CHAPTER 1

TALKING ABOUT SEXUAL ISSUES: HISTORY-TAKING AND INTERVIEWING

Significant obstacles exist between the clinician's capacity to ask a question and the patient's capacity to respond. Whereas comprehensive knowledge is required of the cardiovascular system to cover all the symptom bases, these questions are typically asked without anxiety or inhibition once the questions are memorized and their rationale understood. Similarly, the patient experiences little or no hesitancy in responding truthfully to these paths of inquiry. The same milieu does not generally exist with sexual history taking.

GREEN, 1979[1]

Other than descriptions of interviewing methods used by researchers[2] and opinions of specialist-clinicians who treat people with sexual difficulties,[3] health professionals have little guidance on the subject of talking to patients about sexual issues. Less still is any direction given to primary care clinicians for integrating this topic into their practices. For guidance on sex-related interviewing specifically, the primary care clinician may want to begin by examining clinical research in the general area of interviewing, as well as the observations of those who have written about their personal general interviewing ideas and practices.[4]

SOME RESEARCH ON GENERAL ASPECTS OF HEALTH-RELATED INTERVIEWING AND HISTORY-TAKING

As Rutter and Cox stated, "many practitioners have advocated a variety of approaches and methods on the basis of their personal experience and preferences. . . [but]. . . there has been surprisingly little systematic study of . . .interviewing techniques for clinical assessment purposes."[5] Only a few items from the research literature in the area of health-related interviewing are described here.

Direct Clinical Feedback

One interviewing-research question has been the value of direct clinical supervision in the development of interviewing skills generally. While this form of supervision makes sense intuitively, the process has been subject to little research. One study compared the value of direct clinical feedback to medical students using four different techniques: three of them (audio replay, video replay, and discussion of rating forms) were compared to a fourth whereby a student interviewed a patient and subsequently discussed findings (indirectly) with a supervisor.[6] The students who received any of the three *direct* clinical feedback methods did much better. The same individuals were

assessed five years later as physicians and strikingly (since long-term follow-up studies in health education are quite unusual) those who received feedback "maintained their superiority in the skills associated with accurate diagnosis."[7]

In another study, two groups of medical students were videotaped on three different occasions during the school year while performing a history and physical examination.[8] Both groups viewed their own tapes but one group received additional evaluative comments by a faculty member. By the end of the year, those in the latter group performed significantly better in the following:

- Their interviewing verbal performance
- The content of the medical history they obtained
- Their use of physical examination skills

Teaching Interviewing Skills

One might conclude from the findings of both studies that if direct supervision proved superior in the process of learning interviewing skills generally, the same conclusion might be drawn for interviewing a patient about a specific subject such as "sex." The importance of this conclusion can not be exaggerated when one considers the dearth of questions about sexual issues in ordinary health histories. One way to change this situation is to deliberately teach the skill of sex history-taking and interviewing in health professional schools instead of (as now often seems to be the case) seemingly expecting clinicians to absorb this skill in the course of developing their clinical practices.

It may be instructive to also consider a series of studies of interviewing styles that were based on talks with mothers who were taking their children to a child psychiatry clinic.[5,9-14] These interviews were conducted by experienced health professionals. Four experimental interviewing styles were compared for their efficacy in eliciting factual information and feelings. The four were given the following names:

- Sounding board
- Active psychotherapy
- Structured
- Systematic exploratory

The research group concluded that good-quality factual information required detailed questioning and probing, that several approaches were successful in eliciting feelings, and that these two issues were compatible in the sense that attending to one did not detract from the other. Although their findings were related more to the process of interviewing and not specific to any particular topic, their conclusions seemed as applicable to the area of "sex" as with any other. The clinically apparent need for the health professional to initiate sex-related questions when talking with patients (see "Interviewer Initiative" in Chapter 2) echoes the conclusion of these studies that asking detailed questions is more productive. In extrapolating from these studies and insofar as "sex" can legitimately be seen as psychosomatic, there should be no incompatibility in the attention that a clinician might give to the acquisition of information that is factual and related to feelings when talking to a patient about sexual matters.[15]

Another study that examined the proficiency in history-taking generally in second-year medical students also may have implications for sex history-taking.[16] Two methods of measurement were used:

- The Objective Structured Clinical Examination (OSCE)
- A written test

The authors believed that patient information could be divided into three domains:

1. Information required to make a diagnosis
2. Information to determine risk for future disease
3. Information to assess the patient's available support system

The study found that students concentrated on obtaining diagnostic information on both of the tests used and that, unless modeled by faculty, information on risk factors and psychosocial data was omitted. Since sex-related problems are often relegated to the psychosocial arena, an assumption that one might derive from this study is that unless a sexual problem is given by the patient as a chief complaint (and therefore in the "diagnostic" arena) it is unlikely to be detected—unless faculty modeling occurs.

Extrapolations from all of these studies in interviewing and history-taking as far as "sex" is concerned imply the following:

1. Teaching of skills by direct supervision should be included in health science educational programs
2. Direct questions are more productive
3. There is no difficulty in attending to factual information and feelings
4. Faculty modeling is a significant element in the learning process

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INTEGRATING SEX-RELATED QUESTIONS INTO A GENERAL HEALTH HISTORY

Texts on general aspects of health-related history-taking and interviewing reveal great inconsistency in the definition of a "sexual history" and consequently in what is expected of the health professional. Some texts contain little or no information on the subject[17]; others include a separate chapter [1,18-22] or portion of a chapter.[4,23] Complete or partial chapters are usually brief and the information is so concentrated that the content is difficult to use in a practical sense. Some authors focus on "sex" as it relates to a particular psychiatric or medical disorder, for example:

1. Sexual desire in depression[24]
2. Sexual abuse as it relates to dissociation, posttraumatic stress disorder, and somatization disorder[25]
3. The "hysterical" patient[26]
4. Sexually transmitted diseases[27]

Others focus special attention on a particular sexual problem.[21] Some authors recommend asking about the patient's past sexual development[28]; others suggest a focus on current problems.[20] Specific suggested questions are offered by some,[19] and others may

also include a brief rationale for these questions.[29] When questions are suggested, little guidance is usually given on when they should be asked.

"Human Sexuality" textbooks are also of limited help. Some may include a chapter on "assessment" or "sex" history-taking and interviewing.[30-32] Although the quality of information in these chapters may be high, the amount that is squeezed into this one section results in "information overload" and therefore becomes of minimal practical use to the frontline clinician.

Journal articles on sex history-taking provide a similar variety of opinions about what should be included. The advent of HIV/AIDS has pushed physicians into promoting the need for taking a sex history.[33,34] So, too, is the effect on health professionals of the recognition of the frequency of child sexual abuse in the history of adults.[35] Sometimes, history-taking suggestions are in the form of topics to be covered rather than specific questions to be asked.[36]

Among the more informative sources of information on sex-related interviewing and history-taking (but still of limited value to primary care clinicians) are the comments about interviewing that are attached to some of the community based research reports on sexual behavior. Kinsey and his colleagues included a chapter on the subject of interviewing in their volume *Sexual Behavior in the Human Male*.[37] More recently, large-scale "sex" surveys in the United States[38] (see introduction to PART I), the United Kingdom,[39] and France[40] included reports about the interviewing process when outlining their study design (see Table 1-1 for a comparison of some aspects of the three surveys).

Table 1-1 Comparison of Three Major "Sex" Surveys Published in the 1990s

SURVEY ASPECTS	UNITED STATES	UNITED KINGDOM	FRANCE
Government Opposition	Yes	Yes	No
Financial support	Private	Private	Government
Random survey Method	Yes	Yes	Yes
Principal Interview Method	Face-to-face	Face-to-face	Telephone
Completed Interviews	3432	18,876	20,055 (Short: 15,253) (Long: 4820)
Response rate (%)*	79	63.3-71.5	65.5-72
Population age Range	18-59	16-59	18-69
Interviewers Specially trained	Yes	No	Yes
Duration of Interview (minutes)	90	46-60	Short interview: 15 Long interview: 45

*Range depends on method of calculation.

Thus health-related interviewing texts, specialty books on "Human Sexuality," and journal articles are enormously variable in their content when considering sex history-taking and tend to be disappointing in that they provide little aid to clinicians.

STUDIES IN MEDICAL EDUCATION THAT RELATE TO GENERAL ASPECTS OF SEX HISTORY-TAKING

In the 1960s and 1970s, sex education in medical schools concentrated on providing information about "sex" and helping people to be more at ease with the subject. Beginning in the 1980s, some schools added a focus on skills, that is, interviewing and history-taking, or, to put it differently, they added focus on the practical issue of how physicians and patients actually talk about the subject of sex. Attitudes and practices of sex history-taking have been examined from a research viewpoint, and understanding conclusions from these studies may provide some practical direction.

Comfort and Preparedness

Comfort and preparedness in "taking a sexual history" was studied in a group of first-year medical students.[41,42] The idea of including this topic in a medical history, as well as facilitating factors and obstacles, was examined. The authors found that the sexual orientation of the patient seemed an important variable in that students expected to be most comfortable with heterosexual patients of the same sex and least comfortable with an (presumably gay) AIDS patient. The authors also found that "the most consistent predictor of both knowledge and attitudes about sexual history-taking was a student's personal sexual experience." The kinds of experiences that were particularly linked with comfort and preparedness in taking a sexual history were:

1. Having taken a sexual history in the past
2. Having spoken to a health professional oneself about a sexual concern
3. Having a homosexual friend

Age seemed related only to the extent that older students expected to be more comfortable with an AIDS patient.

Practice

The importance of practice was seen in a study of medical students who were involved in different sexuality curricula at two different schools.[43] In one, students were not expected to be involved in sex history-taking. In the other, students conducted a sex history with a volunteer or observed one taking place. The curricula were otherwise similar. The three groups (no interview, conducting an interview, and observing an interview) were assessed regarding knowledge about:

- Sexual issues
- The propriety of including sex-related information in a medical history

- Self-confidence in the ability to conduct the interview

The students who previously conducted a sex-related interview did significantly better than those who were neither participants nor observers. However, findings relating to students who were in the observer group were intermediate on measures of knowledge and perceived personal skill.

The reasons, "why other doctors fail to take adequate sex histories," were determined in another study[44] and include the following:

1. Embarrassment of the physicians
2. A belief that the sex history is not relevant to the patient's chief complaint
3. Belief that they (the subjects) were not adequately trained

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Social and Cultural Factors

Social and cultural factors relating to the patient also seem to influence whether or not a sex history is taken. Sixty emergency room medical records of adolescent girls who complained of abdominal pain that required hospitalization were reviewed.[45] The authors found that asking about sexual issues in the context of an emergency room occurred a great deal more with individuals from minority groups than with white adolescents with the same complaint. They concluded that racial stereotyping was an important factor in asking questions about sexual experiences. Although they supported the inclusion of such questions in an assessment, the authors argued that histories in an emergency room should be characterized by efficiency and a minimum of irrelevant questioning, and that, in spite of the pertinence of questions about sexual experiences to the complaint of abdominal pain in an adolescent girl, such questions were more often omitted in those who were white.

Skills Versus Self-awareness

In a demonstration of the sex history-taking usefulness of direct teaching of skills compared to sexual self-awareness, family practice residents were randomly allocated to two groups emphasizing one or the other of these approaches.[46] Each group received two hours of training. The first hour was common to both groups and involved general counseling skills and information about sexual dysfunctions. In the second hour, the two groups were separated and concentrated on sexual history-taking issues or the comfort and sexual self-awareness of the resident. One week later, residents conducted a videotaped interview with a simulated "patient" with sexual and other problems but who was also instructed to reveal sex-related information only if asked directly. Almost all subjects (11/12) in the skills-oriented group asked the "patient" about the nature of her sexual difficulty, compared to 25% (3/12) of the awareness-oriented group.

Clinical Practice

Physicians in clinical practice (versus medical students and residents in educational programs) also have been studied. In a widely quoted and well-conceived study, a group of primary care internists were taught to ask a set of specific sex-related questions of all new patients attending an out-patient clinic.[47] These physicians were then compared to nontrained colleagues. After the visit, physicians completed a questionnaire and patients were interviewed concerning their encounter with the physician. The following results were noteworthy and instructive:

1. More than half of the patients had one or more sexual problems or areas of concern
2. Age and sex did not influence the prevalence of sexual problems
3. Many more patients (82%) who saw trained physicians were asked about sexual functioning than those who saw untrained physicians (32%)
4. Among both groups of physicians, discussions about sexual issues were more likely if the patient was less than 44 years old
5. Ninety one percent of the entire group of patients thought that a discussion about sexual issues was, or would be, appropriate in a medical context and approval was almost unanimous (98%) among patients whose physician had, in fact, included a sex history
6. Age of the patient was not a factor in the determination of appropriateness
7. Thirty eight percent of the entire patient group thought that follow-up for sexual problems would be helpful
8. Physicians found that, in many instances, the sex history was helpful in ways other than simply as a means to identify sexual problems or concerns

In summary, medical students, family practice residents, and physicians in clinical practice in the community have all been studied on the issue of sex history-taking. The following factors appear to influence the learning process:

1. Having talked to patients about sexual issues in the past
2. Having a sexual problem oneself and having discussed it with a health professional
3. The sexual orientation of the patient
4. Having a homosexual friend
5. The belief that asking about sexual issues is relevant to the patient's concerns
6. Having received specific training
7. Social and cultural issues

STUDIES IN MEDICAL EDUCATION ON SEX HISTORY-TAKING IN RELATION TO HIV/AIDS

There is little question that HIV/AIDS is the major impetus for the recent teaching of sex history-taking in medical schools and the promotion of sex history-taking among practicing physicians. This development results from the knowledge that sexual activity represents the prime method of viral transmission. Many agree with the statement "that the taking of a candid and nonjudgmental sexual history is the cornerstone of HIV preventive education. . ."[48] Recognition of the crucial position of

physicians in HIV prevention has resulted in several studies of physician sex history-taking practices.

In general, studies of physicians with different levels of medical education and experience (e.g., internal medicine residents, primary care clinicians) and using various research techniques (e.g., standardized patients, telephone interviews) indicate the infrequency and/or inadequacy of history-taking around vulnerability to HIV/AIDS infection and the consequent inability to take preventive measures.[48,49-52] One of these surveys demonstrated that in spite of the finding that 68% of 768 respondents said they had received "human sexuality training" in medical school, only a small minority of primary care physicians routinely screened patients for high-risk sexual behavior.[51] "Sexuality Training" was evidently helpful *after the fact*, since physicians who received this training in their medical education "felt more comfortable in caring for patients known to be infected. . ." with HIV. Another study showed that while self-reports of questions concerning homosexuality doubled and questions about the number of sexual partners tripled, questions concerning sexual practices increased by only 50% over the five years of the project (1984-89).[53] Yet another study demonstrated that only 35% of primary care physicians reported that they routinely (100%) or often (75%) took a sex history from their patients. Less than 20% of those who took histories reported asking questions regarding sexual activities that increase the risk of acquiring HIV/AIDS.[54]

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Two particularly revealing projects involved a visit to primary care clinicians by a simulated patient. In the first study, physicians agreed to participate after being told that a simulated patient would appear in their practice.[55] The "patient" was female in order to include obstetrician-gynecologists. Other than obtaining prior agreement, the "patient" was unannounced. She revealed the following information:

- That she had been exposed to *Chlamydia* by a previous partner
- She expressed interest in engaging in sexual activities with a new partner
- She wanted to talk about concerns regarding STDs generally and HIV in particular

Comparisons were subsequently made between the report of the "patient" and the self-report of the physician on several issues, including risk assessment and counseling recommendations. The greatest discrepancies (all of which involved physicians overestimating their history-taking skills in the opinion of the "patient") occurred with the following topics:

- STD history
- Patient use of IV drugs
- Patient sexual orientation
- Condom use
- Counseling concerning anal intercourse and use of a condom
- Safe alternatives to intercourse

In the second simulated-patient study, the "patient" had a history of engaging in sexual activities that made her vulnerable to HIV/AIDS infection.[56] Physicians were provided with educational materials before the visit. Whether these materials were used or not did not alter the finding that the questions least frequently asked of the "patient" were about oral or anal sex practices, sexual orientation, and the use of condoms. The authors concluded that there was a need for prevention training.

The generic form of "Human Sexuality" training in medical schools seems to result in greater acceptance toward those who already have HIV/AIDS but it is insufficient in *preventing transmission.* Effective preventive behavior by physicians evidently requires more specific curricular intervention that addresses history-taking skills and, in particular, inquiry about patient sexual practices.

From these HIV/AIDS-related studies, one might conclude that the generic form of "Human Sexuality" training in medical schools seems to result in greater acceptance toward those who *already have* HIV/AIDS but it is insufficient in *preventing* transmission. Effective preventive behavior by physicians evidently requires more specific curricular intervention that addresses history-taking skills and, in particular, inquiry about patient sexual practices.

WHAT, THEN , IS THE DEFINITION OF A SEX (OR SEXUAL) HISTORY?

Is taking a sex history by a family physician who has only a few minutes to ask questions about sexual issues and wants to concentrate on, for example, STDs and HIV/AIDS-related sexual behavior the same as for a forensic psychiatrist who is evaluating a patient referred because of pedophilia? Is it the same (in time and content) for a health professional asking questions about child sexual abuse as for an interviewer involved in a population survey in which each interview might take hours to complete? Is it the same for a clinical psychologist or psychiatrist who asks a few screening questions as part of the assessment of a patient who is depressed as it is for a clinical sexologist who is evaluating a couple referred specifically because of erectile problems?

The answer to these questions is obviously "no." In all these situations, the result might be called a "sex history" but the time involved and the questions asked would be quite different. Rather than use the singular, it might be more reasonable to talk in the plural, that is, of sex histories—inquiries that are sexual in nature but differ because of the diverse requirements of the situations. In fact, instead of considering a "sex history" or "sex histories," it may be easier to simply think about the task of talking to a patient about sexual matters.

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A primary care clinician must therefore be skilled in talking to patients about a variety of sexual issues, depending, among other things, on the patient, the problem presented, the amount of time available for questioning, and the context in which the patient is seen.

PRACTICAL ASPECTS OF INTRODUCING SEXUAL QUESTIONS INTO A HEALTH-RELATED HISTORY

Practical aspects of talking to patients about sexual matters can be viewed in the context of the familiar format of why, who, where, when, how, and what. This conceptual

arrangement has been used elsewhere in dissecting this subject but the content here is different.[1] So is the order. Issues that involve the manner in which questions are phrased (how) are considered in Chapter 2, and which questions to ask (what) are discussed in Chapters 3, 4, and 5.

Why Discussion May Not Occur (Box 1-1)

Not knowing what to do with the answer is the most common reason given by physicians for avoiding the topic of sex.

The following may be reasons why discussions of sexual topics in a health care setting do not occur:

1. Not knowing what to do with the answers is the most common reason given by physicians in particular for avoiding the topic of "sex" in medical history-taking. When investigating what this explanation means, two factors become evident:

   - Uncertainty about what the next question should be
   - Perplexity regarding what to offer the patient after all the questions are asked and "Pandora's box" is opened

2. Worry that patients might be offended by an inquiry into this area is a recurrent theme of medical students. In spite of the almost uninhibited media display of sexuality, many people (including medical students and physicians) continue to regard sexual issues as "personal" and are concerned that questions in this area might be regarded as intrusive.
3. Lack of justification is a common explanation given by medical students for the frequent omission of sexual topics from medical histories. However, when some medical problems are presented to a physician, specific aspects of a person's sexual life experience are often the subjects of inquiry (e.g., issues that may be medically relevant). Examples include:

   - Sexual dysfunctions associated with diabetes mellitus[57]
   - Sexual sequelae of child sexual abuse[35]

   Thus it seems as if an association between "sex" and a medical disorder must be *demonstrated* before there is sufficient rationale to include sex-related questions in a medical history. A closely related issue is doubt among some health professionals about the acceptability of sexual issues in health care apart from disorders that affect others (such as STDs).
4. Talking with older patients about sexual matters appears difficult for health professional students. The age of the student may be relevant, since many are much younger than their patients. The student may find that this situation resembles talking with their parents about the subject (an experience that most would not have had and that may be thought of as highly embarrassing if it did occur). Avoidance of discussing sexual issues with older patients is particularly unfortunate because some sexual difficulties clearly become more common with increasing age. For example, menopause in women can result in discomfort with intercourse, which, in turn, is explained by decreased estrogen, resulting in diminished vaginal lubrication.[58] Menopausal women will obviously not be well served by the medical establish-

Box 1-1 Why 'Sex' Questions Are Not Asked

1. Unclear what to do with the answers
   Unfamiliarity with treatment approaches
   - Uncertainty about the next question
2. Fear of offending patient
3. Lack of obvious justification
4. Generational obstacles
5. Fear of sexual misconduct charge
6. Sometimes perceived irrelevant
7. Unfamiliarity with some sexual practices

ment if they are not asked about discomfort or pain with intercourse. Not surprisingly, when women in general are surveyed on the acceptability of talking to a physician about sexual concerns, almost three fourths think that it is appropriate to do so. Moreover, the response seems to be age related in that approval *increases* with age.[59]

5. Magnified concerns about professional sexual misconduct and consequent licensure problems result in reluctance by some health professionals to initiate conversations with patients about sexual issues. The primary organization responsible for medical malpractice insurance in Canada has, in an exaggerated way, cautioned their clients about discussions with patients on the subject of sex and has thereby magnified the already difficult problem of health professional restraint.[60]
6. The appropriateness of sex-related questions in the acute stage of an illness may be viewed by the health professional as a dubious focus because of more pressing patient concerns. An example is when the patient has little opportunity for sexual experiences with a partner (e.g., a situation that occurs when a patient is in hospital). In this illustration, sex is defined narrowly as related only to the function of the genitalia.
7. Unfamiliarity with some sexual practices (e.g., gay patients talking to a heterosexual physician) may restrain the health professional from introducing the topic.

Why Discussion Should Occur (Box 1-2)

Reasons why discussions should occur in a health care setting include the following:

1. HIV/AIDS, as everyone knows, is a *sexually* transmitted disease that is also lethal. It has become a powerful (perhaps, *the* most convincing) stimulus for sex history-taking by health professionals (see introduction to Part I).[61] Considering HIV/AIDS, prevention is, at the moment, the best deterrent. This, in turn, means talking to patients about their sexual practices. As used here, the term *sexual practices* refers to:

Considering HIV/AIDS, prevention is the best deterrent. This means talking to patients about their sexual practices.

- The types of sexual *activities* engaged in by the patient, as well

as the nature of *relationships* with sexual partners
- The characteristics of sexual *partners*
- The "*toys*" (mechanical adjuncts such as vibrators) used in sexual activities
- Methods used to prevent STD transmission and conception

In the words of Hearst: "Responsible primary care physicians no longer have the option of deciding whether to do AIDS prevention; the question today is how to do it. . . ."[62] Health professionals are simply not fulfilling their role if inquiry is not made about sexual practices, and if, in the process, the opportunity for dispensing preventive sexual advice is lost. Physicians, in particular, are thought to be in a unique position to prevent HIV infection, since 70% of adults in the United States visit a physician at least once each year and 90% do so at least once in five years.[51]

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2. Many medical disorders such as depression[63] and diabetes[57] are known to disrupt sexual function. A comprehensive view of such disorders is plainly impossible without also asking how a patient's sexual function is affected (see Chapter 8).
3. Treatments such as surgery[64] or drugs[65] can interrupt sexual function. A health professional should inquire about drug side effects (see Chapter 8 and Appendix III).
4. Inquiry into past sexual events may be essential to understand the nature of a disorder in the present. Such is the case with lack of sexual desire after sexual assault as an adult or child (See Chapters 8 and 9).[66]
5. The observation that ". . .sexual function is a lifelong capacity, not normally diminished by middle or older age" represents a change in social attitudes.[67] The aging of the population translates into increasing expectations by many patients regarding sexual function. These hopes may conflict with the difficulty that many young health professionals experience in discussing sexual matters with older people.
6. Sexual dysfunctions are common, at least on an objective level.[68] So, too, are sexual difficulties. Intuitively, it seems reasonable for a health professional to ask particularly about problems that occur most frequently (sexual dysfunctions and difficulties) as compared to problems that are unusual.
7. On the topic of sex as well as others, health professionals tend to be problem oriented. This book and many others on the same subject admittedly "focus on the darker side. . .more than on its brighter side"[38] (p. 351). However, the "other side" is what happens when "things go right." Laumann and colleagues (see introduction to PART I) addressed this side of sex in their chapter (brief by their own admission) on the association between sex, and health and happiness (pp.351-375).

   Sexual activity and good health are related. Of patients in the Laumann et al. study who had no sexual partners in the past 12 months, most (6% versus 2% of the entire sample) were in poor health.[38] Sexual activity and happiness were correlated. Of those who considered themselves "extremely or very happy" (compared to those who were "generally satisfied" or "unhappy"), three groups of respondents were most prominent:

- Those who had one sexual partner
- Those who had "sex" two to three times per week
- Women who "always" or "usually" experienced orgasm in partnered sex (p. 358)

The association between "sex," emotional satisfaction, and physical pleasure was examined also in the Laumann et al. study[38] (pp. 363-368). Those who found their relationships "extremely or very" pleasurable or satisfying were more often the people who had one (versus more than one) sex partner, especially if the partner was a spouse or there was a cohabitational relationship (p. 364). The authors commented that while "association is not causation (p. 364)," "the quality of the sex is higher and the skill in achieving satisfaction and pleasure is greater when one's limited capacity to please is focused on one partner in the context of a monogamous, long-term partnership"(p. 365).

8. Why not? Masters and Johnson asked this question (still germane more than 25 years later) in a medical journal editorial that did not receive the attention that it seemingly deserved.[69] They were critical of the opinion that physicians apparently needed special justification for asking "sex" questions while paradoxically being taught to ask questions about everything else in the course of a general medical examination. "The biologic and behavioral professions must accept the concept that sexual information should be as integral a part of the routine medical history as a discussion of bowel or bladder function."
9. Not including sexual matters in a health history can sometimes be considered negligent and possibly unethical. An example is the second case history provided in the introduction to PART I. In that instance, the physician (in a "sin" of omission rather than commission) clearly failed the medical dictum of "do no harm."

Almost all patients should be given the opportunity to talk about a sexual concern in a health professional setting.

Who (which patients) Should Be Asked About Sexual Issues?

Almost all patients should be given the *opportunity* to talk about a sexual concern in a health professional setting. Providing such an opportunity

Box 1-2

Why Ask Questions About "Sex"?

1. Morbidity and mortality—STDs and HIV/AIDS
2. Symptoms of illness
3. Treatment side effects
4. Past may explain present problems
5. Function potentially lifelong
6. Dysfunctions and difficulties are common
7. Association with health and happiness
8. Why not?
9. May be negligent if ignored

does not mean asking a "sex" question but rather using a method that involves asking if it's OK to ask a "sex" question (see "Permission" in Chapter 2 and an example of a specific permission question in Chapter 3).

Common sense dictates at least two exceptions to routinely giving everyone an opportunity to talk about sexual issues. First, it obviously does not apply to an emergency setting (unless, for example, the emergency is sexual in nature, such as sexual asphyxia [see Chapter 8 for definition]). Rather it applies to situations such as the first few visits of an "intake" procedure. Second, when applied to physicians, the idea of routinely giving everyone this opportunity relates more to generalists, that is, primary care specialists (e.g., in medicine: family physicians, pediatricians, gynecologists, and internists) and medical specialists whose area of work is directly related to sexual function (e.g., urologists). Providing an opportunity to talk about sexual issues on a routine basis rather than a selective basis does not apply to medical specialty areas such as Ophthalmology and ENT (ear, nose, and throat).

Where (in a health professional history) Should Questions Be Asked About Sex?

Sometimes, a patient spontaneously indicates that a sexual concern is the principal reason for the visit. When this occurs, the sexual problem obviously has priority. However, such information usually has to be elicited carefully. In a medical setting, three different circumstances (not mutually exclusive) exist in which this could happen:

1. The prime location in a medical history for asking about sex-related information is within a Review of Systems (ROS [sometimes referred to as a Functional Inquiry]; see "Permission" in Chapter 2 for an example). A ROS consists of a few questions about each body system to ensure that nothing is wrong with a patient other than the initial complaint(s). In such a context, a few additional questions about sexual concerns could be easily included.
2. Another possibility for the introduction of questions about sexual issues is within a Personal and Social History. For example, in the process of asking about relationships, one could ask about sexual concerns.
3. A sex-related question could be asked during a physical examination (least desirable and an option that is, obviously, unavailable to nonphysicians). For example, one could ask about genital function in the process of examining genitalia. In one sense, this situation is easier for physicians, since it seems that psychological defenses of patients are diminished when their clothes are off. However, the lowering of defenses during a physical examination can be hazardous to the patient because questions about sexual issues can be misinterpreted as a physician's sexual invitation and the patient's misconception could provoke a charge of sexual harassment or misconduct. Although sex-related questions during a physical examination may represent a more efficient use of professional time, the potential for misunderstanding is sufficiently great that this method should be avoided.

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When Should Questions About Sex Be Asked?

Green offered a clear and sensible opinion on when questions should be asked about sexual issues: "The optimal time. . .is not when a patient's initial visit has been prompted by influenza, otitis media and bronchitis. Nor is the appropriate time the anniversary of the physician-patient relationship. . .Delay in approaching the topic communicates discomfort. The effect when 'the subject' is finally broached is comparable to the painfully familiar scene of a father who initiates discussion of the 'facts of life' with his son on his 13th birthday."[1] Generally speaking, the aphorism of 'the earlier the better' should be applied. Screening questions (see Chapter 3) can be introduced after the acute problem that initially led the patient to the health professional has disappeared or is under control.

If a problem is introduced in the process of screening, more detailed diagnostically oriented questions can be asked on a subsequent occasion (see Chapter 4). The diagnostic process may involve a physical examination (see Chapter 6) and the use of laboratory tests (see PART II).

SUMMARY

Extrapolations from studies on general aspects of health- related interviewing and history-taking imply the following:

1. Concerning sexual issues, teaching of skills by direct supervision and feedback should be included in health science educational programs
2. An interviewer can attend to both factual information and feelings
3. Faculty modeling in obtaining information about the patient's psychosocial status and risk factors is a significant element in the learning process

When considering the integration of sex-related questions into a general health history, interviewing texts, books on "Human Sexuality," and journal articles appear to be of limited practical help.

Studies in sex history-taking have involved medical students, residents, and practicing physicians. The studies can be separated into ones that considered sex history-taking in general and those that focused on the specific subject of STDs. In the former group, factors found to be associated with positive attitudes toward sex history-taking and conducting such a history were:

1. Personal sexual experience
2. The belief that such questions were relevant to the patient's chief complaint
3. Feeling adequately trained
4. Confidence in taking a sex history
5. Having previously taken a sex history
6. Having spoken to a health professional oneself about a sexual concern
7. Having a homosexual friend
8. Social and cultural factors
9. Skill training (as compared to personal comfort and self-awareness)

Studies that focused on "sex" history-taking as it applies to HIV/AIDS prevention indicate that relevant questions occur infrequently and inadequately. Previous "sexual-

ity training" appeared to be helpful to physicians in caring for those already infected with HIV but it was insufficient in the process of preventing transmission, which, in turn, required an inquiry into the sexual practices of the patient.

Rather than attempting to define a "sex" history (there are many such definitions), it might be more productive to simply talk about asking questions of patients about sexual matters. One might consider the introduction of such questions under the headings of Who, What, When, Where, Why, and How.

Reasons why "sex" history-taking does *not* regularly occur include:

1. Not knowing what to do with the answers
2. Concern that patients might regard "sex" questions as intrusive
3. Lack of a sense of justification
4. Difficulty in talking to older patients about this subject
5. Concern about accusations of sexual misconduct
6. The sense that such questions are inappropriate in the context of other difficulties manifested by the patient
7. Lack of familiarity with some sexual practices

Reasons why "sex" questions *should* occur in a health history include finding that:

1. Such questions provide an opportunity to introduce HIV/AIDS prevention information
2. Disrupted sexual function may be a symptom of a medical disorder or it may be a side effect of its treatment
3. Past sexual history may help explain the present
4. Sexual issues are important at all stages of the life cycle
5. Sexual dysfunctions in particular are quite common
6. Sexual function is related to general health
7. There is no explanation for not asking questions of a sexual nature
8. Not asking "sex" questions may constitute negligence from a legal point of view

The problem of who should be asked questions about sexual issues can be resolved by saying that almost everyone should have the *opportunity* to talk about sexual concerns if they so choose. Other than situations in which a sexual problem is the main issue that brought the patient to the health professional, questions can be asked in the context of a medical review of systems (ROS) or a personal and social history. Physicians may also ask questions during a physical examination but caution should be exercised because of the possibility of misinterpretation of the intent and consequent accusations of sexual misconduct. It may be easier to say when the time to ask such questions is not optimal than when it is.

"Sex" questions are improper in the midst of concern over some other issue that brought the patient to the attention of the health professional. (Questions about many topics are reasonably omitted in such situations). The context for "sex" questions is

after the acute problem subsides and the professional is reviewing general aspects of the patient's health history.

The "how" (or methods used) of asking "sex" questions is considered in detail in Chapter 2 and is therefore not included here. Similarly, the "what" (content) did not form part of Chapter 1, since it forms the content of Chapters 3, 4, and 5 and subsequent portions of the book.

REFERENCES

1. Green R: Taking a sexual history. In Green R (editor): *Human sexuality: a health practitioner's text*, ed 2, Baltimore and London, 1979, Williams and Wilkins, pp 22-30.
2. Pomeroy WB, Flax CC, Wheeler CC: *Taking a sex history: interviewing and recording*, New York, 1982, The Free Press.
3. Risen CB: A guide to taking a sexual history, *Psychiatr Clin North Am* 18(1):39-53, 1995.
4. Morrison J: *The first interview: revised for DSM-IV*, New York, 1995, The Guilford Press.
5. Rutter M, Cox A: Psychiatric interviewing techniques: 1. methods and measures, *Br J Psychiatry* 138:273-282, 1981.
6. Maguire P et al: The value of feedback in teaching interviewing skills to medical students, *Psychol Med* 8:695- 704, 1978.
7. Maguire P, Fairbairn S, Fletcher C: Consultation skills of young doctors: 1—benefits of feedback training in interviewing as students persist, *Br Med J* 292:1573-1576, 1986.
8. Stone H, Angevine M, Sivertson S: A model for evaluating the history taking and physical examination skills of medical students, *Med Teach* 11:75-80, 1989.
9. Cox A, Holbrook D, Rutter M: Psychiatric interviewing techniques VI. Experimental study: eliciting feelings, *Br J Psychiatry* 139:144-152, 1981.
10. Hopkinson K, Cox A, Rutter M: Psychiatric interviewing techniques III. Naturalistic study: eliciting feelings, *Br J Psychiatry* 139:406-415, 1981.
11. Rutter M et al: Psychiatric interviewing techniques IV. Experimental study: four contrasting styles, *Br J Psychiatry* 138:456-465, 1981.
12. Cox A, Rutter M, Holbrook D: Psychiatric interviewing techniques V. Experimental study: eliciting factual information, *Br J Psychiatry* 139:29-37, 1981.
13. Cox A, Holbrook D, Rutter M: Psychiatric interviewing techniques VI. Experimental study: eliciting feelings, *Br J Psychiatry* 139:144-152, 1981.
14. Cox A, Rutter M, Holbrook D: Psychiatric interviewing techniques—a second experimental study: eliciting feelings, *Br J Psychiatry* 152:64-72, 1988.
15. Kaplan HS: Sex is psychosomatic (editorial), *J Sex Marital Ther* 1:275-276, 1975.
16. Rezler AG, Woolliscroft JA, Kalishman SG: What is missing from patient histories? *Med Teach* 13:245-252, 1991.
17. Newell R: *Interviewing skills for nurses and other health care professionals*, London, 1994, Routledge.
18. Attarian P: The sexual history. In Levinson D (editor): *A guide to the clinical interview*, Philadelphia, 1987, W.B. Saunders Company, pp 226-234.
19. Long LG, Higgins PG, Brady D: *Psychosocial assessment: a pocket guide for data collection*, Norwalk, 1988, Appleton & Lange, pp 105-117.
20. Turnbull J: Interviewing the patient with a sexual problem. In Leon RL: *Psychiatric interviewing: a primer*, ed 2, New York, 1989, Elsevier Science Publishing Co., Inc., pp 151-155.
21. Kraytman M: *The complete patient history*, ed 2, New York, 1991, McGraw-Hill, pp 468-470.
22. Lloyd M, Bor R: *Communication skills for medicine*, Edinburgh, 1996, Churchill Livingstone, pp 73-84.
23. Coulehan JL, Block MR: *The medical interview: a primer for students of the art*, ed 2, Philadelphia, 1992, F.A. Davis Company, pp 217-224.
24. Shea SC: *Psychiatric interviewing: the art of understanding*, Philadelphia, 1988, W.B. Saunders Company.

25. Othmer EO, Othmer SC: *The clinical interview using DSM-IV*, vol 1, *Fundamentals* and vol 2, *The difficult patient*, Washington, 1994, American Psychiatric Press, Inc.
26. Mackinnon RA: *The psychiatric interview in clinical practice*, Philadelphia, 1971, W.B. Saunders Company, pp 115- 117.
27. Cohen-Cole SA: *The medical interview: the three-function approach*, St. Louis, 1991, Mosby-Year Book, Inc., p 82.
28. MacKinnon RA, Yudofsky SC: *Principles of the psychiatric evaluation*, Philadelphia, 1991, J.B. Lippincott Company, pp 53-54.
29. Aldrich CK: *The medical interview: gateway to the doctor- patient relationship*, New York, 1993, The Parthenon Publishing Group, pp 102-104.
30. Semmens JP, Semmens FJ: The sexual history and physical examination. In Barnard MU, Clancy BJ, Krantz KE (editors): *Human sexuality for health professionals*, Philadelphia, 1978, W.B. Saunders Company, pp 27-43.
31. Marcotte DB: Sexual history taking. In Nadelson CC, Marcotte DB (editors): *Treatment interventions in human sexuality*, New York, 1983, Plenum Press, pp 1-9.
32. Hogan RM: *Human sexuality: a nursing perspective*, ed 2, Norwalk, 1985, Appleton-Century-Crofts, pp 161-173.
33. Lewis CE: Sexual practices: are physicians addressing the issues? *J Gen Intern Med* 5(5 suppl):S78-81, 1990.
34. Gabel LL, Pearsol JA: Taking an effective sexual and drug history: a first step in HIV/AIDS prevention, *J Fam Prac* 37:185-187, 1993.
35. Wyatt G: Child sexual abuse and its effects on sexual functioning, *Annual Review of Sex Research* 2:249-266, 1991.
36. Alexander B: Taking the sexual history, *Am Fam Physician* 23:147, 1981.
37. Kinsey AC, Pomeroy WB, Martin CE: *Sexual behavior in the human male*, Philadelphia and London, 1949, W.B. Saunders.
38. Laumann EO et al: *The social organization of sexuality: sexual practices in the United States*, Chicago, 1994, The University of Chicago Press.
39. Johnson AM et al: *Sexual attitudes and lifestyles*, Oxford, 1994, Blackwell Scientific Publications.
40. Spira A, Bajos N, and the ACSF group: *Sexual behavior and AIDS*, Brookfield, 1994, Ashgate Publishing Company.
41. Vollmer SA, Wells KB: How comfortable do first-year medical students expect to be when taking sexual histories? *Med Educ* 22:418-425, 1988.
42. Vollmer SA, Wells KB: The preparedness of freshman medical students for taking sexual histories, *Arch Sex Behav* 18:167-177, 1989.
43. Vollmer SA et al: Improving the preparation of preclinical students for taking sexual histories, *Acad Med* 64:474-479, 1989.
44. Merrill JM, Laux LF, Thornby JI: Why doctors have difficulty with sex histories, *South Med J* 83:613-617, 1990.
45. Hunt AD, Litt IF, Loebner M: Obtaining a sexual history from adolescent girls: a preliminary report of the influence of age and ethnicity, *J Adolesc Health Care* 9:52-54, 1988.
46. Liese BS et al: An experimental study of two methods for teaching sexual history taking skills, *Fam Med* 21:21-24, 1989.
47. Ende JE, Rockwell S, Glasgow M: The sexual history in general medicine practice, *Arch Intern Med* 144:558-561, 1984.
48. Calabrese LH et al: Physicians' attitudes, beliefs, and practices regarding AIDS health-care promotion, *Arch Intern Med* 151:1157-1160, 1991.
49. Bresolin LB et al: Attitudes of U.S. primary care physicians about HIV disease and AIDS, *AIDS Care* 2:117-125, 1990.
50. Boekeloo BO et al: Frequency and thoroughness of STD/HIV risk assessment by physicians in a high-risk metropolitan area, *Am J Public Health* 81:1645-1648, 1991.

51. Ferguson KJ, Stapleton JT, Helms CM: Physicians' effectiveness in assessing risk for human immunodeficiency virus infections, *Arch Intern Med* 151:561-564, 1991.
52. Curtis JR et al: Internal medicine residents' skills at identification of HIV-risk behavior and HIV-related disease, *Acad Med* 69:S45-47, 1994.
53. Lewis CE, Montgomery K: The AIDS-related experiences and practices of primary care physicians in Los Angeles: 1984-89, *Am J Public Health* 80:1511-1513, 1990.
54. McCance KL, Moser R Jr., Smith KR: A survey of physicians' knowledge and application of AIDS prevention capabilities, *Am J Prev Med* 7(3):141-145, 1991.
55. Russell NK et al: Extending the skills measured with standardized patient examinations: using unannounced simulated patients to evaluate sexual risk assessment and risk reduction skills of practicing physicians, *Acad Med* 66 (Sept Suppl), S37-S39, 1991.
56. Bowman MA et al: The effect of educational preparation on physician performance with a sexually transmitted disease-simulated patient, *Arch Intern Med* 152:1823-1828, 1992.
57. Schiavi RC et al: Diabetes mellitus and male sexual function, *Diabetologia* 36:745-751, 1993.
58. Masters WH, Johnson VE: *Human sexual response*, Boston, 1966, Little, Brown and Company, p 240.
59. Maurice WL, Sheps SB, Schechter MT: *Physician sexual contact with patients: 2. A public survey of women in British Columbia*. Paper presented at the meeting of the Society for Sex Therapy and Research, New York, March 1995.
60. *Information letter*, *Can Med Protect Assoc* 7:2, 1992.
61. Canadian AIDS Society. *Safer sex guidelines: health sexuality and HIV*, Ottawa, 1994, *Can AIDS Society*.
62. Hearst N: AIDS risk assessment in primary care, *J Am Board Fam* Pract 7(1):44-48, 1994.
63. Nofzinger EA et al: Sexual function in depressed men, *Arch Gen Psychiatry* 50:24-30, 1993.
64. Yavetz H et al: Retrograde ejaculation, *Hum Reprod* 93:381-386, 1994.
65. Barnes TRE, Harvey CA: *Psychiatric drugs and sexuality*. In Riley AJ, Peet M, Wilson C (editors): *Sexual pharmacology*, New York, 1993, Oxford University Press.
66. Becker JV et al: Level of postassault sexual functioning in rape and incest victims, *Arch Sex Behav* 15:37-49, 1986.
67. Tiefer L, Melman A: Comprehensive evaluation of erectile dysfunction and medical treatments. In Leiblum SR, Rosen RC (editors): *Principles and practice of sex therapy: update for the 1990s*, ed 2, New York, 1989, The Guilford Press, p 208.
68. Frank E, Anderson C, Rubenstein D: Frequency of sexual dysfunction in normal couples, *N Engl J Med* 299:111-115, 1978.
69. Masters WH, Johnson VE: Undue distinction of sex, *N Engl J Med* 281:1422-1423, 1969.