A Rationale and Method for the Sexual History in Family Practice

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The taking of a sexual history produces a therapeutic effect for the patient by giving the patient permission to be sexual, filling patient knowledge gaps, providing a reality check, and beginning the process of self-acceptance by the patient.

The physician's own empathy may seem to interfere with his feeling comfortable while eliciting a sexual history; at the same time the patient may struggle with feelings of shame and embarrassment.

The physician can alleviate patient discomfort by being accepting and empathetic, and by assuming the patient has thought, felt, and done everything in the sexual area. He can also help by beginning with general questions, avoiding "why" questions and jargon, and gently reporting inconsistencies.

Although history-taking has become an accepted part of the physical examination, the idea of eliciting a sexual history as part of the social history is not so well accepted, nor are its purposes understood. The purpose of this paper is to clarify the rationale for physician use of time on this activity, to delineate the important role of the physician regarding this task, and to provide a brief format for the history itself.

According to research by Masters and Johnson, approximately 50 percent[1] of marriage relationships suffer from sexual difficulties at some time during the life of the relationship. This implies that a large percentage of patients at some time in their contact with the physician are not fully functioning sexually. The implications of this dysfunction for marital and family stress, as well as psychosomatic complaints, are enormous.

However, many physicians have legitimately questioned the value of eliciting a sexual history when they lack the time or interest to provide the sexual therapy itself. To elicit information and not be willing to help with the problem may seem unfair to the patient. But one physician, discussing the issue with residents, said, "There are a lot of problems that I don't deal with directly but that doesn't stop me from casefinding and trying to get the patient to the appropriate specialist." (James Rohde, MD, Meadowbrook Family Care Clinic, St. Louis Park, Minnesota, personal communication) Besides casefinding, though, there is another extremely important rationale for devoting time to a sexual history.

The Therapeutic Effect of History-Taking

Although histories are typically seen as vehicles for collecting data so that a treatment plan can be formulated, it is important to recognize that the very process of taking a sexual history can be helpful to the patient. The therapeutic effect of an active, sensitive listener and information-giver is frequently underestimated.

First of all, the physician, as an authority figure, gives the patient *permission to be a sexual person* by the very act of soliciting sexual information. The physician's questions to the patient regarding the patient's sexuality say, in effect, "I expect you to be a sexual person. I also expect that you, like most other people, have some questions or concerns about sex." Questions concerning a patient's sexuality and sexual behavior deliver a message with a high degree of permission-giving.

Then, as the physician questions and listens in an accepting manner, the *patient begins to "borrow" that acceptance from the physician.* Patients with sexual concerns frequently believe they are different from other people. They expect the physician to judge them in the same negative way they have judged themselves. As the patient sees and hears the physician's acceptance, he or she begins to experience relief: "Perhaps I'm not so different and bad after all."

Most patients have gaps in their information regarding sexuality, and as the physician becomes aware of these gaps, he or she may *serve as an educator and information-giver.* Patients frequently lack basic physiological information and carry with them many myths about sexuality that once corrected, provide relief.

For example, one husband complained that his wife was not very affectionate with him except during intercourse. When a sexual history was elicited from the wife she revealed that she believed that if her husband had an erection and did not have sexual intercourse he would suffer pain. She then concluded that she had better not touch him unless she was willing to have intercourse because it would be unfair to him.

Aging patients, in particular, need information. The anxiety produced for one patient when his erections were not as firm as in the past, led to impotence. Information provided on the process of aging and its effect on erections helped to dispel his anxiety.

In each of these situations some very simple, basic information relieved the anxiety and stress.

The sexual history is important even if the patient is not responsive to questions regarding sexuality. The unresponsive patient has heard the questions and experienced the atmosphere in which they were asked. *The patient*

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now knows that the physician is an accepting resource person. Initially, some patients, because of their own embarrassment and surprise, or because they have no concerns at the time, do not give much information about themselves. But, because the questions have been asked in a matter-of-fact manner, the patient leaves the office with the realization that the physician is a person available to talk to in an area that most people will not talk about; and certainly not talk about in an informed way. That important availability can give a patient enough hope and courage to be able to speak up next time, or when a concern does arise.

Eliciting a sexual history acts for the patient as a reality check of his or her actual condition and begins to counteract the patient's feelings of hopelessness. The patient presents the physician with a sexual difficulty, and the physician can inform the patient that it is treatable. In spite of all the available information from books and magazines, patients continue to believe many myths. Some women, for example, believe that if they are experiencing physical pain during intercourse, they are doomed to this "condition" for life. A male who is impotent may believe there is no help for him. One male patient had been impotent for eight years and talked to his physician about his problem only because his wife was threatening to leave him – not because he had any hope for change.

Finally, the physician can act as a *referral source.* Sexual dysfunctions may require a particular form of treatment that the physician chooses not to implement himself. The patient may have the option of being treated by other resources in the community, and the family physician, as usual, plays a key role in this referral.

The Physician's Own Discomfort

The qualities that enable a physician to be warm and supportive of patients – humanness, sensitivity, and ability to empathize – are the very qualities that add to his or her discomfort when discussing sexual issues with the patient. Like patients, the physician has grown up with some of the same rules and myths that frequently make discussing sexual matters uncomfortable and embarrassing. Out of kindness, the physician may fear embarrassing a patient or becoming too intrusive. He/she will probably empathize with the patient's initial discomfort and wonder whether to proceed. If the physician does proceed, he/she will break some powerful rules:

- Sex is not to be talked about.
- Sex is private so that any questions are an invasion of privacy.
- Sexual feelings and behavior are embarrassing and not "okay."

The list could go on, but one of the quickest ways to alleviate discomfort and to become more aware of one's personal biases is to exchange roles of history-taker and patient with a colleague. The history can be role-played, because the process of soliciting and giving sexual information is very helpful, whether or not the information is accurate. Another way to raise one's own comfort-level is to "do it." The physician can dive in and take sexual histories from patients two or three times. The process helps alleviate the anxieties and dispels many myths about how patients actually react.

The Patient's Discomfort

There are many myths that add to the patient's discomfort:

- If you are really a man or really a woman, you will automatically know how to perform sexually when you find a partner or get married.
- A "normal" person doesn't have a dysfunction, or have certain thoughts, or enjoy certain behavior.
- A real man can have an erection immediately; he is ready anytime.
- A real woman is not only orgasmic but multi-orgasmic.

These myths and others like them produce very real feelings for the patient. The physician, in an interview, may face a patient who feels embarrassed, ashamed, and guilty for not living up to an ideal self-image and for disappointing other important persons in his/her life. Patients often believe that no one could understand their feelings of disappointment and disgust with themselves, and the possibility of being seen as valuable human beings, with their feelings and concerns understood and accepted, seems remote indeed.

Helping Patients to Become More Comfortable

There are a number of specific things that the physician can do to help minimize patient shame and embarrassment. First of all, the physician can provide an atmosphere of acceptance:

- An accepting attitude can be demonstrated by eye contact with the patient and by permitting his/her natural warmth to emerge.
- The physician can be empathetic *and* let the patient know it. The patient's feeling of being understood is an important part of the process of sexual history-taking. Most physicians are able to empathize, and by putting into his or her words what the patient seems to be saying and feeling, the physician communicates the fact that the patient is being understood. The physician should continue to put into words what the patient is saying and feeling until the patient acknowledges feeling understood.
- The physician can be direct and use terms that he feels comfortable with, avoiding the use of jargon. When the physician tries to use terms that the patient has used with which the physician is uncomfortable, the patient will sense the discomfort and misinterpret it.

The kinds of questions and the way they are asked can also help the patient's comfort-level:

- The physician should begin with general, open-ended, less-threatening material and gradually move to more specific, more risky issues.
- The physician can assume that the patient has thought, felt, and done everything. Don't ask, "Do you masturbate?"; instead ask, "How often do you masturbate?" This will avoid putting the patient in the position of thinking that he must admit, or is caught at, something abnormal or not acceptable.
- The physician should avoid "why" questions. "Why" questions sound as though they are a request to justify, and the patient may begin trying to explain or defend himself or herself. "What," "how," and "when" questions more directly elicit the patients' explorations of their own processes.
- The physician can watch for inconsistencies and gently report his or her own confusion about them. For example, "I heard you say that your sex life was satisfactory but your tone of voice sounds angry or sad as you talk about it." This kind of reporting can help the patient become more aware of his or her own feelings and denials. And it avoids putting the patient on the spot,

with the accompanying need to defend the inconsistencies.

- The interview should be closed by first summarizing what has been seen and heard from the patient, and then contracting where to go from there. It is important to find out what the patient wants and to let the patient know what kind of help is appropriate and available.

The Sexual History

Where to include the sexual history in the physical examination is primarily an issue of comfort; the history should be included wherever it seems to fit for the individual physician. If comfort is not the issue, including the sexual history as part of the marital history works the best. But it can also become a part of the urological-genital examination, the family history, or the checking-out of the side-effects of drugs.

As the physician examines the sexual history outline, some thought should be given to ways in which further clarification is invited. As a patient acknowledges a concern, the physician can focus on that particular worry and move from the general to the specific. From general questions:

- Have there been any changes in your sexual feelings or behavior?
- How is your sexual life – satisfactory or not satisfactory?

To specific questions inviting further clarification:

- Do you mean you feel disappointed with yourself, your partner, or both?
- Do you mean you don't reach an orgasm – or sometimes you lose your erection when you don't want to?

Table 1 presents a brief outline of the sexual history in a form which serves as an effective initial approach to this general area and provides sufficient background information and rapport to proceed with later management of specific areas of sexual dysfunction.

Table 1. Outline of Sexual History

Identifying Data

- Presenting concern
- Age
- Sex
- Marital status

Marital History

- How many years married?
- How satisfactory has the relationship been?
- Which years were the happiest?
- How has the relationship changed over the years?
- What are one or two things you are most satisfied with?
- What are one or two things you are least satisfied with?

Sexual History

- How would you describe your affectional-sexual life?
- Do you, like most people, have questions or concerns about sex and/or your sexual activity?
- What activity in your sexual life gives you the most pleasure?
- What do you feel most dissatisfied with sexually?
- What changes have there been in your sexual life, ie, frequency, amount of pleasure, ability to perform in the way you want yourself or your partner to?
- What changes have there been recently?
- How often do you have intercourse?
- Is that satisfactory?
- What other ways do you have of meeting your sexual needs?
- Was there anything about sex that surprised you after you married?
- Was there anything about sex that disappointed you after you married?

Puberty

- A time of sexual change is often difficult to experience.
- How were you prepared for the changes?
  - ie, (1) menstruation
  - (2) nocturnal emissions and ejaculation
- Was there anything about your sexual feelings and/or behavior that surprised you?
- Was there anything about your sexual feelings and/or behavior that disappointed you?

If you could magically make your sex life so it could be just the way you want it, how would it be?

Summarize what you have heard.

Contract for future contact. Where to go from here?

Reference

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Suggested Reading

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2. Brenton M: Sex Talk. New York, Stein and Day, 1972
3. Miller S, Nunnally EW, Wackman DB: Alive and Aware: Improving Communication. Minneapolis, Interpersonal Communication Programs, 1975