CHAPTER 3

SCREENING FOR SEXUAL PROBLEMS

The most basic, and also most difficult, aspect of studying sexuality is defining the subject matter. What is to be included? How much of the body is relevant? How much of the life span? Is sexuality an individual dimension or a dimension of a relationship? Which behaviors, thoughts, or feelings qualify as sexual—an unreturned glance? Any hug? Daydreams about celebrities? Fearful memories of abuse? When can we use similar language for animals and people, if at all?

TIEFER, 1995[1]

Defining the subject matter of "sex" is, indeed, difficult but nevertheless crucial, since its meaning will determine which difficulties one is searching for in the process of screening. The definition and the screening mechanism must be broad enough to encompass problems with sexual *function* and sexual *practices*. Problems with sexual function are reported by patients rather than observed by health professionals. In contrast, some sexual practices may be seen only as problematic by health professionals. In both instances, the onus remains on the health professional to elicit the information.

Problems with sexual function have been classified in DSM-IV[2]—a system heavily influenced by the research of Masters and Johnson[3] and Kaplan's revisions.[4] On the basis of direct observation of physiological changes associated with sexual arousal, Masters and Johnson described a "*sex response cycle*" that included four phases[3] (pp. 3-8) (Figures 3-1 and 3-2):

- Excitement
- Plateau
- Orgasm
- Resolution

Kaplan added a prior "interest" or motivational phase to Masters and Johnson's system[4] (pp. 3-7). In so doing, she reconceptualized the sex response cycle from four parts into three, which she renamed:

- Interest
- Response
- Orgasm

Kaplan referred to her revision as a "*triphasic model*" (Figure 3-3).

SCREENING CONTENT: DYSFUNCTIONS VERSUS DIFFICULTIES

While ideas based on the sex response cycle are widely used, they have not been universally accepted. One criticism is that when considering sexual function, the cycle seems to progress from one step to another but that this is not how sexual response is always ordered. For example, clinicians will sometimes encounter the occurrence of orgasm in a woman who does not feel any preexisting sexual desire. The reality of this

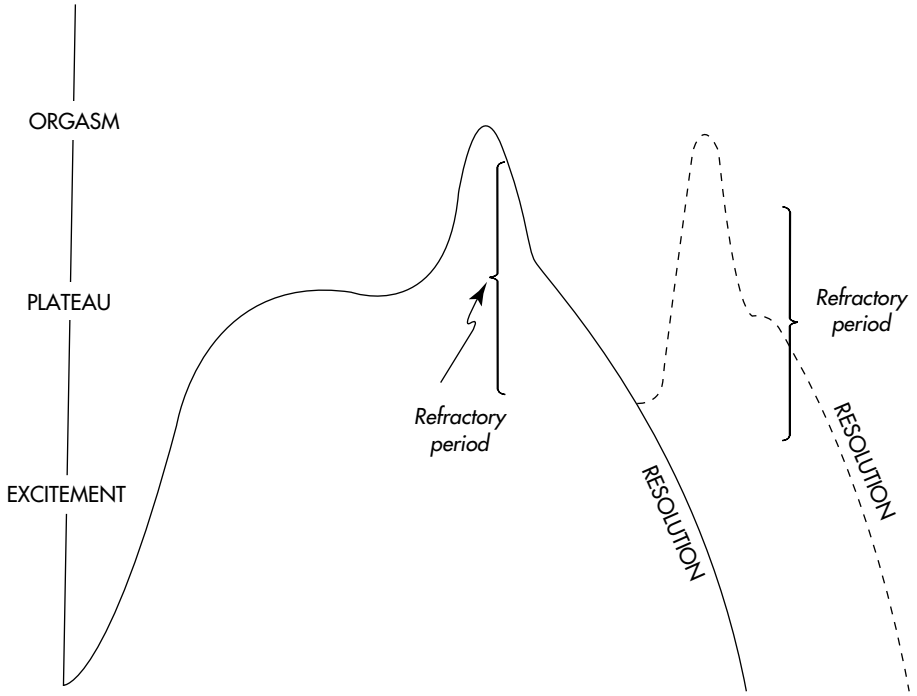

Figure 3-1 Male sexual response. (From Masters WH, Johnson VE: *Human sexual response,* Boston, 1966, Little, Brown and Company, p. 5.)

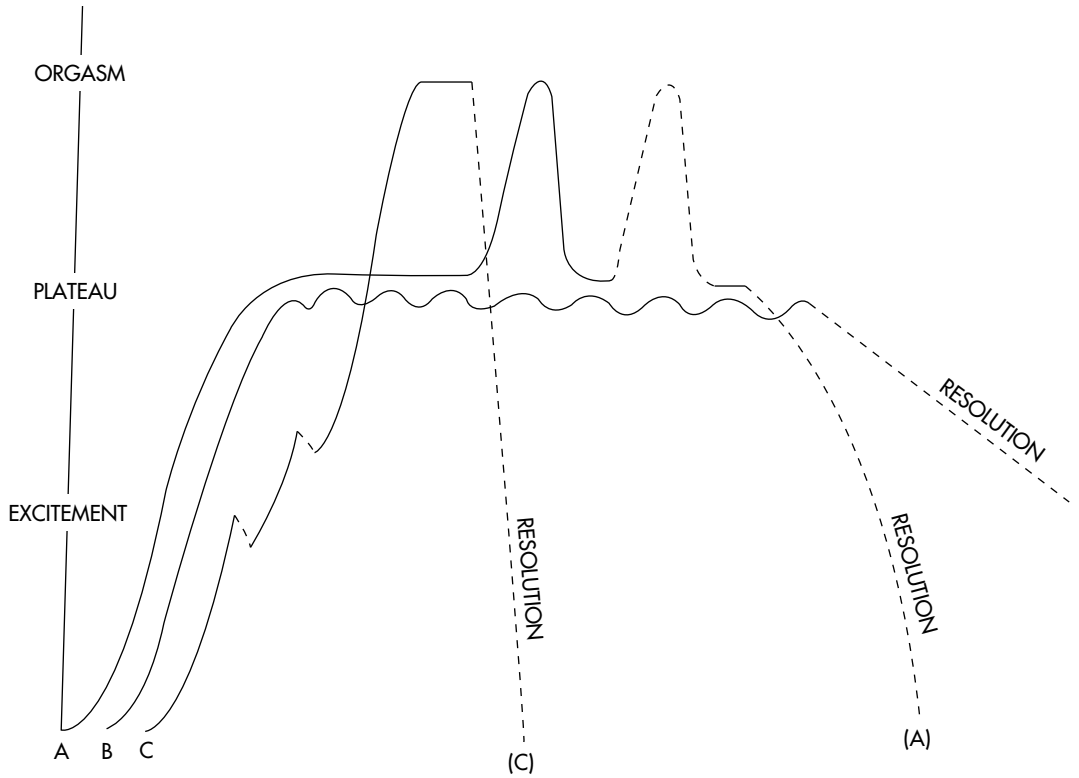

Figure 3-2 Female sexual response. (From Masters WH, Johnson VE: *Human sexual response,* Boston, 1966, Little, Brown and Company, p. 5.)

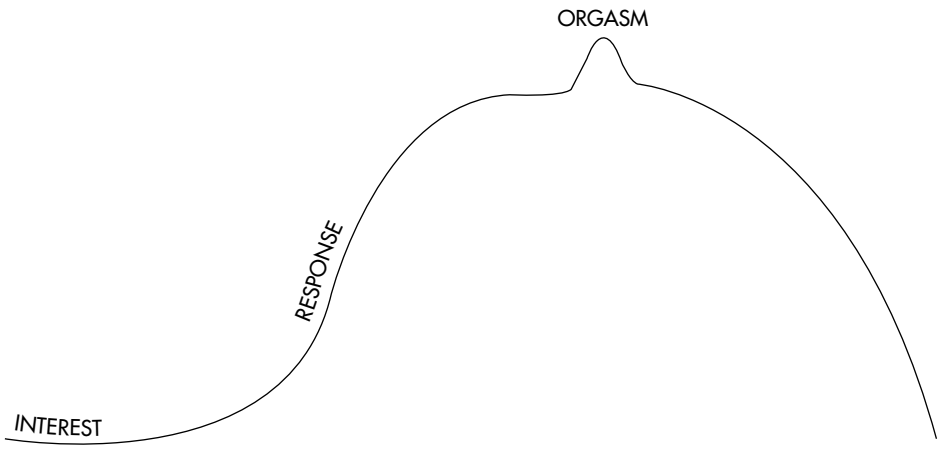

Figure 3-3 Triphasic model of human sexual response.

particular observation of the disconnection between desire and orgasm has been established in a research context.[5]

A second critique relates to gender and the different meanings of "sex" to men and women. In an exquisitely detailed and incisive analysis, Tiefer examined the entire concept of the sexual response cycle and the extent to which women have been absent in the formulation of sexual disorders in the various versions of the DSM[1] (pp. 41-58, 97-102). She faults the DSM classification system for the following:

1. Excessive "physiologizing"
2. Viewing sexual expression as consisting of reactions of body parts
3. Being "genitally focused"
4. Thinking of "heterosexual intercourse as the normative sexual activity, repeatedly defining dysfunctions as failures in coitus"

From Tiefer's perspective, the sexual concerns of women are different and have been sufficiently outlined in popular surveys, questionnaire studies, political writings, and fiction to include such issues as: intimacy, communication, emotion, commitment, pregnancy, conception, and getting old. ". . . women rate affection and emotional communication as more important than orgasm in a sexual relationship. . . "[1] (p. 56).

One well-executed, frequently quoted, and revealing questionnaire study referred to by Tiefer and which serves to buttress her argument was conducted by Frank and her colleagues.[6] One hundred predominantly white, well-educated, and "happily married" volunteer couples were questioned concerning the frequency of sexual problems. The authors found that in addition to the fact that 40% of the men and 63% of the women reported sexual dysfunctions, 50% of the men and 77% of the women reported "*difficulty that was not dysfunctional in nature.*" The "difficulties" are outlined in Box 3-1. Most importantly from the point of view of screening, *the number of difficulties reported was more strongly and consistently related to overall sexual dissatisfaction than the number*

Box 3-1

Sexual "Difficulties"

- Partner chooses inconvenient time
- Inability to relax
- Attraction(s) to persons other than mate
- Disinterest
- Attraction(s) to persons of the same sex
- Different sexual practices or habits
- "Turned off"
- Too little foreplay before intercourse
- Too little "tenderness" after intercourse

Adapted from Frank E et al: Frequency of sexual dysfunction in "normal" couples, *N Engl J Med* 299:111–115, 1998.

of "dysfunctions." If one therefore accepts the argument and evidence presented by Tiefer, a useful screening system must consider sexual problems to be impairments in physiology (sexual dysfunctions) *and* impairments in the "human relations" part of "sexual experiences" (i.e., difficulties or consequences of the ways people conduct themselves sexually).

EPIDEMIOLOGY OF SEXUAL PROBLEMS IN PRIMARY CARE

Apart from what one looks for in screening (sexual "dysfunctions" and/or "difficulties") a major rationale for the inquiry process is how common the detected phenomena are in general (epidemiological information about specific dysfunctions are included in Part II). The extent of sexual problems found in medical practices has been studied on several occasions.

One widely quoted study of sexual issues in general medicine practice was described in detail in Chapter 1.[7] Another study used a questionnaire (whose validity and reliability was previously tested) that contained items concerning dysfunctions and difficulties.[8] Of the 152 patients who were asked to complete the questionnaire, almost all did so (93%). The majority of patients (56%) identified at least one sexual problem on the questionnaire, and this compared to 22% having a marital or sexual problem found by simply examining the patient's medical record. Multiple reasons were cited for the discrepancy, including:

1. The physician did not ask relevant questions
2. The patient did not spontaneously report problems
3. The physician did not record the information in the patient's chart

Although identification of a problem by 56% of patients may appear to be an overwhelming number to a clinician, one must remember that not all people with sexual problems want treatment.[9]

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SCREENING CRITERIA

Given the immense numbers of patients with sexual problems, the need becomes obvious for a triage system whereby the nature of a problem and its impact can be evaluated and proper action taken: (1) further assessment and treatment or (2) referral. The beginning of this process requires a reasonable, respectful, and regular practice by which the presence of sexual problems can be identified with just a few questions. For reasons discussed in Chapter 1, it is a "given" that patients be provided the opportunity to discuss a sexual issue if they desire. To accomplish this goal, some sort of sex-screening question must be included in an assessment.

Other than considering specific sexual practice issues involved in STD and HIV/AIDS transmission, the idea of including general sex-screening in a health assessment has been considered only briefly by a few authors. Concepts vary from an elaborate "screening history" requiring 30 minutes[10] to a small number of specific screening questions.[11]The rationale for choosing particular questions was not always clear.

Useful screening questions in any area should observe at least four rules:

1. *Screening questions should encompass a wide spectrum of common problems*

A variety of sexual problems may exist in any community, ranging from frequent (concerns about genital function, sexual practices, or emotional communication) to unusual (confusion about one's status as a man or woman). A screening system must be sufficiently sensitive to at least "pick up" problems that are common. Freund's opinion is that "a problem must be sufficiently common to justify investigation of an entire population of patients."[12] Sexual dysfunctions and difficulties, as well as problems related to STDs and child sexual abuse, are far more numerous than other sexual disorders and these must be uncovered in any practical sex-screening process[13] (pp.43-55).

2. *To be practical, screening questions should be few in number*

Realistically and reasonably, only a small amount of health professional time will be used to ask questions about sexual matters when the patient's major concern is elsewhere. Suggesting more than a few screening questions dooms the entire process from the start.

A small number of questions recognizes the limited amount of time that health professionals (especially nonpsychiatric physicians) spend with patients and the reticence that many patients have in spontaneously talking about sexual issues. Realistically and reasonably, only a small amount of health professional time will be used to ask questions about sexual matters when the patient's major concern is elsewhere. Suggesting more than a few screening questions dooms the entire process from the start.

3. *The problem must be of sufficient severity to justify the effort of asking questions of the population*[12]

The consequences of sexual problems must be considered from individual and social perspectives. In some instances, the severity of the impact on an individual is easy to discern (e.g., STDs) but in others the effect may be more subtle (e.g., repercussions on a relationship of a coexistent sexual dysfunction). Without "quality of life" information in the area of sexual problems, it becomes difficult to provide clear evidence about the effect of some problems on the individual. The existing literature on the effects of

sexual dysfunctions on individuals and relationships, as well as clinical impression, suggest substantial repercussions[13] (pp. 52-55). The outcome of some sexual experiences such as child sexual abuse are well documented.[14] Newspapers have well reported the social disruption caused by STDs and HIV/AIDS, pedophilia, and child sexual abuse.

4. *There must be effective treatment for problems that are common*

The treatments of sexual dysfunctions and their usefulness are reviewed in Part II.

These four screening criteria can be applied, for example, to one of the screening systems commonly used in medical practice. Part of any medical evaluation includes asking a series of questions about the function of different parts of the body. This brief health questionnaire has been variously called the "Review of Systems" (ROS) or "Functional Inquiry" and includes a few questions about each body system. It is meant to accomplish two objectives, as follows:

- To provide more information about concerns not obviously connected to the patient's main complaint
- To uncover undiscussed problems that the patient may have thought to be irrelevant or unimportant

Until recently, questions about sexual issues were not usually part of a medical screening process. Questions relating to this subject were not asked or were buried in questions about other body systems. For example, questions about sexual function were included with questions about a man's urinary function.

There is no universally applicable sex-screening formula. Several approaches can be used, depending, for example, on such factors as the comfort and skill of the interviewer or the age of the patient. Screening questions asked of adolescents might well differ from questions asked of elders.

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With the understanding that *variety and flexibility* in sex screening are desirable, one general method is described below. This approach can be incorporated easily into the assessment of any patient whose main concern is not primarily sexual, specifically, into the medical "review of systems." (The ROS concentrates on body function or dysfunction; therefore sexual practice issues can be included easily.) When judging the usefulness of the proposed sex-screening process, one should recall the four criteria mentioned previously, that is, questions should:

- Cover a wide spectrum of common problems
- Be few in number
- Justify the severity criterion
- Be concerned with problems that have effective treatments

Questions should include an additional criterion as well, namely, practicality.

When health professionals choose sex-screening approaches, the selection is not usually between systems that are brief or lengthy. The choice is usually between (1) a system that is brief and comfortable to the clinician and inoffensive to the patient or (2) a complete *absence* of any sex-related screening questions whatsoever.

SEX-SCREENING FORMATS

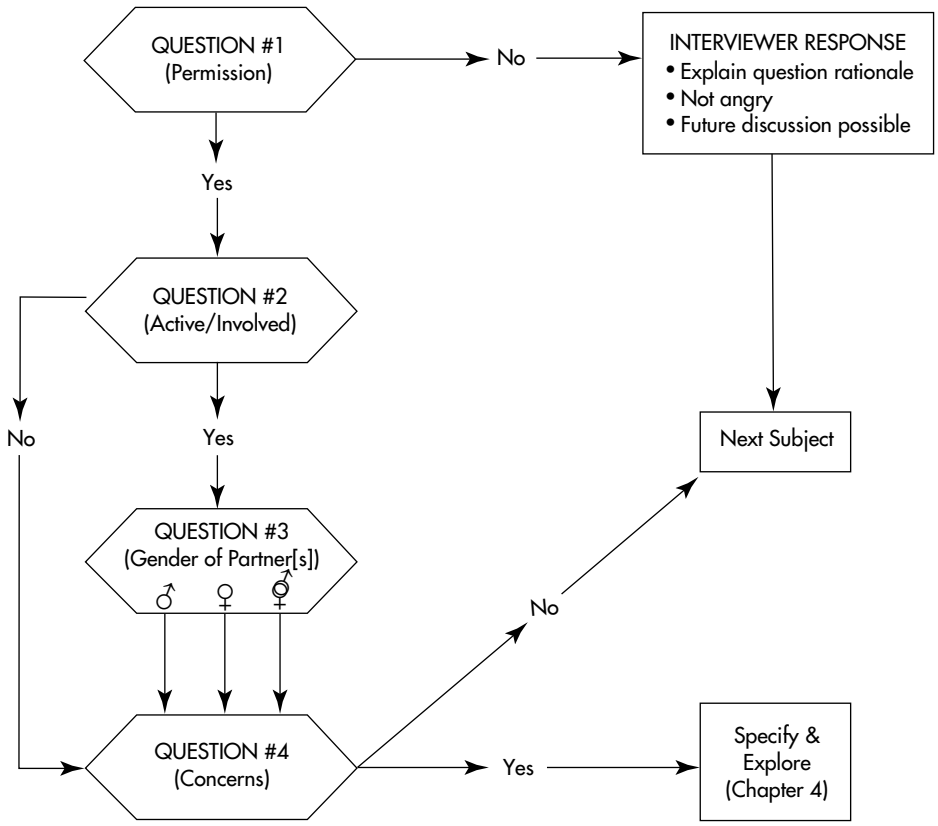

Figure 3-4 Flow chart for "sex" screening questions.

The older style sex-screening approach used to be: "How's your sex life?" While this fulfilled the wide spectrum and brevity criteria, it was also nebulous and indefinite. Being so general, it usually elicited an equally vague answer ("fine"), which was undoubtedly inaccurate on many occasions. In addition, the question potentially covered the whole of a patient's current sexual experience rather than concentrating on what was problematic and required attention.

The answer to a permission question is usually "yes." After consent is given, the interviewer naturally continues to the next question. However, in the unusual situation that the patients says "no," the interviewer has no ethical alternative but to respect the patient's decision and continue to the next subject.

A preferred approach (*Figure 3-4 and Box 3-2*) begins with the question: "**CAN I ASK YOU A FEW QUESTIONS ABOUT SEXUAL MATTERS?**"

This is not really a "sex" question but rather preliminary to other questions that might follow. Use of the permission technique was discussed in Chapter 2.

The answer to a permission question is usually "yes." After consent is given, the interviewer naturally continues to the next question. However, in the unusual situation that the patient says "no," the interviewer

has no ethical alternative but to respect the patient's decision and continue to the next subject. Before proceeding, some of the implicit issues mentioned above should be made explicit. In particular, the interviewer should explain the rationale for asking the question in the first place. Reasons given may include the following:

- That this area is legitimate for discussion in a medical setting even if unconventional from the patient's point of view
- That the interviewer's response is one of understanding rather than anger
- That the patient is free to raise the topic at any time in the future

The second screening question asks the patient: "**ARE YOU SEXUALLY ACTIVE?**" This question is common especially in relation to HIV/AIDS prevention. The question could be made sharper if a time frame is added. For example, it might be phrased: "**HAVE YOU BEEN SEXUALLY ACTIVE IN THE LAST SIX MONTHS?**" This revision might be useful particularly in situations where sexual activity may be regular but not necessarily frequent, as for example, in the elderly.

The meaning of the phrase "sexually active" could be more specific if it included some definition of the word "active." "Active" might refer to actions with a partner, with oneself (masturbation), or both. If a patient has a partner, couple sexual activities should be the focus of this question, so that the question might be: "**HAVE YOU BEEN SEXUALLY ACTIVE WITH A PARTNER IN THE PAST SIX MONTHS?**" If the patient does not have a sexual partner, the definition of "active" might logically include solo sexual experiences. However, since the subject of masturbation is often a sensitive one for patients and clinicians and, since it is infrequently reported as a problem with sexual function or practice, one might reasonably refrain from asking about this specific subject in the context of screening questions.

There are two potential problems with the word "active":

- Teenagers may not understand what the word encompasses. Talking with teenagers may be one instance in which the word "sex" is useful, since teens (unlike adults) often have a broader definition than simply intercourse. In using this approach, the health professional must clarify what practices are entailed within the word "sex."
- Some people interpret the word "active" concretely and consider themselves "passive," so that even if sexually involved with another person they might answer the question in the negative. It might be better to

Box 3-2

Sex Screening Questions

1. Can I ask you a few questions about sexual matters?
2. Have you been sexually active with a partner in the past six months?
3. With women? men? both?
4. Do you or your partner have any sexual concerns?

use the word "involved" instead of "active" in such situations. (A strong counter argument is that the word "active" has become part of the English lexicon and that professionals and adult patients are adjusted to its use.)

The final version of the second sex-screening question might therefore be: "**HAVE YOU BEEN SEXUALLY ACTIVE (OR INVOLVED) WITH A PARTNER IN THE PAST SIX MONTHS?**"

A "yes" answer to the question of sexual activity results naturally in the interviewer proceeding to the next item, which may be about the gender of the partner—opposite or same sex. (Questions are formulated by using the words, "men" and "women," rather than "opposite" and "same"[see immediately below].) Acquiring information about sexual orientation is vital for reasons outlined in Chapter 7 (see "Sexual Orientation: Issues and Questions").

The third sex-screening question is actually an extension of the second and attempts to determine with whom the patient has been sexually active. The question is asked only if the patient says "yes" to the second question and can be phrased (e.g., when talking with a man): "**HAVE YOU BEEN SEXUALLY ACTIVE WITH WOMEN, OTHER MEN, OR WITH BOTH?**"

Following a "no" answer to the question of whether or not a patient is sexually active, an attempt should be made to discover whether or not the person's inactivity is a concern. If it is, this requires some exploration by the interviewer and an explanation from the patient. This, in turn, leads into a diagnostic process. If sexual inactivity is not a concern, the interviewer could naturally proceed to the fourth and last screening question, which is: "**DO YOU OR YOUR PARTNER HAVE ANY SEXUAL CONCERNS?**"

The utility of a question about "concerns" lies in the fact that it is open-ended and problem-oriented. However, one problem with this question is its subjectivity. A more direct, objective, and still open-ended and problem-oriented version would be, "**DO YOU OR YOUR PARTNER HAVE ANY SEXUAL DIFFICULTIES?**" A third possibility is the same question but with some added specific examples. The question could then become: "(**for a man**) **DO YOU OR YOUR PARTNER HAVE ANY SEXUAL DIFFICULTIES, SUCH AS WITH YOUR INTEREST LEVEL, ERECTIONS, OR EJACULATION?**" (**For a woman**) "**. . . SUCH AS WITH YOUR INTEREST LEVEL, VAGINAL LUBRICATION, ORGASMS, OR INTERCOURSE PAIN?**" These examples are of sexual dysfunctions. A clinician could, if desired, substitute other examples such as STDs.

Any of these four questions should fulfill the four criteria for screening questions described above. If the screening professional can ask only one question, the fourth is the most desirable.

CONCLUSION

A screening system for "sex" questions is a necessity for health professionals. The arrangement must be comprehensive (encompassing problems with sexual function and sexual practices), the questions few in number, and the problems sufficiently severe

and treatable. Practicality also helps. There is not much use in proposing a system that no one will use.

Screening questions about sexual issues are a vital part of the health professional's intake procedure. However, screening questions cannot be definitive. The question inevitably arises: "What do you do if you get a positive answer?" One does, of course, the same as one would do with any other subject. In the practice of a health professional, this means allowing the patient to talk and ask more questions as part of a diagnostic process. This, in turn, leads to a conclusion and to a treatment plan. The next chapter discusses the first of these two steps.

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