CHAPTER 7

TALKING ABOUT SEXUAL ISSUES: GENDER AND SEXUAL ORIENTATION

Intuitively, there might seem to be good reasons to try to match the gender of the interviewer to the gender of the respondent . . . potential respondents were offered the choice of a male or female interviewer if there appeared to be any hesitation about agreeing to give the interview . . . the majority had no clear preference . . .

JOHNSON ET AL, 1994[1]

The effectiveness of any interviewing technique is, in the last analysis, to be determined by the quality of the data that are obtained.

KINSEY ET AL, 1949[2]

GENDER: ISSUES AND QUESTIONS

When Talking About Sexual Issues, do Health Professional and Patient Genders Matter?

When talking about sexual issues with a patient, does it make any difference if the health professional is a man and the patient is a woman (or vice versa)? What if both are women or both are men? The answer to the question of whether gender matters is, "yes."

A 24-year-old woman medical student joined a 45-year-old psychiatrist/sex therapist in a consultation regarding erection difficulty in a heterosexual couple. The medical student stated privately beforehand that she was apprehensive about talking to patients about sexual issues, since this was not encouraged during her previous training and she hadn't done so before.

This visit was the first for the couple. The senior clinician began the interview by asking both partners about themselves. When the woman partner answered her part of the question, she was looking at the woman medical student much of the time. When the details of the couple's sexual encounters were discussed, this was even more evident. The medical student completed her Sexual Medicine clinical experience within the same time as the assessment. The senior clinician continued to follow the couple in treatment by himself without difficulty for the next three months.

Gender is probably always an influence when people are talking about sexual issues. Gender makes a difference because two people of the same gender talk the same language to each other. There is an immediate and implicit assumption of communality of development and experience—probably the principal reason that many women patients seem to preferentially choose women physicians. When talking to one another about sexual issues, men are more comfortable talking with other men (other things being equal such as the absence of homophobia), since both understand what it means to have an erection and to ejaculate. The same can be said of women and, for example, the sexual significance of menstrual periods and breastfeeding.

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Does the importance of gender mean that male health professionals are unable to comprehend the sexual experiences of women and vice versa? Of course not. One thing it *does* mean is that when health science students are *beginning* to talk with patients about sexual issues, it is far easier for women students to talk with women patients and for male students to talk with male patients. As confidence develops, the student advances into the less familiar territory of the thoughts and experiences of the other group. Ultimately, patients want help with problems, and, as important as gender might be to some, *competence* is the crucial factor.

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A 45-year-old woman was referred to a (male) sex-specialist by her (female) family physician because of lack of sexual activity in her relationship with her husband. The patient was sexually assaulted five years before by a (male) psychiatrist. She reported that, despite the referral, her current family physician had difficulty understanding her problems. The patient said that her family physician told her that her vagina was "tight as a drum, like that of a 16 year old." The family physician was also reported as having said that she, herself, was envious and was sure that the patient's husband was quite pleased with the state of his wife's vagina. In fact, the patient had not had any sexual experiences with her husband (or anyone else) for the five years since her sexual assault. Furthermore, the patient felt that her family doctor was unsympathetic, and she was obviously unhappy over the way her situation was handled. Unfortunately, she was unable to talk with her family physician about what she felt to be the latter's insensitive approach.

In extrapolating from their studies on sexual physiology, Masters and Johnson concluded that therapist gender was a matter of consequence in the treatment of dysfunctional couples[3] (p. 4). They believed that the presence of a man and a woman was essential to their research on sexual physiology since ". . . no man will ever fully understand a woman's sexual function or dysfunction . . . [and] . . . the exact converse applies to any woman." Hence they developed the concept of the "dual-sex therapy team" in sex therapy in which each partner has a "friend in court" and an "interpreter."

Two considerations balance the logic and sensitivity of the dual-sex therapy team approach:

1. The issue of competence is ignored when one thinks *only* about the primacy of gender
2. Practicality (insufficient numbers of trained personnel and limited health care financial resources) usually dictate that treatment be provided by one person rather than two

When a single therapist versus a dual sex-therapy team approach was examined from a research perspective, it did not seem to result in any difference in outcome.[4] Sixty-five sexually dysfunctional couples were randomly assigned to treatment by (1) a male or (2) female professional working alone or (3) a dual-sex cotherapy team. The treatment results were the same in all three circumstances. Moreover, it made no difference to the outcome if the therapist who was working alone was a man or woman and the patient was of the same or opposite sex.

A woman was referred to a "sex clinic" by her family physician because of a diminution in her feelings of sexual desire. The referral specified that she be seen by a woman therapist. Although the clinic usually accommodated such requests, it was not possible to do so in this circumstance. The referring physician was told this situation and was also told that one of the male therapists could see the patient within a short time. The referring physician discussed this with the patient and the referral proceeded. The issue of gender difference and its possible impact on history-taking and treatment was explicitly raised by the therapist at the beginning of the first visit and the patient was encouraged to indicate if and when she thought this might be an impediment to anything taking place in the consulting room. Furthermore, the therapist told her that if their gender difference proved to be a problem, he would help her find a woman therapist with whom she might be more comfortable. By the middle of the first visit, and in response to a question by the therapist, the patient said that her discomfort in talking with a man about sexual concerns was much less problematical than she anticipated. The issue of gender did not arise again in the subsequent six months of care.

Suggested Question to Ask Early in the Interview When Patient and Interviewer are Opposite Genders: "**HOW DO YOU FEEL ABOUT TALKING TO A MAN (WOMAN) ABOUT SEXUAL MATTERS?**"

Does Talking About Sexual Issues Evoke Sexual Feelings in the Patient Toward the Health Professional, and is There a Connection Between Talk, Feelings, and Professional Sexual Misconduct?

The answer to the above question is, "maybe." However, the real question should be: are such connections the norm? The answer is unequivocally, "no." If the answer was positive, it is logical to expect that sex therapists (who spend much of their profes-

sional time talking to people about sexual issues) would have to constantly contend with their own, and their patient's, sexual feelings toward each another, as well as the consequences of those feelings. Most professionals working in the area of Sexual Medicine would declare that these are baseless worries.

Nevertheless, the questions are important, since sexual misconduct concerns are prevalent in all health professions. When talking about sexual issues with patients, health professionals exercise a greater degree of caution now than in previous years—a result of social sensitivity to the problem of sexual abuse by individuals in positions of authority (e.g., teachers, clergy, and health professionals). When explaining the reasons for avoiding discussions of "sex" with patients, some health professionals anecdotally include worries that any inquiry about sexual issues may provoke such an accusation.

It is instructive to consider what science demonstrates about the issues of talking to patients about sexual issues, sexual feelings in the health professional toward patients (and vice versa), and professional sexual misconduct. While not all the questions have answers, information exists for some. For example, connections between sexual feeling of the psychologists and sexual misconduct have been examined.[5] In this study, 95% of men and 76% of women report sexual attraction to a client at some time in their careers, although only 9.4% of men and 2.5% of women acted on those feelings. The authors conclude that the two phenomena were (mostly) different—"therapist-client sexual intimacy must be clearly differentiated from the experience of sexual attraction to clients." Despite the fact that the attraction to clients was the norm for men and women psychologists, two thirds of respondents to the survey felt "guilty, anxious or confused" about having such feelings. Although information is not yet available concerning other health professionals, there is little reason to expect different results.

"therapist-client sexual intimacy must be clearly differentiated from the experience of sexual attraction to clients."[5]

A second study of psychologists by the same group confirmed the finding about sexual attraction from the previous study.[6] The authors also report the following data:

1. Almost 60% of respondents reported feeling sexually aroused in the presence of a client
2. Over 50% reported hugs, flirting, and statements of sexual attraction from the client toward the psychologist
3. Client disrobing was "exceptionally rare"
4. Over one third "reported both male and female client (apparent) sexual arousal during sessions"
5. Ten percent of therapists had a complaint filed against them
6. This happened to men three times more often than women
7. Therapists who had some sexual involvement with clients were four times more likely to have had a previous complaint lodged against them (malpractice, ethics or licensing) than those who did not experience such involvement

Concerns of Canadian physicians regarding the connections between sexual talk, feelings, and misconduct became complex as a result of the involvement of the Canadian Medical Protective Association (CMPA; the defense union formed by physicians against malpractice suits). In the early 1990s, the topic of professional sexual misconduct received an almost frenzied degree of public and professional attention in Canada.

In the midst of this upheaval the CMPA issued a bulletin that included the following definition of patient sexual abuse: (patient sexual abuse can be construed during the process of) "Requesting details of sexual history or sexual preferences when not clinically indicated for the type of consultation or presenting problem."[7]

The CMPA warning to physicians served only to underline the inhibitions many already felt when faced with talking about "sex" with their patients. For Canadian professionals having clinical, teaching, and research responsibilities concerning sexual problems, the CMPA bulletin was not a welcome statement since it provoked more questions than it answered:

1. Was there a concern that questions about sexual matters might be misinterpreted by the patient as a sexual invitation by the physician?
2. Was there a worry that including "sex" in the context of a routine medical consultation was, *ipso facto*, an imposition on a patient?
3. Did the definition of sexual abuse represent the attitude of organized medicine or of malpractice insurance companies (a lawyer wrote the CMPA article)?
4. To what extent was the statement part of a larger social concern about sexual abuse?
5. Was there a worry that including "sex" in a medical history might uncover or provoke sexual feelings in the patient toward the physician?
6. (Most importantly), what was the evidence on which the recommendations in the bulletin concerning sex history-taking were based?

The CMPA bulletin failed to take into account the complexity of professional sexual misconduct and the fact that the precursors involve much more than talking about sexual matters. Precursors usually entail problems over "boundaries." The concept of boundaries has gained much attention, particularly within the medical disciplines of Psychiatry and Family Practice. The word *boundary* refers to the unseen line between health professional and patient, and the present focus is on what constitutes crossing over that line for both parties.

A distinction is made between *boundary crossings* and *boundary violations*.[8] "Boundary crossings" are not necessarily harmful (e.g., attending the funeral of a patient who died). A "boundary violation" is a "crossing" that is harmful (e.g., sexual misconduct). The CMPA might view *questions* about sexual issues to represent a "crossing" or even constitute a "violation" unless ". . . clinically indicated for the type of consultation or presenting problem."[7]

Use of the "permission" technique described in Chapters 2 and 3 might substantially lessen the possibility that questions about sexual matters may be interpreted as a "crossing" or a "violation." However, permission is not the equivalent of license. Permission is given to talk about a subject. It is not assent to a question that has not yet been asked. The manner in which questions are posed, or the language used, might, for example, represent a boundary crossing or violation.

Does Disclosure of the Health Professional's Sexual Experiences Help the Patient?

When a health professional has a patient who has sexual difficulties, one might legitimately wonder about the value of disclosing one's own sexual thoughts and experi-

ences. After all, most woman (including women health professionals) have, for example, had at least an occasional time when intercourse caused vaginal discomfort. Likewise, most men have, at some time, probably experienced rapid ejaculation in intercourse. (Neither of these are the same as a sexual dysfunction, which, among other things, is persistent). Logic indicates that this might be useful information to have for a patient with a similar problem. It might even allow a patient to be more optimistic about the result of a treatment program if it was explained that this also happened to oneself. Intuition provides more guidance to professionals on what to do or say in this situation than science.

As logical as self-disclosure might seem, the small amount of research on this subject does not support a great benefit to sharing one's sexual thoughts and experiences with a patient. A survey of 63 male psychologists found that sexual experiences were the least common of the types of disclosure made.[9] From a clinical viewpoint, there are strong opposing opinions to the notion of professional self-disclosure in this area.

First, the crucial question to be answered is: would it help to make the patient better, which, after all, is the "job" of the health professional (or to use more recent jargon, the "objective")? While patients often find it reassuring to know that others have also experienced sexual problems, the mechanism of self-disclosure by a health professional is not the best method. Information is often available from, for example, self-help books and the Internet. Patients want something *different* from a health professional than what they can easily get elsewhere. Patients want specific help in finding a solution to their *own* sexual predicament and are less interested in the personal difficulties of the health care provider.

Second, it may be difficult to separate discussion of professional self-disclosure on sexual matters from the issues of professional sexual misconduct and boundaries. Self-disclosure may be seen, at least, if not more, as a "boundary crossing." Health professionals should be aware that there may be an inclination by "fact finders" (for example, licensing organizations) to consider the presence of boundary violations (or even boundary crossings) to be "presumptive evidence of allegations of sexual misconduct."[8]

Self-disclosure, in particular, was one of the issues examined by a Massachusetts task force that was established for the purpose of developing guidelines on maintenance of boundaries in psychotherapy.[10] While specific to psychotherapists, the ideas generated are unquestionably serious issues for other health care professionals as well. The guidelines acknowledge that in some areas, self-disclosure is accepted. One area is in the treatment of substance abuse. Another is in the selection of a health professional with the same sexual orientation (gay or lesbian). However, the guidelines also categorically state that, "It is never appropriate for physicians practicing psychotherapy . . . to disclose details of their sexual lives."

Suggested Statement in Response to a Patient Asking About a Health Professional's Sexual Experiences: **"YOU CAME TO SEE ME TO DISCOVER THE EXPLANATION FOR YOUR OWN TROUBLES AND TO FIND HELP TO DO SOMETHING ABOUT THEM. I DON'T BELIEVE THAT TALKING ABOUT MY SEXUAL EXPERIENCES ASSISTS YOU IN DOING THAT."**

In a corollary to the issue of "boundary violation," some think that "excessive distance" from a patient (rather than excessive involvement) might constitute another example of a violation.[11] In this view, an act of "omission is at least as dangerous as (one of) commission." If one accepts this, *avoiding* the subject of "sex" in a history might be seen as an act of omission constituting a "boundary violation."

SEXUAL ORIENTATION: ISSUES AND QUESTIONS

". . . homosexuality . . . [should] . . . not be defined by behavior but by the predominant erotic attraction to others of the same sex . . . One need not engage in sexual activity to be homosexual, any more than one need engage in sexual activity to be considered heterosexual."

RICHARD ISAY, 1969[12]

All of the issues and questions related to the subject of sexual orientation can not possibly be reviewed in this chapter. The focus in this section is on matters that are problematic in primary health care. Developmental and frequency aspects of homosexuality are included in Chapter 5 (see "Puberty and Adolescence—Sexual Orientation").

Terminology

The word "homosexual" is often used in the community and among health professionals to define people who have sexual connections with same-sex partners. However, some prefer use of the words "gay" and "lesbian" and find the word "homosexual" uncomfortable and even offensive. One disadvantage to the use of the word "gay" to describe both groups is that it tends to render individuals apart from gay men as somewhat invisible.[13]

A second objection to the word "homosexuality" is that it leaves out the subject of "heterosexuality" as something that is an equally interesting subject to study (Tiefer L, personal communication, 1997). (The origins of both are only beginning to become unraveled).

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A third problem with the word "homosexuality" is the emphasis on the sexual part of the relationship rather than the caring that might exist between the two people.

The word "homosexuality" implies a meaning that is clear and specific but in fact the opposite is true. For example, does "homosexuality" refer to *sexual behavior* only, without considering what is in a person's *mind*? Or could it refer to the exact opposite, considering only what is in one's mind without reference to sexual behavior? Could someone be homosexual but sexually inactive just like a person who is heterosexual and sexually inactive? If the interviewer *is* considering mind-issues apart from behavior, does that include only sexual images such as fantasies, or feelings of love for a partner as well?

In fact, there are at least three ways to define sexual orientation:

- Behavior
- Fantasy
- Self-identification

(See "Sexual Orientation" in Chapter 5 and Table 5-3 for more discussion on the definition of "homosexuality" and the variety of meanings of the word).

Why is it Necessary for a Health Care Professional to Know the Sexual Orientation of a Patient?

Interest in the health and happiness of the patient is one of the principal reasons for knowing about a patient's sexuality, including their sexual orientation (see "Why Discussion Should Occur" in Chapter 1; see also Box 1-2). (Before homosexuality was deleted from the system of psychiatric diagnoses, the principal rationale for asking about sexual orientation was diagnostic).[14]

Gay men and lesbians may have an increased vulnerability to some medical and emotional disorders. Examples of such medical disorders in men[15] include the following:

- HIV/AIDS in those who engage in anal intercourse with other men
- Other STDs
- Hepatitis
- Anal cancer
- Urethritis

Examples of a possible increased risk of medical disorders in lesbians include the following:

- Ovarian cancer as a result of loss of the protective effect of pregnancy[16] (although an increasing number of lesbians are choosing to have children) and the use of oral contraceptives[17]
- Breast cancer because of increased risk among women who have not given birth
- Cervical cancer based partly on the "false assumption that lesbians do not engage in risk behaviors for cervical cancer . . . [when in fact] the majority of respondents to surveys . . . report a history of heterosexual activity, often involving multiple partners"[18]
- STDs (including HIV/AIDS) among bisexual women[15]

Gay men and lesbians may also have an increased vulnerability to problems affecting mental health[13,15]:

- Acceptance
- Ostracism
- Discrimination
- Personal losses
- Stigmatization
- Depression
- Violence (anti-gay and battering)
- Substance abuse

Risk of suicide has been reported as a particular issue among gay adolescents.[19] A population-based study of over 36,000 US junior and senior high school students indicated that bisexuality/homosexuality was a substantial risk factor for attempted suicide in male (but not female) adolescents.[20] A large proportion (27%) of men with eating

disorders are reported to be primarily gay or bisexual.[21] The National Lesbian Health Care Survey provides more specific information about lesbians and reported on information gained from 1925 respondents (a 42% response rate).[22] The survey found that 30% of respondents used alcohol more than once weekly and 6% used it daily, about 75% "had received counseling at some time, and half had done so for reasons of sadness and depression."[22]

In addition to medical and mental health issues, there is evidence that sexual concerns among gay men are not identical to those in heterosexual men.[23] In one study, homosexual men cited that the following occurred at least once in their lifetime:

- Painful receptive anal intercourse
- Concerns about the "normality" of their thoughts, feelings, or fantasies
- Harassment for being gay/homosexual/bisexual

(In a comparative group of heterosexual men, premature ejaculation and low sexual desire were most common).

What is the Relevance of Past Homosexual Behavior to a Current Sexual Dysfunction?

In the course of asking someone about sexual orientation issues, the health professional might discover, for example, that the patient has had same-sex sexual experiences in the past or same-sex sexual fantasies in the present. What does this mean? In some instances sexual orientation may be a peripheral factor; in others, it may be central.

A 30-year-old woman with her husband of four years was referred by her family physician to a "sex clinic" with her husband of four years because of her diminished sexual desire. The couple were initially seen together, but when she was subsequently seen alone, it became apparent that her sexual interest was far from absent and that her sexual fantasies included both men and women. Unknown to her husband, and apart from her relationships with men in her teens and beyond, she lived with another woman in a romantic and sexual relationship for about three years in her early 20s. She regarded herself as bisexual and said that her sexual desire had never been a problem in the past with women or men (*including* her husband). She was deeply in love with her husband and concerned about their present sexual difficulties, which, she thought, more likely involved his erection problems than her sexual orientation. With an ultimately successful treatment focus on his situational erectile disorder, the sexual desire issue disappeared.

A 19-year-old student was referred by his family physician because of an inability to ejaculate. He had not previously disclosed to other health professionals that he could ejaculate when alone and when with a male partner. His principal sexual

concern was the inability to have the same experience when having intercourse with a woman. In that circumstance, ejaculation could occur only if he simultaneously fantasized about having a sexual encounter with a man. He was distressed about being able to ejaculate only in this way and was concerned that this might indicate that he was gay. He described his fantasies during masturbation as involving only men since he began at the age of 13 and added that men were included when he thought about his most pleasurable sexual experiences with a partner. His apparent reluctance to accept his homosexuality led him to attempts at intercourse with four different women, which resulted in an inability to ejaculate without fantasizing about men on all four occasions.

Suggested Question Directed Toward a Man and Asked in the Context of a Discussion About a Sexual Dysfunction: "**WHAT IS YOUR OPINION ABOUT THE CONNECTION BETWEEN THE PROBLEM OF iiiiii (E.G., ERECTIONS) AND YOUR SEXUAL EXPERIENCES WITH OTHER MEN (WOMEN)?**"

Disclosure of Sexual Orientation to Health Professionals

Primary care health professionals learn about the sexual orientation of their patients in two ways:

- The information is spontaneously revealed
- The patient waits for the health professional to ask specific questions

Of these two possibilities, survey data indicate that many gay men and lesbians choose the latter. These surveys leave unclear the answer to the question of the impact of HIV/AIDS on the extent of disclosure.

Interviews were conducted with 623 gay men in the United Kingdom who were registered with a general practitioner.[24] Forty-four percent of the men had not revealed their sexual orientation to their family doctor. This was true as well for 44% of the 77 men who were HIV positive (in most instances, they were tested in a specialized clinic).

One part of another study of 105 bisexual men assessed the degree to which male subjects revealed their sexual attraction to other men to various people in their network.[25] Only 23% "fully disclosed" this information to a "doctor or clinic" and, even more surprisingly, only 53% disclosed this information to a "counselor or psychologist."

A group of 424 bisexual and lesbian respondents to another survey indicated that over one third (37.5%) "believed that disclosure of sexual orientation to their physician would adversely affect their health care."[26] In addition, over one third of the respondents "said that they would like to disclose their sexual orientation to the physician providing their gynecologic care, yet they hesitated to do so."[26] Moreover, 60% indicated that they would be willing to discuss their sexual orientation *if the information was not put in the medical record*. In the experience of

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Suggestions for physicians regarding sexual orientation:

1. Offer to not record sexual orientation information in the medical record
2. Allow a friend or partner to be present during the examination
3. Include the friend or partner in treatment discussions
4. Ask questions in a manner that does not presume heterosexuality

respondents (apart from opinions and desires), only 41% disclosed their sexual orientation.

The authors of this study concluded with some concrete suggestions for physicians:

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3. Include the friend or partner in treatment discussions
4. Ask questions in a manner that does not presume heterosexuality

Of 622 men and women subscribers to a gay newspaper who responded to a questionnaire survey, 49% of the respondents explicitly revealed to their primary health professional that they were homosexual.[27] However, an additional 34% said they would provide this information to their health professional if they "thought it was important." This finding suggests that many gay patients may be willing to reveal their sexual orientation if asked and if the rationale for the question is made clear.

"Homophobia" (defined as "the irrational fear, distrust, and/or hatred of lesbian/gay people") seems to be the main deterrent to disclosure of one's status as gay or lesbian to health care professionals.[13] Some regard an attitude of "Heterosexism" (defined as a "world-view value system that prizes heterosexuality") with homophobia. Heterosexism assumes that heterosexuality is the only appropriate manifestation of love and sexuality and devalues homosexuality and all that is not heterosexual.[13] In one of the surveys described above, 89% of respondents who rated their primary health professional's attitude as very supportive candidly discussed their sexual orientation with that person, compared to 48% of those who judged their health professional to be hostile.[27] As a result of homophobic attitudes among health professionals, many lesbians reportedly turned to "complementary health care providers. . . . [and are therefore] . . . . unlikely to receive any of the standard medical screening tests. . . . The effects of this alienation. . . . *may result in a significant increase in morbidity and mortality*".[28]

What Questions Does One Ask?

Given that there *is* reason to ask about sexual orientation in a health setting and that the majority of patients do not reveal this information spontaneously, what question(s) does one ask? How does one determine sexual orientation anyway? By self-identification? By the fantasies of a person? By the sex of sexual partners? By some combination of these elements?

"orientational identity and sexual behavior are not synonymous and require separate and specific inquiry."[28]

Questions that help establish sexual orientation are theoretical and have a serious practical application as well. For example, in one survey, 78% to 80% of lesbians reported sexual activity with a man in the previous one to five years. The author concluded from this report that "orientational identity and sexual behavior are not synonymous and require separate and specific inquiry".[28] Such information might, for example, be helpful in learning about the origin of a patient's STD.

In asking for "identifying information" from a new patient, one usual question relates to clarification of the person's living circumstances. If the patient is living with some-

one, the interviewer can simply ask if the relationship is one that is also romantic (apart from sharing the cost of the accommodations). If the gender of the other person has not already been identified (unusual), this question too can easily be asked.

Another approach to clarifying the sexual orientation of a patient is to use the screening outline provided in Chapter 3. However, one of the problems with this approach is having to wait until the subject of "sex" arises in the "Review of Systems." If one *does* delay until this point, the specific question(s) asked by a health professional become influenced by their purpose(s). For example, one reason is to simply clarify the sexual orientation of a new patient while learning about the person in the first few visits. Another intention might be to consider an STD in the differential diagnosis of a patient with a particular medical complaint. A third purpose might be to clarify the nature of the relationship between a patient who is depressed and a friend who just died.

The Chapter 3 screening method (with suggested questions) is easily applied to sexual orientation questions involving a new patient. The four-question model (see Figure 3-4) entails asking:

1. A preamble/permission question
2. A question that addresses the issue of whether the person is sexually active
3. Whether the partner(s) was(were) a man, a woman, or both
4. If the patient has any sexual concerns (see Figure 3-4)

Questions from a health professional regarding same-sex sexual experiences are easily accepted by most patients and do not elicit the same response from people as in a social situation.

A question about the gender of the partner immediately (but implicitly) tells the patient that the interviewer is not assuming that person to be heterosexual. "Simply *having* a nonjudgmental, non homophobic attitude is not enough. The responsible practitioner needs to *convey* his or her nonjudgmental attitude to all patients."[28] On the basis of clinical impression, questioning the possibility of same-sex sexual experiences by a health professional is easily accepted by most patients and does not elicit the same response from people as in a social situation.

Initial use of the undifferentiated word "partner" (rather than spouse, husband, wife, boyfriend, or girlfriend) also conveys to the patient that the interviewer is not making any assumption regarding sexual orientation. Furthermore, this approach is beneficial in talking to heterosexual patients, since it also implicitly dispels any supposition of particular linkages with sexual activity (such as marriage).

With gay and heterosexual patients, use of the word "partner" conveys an attitude of acceptance. The health care professional must attend to such issues during an interview, in the use of patient forms, and in waiting room information pamphlets.

Last, clinicians should be clear about the sexual orientation of the patient *before* questions about birth control are asked. To do otherwise risks alienating the patient. (The comment refers to the order of questions not the relevancy. The health professional should not assume that questions about birth control are immaterial because someone is a lesbian. What determines the relevancy is the patient's behavior).

Confidentiality

When a gay or lesbian patient is in a partnership, the health care professional should inquire about the involvement of the partner in appointments and the extent to which

the partner's influence is desired in any future medical emergency involving the patient. O'Hanlan suggests that couples be encouraged to consider preparing a medical power of attorney, particularly before elective surgery or obstetric delivery.[28]

Fearing repercussions, many gay and lesbian patients are unwilling to reveal their sexual orientation unless this information is not recorded in their medical record. One suggested possibility under such circumstances is a coded entry in the chart.[29]

What Does the Heterosexual Health Professional Know About Homosexuality and the Sexual Practices of Gay Men and Lesbians?

When a heterosexual health professional talks about sexual issues with a patient who is gay or lesbian, it should not be any different than talking to a heterosexual person, but it often is. The heterosexual health professional should consider their personal attitudes and knowledge about homosexuality. Gays and lesbians are often quite tolerant of professional knowledge-deficits, providing it is acknowledged and does not extend beyond the "garden variety" lack of information.

A gay male couple in their 40s was referred to a professionally experienced (heterosexual) sex therapist for assessment of an erectile concern of one partner. One of the two men was himself a health care professional and explicitly stated on the first visit that he had "checked out" the therapist before proceeding with the appointment. (The patient never said what facets of the therapist made him acceptable but the implication was that it was connected to his professional attitude). The therapist agreed to continue seeing the couple in treatment but made it understood that, since the majority of his patients were heterosexual, he would need to be taught some aspects of the sexual practices of gay men. They were completely at ease with the professional's request for more information.

Suggested Statement and Question to a Gay Man or Lesbian in the context of an HPI: **Man or Lesbian in the Context of an HPI: "I KNOW VERY LITTLE ABOUT THE ACTIVITIES OF GAY MEN (OR LESBIANS) WHEN THEY ARE BEING SEXUAL WITH ONE ANOTHER. IS IT OKAY IF I IF I ASK YOU ABOUT THEM?"**

Additional Question if the Answer is, `yes': **"TELL ME WHAT YOU AND YOUR PARTNER USUALLY DO TOGETHER."**

The principal driving force behind the recent large-scale "sex" surveys has been presence of the HIV/AIDS epidemic together with the absence of reliable information about community sexual practices (see Table 1-1 in Chapter 1). As a result of these surveys, more is known concerning gay and lesbian sexual activities. For example, in the French survey, gay and bisexual men described the following most common sexual activities during their last intercourse:

- Stroking each other tenderly (96%)

- Reciprocal masturbation (77% to 82%)
- Fellatio—active or passive (72% to 76%)
- Anal penetration—active or passive (28% to 36%)

Anal penetration occurred without a condom in 12% to 15%. Inserting a fist in the anus was unusual (6%)[30] (p. 131). (See also Tables 5-1 and 5-3 in Chapter 5).

What Information Can a Health Professional Provide to Patients about Sexual Orientation and Sex-related Issues?

PFLAG (Parents, Families and Friends of Lesbians and Gays) is an international organization that is devoted to support, education, and advocacy. PFLAG circulates a list of recommended readings (most in paperback) on various sexual orientation issues. Some readings are directed toward parents, spouses, and children of gays and lesbians; others focus on particular subjects such as religion and spirituality, history and civil rights, and HIV/AIDS.

Most large cities in North America have speciality bookstores devoted to gay, lesbian, and bisexual themes. Health professionals could direct patients to such locations. Several recent publications seem particularly useful (for patients and for health professionals):

- *Becoming gay: the journey to self-acceptance*, Isay R (author): a sensitive and readable book on self-acceptance and the development of homosexuality in the individual. It is written from the perspective of a practicing gay psychoanalyst[12]
- *A natural history of homosexuality*, Mondimore FM (author): an informative review of all aspects of the topic of homosexuality from its history to recently published research into genetics and the brain[31]
- *The complete guide to safer* sex, McIlvenna T (author): in addition to sexual orientation issues, this material (available in paperback) offers a thorough review of all aspects of safe sex behavior[32]

Last, the Internet is a significant resource on gay, lesbian and bisexual issues and includes a large amount of information (see Appendix IV).[33]

SUMMARY

The gender of the participants in a health care interview that includes sexual issues and the sexual orientation of the patient are pervasive factors regardless of the setting, be it medical or mental health. These two issues always must be considered.

Usually, the fact that the health professional is a man or woman does not interfere with talking about "sex," regardless of the gender of the patient. However, for some, the gender of the professional is important (e.g., some women patients have a sense of satisfaction and safety only when talking with other women). The expectation of comfort seems mostly related to a communality of life experience.

Some health professionals might be concerned that they or their patient will become sexually stimulated by a discussion of the topic. Sexual feelings may, in fact, appear, but when they occur, they are often results of factors that are not necessarily related

to any specific discussion about sexual issues. Whatever the reason for the patient or professional developing sexual feelings, only infrequently does the other person know, and less common still is the possibility that either may act on those feelings. "Boundary violations" that result from sexual feelings, including professional sexual misconduct, interfere with the entire relationship between health professional and patient. Professional self-disclosure in relation to sexual issues (other than sexual orientation) may do the same. At very least, self-disclosure is unconventional, if not unproductive.

In contrast to the gender of the participants in the interview (obvious to all) their sexual orientation is often hidden. Primary care professionals must have this information because of its direct relationship to a patient's health and happiness. Gay men and lesbians seem particularly vulnerable to some disorders, and importantly the expectation of a homophobic reception interferes with many undergoing regular screening procedures.

There are two ways that a health professional discovers the sexual orientation of a patient:

- The patient spontaneously reveals the information
- Specific questions are asked

Studies show that the former happens in only a minority of situations. An interviewer might ask about whom the patient lives with and whether the relationship is one that is also romantic or involves sexual experiences. Somewhat later in the interview, within a Review of Systems (ROS), the screening outline presented in Chapter 3 suggests a single straightforward question that asks the patient if their sexual partner is a man or woman or both. Using the word "partner" and not making assumptions about the gender of the other person conveys an attitude of acceptance. Questions about birth control without first clarifying a patient's sexual orientation risks alienating that person. Clinicians would also do well to discuss issues related to confidentiality: whether and how information about sexual orientation should be recorded in the medical record, and the extent to which a partner is involved in the patient's medical care.

To better understand their patients, heterosexual health professionals should learn more about the nature of gay and lesbian relationships, and specifically, about the sexual practices that their patients experience.

Some of this information is acquired by talk; some is acquired by reading. Patients should also be encouraged to make use of the self-help literature and information on the Internet.

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