Part I

Sex History-taking, Interviewing, and Assessment

If you want to understand music better you can do nothing more important than listen to it . . . everything that I have to say in this book is said about an experience that you can only get outside this book.

Aaron Copland, 1957[1]

In the era in which we live, public sexual speech sometimes seems everywhere, from prime-time TV drama where a "call girl" explains to a private detective that her client usually shouts the name of his wife when he "comes,"[2] to a magazine ad for women's shoes that depicts an actress reading a newspaper while sitting on a toilet with her underpants just above her ankles,[3] to everyday radio and TV talk shows on which people seem to compete in verbally exhibiting the most intimate details of their sexual problems.

At the same time that the media have become more tolerant concerning private sexual behavior and public sexual speech, conservative political forces demonstrate considerable opposing strength. This social ambivalence was the background against which Laumann and his colleagues planned and executed their landmark "sex" survey in 1992 (The National health and Social Life Survey [NHSLS]) on a nationally based random sample of the United States population. Results of the study—referred to frequently in this book—were published in the form of two volumes. The first volume is titled *The Social Organization of Sexuality: Sexual Practices in the United States* and was written for medical and social scientists. The second volume is a distillation of the first, titled *Sex in America: A Definitive Survey*, and was written for a public audience.[4,5]

In spite of the enormity of the HIV/AIDS crisis and the desire of all to have more and better information with which to combat HIV/AIDS, the description of the United States government's failure to support the Laumann et al. project is sobering (see pp. 35-42 in "*The Social Organization of Sexuality*"). The unacceptability of broaching particular topics (e.g., masturbation) with study subjects, government rejection of the project, and the ultimate support of a consortium of private funding sources are additional demonstrations (if more are needed) of jumbled social attitudes toward sexual issues.

In the study by Laumann et al, almost 80% of 3432 adults between ages 18 and 59 answered detailed questions about their sexual behavior, thoughts, and feelings in face-to-face interviews that lasted about 90 minutes and were conducted by interviewers who were

complete strangers.[4] The interviewers were *not* health professionals but lay people working for the National Opinion Research Center (NORC). Although most had previous experience in public survey interviewing, an additional *short* training program was designed for this particular survey.

If lay interviewers who received only brief extra training can talk with ordinary people for a lengthy period of time about the minutiae of one of the most intimate and private areas of their lives, health professionals certainly could do the same. Laumann et al. concluded, in fact, that adults are quite willing to talk about their sexual behavior, providing that the "interview is conducted in a respectful, confidential, and professional manner"[4] (p. 602).

While the "sexual revolution" of previous decades brought changes in private sexual behavior, these changes did not necessarily extend into the consulting rooms of health professionals. *Talking about "sex"* is what begins this process. *Talk* is the key to the search for understanding sexual thoughts, sexual feelings, and sexual actions—ultimately it is the key to helping patients. Talk is the focus of Part I of this book. Before the past decade or so, only health professionals with a special interest in sexual problems would talk to patients about sexual issues. Today, the greater degree of societal openness about sexual matters has resulted in greater patient acceptance and understanding that questions about sexual issues are legitimately related to health.

A woman in her mid-30s and a man in his mid-40s lived together for five years. They were seen because of a problem with "intimacy." In talking about their sexual activity, it quickly became evident that none had occurred between the two of them (or anyone else) in three years. Neither had previously talked with a health professional about these issues, apart from a recent discussion with their family doctor who referred the couple. When asked why they were seeking help now rather than at some time previously, the woman explained the following:

- She and her husband recently changed family doctors and the new physician asked her about birth control
- Their previous family doctor had not discussed birth control. If the previous physician had asked, the woman would have said that she was not using any form of birth control. If asked why, she would have said that birth control was not necessary, since no sexual activity had occurred in years

The woman was unwilling (or unable) to volunteer the above information but had no difficulty explaining her status to her current family doctor when pertinent questions were asked.

In addition to the greater appreciation of connection between sexual issues and health, the advent of HIV/AIDS and child sexual abuse has markedly changed attitudes toward talking about sexual issues in health settings. Professionals who work in such areas might be regarded as negligent (or even unethical) if they bypass sex-related questions in the process of their investigations.

A married man underwent cardiac surgery in a Canadian hospital on several occasions. The last occasion was six years before his death at the age of 59. He received a blood transfusion during his last operation, and one year later the blood donor tested positive for HIV when attempting to donate blood a second time. Two years passed before the Red Cross Society traced the blood donation to the hospital where the patient had his surgery. Another two years transpired before the hospital traced the unit of blood to the transfusion given five years earlier.

At that point, the family physician was informed that the blood transfusion given to his patient might have been contaminated by HIV. Parenthetically, the physician was prominent and well regarded in his community and, at the time his patient's cardiac surgery occurred, he held a significant position in the medical licensing body of the Province. The physician chose not to tell the patient of the possibility that he (the patient) was infected with HIV and therefore was unable to test for this infection, since patient consent was required. One of the reasons given by the physician for not disclosing the patient's HIV status to him was that the patient was sexually inactive and therefore of no risk to his wife.

Evidence for the patient's sexual inactivity was based on a review of the chart. The patient had seen a cardiologist one year before his surgery and the report of the specialist noted that the patient experienced "impotence." In addition, in a functional inquiry performed by the family doctor earlier in the year of the cardiac surgery, there was a notation saying that the patient's libido was "slightly decreased." Also, on two other occasions (two and four years after the surgery), the physician's notes indicated that the patient's libido was "none." There was no elaboration in the notes of the meanings of the words, "impotence" and "libido." The physician evidently assumed that "impotence" and the absence of sexual desire were equivalent to the cessation of sexual activity. In fact, the couple had been sexually active (including intercourse) at varying levels for much of the time after the patient's surgery.

Six years after his cardiac surgery, the patient again entered the hospital, was tested for HIV antibodies, and was found to be positive. He died during this hospitalization of AIDS-related pneumonia. Within weeks after the patient's death, his wife was notified that her husband had been HIV positive. She was immediately tested, and six weeks later she was told that she was positive as well.

The medical licensing body in that jurisdiction penalized the physician by suspending (albeit temporarily) his license to practice medicine.[6] In addition, the estate of the patient, his wife, and his children, sued the hospital, the Red Cross, and the family physician for damages for personal injuries. After a trial that lasted for more than one year, the three defendants were deemed negligent. Liability of damages of over $500,000 was apportioned[7]:

Hospital	30%
Red Cross	30%
Physician	40%

Neither the licensing body nor the court explicitly acknowledged in their judgements the crucial role of the physician's evident inability to talk candidly with his patient about sexual matters despite the great potential significance of this factor to his health and that of his wife.

The physician in this true case history is testimony to the pitfalls involved in avoiding sexual issues, since he lost his license to practice medicine and also suffered social disgrace on a national level. Once thought of as elective in health care, the notion of inquiring into sexual function and practices is now commonplace within the mainstream of public and health professional expectations.

At least two elements explain the reluctance to talk about sexual issues in a clinical heath care setting (there are others—see Box 1-1 in Chapter 1):

- If the health professional introduces the issue of sexual difficulties and the patient says that "yes, a problem exists," the health professional has to know what the *next* question should be (or, in other words, the health professional must know what to do with the answers). Without thinking of the implications, many health professionals seem to conclude (by inaction) that it may be better to omit questions about sexual issues rather than face the hazard of not having prepared follow-up questions.
- After the nature of a problem is thoroughly investigated by a health professional, what does one do about it? Again, many health professionals appear to conclude that it is better not to ask if one can not bring about some change. (This topic is the focus of PART II.)

How does one inquire and what questions does one ask? Regardless of which of the urgent health/social themes is being discussed—HIV/AIDS, sexual assault, paraphilias, teen pregnancy, or sexual dysfunctions—talk is the means by which information is acquired. Theoretical issues involving history-taking (including the inquiry into sexual matters) and the circumstances governing such an exploration (see Chapter 1. Sets the stage for the remainder of the book.)

Consideration of special interviewing techniques used in asking sex-related questions (Chapter 2) implies that the subject of "sex" is different from other subjects in health care, a correct notion that reflects a social situation in which health professionals are no less victims than everyone else in the community. That specialness of the topic governs the content of questions in two ways:

- The nature of the general screening questions that are asked (Chapter 3)
- The specialized questions which elicit more detailed information of a person with a particular sexual dysfunction (Chapter 4)

Given the setting of health care, an assumption is made that investigation of a sexual concern is grafted onto a basic health assessment that includes essential medical information. Added to this is an etiological inquiry into the recent sexual experiences and sex-developmental history of the individual (Chapter 5). Chapter 6 provides a detailed description of the process involved in the investigation of the most common sexual complaint, namely, a sexual dysfunction.

When talking about any sexual issue within a health care setting, two previous, omnipresent, and nonpathological factors must always be considered: the gender and sexual orientation (1) of

the patient and (2) of the health professional. These two issues are discussed in Chapter 7. Neither gender nor sexual orientation of the health professional has any necessary connection to the care of the patient, which after all, is the central objective in health care. Nevertheless, one or both factors may influence the process, since patients may have views that pull or push them from, for example, women or gay health professionals.

The gender of each party is obvious and therefore can affect the health professional/patient relationship. In contrast, sexual orientation is hidden and becomes apparent only when one or both parties choose to disclose it.

Chapter 8 reviews the many issues and questions that an interviewer must address concerning medical, psychiatric, and sexual disorders (apart from dysfunctions). Chapter 8 completes the PART I focus on general aspects of talking to people about sexual matters.

REFERENCES

1. Copland A: *What to listen for in music*, New York, 1967, McGraw-Hill.
2. Chandler & Co: *PBS/KCTS*, April 11, 1996.
3. *The Globe and Mail*, Adacity, C 1, June 7,1997.
4. Laumann et al: *The social organization of sexuality: sexual practices in the United States*, Chicago, 1994, The University of Chicago Press.
5. Michael RT et al: *Sex in America: a definitive survey*, Boston, 1994, Little, Brown and Company.
6. *Members' Dialogue*, College of Physicians and Surgeons of Ontario, September 1993.
7. Pittman estate v Bain: 112 D.L.R. (4th) 257 (Ont Gen Div 1994).