

How to take a sexual history (without blushing)

Practice makes it easier to talk to patients about sex



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When you address sexuality, you open a window to the patient's psychology. Talking about sex may illuminate important clues about the individual's capacity to:

- give and receive pleasure
- love and be loved
- be psychologically intimate
- manage expected and unexpected changes throughout adulthood.¹

The opportunity to listen to sexual histories over time will help you become proficient in generating causal hypotheses and using them to help your patients.

Patients think—often erroneously—that all psychiatrists are knowledgeable, skillful, and interested in addressing sexual concerns. But psychiatric practice has turned away from clinical sexuality, and most of us learn on our own how to take a sexual history and to bring up relevant topics during subsequent sessions.

These activities are not particularly difficult,² but they often bump up against one or more clin-

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ician fears (*Table 1*).³ You can master these apprehensions by:

- identifying them in yourself
- thinking about them rationally
- learning about the broad range of human sexual expression
- understanding professional boundaries.⁴

ASSESSING SEXUAL COMPLAINTS

Sexual behavior—normal and abnormal, masturbatory and partnered—rests upon biological, psychological, and interpersonal elements, and cultural concepts of normality and morality.⁵ These four components also are the sources of sexual problems (*Table 2, page 18*).^{6,7}

To accurately assess individuals' and couples' sexual problems, we must consider the four components' present and past contributions in every case. We may declare a hypothesis of cause after one or two sessions, but the explanation usually evolves and becomes more complex with time.⁸

Outside of sexuality clinics, we usually learn about a patient's sexual complaint during therapy for another problem:

- **Individuals** may bring up cross-dressing, anxiety about possibly being homosexual, concern about violent sexual fantasies, or other issues of sexual identity. Sexual function concerns may include new difficulty attaining orgasm, aversion to intercourse, painful intercourse, too-rapid ejaculation, episodic inability to maintain an erection, or longstanding inability to ejaculate while with a partner.

- **Couples** may present with difficulty orchestrating their sexual lives. Their complaints may involve discrepancies in sexual desire, inability to bring a young wife to orgasm, cessation of sex, infidelity, dyspareunia, erectile dysfunction in a newly married couple in their 60s, or a wife's distress over her husband's use of Internet pornography.

Ask about erotic fantasies, knowing you may encounter behaviors contrary to your own values

Table 1

Clinicians' 5 worst fears about taking sexual histories

Personal or patient sexual arousal while talking about sex

Not knowing what questions to ask

Not knowing how to help with patients' sexual problems

Sudden awareness of one's own sexual concerns

Having the patient see our moral repugnance about certain sexual practices

Source: Reference 3

- **Referrals** may come from a social agency about an individual whose sexual behavior clashes with social values or laws. Judges, lawyers, state boards, clergy, or medical chiefs-of-staff may request assistance with individuals who cross sexual boundaries at work, are accused of sex crimes, or have been sexually victimized.⁵

ASK ABOUT SEXUAL IDENTITY

By the end of adolescence, most individuals have stably in place the three self labels that encompass sexual identity:

- gender identity—the degree of comfort with the self as masculine or feminine
- orientation—the gender of those who attract or repel us for romantic and sexual purposes
- intention—what we want to do with our bodies and our partners' bodies during sexual behavior.⁹

As you take a sexual history, explore how the patient views his or her sexual identity. Assess whether the patient's concerns indicate a gender



Table 2

4 components of sexual behavior: Where sexual problems may arise

| Component | Related sexual problems (examples) |
|--|---|
| Biological elements | Congenital androgen receptor disorder, ⁹ undiagnosed prolactinoma, ¹⁰ medical disorders (such as multiple sclerosis), medication side effects, heroin abuse |
| Psychological elements | Developmental processes (neglect, lack of warmth, or physical and sexual abuse from childhood caretakers) or present states (affect disorder, paranoia) |
| Interpersonal elements | Lack of psychological intimacy, marital alienation, disapproval of spouse's behavior (such as gambling or excessive shopping), disrespect for spouse's parenting style, past infidelity |
| Cultural concepts of normality and morality | Inability to free oneself of antisexual religious attitudes, homophobia, or belief that masturbation or oral-genital contact is abnormal sexual behavior |

identity disorder; whether his or her orientation is heterosexual, homosexual, or bisexual; and if the patient's fantasies and behavior indicate paraphilic intentions (Table 3).

Conventional sexual identities do not pose a countertransference problem for most professionals after they become accustomed to discussing sexual matters. But unconventional identities—such as a gender identity disorder, homosexuality, or a paraphilia—can cause anxiety and avoidance for sexually conventional psychiatrists.

Paraphilia. The most upsetting paraphilia to learn about is pedophilia. The patient typically is nervous about revealing his (or rarely her) fantasy focus on boys, girls, or both. Pedophiles may be exclusively interested in particular age groups—such as preschoolers or grade school children—or be preoccupied with children while also having more conventional adult sexual interests.

Learn to ask about erotic fantasies, knowing that occasionally you will encounter behaviors or thoughts that are contrary to your own values. Knowing that you will encounter paraphilia enables you to anticipate and work through any private moral outrage before you meet the patient.³

Want to know more?

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- ▶ Sexual dysfunction and love
JULY 2006
- ▶ Cases: Paraphilia countertransference
JULY 2005

ASK ABOUT SEXUAL FUNCTION

Desire, arousal, and orgasm are the three dimensions of sexual function listed in DSM-IV-TR. Sexual dysfunction may be classified as lifelong (since onset of sexual activity) or acquired (after a symptom-free period). If a patient's sexual dysfunction is acquired, determine whether it occurs in all sexual encounters or is situational (with only one partner or present sometimes with a

partner). These distinctions allow you to rationally pursue the cause (Table 4, page 20).

If a patient complains of loss of desire for sex, determine if it is manifested by:

- absence of sexual thoughts, fantasies, attractions, or masturbation (as might be seen in acquired hypogonadal states)
- lost motivation to approach his or her partner for sex (as commonly occurs when partners become alienated).¹⁰

As medical doctors, psychiatrists can recognize organic causes from sexual symptom patterns, take a relevant medical history, order appropriate lab tests, and ensure that genital examinations are done when indicated. After gathering such information, you can decide on a suitable referral.

Common sexual dysfunctions such as premature ejaculation, female anorgasmia, hypoactive sexual desire disorder, and arousal dysfunctions often have no significant genital findings. Erectile dysfunction in middle-aged and older men indicates the need to do a workup for early vascular disease and metabolic syndrome.

Desire versus arousal. Differentiating sexual desire and arousal can be complicated because they overlap, particularly during middle age or as individuals settle down with a consistent partner. Desire is also complicated by a vital gender difference.¹¹ Most women in monogamous relationships eventually notice that the arousal stimulated by sexual behavior *precedes* their intense desire for sex, whereas most men report that their desire

Table 3

Ask about 3 components of sexual identity

| Component | Sample questions |
|------------------------|---|
| Gender identify | Are you happy that you are a male (female)? Do you privately feel sufficiently masculine (feminine)? |
| Orientation | Are you sexually and romantically attracted primarily to males, females, or both? |
| Intention | Are your sexual fantasies focused on unconventional images involving sadism, masochism, exhibitionism, voyeurism, clothing, animals, or children? |

for sex precedes their arousal through much of the life cycle. Understanding these concepts will shape your follow-up questions about desire and arousal experiences.

Determine if loss of desire for sex means an absence of sexual thoughts or lost motivation

ADULT SEX LIFE: 6 STAGES

Sexual dysfunction symptoms may be the same throughout the life cycle, but their meanings to patients vary dramatically. For example:

- A psychological stress that creates erectile dysfunction in a 60-year-old might not affect a 25-year-old because biological capacities for arousal are different at these life stages.
- Anorgasmia in a 22-year-old does not have the same psychological and biological sources as anorgasmia in a 62-year-old.

My experience in taking sexual histories indicates that adults pass through six sexual stages,¹ and sexual symptoms can have very different psychological, interpersonal, cultural, or biological sources, depending on the stage at which they appear.

Stage 1: Sexual unfolding usually corresponds with adolescence and single adulthood. It is



Table 4

Ask about 3 components of sexual function

| Component | Sample questions |
|----------------|---|
| Desire | Are you ever “horny”—that is, have spontaneous feelings of mild sexual arousal? Tell me what motivates you to have sexual behavior with your partner |
| Arousal | Explain what is it like for you during lovemaking. Do you get excited? Do you stay excited? |
| Orgasm | Please tell me about your concerns about attaining orgasm |

characterized by growing awareness of individual identity and functional characteristics and experiments in managing sexual drives, sexual opportunities, and relationships through masturbation and partner sex. It ends when a person depends on one partner for sexual expression.

Stage 2: Sexual equilibrium is established as part of a monogamous partnership. This equilibrium, which shapes the couple’s unique pattern of sexual expression, is formed by the interaction of their individual identity, desire, arousal, and orgasmic attainment characteristics.

The power of this interaction can be seen in previously functional men and women who quickly become dysfunctional in a new equilibrium

because they discern their partner’s displeasure, lack of satisfaction, or lack of interest in particular sexual acts. Their perception of their partner’s unhappiness can quickly induce performance anxiety during sex, anger about sex, or a sense of hopelessness about getting one’s needs met.

The sexual equilibrium’s power is evident in previously dysfunctional individuals who quickly

become comfortable and capable when they sense that their partners are pleased with them as partners. Inhibitions gradually lessen, and the couple’s sexual life begins on a good footing.

Stage 3: Preservation of sexual behavior refers to maintaining partnered sexual activity as life becomes more complex because of expected events such as pregnancy, rearing children, new job responsibilities, illness in parents, etc. The couple’s ability to preserve their sexual relationship rests on their capacity to:

- manage disappointment over emerging knowledge of the partner’s character
- resolve periodic nonsexual disagreements
- re-attain psychological intimacy
- understand how important sex is as a means to erase anger, reduce extramarital temptation, reaffirm the couple’s bond, and have fun.

During this stage, then, sexual function cannot be separated from nonsexual psychological and interpersonal matters.

Stage 4: The physiologic downturn in midlife for women begins during perimenopause and is characterized by diminished drive, vaginal dryness, and reduced vulvar and breast erotic sensitivity.¹² Men’s physiologic decline—usually apparent to

Talking to patients about sexual identity and function strengthens the doctor-patient relationship and illuminates the patient’s personal and relationship psychology. Taking the sexual history will help you understand how the patient’s psychopathology affects the ability to love and be loved.

BottomLine

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them by their mid-50s—is characterized by reduced drive and less-firm penile tumescence.¹³

Stage 5: Aging effects emerge gradually as individuals move into their 60s. Both sexes usually find orgasm more difficult to attain. Women may say they have sex primarily to please their partners, and men may notice less consistent potency.

Both sexes rely on motivational aspects of desire to have sex, not on sex drive per se. A man may say he wants to have sex, for example, because “it is normal to want to have sex as long as the body is willing; it makes me feel manly.” Women who maintained natural vaginal lubrication during their 50s often now use lubricants.¹⁴

Stage 6: The era of serious illness—whether psychiatric or physical—can occur any time in the life cycle. Illnesses ranging from congestive heart failure to complicated grief can limit a person’s sexual activities. Some changes can increase the frequency of sex—such as hypomania or mania, the new appreciation of a now-impaired spouse, or substance abuse that decreases sexual restraints—but most serious illnesses diminish the patient’s or partner’s sexual desire and arousal.

When death, divorce, or other separations disrupt relationships and individuals find themselves unattached, they return to stage 1: unfolding. With new partners, they will have different desire, arousal, and orgasmic characteristics than they did when last unattached. Their next sexual equilibrium will be different from the one before.

Related resources

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- ▶ Risen CB. Listening to sexual stories. In: Levine SB, Risen CB, Althof SE (eds). *Handbook of clinical sexuality for mental health professionals*. New York: Brunner/Routledge; 2003:1-20.

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