

# CHAPTER 3

## Counseling Guidelines

www.gmhc.org, www.plannedparenthood.org or www.aasect.org

### *Advantages of counseling:*

- Involves patient in his/her own care and dispels misconceptions, myths and rumors
- Improves success with complicated regimens
- Helps people change risky behaviors— a vital, yet difficult, task
- Facilitates the decision-making process regarding contraception and STI prevention
- Explains possible side effects, which reduces anxiety, increases success with method and encourages clients to return if problems occur
- Reduces severity of serious complications through early recognition
- Builds and strengthens the provider/patient relationship

### *Principles of good counseling:*

- **Allow plenty of time**
- *Listen*, look at your patients, allow them to speak freely, repeat what you hear
- Remember LISTEN and SILENT use the same letters! ←
- *Respect*, recognize and accept each individual's unique situation
- Accept and anticipate that behavior change occurs slowly and incrementally. ←  
Remember that "**a lapse is not a relapse**" [Prochaska-1994]
- Ensure and maintain *confidentiality*
- Remain *sensitive*
- Be *nonjudgmental* and encourage *self-determination*; avoid *false reassurance* ←
- **Urge all your patients to know their HIV status**; Each encounter offers opportunity to counsel about STI/HIV prevention and contraception
- Inquire about problems patients may have had with previous medical recommendations;
- Know what you are talking about!
- Realize your patient will remember only 1-4 points ←

### *The GATHER method suggests the following steps:*

- **Greet** patient in a warm, friendly manner; help her to feel at ease
- **Ask** patient about her needs and reproductive goals; ask about risk for STIs
- **Tell** patient about her choices, explaining the advantages and disadvantages of all options
- **Help** patient to choose
- **Explain** the correct use of the method or drug being prescribed
- **Repeat** important instructions to the patient and clarify time and conditions of return visit

### *Reproductive/Contraceptive Goals:*

| GOAL:                                  | MAIN CONTRACEPTIVE CONCERNS MAY BE:   |
|--|---|
| Delaying birth of first child          | Effectiveness of method, future fertility and STIs  |
| Wants to avoid abortion for any reason | Need for maximal effectiveness;<br>May want to use 2 methods consistently                       |
| Spacing births                         | Most convenient method;<br>(Concern over failure of methods may be less)                        |
| Completed childbearing                 | Needs effective method for long term: offer IUD or sterilization as extremely effective methods |

***Taking Sexual Histories***

Although historically health care providers have been reluctant to inquire about sexual issues because of both time and social constraints, more clinicians are realizing that sexual histories are essential to identifying at-risk individuals and to providing appropriate testing and treatment. Explain to the patient that obtaining sexual information is necessary to provide complete care, but reassure her that she has the right to discuss only what she is comfortable divulging. Patients often want correct sex information and need to discuss sexual concerns that may be affecting their sexual performance or satisfaction. Ask patients less direct questions in the beginning to build trust, then ask the questions that explicitly address sexual issues once you have their confidence.

***Initiating the Sexual History***

- I will be asking some personal questions about your sexual activity to help me make more accurate diagnoses and to take better care of you. This is a normal part of the exam I do with all patients
- Is this all right with you? Your information is confidential
- You only need to tell me as much as you are comfortable sharing
- Some patients have shared concerns with me related to their risks of infections or sexual activity. If you have any concerns, I would be happy to discuss them with you

***Sexual History Questions***

- **What are you doing to protect yourself from HIV and other infections? OR What are you doing to put yourself at increased risk for AIDS?**
- Do you have questions regarding sex or sexual activity?
- How old were you when you had your first sexual experience?
- Do you have sex with men, women or both?
- Do you think you need contraception? How are you protecting yourself from pregnancy?
- How many sex partners have you had in the last 3 months? in the last 6 months? in your lifetime?
- How many sex partners does your partner have?
- Do you have penis in vagina sex, penis in mouth sex or penis in rectum sex?
- Do you drink alcohol or take drugs in association with sexual activity?
- Have you ever been forced or coerced to have sex?
- As a child, did anyone ever touch your genitals or ask you to touch theirs?
- Do you have sex for money, food, protection, drugs or shelter?
- Do you enjoy sex? Do you have orgasms? Do you have pain with sex?
- Do you or your partner(s) have any sexual concerns?

***Avoid Assumptions***

Making assumptions about a patient's sexual behavior and orientation can leave out important information, undermine patient trust and make the patient feel judged or alienated, causing her to withhold information. This can result in diagnostic and treatment errors. Do not assume that patients:

- Are sexually active and need contraception
- Are NOT sexually active (e.g., older patients, young adolescents)
- Are heterosexual, homosexual or bisexual
- Know if their partners have other partners
- Have power (within a relationship) to make or implement their own contraceptive decisions

## FEMALE

**Dyspareunia**

- **Definition:** Pain during vaginal intercourse or vaginal penetration
- **Key questions:** Does she have pain with vaginal penetration? Does she have pain with early entry in the mid vaginal area? Is there pain with deep thrusting? Is pain occasional or consistent? With every partner? Does the pain change with different sexual positions? Is she aroused and lubricated before penetration?
- **Causes:** Organic - vestibulitis, urethritis/UTI, vaginitis, vulvodynia, hypoestrogenism, PID, endometriosis, surgical scars or adhesions, pelvic injuries, tumors, hip joint or disc pain, female circumcision, orgasmic spasm  
Psychological - current or previous abuse, relationship stress, depression, anxiety, fear of sex
- **Treatment:** Directed to underlying pathology including depression. If dyspareunia is chronic, consider supplementing medical management with supportive counseling and sex therapy

**Vaginismus (special case of dyspareunia)**

- **Definition:** Painful involuntary spastic contraction of introital and pelvic floor muscles with attempted vaginal penetration
- **Causes:** Organic - may be secondary to current or previous dyspareunia and its causes. Psychological - sexual abuse, fears of abnormal anatomy (e.g. terror that vagina will rip with penile or speculum introduction), negative attitudes about sexuality
- **Treatment:** Education is critical. Insight into underlying causes helps. After source is recognized, start progressive desensitization exercises, which can include self manipulation and dilators. Sex therapist/psychologist intervention needed to deal with unconscious fears unresponsive to education

**Decreased Libido (Hypoactive Sexual Desire)**

- **Definition:** Relative lack of sexual desire defined by individual as troublesome to her sexual relationship; no absolute level "normal"
- **Causes:** Organic - may be due to acute or chronic debilitating medical condition (e.g., diabetes, stroke, spinal cord injury, arthritis, cancer, chronic obstructive pulmonary disease, coronary artery disease, etc.), medications (e.g. sedatives, narcotics, hypnotics, anticonvulsants, centrally-acting antihypertensives, tranquilizers, anorectics, oral contraceptives, Depo-Provera, and some antidepressants), dyspareunia, incontinence, alcohol, hormonal imbalance, or postpartum healing episiotomy  
Sexual practices - inadequate sexual stimulation or time for arousal. Sexual desires discordant with partner's desires.  
Psychological - depression, anxiety, exhaustion, life stress (finances, relationship problems, etc.), poor partner communications, lack of understanding about impacts of aging. Change in body image (breast-feeding, postpartum, weight gain, or post mastectomy or hysterectomy)
- **Treatment:** Treat underlying causes where possible. Rule out hyperactive sexual desire disorder of partner. Reassure about normalcy, if appropriate. Help patient create time and special space for sexual expression - no distractions from children, telephone, household chores. Suggest variety in sexual practices perhaps with aid of fantasies (romance novels are discrete source of fantasies for many women akin to Playboy for men). Physiologic androgen replacement can enhance libido. New drugs, including Viagra and ointments causing increased blood flow to the clitoris, are also under investigation. Consider referral to sex therapist

### **Excessive Sexual Desire (Hyperactive Sexual Desire)**

- **Definition:** Excessive sexual activity resulting in social, psychological and physical problems. See Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)
- **Cause:** Abuse at young age; attention seeking; acting out; mania; other such as bipolar disease
- **Treatment:** Refer for psychological counseling and therapy, Sex Addicts Anonymous

### **Orgasmic Disorders: Anorgasmia or Primary Anorgasmia**

- **Definitions:**
  - **Preorgasmia or Primary Anorgasmia:** Never experienced orgasms and desires to be orgasmic
  - **Secondary Anorgasmia:** Orgasmic in past, no orgasms currently, desirous of orgasm
- **Cause:** Organic - may be secondary to dyspareunia, neurological, vascular disease, medications (e.g. sedatives, narcotics, hypnotics, anticonvulsants, centrally-acting antihypertensives, tranquilizers, anorectics, and some antidepressants - particularly SSRI class antidepressants), or poor sexual techniques of partner (painful, premature ejaculation) Psychological - negative attitude about sexuality, chronic relationship stress; lack of knowledge about body and sexual response
- **Treatment:** Treat underlying organic causes, if possible. Explain sexual response (suggest reading of **Our Bodies Ourselves**). Add behavioral/psychological approach using PLISSIT model (see Abbreviations, p. vi), and sensate focusing exercises. Help couple set alternative pleasuring goals. Refer to sex therapist if initial interventions not successful. Have woman learn how to have an orgasm on her own in comfortable environment and then she can teach her partner how. Use lubricants, vibrators and sex toys

## **MALE**

### **Decreased Libido (Hypoactive sexual desire disorder)**

- No absolute level "normal"; "decreased libido" usually related to previous experience
- Evaluation and treatment similar to female's (see above)

### **Premature Ejaculation**

- **Definition:** Recurrent ejaculation before or shortly after vaginal penetration or ejaculation occurs earlier than patient or partner desires. Average time from entry to ejaculation in "normal" couples is 2 minutes; shorter interval is consistent with diagnosis.
- **Causes:** Organic - urethritis, prostatitis, neurological disease (e.g. multiple sclerosis). Psychological - learned behavior, result of anxiety (especially among teens)
- **Treatment:** Education and reassurance is important. If goal is pleasuring of partner, teach other techniques to arouse her prior to intercourse. "Start and stop" technique can be used to prolong erection; man stops stimulation for at least 30 seconds when he feels ejaculation imminent. "Squeeze" technique helpful; when man feels impending ejaculation, partner firmly squeezes the head of the penis beneath the glans for 4-5 seconds to decrease erection. Selective serotonin reuptake inhibitors (SSRIs) in low doses may be helpful if these other techniques are not adequate. Refer to sex therapist (or urologist if cause organic) for additional treatment if needed

### **Delayed (Retarded) Ejaculation**

- **Definition:** Inability to or difficulty in experiencing orgasm and ejaculation with a partner
- **Cause:** usually psychological; learned behavior; may occur when a man has masturbatory patterns that cannot be duplicated with partner; overemphasis on sexual performance. Rule out organic problems carefully
- **Treatment:** referral to sex therapist recommended

## **Erectile Dysfunction/Disorders (ED) (Impotence)**

- **Definition:** Inability to attain or sustain an erection that is satisfactory for coitus
- **Primary:** never achieved erection
  - **Causes:** Organic - low testosterone levels due to hypothalamic-pituitary-testicular disorder; severe vascular compromise. Psychological - usual cause
- **Secondary:** inability to currently attain erection (may be situational)
  - **Causes:** Organic - diabetes mellitus, alcohol abuse, hypothyroidism, drug dependency, medications (e.g. sedatives, narcotics, hypnotics, anticonvulsants, centrally-acting antihypertensives, tranquilizers, anorectics, and some antidepressants), hypopituitarism, penile infections, atherosclerosis, aortic aneurysm, muscular sclerosis, spinal cord lesions, orchiectomy or prostatectomy  
Psychological - depression, relationship stress, prior abuse, etc. Suspect when patient has morning erection or is able to masturbate to ejaculation
- **Treatment:** Treat underlying cause. Switch medications if possible. Same measures which help women's sexual desire may be useful. Medical or mechanical treatments available:
  1. **Testosterone.** Shown to be useful in wasting diseases (AIDS) and other low testosterone conditions. Available in patches for ease of use
  2. **Sildenafil citrate (Viagra)** 25-100 mg (usual dose 50 mg) tablet one hour prior to intercourse. Contraindicated with other ED treatments, retinosis pigmentosa, priapism or nitrates (nitroglycerin, isosorbide mononitrate, isosorbide nitrate, pentaerythritol tetranitrate, erythrityl tetranitrate)
  3. **Alprostadil injections (Edex or Caverject)** prostaglandin E1 ~ 1 cc injected into corpus cavernosa (strengths 125 µg - 1000 µg. Dose determined in office visit.) Excessive injection may cause priapism. Erection achieved with stimulation lasts 30-60 minutes. Avoid in anticoagulated patients and with vasoactive medications. Limit 3 per week
  4. **Alprostadil suppository (Muse)** prostaglandin pellet E1 (125-1000 µg) placed inside urethra. Erection occurs as drug absorbed. 70% successful. Contraindications - anatomical penile abnormalities (strictures, hypospadias, etc.), and thrombosis risk factors. Limit 2/day
  5. **Yohimbine hydrochloride.** Prescription pill composed of indole alkaloid. Modestly successful. Avoid in psychiatric patients (causes agitation and hallucination).
  6. **Vacuum Erection Device (VED).** Use of a vacuum pump and different size rubber bands maintains an erection for 30 minutes. Safe and effective (90% success rate). May be cumbersome and decrease spontaneity
  7. **Penile implants (protheses).** Bendable rods or inflatable reservoirs permanently implanted surgically into penis. Activated/inflated for intercourse. Success rate high, but associated with surgical risks and the risk that natural erections disappear
  8. **Microsurgery.** Used in men with atherosclerosis of penile arteries or venous pathology; over 50% success rate

### **TO FIND SEX THERAPISTS:**

- Ask your gynecologist or nurse practitioner
- Call your local Planned Parenthood clinic

# CHAPTER 6

## Adolescent Issues

advocatesforyouth.org, youngwomenshealth.org, teenwire.com, arhp.org/arhpfamepatetd.htm ←

Adolescents are very interested in sex, contraception, and STIs, but they rarely raise these issues with their providers. Although sexual abstinence may be increasing slightly among teens, most American adolescents have had intercourse before high school graduation. Helping adolescents to grow in self respect, positive self-image is the most important goal of all who work with teens.

### COUNSELING CHALLENGES POSED BY ADOLESCENTS

**Teens are not “young adults.”** Developmentally appropriate approaches are needed

- Age 12-14 – teens are very concrete, egocentric (self-focused) and concerned with personal appearance and acceptance, and have a short attention span
- Age 14-15 – teens are peer oriented and authority resistant (challenge boundaries), and have very limited images of the future
- Age 16-17 – teens are developing logical thought processes and goals for the future

**Nonjudgmental, open-ended and reflective questions** are better than direct yes-no inquiries. Try reflective questions such as “What would you want to tell a friend who was thinking about having sex?” instead of “You’re not having sex, are you?”

### CONFIDENTIALITY

Adolescents are often afraid to obtain medical care for contraception, pregnancy testing or STI treatment because they fear parental reaction. Over two-thirds of teens never discuss with their parents anything sexual that they have done; over one-half feel that their parents could not handle it. All teens should be entitled to confidential services and counseling, but billing systems and/or laws in some states affect their confidential access to family planning services. Know your local laws and refer to sites that may be able to meet all the teen’s needs if your practice can not.

**ADOLESCENTS AND THE LAW:** This table provides information on an adolescent’s right to consent to reproductive health, contraception, and abortion services.

**Table 6.1 Adolescents and the Law** ←

|         |         |         |         |         |         |         |
|---------|---------|---------|---------|---------|---------|---------|
| AL ●■□★ | DC ●■+  | IA ○■◆  | MI ○■□★ | NH ●■+  | OK ●■□◆ | TX ○■□◆ |
| AK ●■☆  | FL ●■◆  | KS ●■□◆ | MN ●■□◆ | NJ ●■□◆ | OR ●■+  | UT ○■◆  |
| AZ ●■☆  | GA ●■□◆ | KY ●■□★ | MS ●■★  | NM ●■☆  | PA ●■★  | VT ○■+  |
| AR ●■□◆ | HI ●■□+ | LA ○■□★ | MO ○■□★ | NY ●■+  | RI ○■★  | VA ●■◆  |
| CA ●■☆  | ID ●■★  | ME ●■□+ | MT ●■□◆ | NC ●■★  | SC ●■★  | WA ●■+  |
| CO ●■◆  | IL ●■□◆ | MD ●■□◆ | NE ○■◆  | ND ○■★  | SD ○■◆  | WV ○■◆  |
| CT ○■+  | IN ○■★  | MA ●■★  | NV ●■◆  | OH ○■☆◆ | TN ●■★  | WI ○■★  |
| DE ●■□◆ |         |         |         |         |         | WY ●■★  |

● = Minor may consent to contraceptive service (including some states with special circumstances such as the minors’ health, marital, or pregnancy status)

○ = No explicit policy related to minors’ access to contraceptive services

■ = Minor may consent to testing and treatment for STDs

□ = Physician may inform parents about STD testing and treatment but is not required to

★ = Parental consent required before a minor may obtain an abortion

☆ = Parental consent law exists but not in effect (e.g., declared unenforceable by courts)

◆ = Parental notification required before a minor may obtain an abortion

◇ = Parental notification law exists but not in effect (e.g., declared unenforceable by courts)

⊕ = Does not require parental involvement before a minor may obtain an abortion

Sources: *State Policies in Brief: Parental Involvement in Minors’ Abortions; Minors’ Access to STD Services; Minors’ Access to Contraceptive Services. As of January 1, 2002. Alan Guttmacher Institute.*

Note: Many of the laws contain specific clauses that affect their meaning and application. The authors encourage readers to consult the above documents (updated monthly) for more details: [www.agi-usa.org](http://www.agi-usa.org).

## ADOLESCENTS AS RISK TAKERS

- Full evaluation of behaviors is important to personalize counseling. Teens must move away from parental authority figures to become independent adult individuals, but, along the way, they may take excessive risks
- HEADSS interview technique helpful as an organized approach. Ask each teen about Home, Education, Activities, Drugs, Sexuality (activity, orientation and abuse) and Suicide
- Guidelines for Adolescent Preventive Services (GAPS) developed to help health care providers encourage adolescents to prevent or modify health-compromising behaviors
- Look for the athletic triad: eating disorders, amenorrhea and osteoporosis

## SEX EDUCATION

The sex education, contraception and STIs curricula offered in many schools are frequently not medically correct, and many students have only superficial understanding of what these topics mean. Information teens obtain from peers is also often inaccurate:

- *You cannot get pregnant the first time you have intercourse*
- *You cannot get pregnant if you douche after sex*
- *Having a baby makes you a woman, makes your boyfriend love you, and gets you the attention you deserve*
- *Making a girl pregnant means that you are a man*

***Adolescents need very concrete information and opportunities to role play and practice:***

- How to open and place a condom and where to carry it
- How to negotiate NOT having sex
- How to negotiate condom use with sex partner
- How to punch out the pills and where to keep the pack
- How to move in direction of dual protection: condoms and another contraceptive
- How to remember when to return for Depo-Provera injections
- How to use emergency contraception

## ADOLESCENT HEALTH RESOURCES

**American Medical Association: (800) 621-8335**

***AMA Guidelines for Adolescent Preventive Services (GAPS): Recommendations and Rationale***

- Provides review of the scientific basis for recommendations

***GAPS Clinical Evaluation and Management Handbook***

- Presents an algorithmic approach to diagnosis and management of GAPS conditions

***GAPS Implementation and Resource Manual***

- Identifies resources for health guidance materials, confidentiality, and practical strategies for implementation

***GAPS Implementation Forms***

- Reproducible forms, including adolescent and parent questionnaires, preventive services tracking chart, body mass index charts, blood pressure graphs, and health guidance prompt sheets

***Internet***

- Adolescent Health On-Line: [www.ama-assn.org/adolhlth/adolhlth.htm](http://www.ama-assn.org/adolhlth/adolhlth.htm)
- Division of Adolescent and School Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention: [www.cdc.gov/nccdphp/dash/index.htm](http://www.cdc.gov/nccdphp/dash/index.htm)
- Society for Adolescent Medicine: [www.adolescenthealth.org](http://www.adolescenthealth.org)