said by me and why. Names and other identifying information have been changed for confidentiality purposes.)

Comment: The patient is greeted in the waiting room where there is an exchange of names and handshakes. I then usher the patient to my office. My first order of "business" is to explain the process; the second is to obtain some "identifying information" (see Chapter 6).

WLM: I'd like to meet with you today and for one or two more visits in the near future. Each visit will be for a bit less than an hour. The purpose of these first few appointments is to establish as clearly as possible the reasons for coming here, what sort of help you are looking for, and what I could do to be of some assistance to you. It generally takes more than one visit to accomplish that. When we get to that point, we'll put together the information and decide where to go from there. Is that OK?

Patient: OK.

WLM: I understand that you're here because of sexual difficulties but before getting to that subject I'd like to learn something about you. Tell me something about yourself such as your age, your living circumstances, and how you spend your days.

Comment: I ask people how they are spending their days rather than more directly (initially) about "work." I do this because some people are involuntarily unemployed and feel sufficiently badly about this without me making matters worse with a more direct question. Asking the question this way also circumvents the issue of whether the patient considers the domestic labor of a woman looking after children at home to constitute "work."

Patient: I'm thirty and in my time off during the winter, I'm an avid skier. Otherwise I work as an accountant.

WLM: Do you live on your own or with someone?

Comment: As well as finding out about relationships and other adults at home (e.g., grandparents), this is an indirect way of finding out about children. If necessary, a more explicit question about children can be asked later.

Patient: Now I live on my own. I was living with a girlfriend for 2 years, until we broke up 3 months ago.

WLM: Apart from her, have you had other relationships that involved living with the person?

Patient: No.

WLM: What about sexual relationships with other men? Has that been part of your experience?

COMMENT: I asked a question about his sexual orientation for several reasons: to signal that we could discuss such an issue if he wanted, to consider possible differences in his sexual function with opposite or same-sex partners, and to consider possible sexual practices that would make him vulnerable to STDs and HIV infection.

Patient: Never.

WLM: What's your health like generally? Do you have any major health problems?

Comment: In the context of an assessment of a sexual difficulty, I include questions about health, medications, alcohol, tobacco, and street drugs as part of an introduction, since any of these can have a major influence on sexual function.

Patient: Not really.

WLM: How about STDs or sexually transmitted diseases?

COMMENT: I don't ask this question when a partner is present, since it could pressure the patient into revealing information about past sexual liaisons that he/she might prefer to keep private. I do, however, ask this question when I see patients alone.

Patient: Only once. I got crabs when I was 15.

WLM: Do you take any medications on a regular basis?

Patient: No. Except for vitamins.

WLM: How about alcohol or street drugs, now or in the past?

Patient: Alcohol only once in a while at parties. I use marijuana a few time a year. I drank a lot more for a few years when I was in high school.

WLM: What about tobacco?

Patient: I stopped about a year ago but used to smoke . . . . smoked about 1½ packs a day.

WLM: Since?

Patient: Since I was about 17.

WLM: Have you ever seen any counselors because of sexual or other problems?

Comment: I often ask a patient to retrace the steps that led to a referral to me. A reasonable alternative is simply to ask the patient to state what the major sexual problem is now. The first method described is slightly less abrupt.

Patient: Nope.

WLM: Tell me how you ended up being referred here?

Patient: Dr. Fleming referred me here. He's my family doctor.

WLM: What did you say to him about sexual difficulties that ended up with you being referred here?

Patient: He referred me to a urologist who did some tests. The urologist talked about it being psychological.

WLM: What did you think about what the urologist said?

Comment: The patient never really answered the question that I asked so I quickly changed my approach and followed his replies. His answers had more to do with the process that he followed rather than providing a statement of the problem.

Patient: I don't know really. I didn't completely understand what he was saying. You know, I've been thinking about this for a long time. This problem goes back a long way.

WLM: When do you figure it started?

Comment: I generally start an inquiry about sexual difficulties by finding out what is happening now, (meaning the past month or so) and then comparing this to the "best ever" period in the past. Sometimes (and this was one such time) the flow of the interview

is such that I start my questioning instead around the onset of the problem and work my way forward in time. My attitude about an assessment is that there is a *body* of information that I eventually want to have but that the *order* in which this information is obtained is not crucial. The order is determined more by art than by science. Rigidly following a specific interview formula usually means thinking more about the questions than the answers. This form of interviewing is more typical of TV interviews where follow-up questions take "a back seat" to the interviewer finishing a list of "first generation" questions (a process that is only superficially revealing and inappropriate to the health professional's consulting room).

Patient: Um. I don't know. Maybe eight years ago.

WLM: Eight years ago. What did you notice at that time?

Comment: I returned to asking him about the nature of his difficulty, anticipating that he was now ready to discuss what it was.

Patient: Not being able to maintain an erection, or having an erection and then it going away.

WLM: And you didn't have any problems before that time?

Comment: This is a leading question and also one that is negatively phrased (the worst kind of leading question in my opinion). The question would be better if phrased "and what were your erections like before that time"? One always knows a leading question has been asked when the patient is forced into answering only "yes" or "no". Since patients are often compliant (in the office), they are likely to answer "yes" to avoid offending the health professional, rather than answering candidly. The outcome might be that the interviewer becomes engaged in a circular conversation with him or herself.

Patient: Not that I can recall. That was so long ago. It was an ongoing thing and part of it was just being a man, a man with a macho image. You know, I didn't want to say . . . I didn't want to do anything about it because it was going to go away. Now, this time it cost me a relationship that really meant something to me. So I figure enough is enough.

WLM: I understand how you feel but I want to be sure that I get the time clearer in my mind. It started eight years ago. Did it begin gradually or suddenly?

Comment: It is essential to acknowledge his feelings but one must also obtain his history. Balancing both objectives is part of the art (rather than the science) of interviewing. An attempt to establish whether a problem is lifelong or acquired (Chapter 4) is not always

easy. Sexual problems typically present after having existed for years (rather than weeks or months), and a patient's memory for sexual events many years before is often cloudy.

Similarly, sometimes the onset of the difficulty dates from a specific event but this kind of story is more likely to be the stuff of TV drama. More often than not, the beginning is gradual and the duration may be more accurately described in terms of a range of time, rather than a specific amount of time.

Patient: I'd say gradual but it's been so long I can't remember.

WLM: Looking back, what was the first thing you noticed?

Patient: I couldn't get an erection.

WLM: In any sort of situation?

Comment: I asked a leading question again. It would have been better to ask: "In what kind of situation?"

Patient: More or less. Well, no, not really. It would be there sometimes, and sometimes it wouldn't.

WLM: Did it follow any pattern?

Patient: No, not really.

WLM: What about your experience with erections recently. Are there times when you don't have problems?

Comment: I switched the time period about which I was asking questions, from the past to the present, partly because of the patient's lack of precision about the past but also to clarify what was occurring nowadays.

Patient: No. If I did get an erection it would be just like I was suffering from premature ejaculation.

Comment: I tried to determine whether the erection difficulty was situational or generalized (Chapter 4). In the process, the whole issue became more complicated with his statement that there was another sexual problem, this one relating to his ejaculation.

WLM: Please explain what you mean.

Patient: There were times we tried to make love and I wouldn't even be hard yet, and then when I did get an erection, it wouldn't last long at all before I'd ejaculate.

WLM: Are you saying that there were two different problems?

Patient: That only happened in the past year. But the main thing was . . . you know . . . sometimes you pass it off . . . you had too much to drink and all that. But that wasn't the case. I was living with this girl for two years and I'd get an erection and we'd go to bed and I'd lose it.

WLM: Within what period of time?

Patient: I don't know. We'd be going through the act of foreplay and during that, I seemed to lose it.

WLM: Gradually?

Patient: It wouldn't soften right up but it wouldn't be hard either.

WLM: Could you still have intercourse even if your penis became softer?

Patient: Sometimes.

WLM: So when was the last time you actually entered her vagina?

Patient: You mean successfully? Like coming inside?

WLM: OK. When was the last time you ejaculated inside her vagina?

Comment: The patient used the slang word "come." I chose to remain with the medical/technical language for reasons explained in Chapter 2.

Patient: About six months before we broke up. I managed to enter some other times but I'd usually fall out before coming.

WLM: When you talk about not having an erection with . . . can I ask you her first name?

Comment: These questions were an attempt to clarify what recently occurred in relation to intercourse with his partner. It is not so unusual for answers to be frustratingly unclear. An interviewer may have to accept that, especially in an initial assessment visit.

Patient: Jane.

Comment: In establishing the erectile problem as

WLM: On a 0 to 10 scale where 0 is completely soft and 10 is hard and stiff, what were your erections like when you'd be with Jane?

generalized or situational (see Chapter 4), I ask about erections with a partner, masturbation, and sleep or on awakening in the morning. I also obtain a description of the fullness of the patient's penis when he's aroused using a 0 to 10 scale. These questions are quite specific, as are the answers.

Patient: About 5/10.

WLM: Was that at the beginning of a sexual experience or when you'd try to enter her vagina?

Patient: At the beginning. It got softer later.

WLM: What about when you masturbate? Is it any different then?

Patient: I don't do that very often but, no, it's just the same.

WLM: What about when you wake up in the morning? What is your penis like then?

Comment: I should have also asked the patient to specifically describe his present A.M. penis status using the same 0 to 10 scale.

Patient: I used to wake up almost every morning with an erection. Not anymore.

WLM: When did that change?

Patient: A couple or three years ago.

WLM: Do you wake up at night for any reason?

Patient: No, hardly ever.

Comment: If he had, I would have been able to include questions about sleep erections to what I had asked.

WLM: When your erections were full a few years ago, did you notice any bending to one side or another?

Patient: No.

Comment: An infrequent problem causing erectile difficulties is Peyronie's Disease, where a growth of fibrous tissue in a particular area of the penis usually causes bending or pain (or both) when an erection occurs. Since patients are so often embarrassed to bring up problems such as this, I took the initiative in asking him this question.

WLM: Have you noticed any problem with your sexual desire or interest since this trouble began?

Comment: I reviewed aspects of his sex response cycle that I didn't already know, and her's as well (see Chapter 4). These, too, are highly specific questions and the answers relatively easily formulated by patients.

Patient: No.

WLM: What about before?

Patient: No.

WLM: What about your ejaculation, apart from it being fast in the past year as you mentioned before?

Patient: No problems.

WLM: Is it the same as it was before?

Comment: I asked a leading question yet again. It could have (and should have) been phrased: "What was it like before?"

Patient: Yes.

WLM: Can I ask you some questions about Jane and how she managed sexually?

Comment: I used the "permission" technique for reasons explained in Chapters 2 and 3.

Patient: Yes.

WLM: Were there any difficulties with her sexual desire or interest?

Patient: No.

WLM: Any problems becoming vaginally wet when she was interested?

Patient: No.

WLM: Problems coming to orgasm?

Patient: Well, yes.

WLM: Tell me about that.

Comment: I asked this (and previous questions about the sex response cycle of his partner) to find out if *she* had sexual difficulties and the extent to which *he* might have contributed to these.

Patient: Whenever we had sex, I couldn't perform long enough.

WLM: Since?

Patient: The beginning.

WLM: Let me make sure I understand what you are saying. You felt there was a problem the whole time you were together?

Comment: I assumed he was talking about his ejaculation rather than his erection but I should have clarified that.

Patient: Yes.

WLM: What were your feelings about all this?

Comment: I temporarily side-stepped the details of her orgasm and his (presumed) ejaculation problem to talk to him about his present feelings, his reaction to his problems (see Chapter 4), and his communication about sexual issues with Jane, all of which seemed to be major areas of difficulty.

Patient: I hated it. It didn't make me feel like a man.

Comment: It is quite common to hear negative comments about masculinity from men with erection difficulties that are substantial enough to interfere with intercourse.

WLM: Did the two of you ever talk about your sexual troubles together?

Patient: We did. At first, she thought it was her, and then I had to keep reassuring her.

WLM: Was there any one time together that sticks out in your mind?

Patient: One time she said "Oh, why do you bother?"

WLM: I don't know if you're a quiet sort of person ordinarily but you seem pretty much so today and not a man of many words. I was wondering if that's the way you usually are, or if it's because of the way you're feeling today?

Comment: Sometimes, an interviewer must put aside the "sexual agenda" to discuss something else that takes priority. This was one such instance. I could have asked him about how he responded to Jane's comment and how he felt but sensed at that moment that his mood was sad. I chose to follow his feelings rather than obtaining more details about the encounter we were discussing.

Patient: I'm not usually loud, but I'm sure it's got something to do with my mood.

WLM: What's your mood been like?

Comment: I felt it important to find out about his present mood state and to search for some of the common accompaniments of depression, since he quickly let me know that he had experienced some aspects of a depressive syndrome. He seemed to have gone through a grief reaction to the loss of a relationship that he prized.

Patient: Down in the dumps for a long time.

WLM: Since?

Patient: Since we broke up.

WLM: Whose idea was it to break up?

Patient: Hers.

WLM: What did she say?

Patient: We had a big fight, and she said "my feelings for you are not the same as before." And that was it.

WLM: Did sex come into the discussion?

Patient: No.

WLM: What part do *you* think it played?

Comment: When a relationship has just ended, many solo men with sexual difficulties often blame this event on "sex." Clinical experience should make one skeptical of this explanation. Obtaining a more balanced perspective often becomes a therapeutic objective.

Patient: It was related.

WLM: You sound pretty sure about it.

Patient: No question about it. If I was with a woman and she didn't . . . I wouldn't like it either.

WLM: You said you were down in the dumps. Tell me a bit more about how that feels.

Patient: I think about her all the time and I think about the past. I think of her going with other people and that I'm never going to see her again.

WLM: You sound really sad. Sometimes when a person feels down, certain parts of their lives don't work the same as before. For example, some people find that their sleep has changed. Has that been your experience?

Comment: This is an example of the statement/question technique (see Chapter 2) used in a nonsexual context.

Patient: It's a lot better now, but it was really bad.

WLM: When?

Patient: For about a month after we broke up. I wasn't eating either. I lost about 20 pounds. My appetite's better so I've gained some of that back.

WLM: What was your energy level like then?

Patient: I've gotten back to playing sports, which I really love. For a while I wasn't doing anything. Not even seeing my friends.

WLM: Did it ever get so bad that you felt life wasn't worth living?

Patient: If you mean did I think about suicide, the answer is "no."

WLM: Sometimes a person in that situation feels that they wouldn't mind if something happened to them—not that they would do anything to bring about their own death. Did you feel that way?

Patient: I suppose so.

WLM: Feel that way nowadays?

Patient: Not in the past few weeks.

WLM: Did you ever do anything to try to kill yourself?

Patient: Never. I like life too much.

WLM: Just one other question about this. Has anything like this ever happened to you before?

Patient: No.

WLM: I'd like to go back to talking about sexual problems. Is that OK?

Comment: Having reassured myself that depression was not an issue that required my immediate attention as a matter of priority, I returned to questions about his sexual concerns.

Patient: Sure.

WLM: Were there times when the two of you agreed not to have intercourse but rather to engage in other sexual activities, since intercourse seemed always to be a problem?

Comment: Non-intercourse sexual activities are sometimes vital to couples when vaginal entry is difficult or impossible. Questions about this become indispensable in such a situation.

Patient: Well, yeah. Do you mean did she masturbate me?

WLM: That might be one thing that might happen, that you might stimulate one another to the point of orgasm using hands or mouths and without trying to put your penis inside her vagina.

Patient: She did it for me . . . using her hands . . . and her mouth . . . but I wasn't fully hard.

WLM: Never?

Patient: Never in the past three years. And she'd use her . . . what's the word for it . . . her female parts?

WLM: The wet area between her legs?

Patient: Right.

WLM: That general area is referred to as the vulva. Apart from that, what effect did that have on you?

Patient: None, erection-wise. It would be semi-hard. I'd ejaculate.

WLM: Were you ever fully hard then?

Patient: No.

WLM: Would you sometimes enter her vagina?

Patient: Yes.

WLM: Was it ever in your mind that you'd become hard but continue to stay outside?

Comment: It is important to establish what was taking place in the patient's *mind* in anticipation of having intercourse. Evidently, this was not the same as what he stated earlier about having planned times together when intercourse wouldn't occur. In his mind, intercourse was always an objective and so "performance anxiety" was always present.

Patient: Are you kidding?

Comment: Again, I used the statement/question technique described in Chapter 2.

WLM: Not really. But let's discuss the reasons for doing that later. I'd like to ask you more about your ejaculation. I'm a bit confused about how long the fact

of you ejaculating quickly has been a problem for you. For some men it's a problem right from the first attempt at intercourse. For others, it begins later. What's been your experience?

Patient: I used to have control over it. That's a long time ago though.

WLM: On the basis of time, how long would you usually last nowadays?

Patient: A couple of minutes. I was thinking in my mind, "Oh, I'm going to lose it."

WLM: What about with masturbation? Is there a problem with control of ejaculation when you're masturbating?

Patient: No.

WLM: If you judge by the number of pushes or thrusts when you're having intercourse, how many could you manage before ejaculating?

Patient: Oh, about 20.

WLM: Would you stop or rest along the way, or would you continue moving from the time you entered her vagina until you ejaculated?

Patient: Stop and go slower.

WLM: Who thought you were fast, you or Jane?

Patient: I did. But she did too.

WLM: What about before Jane? Was that a concern of other sexual partners?

Patient: To tell you the truth, I can't remember. There was this other girl I used to go out with. It didn't last long then either. We are talking way back. With Jane, I didn't have an erection all that many times. Time would go by. Weeks and months.

WLM: What would happen in those weeks and months?

Patient: Nothing. Like a normal life and then when we were in bed she didn't really want to try.

WLM: Are you saying that months would go by without any kind of sexual activity?

Patient: Right.

WLM: When you say months, how long are you actually talking about?

Patient: A month or two.

WLM: Would that include touching each other to the point of orgasm without having intercourse?

Patient: Yeah.

WLM: How would *she* feel about all of this?

Patient: If you're getting to the point that it was something to do with me and her, it's not that.

Comment: I was trying to establish what *her* reaction was to the fact of his sexual difficulties. He couldn't answer this since he didn't know. He was probably so troubled about his own feeling of responsibility for their difficulties that he was unable to be sensitive to her concerns.

WLM: People tend to look for explanations for things that don't go right in life. Have you tried to look for an explanation for your own sexual troubles?

Patient: I don't have one. I don't know what the problem is.

WLM: How much of these problems have you described to your family doctor?

Patient: Not much.

WLM: I would guess that you've been living with this without talking too much to anyone.

Patient: That's right.

WLM: Are there some important things that would help me to understand your difficulties that we haven't talked about today?

Comment: I was beginning to close the interview, and have found that this general question is useful at this point.

Patient: No.

WLM: How have you felt about talking here today? Some of my questions have been pretty explicit.

Comment: I think it is often useful to assess the level of nervousness someone feels after talking for some time. It is quite usual for this to diminish over the

period of the first visit as the patient gains trust in the interviewer and the process. If initial anxiety does not decrease, the health professional has to think about the reasons. Likewise, if a patient claims not to feel nervous right from the onset of the interview, one has to be somewhat skeptical (given our cultural proscriptions against talking in detail about anything sexual).

Patient: Well, they have to be asked, don't they?

WLM: Yes. But that doesn't mean it's easy.

Patient: I realize that. It's a bit embarrassing but I need help so I guess I have to answer.

WLM: A bit embarrassing or a lot?

Patient: I realize it won't go past here. My feelings are that you have to open up. I want to get help. At first I was nervous. I feel better now.

Comment: I thought that the patient may have been implicitly asking for reassurance about the confidentiality of our discussion.

WLM: Indeed, what we talk about is quite confidential. I can't release any information about you without your permission. In addition, everyone's nervous when they come here. No one quite knows what to expect. It's normal to feel that way. I know it's a difficult subject to talk about. People don't usually talk about sexual matters with friends or relatives, much less a stranger like myself. You've done quite well today.

There was one question I forgot to ask you earlier. When was the last time you had a full, stiff, hard erection under any circumstances?

Comment: Almost always an interviewer forgets to ask something of importance during a first visit. There is usually no problem in stating candidly that a topic was unintentionally omitted. The one exception to this is raising an emotionally laden subject at the very end of the interview and having the patient depart from the office upset and possibly in tears. This is unfair to the patient and may result in that person becoming angry at the interviewer at some later time.

Patient: I can't remember. It's been so long.

WLM: More than three years ago?

Patient: Yes.

WLM: Over the past eight years, have you had sexual experiences with other women before Jane?

Patient: Two or three.

WLM: What were your erections like with them?

Comment: I previously asked about his ejaculation with other partners but (unfortunately) not his erections.

Patient: The same as with Jane.

WLM: And before that?

Patient: I had girlfriends but I could get it up without problem.

WLM: We've covered a lot of territory today. I'd like to meet with you again as I mentioned earlier. Is that OK?

Patient: Do you think you can do anything?

Comment: A fair question, and one that is on everyone's mind even when walking into the office of a health professional.

WLM: I believe that I can, but it's difficult for me to answer that question precisely now since I don't know you well enough or have a sufficiently clear idea of the history of your difficulties. I'd like to talk more with you and, perhaps, examine you and order some tests. Then, I'd be in a better position to answer your questions. I *can* say that erection problems are very common and that some very useful ways exist to help people with such troubles. Talking as we did today is usually helpful by itself, since there are so few opportunities for any one of us to talk as openly about sexual subjects as *we* have.

Patient: That's true. I do feel better about that part.

WLM: How much reading have you done about men and sex and sexual problems?

Patient: Not much.

WLM: What would you think if I suggest a pocket book for you to read?

Patient: I'd like that.

WLM: Good, I'll write down the title and author for you and maybe we can discuss the book next time.

Patient: OK.

WLM: I'd like to meet with you again next week. . . .