CHAPTER 2

TALKING ABOUT SEXUAL ISSUES: INTERVIEWING METHODS

. . . with respect to discourse on sexuality there is major discontinuity between the sensibilities of politicians and other self-appointed guardians of the moral order and those of the public at large, who, on the whole, display few hang-ups in discussing sexual issues in appropriately structured circumstances.

LAUMANN ET AL, 1994[1]

Clinicians experienced in talking to people about their sexual difficulties would not question the above quote. When the "appropriately structured circumstances" represent a health setting, patients display little hesitation in talking about sexual matters if they are talking with a health professional who knows what questions to ask and shows no embarrassment. A polished interviewer can often accommodate patient sensitivity with the topic of "sex" but an awkward interviewer presents a predicament for the patient. Some patients decide not to continue when they experience obvious interviewer discomfort and simply find someone else with whom to talk. However, in relation to sexual worries, a lengthy period of time may (and often does) intervene. Years (rather than months or weeks) typically transpire between one unsuccessful effort and a subsequent attempt to talk with a health professional about a sexual problem.

A married couple, both 37 years old, were distressed about their inability to have intercourse. The man had erection difficulties. While the couple developed mutually gratifying sexual experiences apart from intercourse, they were unable to conceive. In the past, they were referred to a physician because of the physician's expertise in the treatment of infertility. Both partners described the physician's impatient attitude that was directed toward the woman. The physician indicated bluntly that she could not find anything wrong during the examination and displayed little feeling for the woman's obvious fear of vaginal entry. The physician suggested that surgery would make the vaginal opening larger. Both partners were uncomfortable with this idea and with the physician's abrupt manner. They stopped seeing her after two visits.

Although they thought about consulting a health professional who was experienced in the treatment of sexual and reproductive difficulties, they were concerned about a repetition of the experience with the first physician. It was another two years before they talked with someone else. The new physician's sensitivity, patience, and skill in treating vaginismus allowed the couple to eventually have intercourse, and conception occurred.

PRELIMINARY ISSUES

Rapport

"Rapport" is one aspect of the health professional/patient encounter that governs other elements of the interview. Like an umbrella, it covers the way *all* information is collected, rather than one specific issue. Rapport means the development of a physician/patient relationship based on trust and respect and within which information can be readily obtained. Developing rapport involves interviewing (the manner in which information is acquired) more than history-taking (the content of the information itself). A health professional engenders rapport in ways that include the following:

1. Demonstration of a caring attitude
2. Respect for the patient and the concerns voiced
3. The manner used in asking questions

Rapport seems more fragile around the topic of "sex" than around other issues. The explanations for this sensitivity are not difficult to find. In talking about sex, the patient:

1. Trustingly reveals something very personal to a health professional
2. Hopes for an empathic and knowledgeable response
3. Really doesn't know what to expect

An interviewer's lack of familiarity with a sexual word or sexual practice can be declared candidly with a minimum loss of respect from the patient, or even the opposite—enhanced regard because of the willingness to acknowledge one's limits.

If the patient encounters embarrassment, rapport (regarding this subject) is diminished. Yet, some uneasiness is to be expected from anyone who is a novice in talking to patients about sexual issues. (With experience—it is surprising how little is needed—one learns to be more composed). If discomfort is obvious, candor and honesty by the interviewer will minimize the loss of rapport. Lack of familiarity with a sexual word or a sexual practice can be declared candidly with a minimum loss of respect from the patient, or even the opposite—enhanced regard because of the willingness to acknowledge one's limits.

Interviewing Versus History-taking

What appears to be missing from interviewing books directed toward health professionals are suggestions about *how* to ask sex-related questions (interviewing), quite apart from *what* to ask (history-taking). The nature of questions may be less disconcerting to patients than the way in which questions are asked.

How, rather than *what*, to ask involves interviewing techniques, some of which are particularly advantageous when talking specifically about sexual issues. There are at least ten such methods (Box 2-1). The use of some of the ten methods are illustrated in Appendices I and II.

INTERVIEWING METHODS

Permission

It is not unusual for "sex experts" to explain the absence of sex-related questions in an interview on the "hang-ups" of the interviewer. Health professionals, however, tend to

Box 2-1

Interviewing Methods

1. Ask patient's PERMISSION
2. Interviewer takes INITIATIVE
3. LANGUAGE: MEDICAL/TECHNICAL versus slang
4. STATEMENT/QUESTION TECHNIQUE
5. PRIVACY/CONFIDENTIALITY/SECURITY
6. DELAY SENSITIVE QUESTIONS
7. Display NONJUDGMENTAL attitude
8. Provide EXPLANATION
9. Discuss FEELINGS
10. Promote OPTIMISTIC ATTITUDE

"blame" the patient for the sex-information gap by saying that to have asked about this subject would have risked alienating the person being interviewed. One way to eliminate blame entirely is for the interviewer to simply request the patient's permission to ask a question about this topic.

The permission technique accomplishes the following objectives:

1. It erases the health professional's worries about being intrusive, since it becomes the patient's responsibility to decide on the acceptability of the topic
2. The interviewer shows respect for the patient and sensitivity toward the patient's feelings
3. Control is explicitly given to the patient by offering the possibility of saying "no"

Chapter 3 offers some suggested responses if, indeed, a patient declines the invitation. Some *will* refuse but most will not. Many actually want to discuss sexual concerns with a health professional. This was illustrated in a random sample survey of 6000 women in the Canadian province of British Columbia.[2] The study pertained to the subject of physician's sexual involvement with patients. Among other things, subjects were asked to respond to the statement that it is "OK for the doctor to ask a question about sexual problems as part of a general check-up on an adult patient." The majority (73.6%) of the 2079 respondents agreed. This opinion was *positively correlated with the age respondent*, a finding that was enlightening in view of the particular difficulty that many young interviewers seem to have when talking about sexual issues with older people (especially older women).

Asking permission may perpetuate the idea that this topic is something special. Little appreciation is thus given to the fact that for many people "sex" is a special subject. Community attitudes dictate this distinction rather than health professional behavior.

Of course, asking permission to talk about sex makes this topic different in any health setting. Some physicians object to asking permission for this very reason, that is, because one does not ask permission to talk with a patient, for example, about liver function or depression. However, tradition seems to allow physicians to ask about, for example, liver function and depression, whereas talking

about the subject of sex in a medical context is to be viewed favorably only when the justification is proven (as in relation to, for example, diabetes or HIV/AIDS). Asking permission may perpetuate the idea that this topic is something special. Little appreciation is thus given to the fact that for many people "sex" *is* a special subject. Community attitudes dictate this distinction rather than health professional behavior. The concept of asking permission reflects a need to be sensitive to popular feeling and thus becomes a practical (rather than ideological) matter for the interviewer.

The permission technique can be used effectively in an interview in two ways: (1) entering the field of "sex" generally and (2) asking about a particular and potentially sensitive aspect of "sex":

A 54-year-old man went to see his family physician because of shortness of breath associated with exertion. The physician conducted a thorough history, during which he included a "review of systems" (ROS). The physician routinely included sexual matters in his ROS and used the permission technique to initiate a discussion on this subject. He typically did this with men after asking about urinary function:

Q: Do you have any pain when you urinate?

A: No

Q: Do you notice any blood when you urinate?

A: No

Q: Is it OK if I ask you some questions about your sexual function?

A: No problem

Obviously, the health professional may ask further questions when a positive reply is given. In the occasional instance when the response is negative, the professional might say something like (see Chapter 3) "it's certainly OK with me if we don't talk about this now but if you change your mind at any time in the future, we could talk then."

Interviewer Initiative

Only occasionally do patients volunteer information about sexual matters to health professionals, especially if a problem exists. Patients have mixed feelings about this apparent paradox. Health problems are the very reason for consulting a health professional but to not divulge information is patently counterproductive. Talking about sexual problems can be so embarrassing that it could paralyze any desire to ask for help. When secrecy exists, it is obviously deliberate. However, when a person does not tell all of the truth, it is not the same as lieing. Patients withhold information only when questions are not asked. Replies are usually truthful when questions *are* asked. (There are also other reasons for a person's lack of

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candor, such as being concerned about giving the "right" answer to a question, but this is less important than questions not being asked.) Therefore to discover the presence of problems, the onus is very much on the interviewer to ask pertinent questions.

Laumann et al. ". . . discovered that respondents found it very difficult to come up with language of their own to talk specifically about sexual practices. It was much easier for them to answer direct, simple questions we posed that asked for yes or no answers or simple indications of the frequency with which some behavior had occurred."[1]

Many mental health professionals use a nondirective method of acquiring information from patients. This technique involves relative silence by the professional and spontaneity by the patient in talking about concerns, whatever they might be. Such an approach directly conflicts with the notion of interviewer initiative. In a nondirective environment, frankness in talking about sexual issues rarely occurs, especially detailed descriptions of problems. Although one reasonably *begins* the inquiry process with an open-ended style of questioning ("Tell me about . . ."), *direct and explict follow up questions are obligatory when sexual issues are being discussed*.

Kinsey and his colleagues cited two possible reasons for the nondisclosure of sexual information[3]:

- Judgmental attitude on the part of the interviewer
- Illegality of the sexual behavior

A third factor should be added, namely, not asking questions. By taking the initiative, the interviewer is in a position similar to the poker player who is asked to show his or her cards first to prove a winning position. It is as if the patient is saying, "prove to me that you're not going to tell me that I'm abnormal or that you won't think less of me for what I've done." This is apparent in entering the field of "sex," as well as asking questions about the details of "who does what to whom" (often called by patients: "nitty gritty").

A man in his late 20s and married for one year talked with his new family doctor about his erectile difficulties. Although embarrassed, the patient welcomed the physician's questions about this problem. Unknown to the patient's previous physician, and in response to direct inquiry from his current physician, the patient reported that he had never experienced intercourse with his wife or anyone else. Moreover, he described erections that were full at all times until the point of attempted vaginal entry, when he would ejaculate. His erection would then promptly disappear. Since his erectile difficulties seemed to result from his rapid ejaculation, the treatment focus shifted away from his concern about erections to the problem of his ejaculation. Using medications to control the timing of his ejaculation, his virtual panic over anticipated erectile loss diminished greatly. The conjoined use of sex therapy techniques allowed the patient and his wife to consummate their marriage within several weeks.

Language

The subject of "sex" is unique in medicine in that there are two languages used to describe the same phenomena: medical/technical language and slang. When health professionals talk about the sexual thoughts, feelings, or behavior of their patients, this usually occurs in the idiom of medical/technical jargon. Such words are almost always safer than slang in preserving the relationship with the patient. Safety is important in protecting the patient from the unwitting imposition of unacceptable values by the interviewer and the subsequent risk of losing that person as a patient.

The following are four potential problems that can arise as a result of using medical/technical terms; all are related to the element of comprehension.

1. One cannot assume that a patient understands medical/technical jargon. In clinical practice, problems related to understanding are more likely to arise when talking to someone from a different linguistic or cultural group. Patients usually don't ask for explanations or definitions of words for fear of appearing ignorant. Men seem more concerned about this than women, especially men from a third world culture where gender role expectations render embarrassment as a result of having "lost face" because of "not knowing." It is diplomatic for the health professional in this situation to begin by assuming lack of understanding of medical/technical terms and to take the initiative in providing definitions.
2. A comprehension problem may result from embarrassment or discomfort with the topic of "sex" on the part of the health professional with the consequent inclination to avoid anything but the most superficial reference to the subject.

A 24-year-old man was referred because of an inability to ejaculate when awake. The family physician who referred the patient had completed an investigation of the man's physical status, blood tests (including a hormonal profile), referral to a urologist, and urological tests that involved a testicular biopsy. The family physician suggested previously to the patient that he "masturbate," since this was not part of the patient's sexual experience in the past. The patient reported that this was ineffective. Referral to a specialty clinic occurred because all the tests were reported as negative. As the discussion proceeded with the patient about the details of his attempts at masturbating (number of times, duration of attempts, where stimulation was applied), he revealed his complete lack of understanding of how men masturbate and his consequent inability to implement the suggestions of his family doctor. Permission was then asked of the patient to demonstrate male masturbation techniques on a rubber model of an erect penis. This was done, and that evening the patient ejaculated while awake for the first time in his life.

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3. Slang (rather than medical/technical words) may help as an alternative form of communication when comprehension is in doubt but this has to be balanced

against the risk that the health professional may alienate the patient in the process. If slang is contemplated, a safer method is by the conjoined use of the permission technique described previously.

A 35-year-old married woman was referred because of her lack of sexual interest and her husband's threats to leave the marriage unless this changed. In talking with her about her sexual desire under various circumstances, it seemed that she did not understand the nuances of some of the questions. She was consequently asked permission to use another word for "desire" or "interest"—a word (so it was explained) that some people find offensive but which everyone seems to understand. She was told that if she disliked the word, she should indicate this to the interviewer so that it would not be used again. She agreed to his arrangement. She was then told that the word was "horny." She replied that the word was certainly familiar to her and that she understood what it meant. She proceeded to describe when she had, in fact, felt this way during her lifetime. However, she added, rather pointedly, that the word "horny" was frequently used by her husband and that she herself found it "disgusting" and preferred that it not be used again.

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4. Patients sometimes stumble in their attempts to use medical/technical terms. An example is the use of the word "organism" instead of orgasm. An approach to this situation is to allow the patient to learn a more accurate sexual vocabulary simply by the interviewer using the correct word repeatedly. The challenge to the health professional is to find a way of adjusting what the patient says without being condescending in the process.

Statement/Question Technique

When talking to people about their sexual thoughts, feelings, and behavior, Kinsey et al. realized that many forms of sexual activity occurred far more often than had been previously assumed.[3] Using the same example and armed with the knowledge that the vast majority of American men had this experience, Kinsey phrased inquiries to convey that ". . . everyone has engaged in every type of activity." This became known as the *ubiquity technique*.[4] The use of the ubiquity technique avoided the necessity of asking men: "have you ever masturbated?" and instead proceeded to the next question, namely, "how old were you when you began to masturbate?" Apart from the "ubiquity" approach specifically, other methods for asking questions about sensitive issues in general have also been suggested.[5]

A variation or alternative to the "ubiquity" technique is not to make assumptions but to preface a question by a statement phrased in such a way that the interviewer is talking of "most" or "many" people rather than everyone. Furthermore, this preliminary statement outlines the subject of the subsequent question. The interviewer then asks the person if their personal experience includes what was just described.

A couple in their mid-20s was referred because the woman was nonorgasmic in sexual activity with her husband. When seen alone, the woman revealed that she regularly came to orgasm through masturbation and that her husband was unaware of this. The fact that "many" women had difficulty in giving explicit directions to a sexual partner was mentioned, and the interviewer asked whether this conformed to the woman's own experience. She answered by saying that she also found it awkward to be completely candid in spite of the fact that her husband was receptive and, in fact, had asked her on many occasions what she "wanted." (What she wanted was to be able to tell him what she wanted.) She felt reassured in knowing that the problem of "communication" was not only hers. She was encouraged to discuss her masturbation experiences with her husband and was told that men usually appreciate such information. As a result of very explicit discussions with her husband she developed a considerably higher level of arousal with him than ever before.

This method of stating something factual followed by a question about the person's own experience seems extremely useful in talking about "sex" for several reasons. First, many people seem to be perennially hungry for sex-related information, especially about the minutiae of what people "do," think, and feel. Since people generally do not talk candidly about these subjects or read the many relevant books and magazine articles available, *the statement part of this technique provides a way of disseminating information.* Second, the initial information statement indicates to the patient that if the description is part of their own personal experience, they should not feel alone, since "many" others are "in the same boat."

However, "many" or "most" does not mean "all," and what is being discussed may *not* have been part of the life experience of the person interviewed. In that situation, the person could say so without feeling deviant and could also know that they, too, had lots of company. In other words, the interviewer "normalizes" the patient's sexual behavior. This approach provides a "win-win" opportunity for the patient.

Privacy, Confidentiality, and Security

- *Privacy*: the property of the individual; a right to control the disclosure of information about oneself
- *Confidentiality*: the extent to which information is disclosed to a third party
- *Security*: the physical property of the system used to process and store information[6]

In the medical system, privacy relates to the patient, confidentiality relates to the behavior of the health professional, and security relates to the method of protecting the information obtained. All are associated with keeping information secret (expected in any health system but secrecy and "sex" are particularly linked).

An example in which the privacy of sex-related information becomes problematic is when a patient is well known to a health professional because of a long association

between the two but the subject of "sex" was never discussed. This circumstance sometimes results in a patient consulting with another health professional solely for the purpose of obtaining a referral to a sex-specialist and doing so without the embarrassment of talking about this subject with his or her usual doctor.

A 35-year-old woman with multiple sclerosis (MS) was referred because of orgasm difficulties that had begun recently. Symptoms of MS began seven years earlier. The patient experienced two episodes of illness, neither of which resulted in any permanent disability. She was married and never previously experienced sexual difficulties. Two months earlier, she found it progressively more difficult to come to orgasm. She was a patient of her family doctor since her teens. She became socially friendly after they met at a swimming pool. Neither her family doctor nor her neurologist ever talked with her about her sexual function. When sexual problems appeared, she found it impossible to discuss the problems with either. As a result, she went to the medical clinic at the university where she worked and asked for a referral to the "sex clinic."

Clinical problems in relation to confidentiality generally arise when one partner does not want information given to the other. Most often this pertains to sexual activity with another person or atypical sexual behavior. In this situation, it is not unusual for patients to ask for an explicit statement of assurance of confidentiality when divulging information that is regarded as potentially damaging. (In providing such reassurance to a patient, health professionals must consider any legal reporting obligation that may exist in their jurisdiction such as a child in need of protection and serious risk of harm to another person or to oneself.)

A couple was referred because of the woman's lack of sexual interest. They both were 28 years old. They were married three years ago and had known each other for two years before their marriage. Her sexual interest lessened in the last year.

In talking with her separately, she was asked questions that attempted to clarify whether her diminished sexual interest related to her husband specifically or was more general. She specifically asked if the conversation was just between the interviewer and herself or whether the information revealed would be given to her husband. She was reassured that anything discussed would be strictly confidential. Two other statements were added. First, the "right" was reserved to tell her that if what she was about to explain was something that her husband should probably know this opinion would be given directly to her rather than her husband. Secondly, she was informed that in the legal jurisdiction in which the interview was taking place, courts had the power to subpoena medical records and that she should be aware of that in case she was about to reveal something that was illegal.

She then proceeded to disclose the following:

- She had fallen in love with another man
- Sexual disinterest was not a problem with her new partner
- She wanted to separate but was concerned about her husband's anger and wanted to tell him in the presence of a health professional present

They were subsequently seen together and when she revealed this information to her husband, he was neither angry nor surprised (although upset), and indicated that for several months, he wondered whether she had become interested in someone else.

Security of medical records represents a special problem that has legal and ethical ramifications. The fact that medical records can be subpoenaed by the courts or medical licensing authorities in many legal jurisdictions can place a very real restraint on the ethical obligation of the health professional to maintain patient confidentiality. Because written documents remain in files for long periods of time and medical records can become legal evidence, the health professional may be justified in keeping skimpy notes. However, when records are not complete and thorough, the interviewer may be handicapped by forgotten information and imprecise memories. Also, information omitted from a medical record is, obviously, unavailable to other health professionals in an emergency situation. If a secret *is* recorded, the special nature of the revelation should be noted in the record. Some clinicians, especially those working in hospital in-patient settings where many people have access to the medical record, keep a second set of records available only to themselves. A second set of notes preserves security in a medical, but not a legal, sense. While charts remain the property of the clinician, recent regulations enacted in many jurisdictions in North America allow patients to have legal access to their medical records. Presumably, this access applies to a second set of records as well.

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A married couple in their early 30s with two young children was seen in consultation because of an impending separation, due, according to the referral source, to sexual difficulties. When the husband was seen alone, he spontaneously talked about having long-standing and frequent sexual fantasies involving men, occasional sexual experiences with men, and a desire to develop a sexual relationship with a particular man with whom he worked. In talking with his wife by herself, she was obviously aware of her husband's wish to form a relationship with a male work-colleague but felt that it was unacceptable for him to have any sexual relationship outside of their marriage. She recalled that before their marriage, he said something (she could not remember the details) about having sexual desires for men as well as women. She thought then that his interest in men was unimportant and not something that would interfere with their development as a couple.

The interviewer puzzled about what to record in the chart, since he recognized the possibility that he might have to account for what he had written if there was a legal contest between the two partners in the future over, for example, custody of their children. In view of the explicit discussion between the two about the husband's current interest in developing another relationship (which was thus not private information) the interviewer concluded that he could incorporate this into the record without problem. However, the interviewer also believed that, since the husband was given assurance of confidentiality when he was seen alone, the husband may have revealed aspects of his history that might otherwise not have emerged. Therefore the interviewer felt that it would not be proper to record details of the man's past sexual history and wrote only brief notes about what his wife already knew concerning his sexual interest in men.

Delaying Sensitive Questions

In an ordinary medical history, the *sensitivity* of patients to particular *questions is* often not of primary concern to the interviewer. For example, in asking about abdominal discomfort, one is not ordinarily concerned about how the person is going to react to the question. However, in a "sex" history, some topics elicit an almost predictably hesitant response from people. In the interest of preserving the relationship with the patient, questions concerning such subjects need to be approached with tact and sensitivity. One method for obtaining the required information while simultaneously maintaining rapport is to delay asking questions about a delicate topic until later in an interview or in a subsequent interview after a greater degree of trust is established. (Although waiting before asking "sensitive" questions is intuitively appealing, research support is inconsistent.)[7]

One example of delaying sensitive questions is in talking to people about the details of a sexual experience. Doing so is quite unlike simply telling someone about the presence of a particular problem, such as ejaculating quickly or not experiencing orgasm. Describing the events of a sexual encounter, however helpful that may be to an interviewer in understanding a problem, is quite alien to most people. Sexual partners may even find it painful to talk so explicitly with one another, in spite of the fact they were both there when the events occurred! In reviewing the dynamics of a sexual circumstance, it is infinitely easier to describe, for example, the preliminary courtship invitations or initial sexual signals than the later circumstances in bed, such as which part of a man's penis his partner usually stimulates with her fingers. While talking about sexual minutiae is never easy, it is less stressful when a greater degree of trust is established between patient and interviewer.

A couple in their early 30s was referred because the woman was nonorgasmic. They were reluctant to discuss this, as well as details of their sexual experiences as a couple, pleading lack of experience in talking with others about their personal experiences and not expecting to have to talk so explicitly during the appointment. The interviewer felt it unwise to pressure them into revealing detailed information

before they were comfortable. Discussion initially concentrated on nonsexual relationship issues.

On the second visit, the couple was only slightly more forthcoming. When they realized their concerns were not being addressed, they became more receptive to explicit questions about their lovemaking. Discussion took place about their "signal system," what would happen before vaginal entry, and aspects of intercourse. They revealed that she was regularly orgasmic with clitoral stimulation when masturbating or when her husband was stimulating her with his fingers. They also explained that he would regularly ejaculate quickly, often before entry. He was particularly embarrassed about this and had told his wife not to reveal information about his ejaculation to the interviewer. She felt that she simply did not have enough time to come to orgasm before he ejaculated.

Another example of the need to delay sensitive questions is when there is the possibility that someone has engaged in an atypical form of sexual behavior.

A couple, married for 10 years and each 39 years old, was referred to a "sex" clinic because of the man's sexual disinterest. His wife discovered a cache of sexually explicit magazines in the trunk of their car one year earlier and, since then, sexual experiences between the two partners had been almost nonexistent. When subsequently seen alone, the husband described an interest in such magazines extending back to his teens, but he did not consider this to be a problem since it hadn't interfered with his sexual experiences with his wife in the past. The magazines were heterosexually oriented and his chief interest was in looking at pictures of women undressed. He spent several hours each week looking for such magazines and about $500 each month in purchases. He masturbated almost every day while looking at the pictures. His wife was unaware of these details.

The interviewer wanted to inquire about other atypical forms of sexual interest but felt that his relationship with the man was tentative, particularly since the referral was initiated by the man's wife. On the next visit, the man was asked about some paraphilic behaviors. It emerged that since his teens he had sometimes privately dressed in women's clothes and stole women's undergarments from clotheslines at night. He was not sexually interested in children, had never exhibited his genitalia in public, and had not engaged in any sexually violent behavior toward others. He never discussed any of his sexual behavior with anyone before and, while he was concerned about his wife discovering his private sexual interests, he felt relieved at being able to discuss these issues with another person. On the fourth visit, and in response to specific questions, he described (with palpable hesitation) having tied a ligature around his neck on several occasions in his life to become more sexually aroused. The last time was several years ago but he was concerned that this might happen again and that there might be life-threatening consequences. He was immediately admitted to hospital and referred to a psychiatrist who was expert in the assessment and treatment of paraphilias.

Nonjudgmental Attitude

The injection of personal values into discussions about sexual behavior was a major issue for Kinsey and his co-workers.[3] Their interviewing observations concentrated on two issues: (1) confidentiality and trust and (2) the interviewer's attitude. They displayed particular sensitivity toward the intrusion of the interviewer's values into the process of questioning when they wrote that ". . .there are always things which seem esthetically repulsive, provokingly petty, foolish, unprofitable, senseless, unintelligent, dishonorable, contemptible, or socially destructive. Gradually one learns to forego judgment on these things, and to accept them merely as facts for the record. If one fails in his acceptance, he will know of it by the. . .quick conclusion of the story."[3]

Patients who describe their private sexual thoughts or experiences and who are also in psychological pain as a result are not usually asking others for an opinion or approval. Rather, such a person is seeking a listener rather than a judge, someone to assist in the process of change. If the patient wanted a right/wrong opinion, they would have consulted a clergyman instead of a health professional. If the interviewer cannot function in a helpful way and without judgment, the patient should be referred elsewhere. The meeting between health professional and patient is not the place for proselytizing. The problem is not a matter of the nature of one's personal values.Indeed every health care professional operates within a personal value system. The problem is one of imposing these values on a patient and, in particular, doing so in a covert manner. In a welcome departure from tradition, Bancroft included a statement of his personal values within the introduction to his text *"Human Sexuality and Its Problems."*[8] Health professionals who have strong beliefs that make it impossible for them to be dispassionate in caring for patients with sex-related concerns should make their philosophical position known beforehand.

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Occasionally, patients ask for an opinion about the propriety of sexual experiences or relationships. One can be precise in answering without simultaneously telling patients how they should manage their lives.

A 22-year-old man was referred because of an inability to ejaculate in attempts at intercourse. His current sexual partner was his first intercourse partner. He experienced noncoital sexual activities with her in the previous three years during which he had no difficulty with ejaculation. The same was true with masturbation.

In the course of talking with him, he revealed, with much reluctance, an event when he (the patient) was 15 years old in which his brother stimulated him to ejaculation. He regarded this as evidence of homosexuality, about which he was persistently distressed. All his subsequent sexual experiences were with women and his sexual fantasies consistently related to women. He described himself as repulsed by the notion of homosexual behavior. He asked the interviewer if his (the patient's) earlier life experience was an indication of homosexuality and the interviewer's opinion about the "decency" of homosexual behavior. The interviewer reassured him by placing the sexual event with his brother in the context of the sexual evolution of a heterosexual adolescent boy; the event seemingly had little or no rele-

vance to the issue of his sexual orientation as an adult. To that was added a statement that the determinants of homosexual and heterosexual behavior were unclear but that, in any case, the "job" of a health professional was to assist in helping to understand and solve problems rather than to give opinions about the correctness of a person's actions. The latter was described as being more a matter for the clergy. An offer was made to help find a priest (the patient was Catholic). The suggestion was accepted.

Explanation

Health professionals, especially physicians, are not renown for giving jargon-free explanations to patients about their difficulties. The impact on patients of information about the nature of a disease varies. However, when talking about sexual disorders in particular the impact can be immense, since lack of information, or misinformation, can be a critical factor in the origin of the problem. Tiefer observed that "the major source of information for the young has been the mass media, both because of parents' silence and because of the dearth of sex education . . . advice in the nonfiction media reinforces the impression that sex is very important without providing the kind of information that ordinary readers or viewers can actually use."[9] Given these circumstances, the provision of information by a health professional can be therapeutically valuable.

A 57-year-old man was referred because he repeatedly delayed the prostate surgery that was recommended by his family doctor and urologist. He had symptoms of prostate gland enlargement and was diagnosed as having "benign prostatic hypertrophy." He previously had used an oral medication to diminish the size of his prostate and found that it helped initially but that his symptoms were worsening. The suggested treatment at this point was transurethral surgery (TURP), which involved the removal of prostatic tissue obstructing the flow of urine through his urethra. The patient was concerned about possible impairment of sexual function as a result of surgery and was not reassured by what he perceived to be bland encouragement by his physicians.

He had been divorced for three years and was sexually active with a woman in her early 40s. They had talked seriously about marriage. He saw, on a TV talk show, information about the use of a penile prosthesis as a treatment for "impotence" after prostate surgery and wanted assurance that this would be available to him after his operation. In a specifically structured visit involving the interviewer and the patient's urologist, the details of the surgery were reviewed with the patient. This was done with the help of a rubber model of the male genitalia, which showed internal and external organs. The mechanism of expected impairment of ejaculation with a TURP procedure was explained, as well as the method by which erections occurred. The reasons for not expecting erectile impairment were also explained. The patient underwent surgery and experienced retrograde ejaculation as a result, without associated erectile difficulties. Neither he nor his partner per-

ceived this as a major interruption of their sexual experiences and did not ask for further treatment.

Feelings

Health-related histories generally contain questions about experiences or behavior, not about feelings. However, sexual disorders often require an understanding of all three. Feelings surrounding sexual issues may be etiologically, diagnostically, or therapeutically prominent. In a developmental history, it may be useful to determine when a particular event occurred and also how the person felt about that experience. Feelings may provide a crucial link between the past and the present.

A couple in their early 40s was referred on the initiative of the husband and because of a lack of sexual desire on the part of the wife. This extended to a time shortly after their marriage and began in relation to her first pregnancy about 15 years earlier.

In the course of talking to the woman alone and in the context of a developmental history, she was asked about her intercourse experiences during each of her three pregnancies. She described diminishing sexual interest as her first pregnancy evolved. This was the opposite of her prior sexual enthusiasm. She related that her disinterest was the result of the prolonged morning sickness and bloating associated with the pregnancy. She denied particular feelings connected to specific sexual experiences that occurred at that time. However, at the end of the interview and in response to a question about whether there was anything else of importance in relation to her sexual concerns, she tearfully recalled the last time she and her husband had intercourse prior to her first delivery. This occurred hours before her "water broke" and the delivery of a stillborn child. Since that time, she believed that "sex" was the main cause of the death of her child but had only recently stated this to her family doctor. Before the current visit, she had not seen the possibility of a connection between feeling responsible for the death of the baby and the disappearance of her sexual desire. She accepted the suggestion of exploring this idea in psychotherapy.

The interviewer must consider feelings from the past as well as feelings in the present, including during the interview itself. In any discussion of sexual matters, it is reasonable to assume that the patient is uncomfortable (in a psychological sense). To suppose otherwise is to not acknowledge the strangeness of talking to someone else about something usually considered private. Embarrassment is to be expected. Indeed, if there is no embarrassment, the interviewer must ask why—at least to him or herself, if not to the patient as well. One way of assessing the patient's feelings about the interview is simply to ask, and to reassure the patient about the usualness of uneasy feelings. The need to do this may extend beyond the first visit. Patients often return on a sec-

ond visit and say that when thinking about the first visit they could not believe they said "those things."

Optimism

Life problems often seem worse than they actually are. Hope is one of the most powerful weapons in the armamentarium of any health professional.[10] Changing the patient's perspective on a problem can be a mechanism for engendering optimism. This is the basis of the proverbial story of the man who cried because he had no shoes, until he saw another who had no feet.

People often perceive a sexual difficulty (especially something that impedes intercourse) in a global way rather than as a limited disorder. Sexual problems thus become reflections of masculinity or femininity. The impact of a health professional's optimism can extend far beyond the sexual problem to the entire view of oneself.

On the surface, sexual problems are no different. However, patients tend to think of themselves as not simply having a sexual problem; they also think they are less of a man or woman in the process. That is, people often perceive a sexual difficulty (especially something that impedes intercourse) in a global way rather than as a limited disorder. Sexual problems thus become reflections of masculinity or femininity. Therefore the impact of a health professional's optimism can extend far beyond the sexual problem to the entire view of oneself.

Patients also tend to magnify the extent of a sexual disability and not to balance this with positive thoughts. Men and women seem to share this inclination equally. This negative point of view is apparent when a problem is first revealed and is also seen repeatedly when treatment benefits are quickly "taken for granted" and put aside in favor of worry over remaining problems. Patients seem to be concerned that they may be prematurely "dismissed," or perhaps, fear that the leftover troubles may be insoluble. Optimism of the health professional may be the major factor that keeps the patient in the treatment process.

A couple in their early 30s described a problem of nonconsummation of their five-year marriage. They both wanted children. This reproductive "agenda" was the main motivation for seeking medical care. Intercourse for the purpose of bonding or cementing their relationship was of secondary importance—at least initially. The sexual diagnoses were vaginismus and retarded ejaculation, both of which were life-long. He ejaculated with "wet dreams" but not otherwise. The vaginismus was treated with the classic Masters and Johnson method, which relies heavily on vaginal "dilators."[11] Over a period of two months, the woman became increasingly confident about inserting dilators into her vagina. Fear of "objects" in her vagina and pain with insertion of the dilators gradually disappeared. Eventually, she was able to introduce her husband's penis into her vagina. They were impassive when it finally occurred. In discussing this attitude, they talked regretfully of the fact that he had not yet ejaculated inside. The clear implication was that perhaps he never would. They were reassured that this would likely happen soon. They remained skeptical until ejaculation did, in fact, occur several weeks later.

SUMMARY

Talking to people about "sex" requires knowing the questions to ask and consideration of the ways in which to discuss the subject. In other areas of talk between patients and health professionals, methods of asking questions can affect the quality of information obtained. In relation to sexual issues, techniques of inquiry may affect the quality and the quantity of the information gathered. In this chapter the methods suggested for use in asking sex-related questions have the potential to enhance both.

The following interviewing methods have particular application to the topic of "sex":

1. Ask permission
2. Assume the initiative
3. Use "language" that fits a particular situation
4. Convey a sense of trust and confidentiality
5. Use a form of questioning that involves providing information followed by a question
6. Display an attitude of nonjudgmentalism
7. Delay inquiry into obviously sensitive areas
8. Provide information by way of explanation
9. Ask questions about feelings in addition to experiences
10. Promote an optimistic attitude

These ten techniques may be useful when interviewing patients generally; however, their use in talking about sexual issues specifically may critically alter the quantity and quality of the sex-related information obtained.

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