CHAPTER 4

SEXUAL DYSFUNCTIONS: DIAGNOSTIC TOPICS AND QUESTIONS

In the Brancacci Chapel of Florence's Carmine Church, Masaccio and Masolino painted (1427-1430) Adam and Eve without fig leaves. Fig leaves were added 225 years later to cover their genitalia. During the recent cleaning of these masterpieces, which signify the beginnings of Florentine renaissance art, fig leaves added in 1650 were removed in 1986-1989. The point . . . is that pictorially the church changed its position on what was morally acceptable. If the church which is not usually considered to be at the forefront of liberal thought, can be this flexible on sexuality, why are physicians still dragging their feet taking better sex histories?

MERRILL ET AL, 1990[1]

The thought that one is "opening a can of worms" is a central deterrent to asking sex-screening questions. Learning "what to do with the answers" is surprisingly not very difficult if one is willing to confront two obstacles:

- Overcoming the awkwardness of talking about this subject
- Learning about sexual disorders in a factual sense

After screening questions are asked and a problem surfaces (see Chapter 3), the next step in exploring the concern involves moving beyond the level of a "chief complaint." A "complaint" indicates only the area of trouble. Examples of referrals to a sex-specialty clinic can serve as illustrations. One form of referral provides virtually no information, as when a request is made to "please see this man for sexual counseling." In this case, the area is general, that is, "sex." Another and more common type of referral is, "This man has frequent trouble with erections. His physical examination is normal. Please assess." In this case the area is "sex" and penile function. This referral is more specific. Both are examples of a "complaint."

A clinical diagnosis is based on information about the complaint, the chronology of the disorder, and the "signs and symptoms" or the way it appears in the present. It can imply some knowledge about the genesis of the problem but this depends on the general level of knowledge of the disorder. A complaint is not enough to begin a treatment program because there is no separation of diagnoses that may appear with the same starting concern. For example, the complaint of a woman being nonorgasmic does not say whether this problem occurs in all situations or if it is limited to certain forms of sexual activity. The treatment approach in these two situations may be very different.

Diagnoses of sexual disorders often can be made on the basis of history-taking alone. Physicians, compared to other health professionals, may conduct physical examinations and use laboratory tests. In relation to sexual dysfunctions, these additional diagnostic procedures are of particular use in the following situations:

- When a woman complains about pain or discomfort with intercourse
- When a woman has disire or orgasmic dysfunctions or when a man has erectile difficulties that may be partly the result of a medical condition

Box 4-1

What to Determine in the Assessment of Sexual Dysfunctions

1. PATTERN OF SEXUAL FUNCTION (see Box 4-2, the principal content of this chapter
2. SEXUAL PRACTICES (see Chapter 5, The Present Context: Immediate Issues and Questions)
3. AFFECTIONATE BEHAVIOR (see Chapter 5, The Present Context: Immediate Issues and Questions)
4. RELATIONSHIP WITH PARTNER (see Chapter 6)
5. SEXUAL-DEVELOPMENT HISTORY (see Chapter 5, The Context of the Past: Remote Issues and Questions)
6. MEDICAL HISTORY (see Part II)
7. PHYSICAL AND LABORATORY EXAMINATIONS (applicable to physicians in selected instances, see Part II)

Otherwise, a physical examination may be *therapeutically* helpful from an educational point of view.

Preferably, to arrive at a clinical diagnosis of a sexual dysfunction, the clinician should have six types of information (seven [physical and laboratory examinations] if the health professional is a physician [Box 4-1]).

When considering the *pattern of sexual functioning* only, seven aspects (explained in the remainder of this chapter) should be investigated (Box 4-2). The application of these aspects is illustrated in Appendices I and II. Each aspect suggests one or more questions and they help answer the plea of the clinician: "What do I do with the answers?" Furthermore, asking about these topics can be done easily in the time frame that health professionals may spend with patients—especially physicians, where the duration of the visit may be ten to fifteen minutes.

Box 4-2

Pattern of a Sexual Dysfunction: What to Ask

1. DURATION of difficulty: lifelong or acquired
2. CIRCUMSTANCES in which difficulty appears: generalization or situational
3. DESCRIPTION of difficulty
4. PATIENT'S SEX RESPONSE CYCLE (desire, erection, ejaculation/orgasm if male; desire, vaginal lubrication, orgasm, absence of coital pain if female)
5. PARTNER'S SEX RESPONSE CYCLE (see #4)
6. PATIENT AND PARTNER'S REACTION to presence of difficulty
7. MOTIVATION FOR TREATMENT (when difficulty not chief complaint)

Although specific words and phrases are suggested for each of the questions, interviewers must find their own ways of asking questions and using words with which they are comfortable.

For purposes of illustration, one particular problem is used, namely an erection complaint of a man who is 45 years old, heterosexual, married, with two children, and who has diabetes mellitus discovered five years ago. Although specific words and phrases are suggested for each of the questions, interviewers must find their own ways of asking questions and using words with which they are comfortable. The specific phraseology is less important than covering the topics.

PATTERN OF SEXUAL DYSFUNCTION

Diagnostic Topic #1: Lifelong or Acquired

Acquired sexual dysfunctions always require a diligent search for an explanation of the change that has occurred.

A sexual disorder may have existed since the onset of adult sexual function (lifelong) or may have been preceded by a period of unimpaired function (acquired). The reason for separating the two is the clinical supposition that different factors may be responsible for the origins of each. In general, acquired sexual dysfunctions always require a diligent search for an explanation of the change that has occurred. One may want to look for the origin of a lifelong disorder as well but this investigation is not always therapeutically necessary.

An example of the importance of determining whether a disorder is lifelong or acquired and of the relative significance of explanatory factors in a patient's history is the problem of a woman being nonorgasmic. In this instance, a lifelong disorder can often be so successfully treated that the reasons for the problem may be of more intellectual than clinical interest. However, acquired orgasmic dysfunction may result, for example, from a large array of medical conditions that may be crucial to understand, especially from a treatment perspective. Thus the reason for the problem may be specific and, if so, the treatment should be specific as well. Hence, the lifelong/acquired differentiation is ultimately needed to give proper therapeutic direction.

Inherent in questions relating to this topic is also the duration of a concern.

An interview with the patient who has a chief complaint of an erection problem in our example may begin like this:

Q. Do you usually have erection difficulties?
A. Yes, as a matter of fact I do. I don't have erections anymore.
Q. Can I ask you some questions about that?
A. Sure.
Q. When did your erection troubles start?
A. About two years ago.
Q. What were your erections like before?
A. No problem.

The dialogue began with a screening question about erections. This was followed by a permission question (see "Permission" in Chapter 2 and Chapter 3) asking for the patient's consent to enter into the "territory" of the specific problem. Questions were

then asked about duration and what the situation was like before the emergence of the trouble.

In this illustration, the man was discovered to be (1) open to questioning and (2) to have an acquired problem with his erections in that he had no difficulty until two years ago.

Diagnostic Topic #2: Generalized Or Situational

A sexual disorder may exist under all (generalized) or just some (situational) sexual circumstances. Discovering whether a problem is one or the other may be extremely valuable in speculating about its genesis. Generally, a problem that appears only sometimes (e.g., with one sexual partner but not with another) can be thought of as arising from psychosocial origins. (Important exceptions to this pattern are discussed in the introduction to Part II.) If, in contrast, a particular problem exists under all sexual circumstances, the interviewer should seriously consider the possibility of an impairment of one of the body systems controlling sexual function. The major categories of erection difficulties in most men can be successfully separated on the basis of sexual history alone.[2] A diagnostically oriented history can, obviously, be crucial in recommending a particular treatment approach.

If a particular problem exists under all sexual circumstances, the interviewer should seriously consider the possibility of an impairment of one of the body systems controlling sexual function.

The interview with the man who has an acquired erectile problem could continue in the following way:

Q. What have you noticed during the past two years about the circumstances in which you have erection troubles?
A. What do you mean?
Q. Well, a man usually has an erection or swelling of his penis under three circumstances:

- Periodically during sleep (at night and when waking up in the morning)
- During sexual activity with a partner
- With masturbation

I'd like to ask you about the first of these. What is your penis like nowadays when you wake up in the morning?
A. I used to wake up hard because of a full bladder but that doesn't happen now.
Q. Actually, people used to think that morning erections had something to do with a full bladder but another explanation having to do with sleep cycles or patterns was discovered some years ago. You may not be aware of this but men who are healthy usually get erections three or four times a night when they are sleeping. Let me return to asking you some questions about your erection difficulties. What happens to your erections during sexual activity

with your wife?
A. We try to have sex but I'm not usually hard enough to get in.
Q. I can see that is distressing and we'll discuss that in more detail in a moment. I also need to know what your penis is like when you're masturbating.
A. It's the same as when I'm with my wife. I don't get hard.

The first question was phrased in an open-ended manner. Although questions that are formulated in an open-ended way are generally promoted in health care settings, this approach may not have the same results when asking sex-related questions. Health professionals may begin with an open-ended question but very likely a patient will ask for more specific questions before answering. In the dialogue, the interviewer became more specific and in the process described something about expected erectile function. In an attempt to discover whether the erectile disturbances were generalized or situational, the interviewer asked separately about each of the circumstances in which a man is expected to experience an erection. The order of the questions was deliberate in that less provocative questions were asked before those that were more difficult to answer (see "Delaying Sensitive Questions" in Chapter 2). Morning erections were easier to discuss than erections with a partner. The topic of masturbation was last because it is a more sensitive subject. The patient's comment about erections with a full bladder provided an educational opportunity regarding normal male physiology (see "Explanation" in Chapter 2.) (Reflection on the distress of a patient was the focus of discussion of "feelings" in Chapter 2.)

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With the questions asked in relation to Diagnostic Topics #1 and #2, the interviewer ascertained that the man had an acquired form of erectile difficulty and that it existed when he woke up in the morning, when he attempted intercourse with his wife, and when he was masturbating. One can conclude, therefore, that his difficulties were acquired and also generalized.

Diagnostic Topic #3: Description

The interviewer must obtain a precise description of the problem as it exists in the present, the circumstances in which the problem arises. A description of pain with intercourse, for example, entails discovering such factors as location of the pain, what it feels like, and what makes it better or worse.

Ethical constraints prevent health care professionals from directly understanding changes in sexual function through direct observation. Hence the great dependence on words to help in comprehending sexual function that has gone awry.

A description is a verbal picture. Although depending on words may be usual for many health professionals, this is not always the case for physicians. Medical doctors measure all sorts of physiological phenomena such as changes in blood pressure or breathing as part of the diagnostic process. They also examine sex-linked structures such as a penis or vagina but sexual complaints often relate to sexual *function* rather than *structure*. Ethical constraints prevent health care professionals from directly understanding changes in sexual function through direct obser-

vation. Hence the great dependence on words to help in comprehending sexual function that has gone awry.

To add descriptive information to what has already been discovered about the illustrated patient with acquired and generalized erectile dysfunction, the following questions could be added:

Q. If you were to compare the hardness of your penis when you wake up in the morning now to the time before you had troubles, what would it be like on a scale of 0 to 10 where 0 is completely soft, 10 is very hard and stiff, and 7 is required to enter a woman's vagina?
A. It varies a bit but it's usually about 5.
Q. How about when you're with your wife?
A. About the same.
Q. What is the hardness of your penis like when you're masturbating?
A. Not much different.

The first descriptive question was one that literally asked the patient what his penis looked like when erect, or rather, his definition of erection (or lack of it). The patient again asked for clarification of the question because he was not used to talking to anyone so explicitly about his erections. The interviewer asked for a precise description by presenting the patient with a quantitative method for providing this information. One can do this by using the 0 to 10 scale (as in the example) or by asking for a comparison on a percentage basis. Another alternative is to simply draw a penis in varying states of fullness and ask the patient to select the drawings that most closely resemble his in the past and the present.

In talking about sexual issues, it is often more useful to use simple English rather than jargon to avoid misinterpretation. For example, the question asking for a description included the words "hard" and "soft." If the question mentions only the word "erection," an incomplete erection might not be noted, since the definition of an "erection" for many men refers only to a penis that is fully hard and stiff.

The patient described a "partial" erection. That is, his penis was neither full nor completely flaccid at its largest but somewhere in-between. This same partial erection existed under all circumstances and had been this way for the past two years.

Diagnostic Topic #4: Patient's Sex Response Cycle

It is necessary to ask questions about the other two phases of the sex response cycle apart from the "response" portion, since the function of different parts of the cycle are, to some extent, interdependent, and consequently problems may exist in more than one area. For example, a man may experience erectile loss and continue to be sexually interested (the first phase) but also experience ejaculation difficulties (the third phase). To understand the sexual context for any patient's difficulty, information is necessary concerning all three phases of the patient's sex response cycle.

Using Kaplan's triphasic model, the interviewer initially asks about sexual interest or desire.[3] The problem that may exist for this phase is the *absence* of interest (referred to in DSM-IV-PC as "Hypoactive Sexual Desire Disorder").[4] This complaint manifests in men and women, although the appearance of the problem tends to be different in each (see Chapter 9).

Specific questions about the patient's sex response cycle include the words "usually" and "often." This is deliberate, since the phenomena that are the subject of inquiry probably occur occasionally in everyone's sexual experience.

The specific questions about the patient's sex response cycle include the words "usually" or "often." This is deliberate, since the phenomena that are the subject of inquiry probably occur occasionally in everyone's sexual experience. Troubles that occur infrequently are not central to the interviewer's questions. *Persistent* and *frequent* problems should be the focus. In addition, the use of a word such as "usually" conveys an accurate but subtle message to a patient that occasional problems are to be expected.

The diagnostic interview with the man who has an acquired and generalized erectile dysfunction in which he consistently experiences partial erections could continue in the following way:

Q. What is your sexual desire or interest level usually like?
A. I think about it just as much as before but I worry about failing when I'm with my wife.
Q. I understand your concern about that but I also need to know what your ejaculation is usually like compared to the time before you had this problem.
A. It's weird. I can come when my penis is soft.
Q. That isn't abnormal. Erection and ejaculation are two separate events, although they usually work closely together. Do you have any problems with the timing of ejaculation such as being too fast or too slow?
A. No.
Q. Have you noticed any change in the intensity of your orgasm—the feeling that you get inside when you ejaculate?
A. It's not like it was when I was 20 but I haven't noticed any change in recent years.

Since the area of "response" (erection in a man) had been reviewed, the other two aspects of the sexual response cycle, namely, interest and ejaculation, became the main focus of inquiry. The words, "desire" and "interest," were used synonymously because in the opinion of the interviewer these words were less confusing than the more technical word, "libido." It was important to uncover whether the man's desire had diminished, since decreased desire may result in impaired erections.

The word, "interest," has several popular synonyms that a patient or interviewer might use. These include "desire," "drive," and "appetite."

Ejaculation, or the emission of semen, represents one of two components of the third phase (orgasm) of Kaplan's "triphasic model" in the male[3] (pp. 3-7). The other is the subjective feeling of orgasm itself. If it is difficult for men (or women) to describe the feeling of orgasm, one can, at least, ask whether the intensity of the

experience has changed. In talking to a patient about ejaculation, one should ask about orgasm as well.

Ejaculation and orgasm are neurophysiologically distinct—a fact that is demonstrated by the prepubertal boy who can masturbate to the point of orgasm but who cannot ejaculate because the mechanism is not fully developed. Ejaculation is objective; orgasm is perceived as subjective but has biological correlates. Ejaculation problems are common in men (especially premature ejaculation); orgasm problems in men are unusual. A patient may be mystified by the differentiation of the terms, *ejaculation* and *orgasm*, since the two phenomena usually occur simultaneously. However, sometimes there is a problem with one and not the other. For example, in the syndrome of Anhedonic Orgasm (see Chapter 10), a man experiences the emission of semen without a powerful internal feeling at the same time.

The differentiation of ejaculation and orgasm also provides an opportunity for the interviewer to introduce some educational information into the discussion. In asking questions about ejaculation, patients may use a slang word such as "come." This word is so commonly used that for some it can substitute for a "technical" term. In the illustrated dialogue the patient used slang. Although this gave some level of permission to the interviewer to do the same, the interviewer continued to use the technical term, "ejaculation" (see "Language" in Chapter 2).

The patient had no evident impairment in the areas of "interest" except insofar as he worried about his "performance." He was puzzled by the ability to ejaculate when his penis was soft, since he was always hard in the past when this happened. Men tend to find this embarrassing and even think it to be "abnormal." Reassurance about the physiological normality of this process can be given through information. The patient did not have any problem with emission or with orgasm.

To summarize, this patient had acquired and generalized erectile difficulties. His erections were always partial and he had no additional trouble with his level of desire or with ejaculation.

Diagnostic Topic #5: Partner's Sex Response Cycle

As is the case with the patient (a man in this illustration), it is essential to ask questions about all phases of the sex response cycle in the partner (a woman in this illustration), since a problem may be confined to one area and not to others. For example, a woman with vaginismus may indicate sexual desire (the first phase), vaginal lubrication (the second phase), and orgasm (the third phase) but still experience significant vaginal discomfort with attempts at intercourse.

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Sexual function involves a partner (except for masturbation) and thus sexual dysfunctions and "difficulties" are also partner-related. Although the partner can *sometimes* be implicated in the genesis of the dysfunction, the partner is *always* involved in terms of impact. Within a set of diagnostic questions, an interviewer thus needs to include information concerning the levels of interest, response, orgasm, and coital pain (if a woman) in the patient's partner.

Obviously, the patient may not know the answers to such questions, may know only by inference, or may have to guess and therefore run the risk of being entirely

inaccurate. The best method for obtaining this information is directly from the partner. Since many patients talk with health professionals alone (at least initially), the issue of a partner is included here even though the data obtained must be considered indirect and preliminary. In instances where partners are seen together, direct questions can be asked of each person.

The assessment or diagnostic interview with the patient with erectile troubles continues with questions about his wife's sex response cycle.

Q. What is your wife's interest in sexual activity usually like?
A. We've always been compatible except now she seems to want it more than me. I'm the one who turns her down. It wasn't like that before. It's not that I don't feel like it. I'm just not sure I can manage.
Q. When the two of you are touching each other and contemplating intercourse, does she often get wet in her vagina?
A. She sure does. She doesn't have any trouble. It's me with the problem.
Q. I understand what you mean but even if she wasn't involved in the generation of the problem, she's involved in the fact that things are not working the way they were before.
A. I suppose so. It's her problem too even if she didn't cause it.
Q. Let's go back to how she manages sexually. How about her coming to orgasm? Does that usually happen?
A. We don't have intercourse that often now but we . . . (pause) . . . have other ways to make that happen. I know she doesn't like other things as much as when I'm inside.
Q. Does she usually experience pain when you have intercourse nowadays, or did pain occur when intercourse was more frequent?
A. She certainly doesn't seem to nowadays. If she had this in the past, she never told me.

Sexual desire is subjective. Information obtained from a partner indirectly rather than from a sexually active person directly must be considered inferential unless the two people involved have had a very explicit discussion about this topic—an unusual event in the lives of many couples. In contrast, it is natural for people (as it was for this patient) to compare their own sexual interest level with that of their partner's and to comment particularly on changes that have occurred.

Problems with vaginal lubrication represent the second phase (response) of Kaplan's "triphasic model" in women.[3] Vaginal lubrication is, from a functional point of view, the equivalent of erection in a man in that both are evidence of pelvic vasocongestion and sexual arousal[5] (p. 279). Problems relating to lubrication in the absence of diminished desire are common in postmenopausal women but is not common at an earlier age. Such difficulties are most often the result of estrogen deficit or vaginal pathology (see Chapter 13).

The question about the patient's wife being sexually excited and vaginally wet involved asking two questions at one time. Generally, this is a confusing interviewing technique and one to be avoided. It was done here because becoming vaginally wet is so closely associated with excitement.

Orgasm is the third phase of Kaplan's "triphasic model" as applied to women[3] (pp.3-7). Although there are objective phenomena associated with orgasm in women, namely, vaginal and uterine contractions, the subjective experience is the focus of inquiry[5] (pp. 128-129).

Orgasm problems in women (in contrast to orgasm problems in men) are common. While the manner in which orgasm is experienced (for example, by masturbation or by vaginal intercourse) is *not* part of this question, it is phrased in such a way that concerns about this can be voiced if so wished by the patient.

Dyspareunia, or painful intercourse, does not easily fit into the "triphasic model." However, the fact that this is a frequent problem for women (although unusual in men) means that it should be included in "sex" questions relating to women.

The patient's wife was, apparently, sexually interested in spite of his troubles. Her response level was such that she became wet, or lubricated, when sexually excited. She seemed to be regularly orgasmic and painful intercourse was not obvious.

The patient with acquired and generalized erectile difficulties had partial erections at all times and no trouble with his level of sexual desire or ejaculation. His wife similarly had no disturbance with sexual desire (as far as he knew), becoming vaginally wet when sexually excited, being orgasmic, and not experiencing pain with intercourse.

Diagnostic Topic #6: Patient and Partner's Reaction to Problem

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The reaction of a patient or partner to the existence of a sexual disorder is partly a result of the universal human search for explanations for unhappy life events. The response could also reflect the difficulty or its treatment. Worries about a sexual problem can become important as a perpetuating factor apart from the original cause. The psyche and soma are difficult to separate when trying to understand what has gone wrong, since there are so many connections between the two. Kaplan talked of "sex" being "psychosomatic."[6] Indeed, one can hardly provide a better example of the links between mind and body.

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Reactions to sexual problems are heavily influenced by the virtually universal tendency of patients to blame themselves for the presence of sexual difficulties. Feelings of guilt are undoubtedly part of this process.

The interview with the patient with erectile dysfunction now concentrates on psychosocial issues:

Q. How do you feel about this problem?
A. Terrible. I feel like I'm not a man any more.
Q. Many people in your situation feel the same way. Has it affected your mood?
A. It's discouraging but I'm not really depressed if that's what you mean.
Q. How does your wife feel about what's happening?
A. I'm really not sure.
Q. Well what does she say?
A. She tells me not to worry so much. She says that it isn't such a big problem from her point of view.

The interviewer attempted to assess the feelings of the patient and the partner. As is the case with most men in this situation, the patient was clearly upset but was able to distinguish between being unhappy and feeling depressed. The interviewer empathically acknowledged the patient's feelings and the normality of his reaction (see "Feelings" in Chapter 2). The patient also connected his disturbance in sexual function to his sense of masculinity. There is, in fact, usually a great sense of loss of masculinity or femininity in the individual who is unable to have intercourse. The most dramatic examples of the impact of a sexual dysfunction on a patient's sense of gender completeness are in women with vaginismus who feel so incompetent as women that they sometimes suggest to their husbands that they "go elsewhere."

The patient in the illustration did not know what his partner thought, since she had not directly told him of her feelings. The interviewer pursued the subject by asking the patient to say something about his wife's reaction. Evidently, the wife's reaction did not reassure the patient.

This man with acquired and generalized erectile difficulty had partial erections but he didn't have trouble in the areas of sexual desire or ejaculation. His wife did not have problems with desire, lubrication, orgasm, or coital pain. This patient felt discouraged but his wife had been reassuring.

Although sexual dysfunctions are extremely common, not every patient wants to change.

Diagnostic Topic #7: Motivation for Treatment

Although sexual dysfunctions are extremely common, not every patient wants to change. This observation is apparent clinically and has been made from a research viewpoint also.[7] Some may be unwilling to do whatever is required to bring about change. The "price" may be too high in terms of, for example, embarrassment in talking to a stranger about "sex" (even a health professional). Given the willingness of some patients to accommodate to the presence of a sexual problem, a health professional can not assume a desire for change, and therefore it becomes essential to ask someone with an apparent sexual dysfunction if, in fact, they want some assistance. Unwillingness to engage in the process of change may be especially evident when a sexual problem is uncovered in the course of history-taking around some other health issue. However, even if a patient rejects the offer of help in this situation, the problem is noted and may be addressed in the future. *Obviously, if a sexual problem is the patient's "chief complaint," motivation is self-evident and a question concerning the desire to change is superfluous.*

The brief diagnostic interview with the patient who has acquired and generalized erectile difficulties ends with the following dialogue (included only for the purpose of illustration rather than clinical need):

Q. Is this a problem that you want some help with in terms of change?
A. What would that involve?
Q. We could talk a bit more and maybe I could see your wife as well. In addition, I'd like to conduct a physical examination and order some laboratory tests, since some aspects of your history suggest that your erectile troubles may be connected to changes in your body.
A. Your plan sounds fine. I'll ask my wife if she wants to come in.

Having determined the dimensions of the problem faced by the patient, the interviewer then asked a "where do we go from here"—type of question. The possibilities were outlined, at least for the near future, taking into consideration the capabilities of the interviewer to further investigate and possibly manage sexual problems.

The diagnostic interview of the 42-year-old man with an erection complaint tells us the following:

1. His erection troubles were acquired and generalized
2. His erections were partial
3. His sexual interest level and ejaculation were unchanged
4. His wife's experience with her level of sexual desire, lubrication, orgasm, and experience with coital pain were similarly unaltered
5. He was concerned about his erection problems, although his wife was reassuring
6. He wanted to investigate the problem and was prepared to include his wife in the process if she was willing

SUMMARY AND CONCLUSIONS

Health professionals sometimes refrain from asking questions about sexual matters because they do not know what to do with the answers. In pursuing a positive answer to a screening question, one must continue beyond the complaint to the level of a diagnosis. In the history-taking part of establishing a clinical diagnosis, clinicians may need information from some or all of six or seven types of information (see Box 4-1).

Obtaining detailed information about the particular problem (see first item in Box 4-1) entails asking questions relating to six or seven topic areas (depending on whether the problem was uncovered in the process of investigating another concern or whether it was presented as the "chief complaint"; see Box 4-2).

The questions that arise from these six or seven topics can be asked easily within the time frame that many health professionals spend with patients. Answers may provide information about the nature of the problem and suggest a direction in the search for possible contributing factors and the kinds of investigations that may prove necessary. Appendix III provides examples of the use of this seven-question model that could be used for role-plays in an educational setting.

The example of a man with erection difficulties was used as an illustration but it assumed the existence of basic information about his physical and psychiatric health. The conclusion of this diagnostic process was that this 45-year-old married man with diabetes mellitus, a disease known to be associated with sexual dysfunctions,[8] had a two-year history of erectile problems. His erections were consistently partial and unrelated to his wife's sexual response. He and his wife seemed to have substantial concerns about the change in their sexual experiences. The preliminary diagnosis was that of an erectile disorder presumably related to diabetes. Further medical investigations and laboratory studies were warranted (see Chapter 11). Talking with his wife (alone, with her husband, or both) may provide useful diagnostic information and allow for an understanding of her willingness to be involved in a treatment program.

Some primary care clinicians might be satisfied with what has occurred so far and prefer to send the patient to an urologist for further care. This course of action may not be possible. An urologist may not be geographically nearby, and having unburdened himself or herself to one person, the patient may be unwilling to do so again. Furthermore, the relationship with the patient may be such that there is a preference, and even a request, for the continued therapeutic involvement of the primary care clinician. In other words, circumstances may dictate the actions of the health professional quite apart from his or her personal desire to continue the investigation. If the patient does not want to be referred, the health professional may wish to explore the reasons for the unwillingness. The patient may, for example, have unspoken fears about talking to another health professional.

The health professional may decide to proceed further before referral and can do so by examining the context in which the sexual dysfunction currently appears and has developed. The present and past contexts of sexual problems are the subjects of the next chapter.

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