

Eliciting the sexual concerns of your patient in primary care

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ABSTRACT Sexual matters are, perhaps, the most personal and delicate subjects that you'll ever discuss with your patients. Not surprisingly, despite the popularity of some recent drug therapies, many people are still hesitant to voice their sexual concerns to their physician. Dr Basson elaborates on the need to initiate open discussion with patients about sexual concerns stemming from medical conditions, outlining the basic questions and interview techniques designed to make patients more at ease and clarify any problems. This is the first article in a series of articles on taking the sexual history.

Sexual concerns are common among men and women¹; approximately 35% of men ages 40 to 70 have erectile dysfunction (ED),² 18% to 20% of premenopausal women have dyspareunia, and 30% to 40% of adult women perceive their sexual desire as abnormally low.³ Less common is the patient who is willing to take the first step in addressing these concerns with his or her physician. Although the majority of patients would welcome help from their primary care physicians,⁴ studies indicate that both men and women are likely to wait for their physician to introduce sexual matters into the discussion, including problems that appear to result from a medical condition.⁵ We need a framework for rapidly predicting how a given medical condition might potentially have untoward sexual consequences, making it easier to assess patients at increased risk for sexual problems. The following discussion outlines such a model, providing a basis for initiating a brief inquiry into sexual function during a review of systems.

Framework for assessing sexual consequences of medical conditions

- Could the disease directly interfere with sexual desire or sexual function?
- Has medication (surgery, radiation) had negative sexual effects?
- Could sexual activity potentially aggravate the condition?
- How has each partner reacted to the presence of the disease?
- How has each partner reacted to any sexual dysfunction?

Assessing sexual complications of a patient with heart disease

Mr B., a 70-year-old man with coronary artery disease, is in for a follow-up. He had quadruple coronary bypass surgery one year ago. Having assessed his

Practice Tips

- | Use a direct approach, with leading questions, when speaking to your patients about sexual issues.
- | Allow your patients to feel in control of the interview by asking for their permission to discuss such topics.
- | Initiate discussion of sexual problems that may be related to the original medical condition.
- | Defer sensitive questions to a time when each partner is interviewed alone.

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TABLE 1 How to briefly clarify a sexual concern

When a patient presents with a medical condition that could potentially have an effect on the patient's sexual health, a direct approach that includes some leading questions would assist you in initiating the sexual inquiry. The following guidelines may be of use in most situations.

- ▮ Clarify exactly what the problem is. For example, "I can't perform," could mean erectile dysfunction, premature ejaculation, or even perceived infertility.
- ▮ How long has the problem been present? Was the onset gradual, acute, or has it been a lifelong difficulty?
- ▮ Is the difficulty always present (generalized) or only sometimes (situational)? For example, are erections similarly soft when you are waking from sleep, when you are stimulating yourself, and when you are attempting sex with your partner? This would also be a good time to respectfully inquire about any other experiences with different partners, including with partners of the same sex.
- ▮ Can a more detailed description be provided (are erections always insufficient for intercourse, is intercourse sometimes possible, but the erection is quickly lost)?
- ▮ What is the rest of the person's sexual response (desire, mental excitement, orgasm, ejaculation)?
- ▮ What is the partner's sexual response (desire, enjoyment, arousal, orgasm, freedom from pain for women)?
- ▮ How has each partner reacted to the problem (distancing, hesitancy, guilt, blame)? Have they tried any treatments (eg, if it's ED, has Viagra been used)?
- ▮ Are they still a sexual couple—maybe avoiding intercourse but stimulating each other orally and/or manually, or are they basically only affectionate and not sexual? Are even simple signs of affection avoided?
- ▮ Are both partners motivated to change and seek help?
- ▮ If the medical, psychiatric, and surgical history is not already known to you, another visit may be necessary.

current cardiac status, you consider the possible impact of his disease on his sexual life. Given that his cavernosal arteries, which supply penile circulation, and the endothelium lining the sinusoids in the spongy tissue of the penis (corpora cavernosa and spongiosum) are likely to be damaged in the same way as his coronary arteries and endothelium of his coronary microcirculation, generalized ED is likely to be present.^{6,7}

MEDICAL CONDITIONS AND SEXUAL ACTIVITY

Commonly, sexual desire is reduced after a myocardial infarction,⁸ with or without coronary artery bypass or other intervention. Mr B. may be hesitant to engage in sexual activity—sensing himself as a "cardiac patient." Perhaps more likely, his sexual partner, his wife of many years, fears sexual activity will be too stressful for him. She notices her husband's less-than-firm erections and interprets this as meaning he is not well enough to engage in sexual activities; she is therefore hesitant to respond to his advances and never initiates sex herself. Sadly, he desperately needs her enthusiasm to trigger his own desire and to help his sexual arousal.

Mr B. fears that if he does attempt sex, he will probably not have a firm erection; the more he worries about this, the more likely he will be correct. When this occurs, he feels like a failure and is not inclined to repeat the experience (which his wife misinterprets as a sign that he is losing his desire as well as his erections).

Medication could also be playing a role in Mr B.'s erectile difficulties. Antihypertensive drugs may critically compromise cavernosal blood flow in patients with generalized vascular disease by reducing perfusion pressure, given that blood flow through these men's cavernosal arteries is already compromised. A number of antihypertensive drugs may, by different pharmacologic mechanisms, further alter sexual response.^{9,10}

Finally, we need to consider whether sexual activity will be safe for Mr B. In one study, 33% of increases in systolic blood pressure and heart rate, particularly with orgasm, could be associated with symptomatic or silent ischemia in the presence of coronary artery disease.¹¹

BE DIRECT

A direct approach, with some leading questions, would be helpful in initiating a conversation about Mr B.'s sexual health. The following dialogue may be useful:

"You're continuing to do well from a cardiac point of view. You know, a number of men with histories of coronary artery disease tell me about some sexual difficulties, particularly with their erections. Are you having any difficulties?"

"Things aren't going very well sexually. In fact, they're getting worse."

"We can begin to assess the situation now, if you're comfortable with that. To be able to help, I need to understand exactly what the problem is. Can you tell me, as completely as possible, about the difficulties you're experiencing? Or can I ask you some questions?"

Most patients need assistance in clarifying the problem, and the questions included in Table 1 may be useful. A second assessment visit may be needed, especially when more than one dysfunction is present, and when the effects on the patient's partner are significant.

Interview skills

Given that many people are not used to speaking about sexual matters in any detail, some interview suggestions, outlined in Table 2, can be helpful.

PATIENT CONTROL

Allow the patient to feel some control of the interview, even though you are asking the questions; for example, "You mentioned that sometimes you have pain as you attempt intercourse. Is it okay if I ask you more about it?" or, "You said you had difficulties with erections. Can I ask you details about this?" or, "You said you have no sexual desire. I hear this very frequently, but I need to ask you a bit more about exactly what you mean. Can I go ahead?"

EXPLAIN NEED FOR DISCUSSION

Giving an explanation of why the question is needed is critical for the patient's comfort.

Using the phrase "many people" can also be very helpful when trying to put a patient at ease. For instance, a 70-year-old woman, apparently quite embarrassed to talk about sexual matters, had said, "Love-making is a bit difficult." We might say, "After menopause many women notice their bodies' responses have slowed down somewhat. Often they are not sufficiently wet in the vagina, making sex uncomfortable. Is that something you're noticing?"

GIVE ENCOURAGEMENT

Patients need to feel they are making progress, and offering encouragement may help. For example, you could say, "You're doing great, I know this is a difficult area to discuss, but I do need to ask more—is that okay?" (Note, we are again asking for permission.)

INITIATE DISCUSSION OF SENSITIVE TOPICS

Patients may need help broaching subjects that are particularly delicate, "Most men self-stimulate—or masturbate—are your erections the same degree of firmness if you stimulate yourself?"

Or, if a woman is complaining of great pain or difficulty when she tries to have intercourse, she is most

TABLE 2 Interview suggestions

- Allow the patient to feel in control
- Provide explanations for questions
- Help the patient to feel less unusual
- Provide encouragement
- Initiate the discussion of sensitive subjects
- Provide alternative answers
- Defer sensitive questions
- Avoid perception of inappropriateness
- Be aware of patient's cultural background
- Ensure confidentiality
- Do not be judgmental

likely too ashamed to admit if the pain has prevented intercourse from ever taking place. By being attuned to your patient's potential problems, you can make her more at ease by asking about the situation she is having difficulty discussing, "You know, many couples experience great difficulty with intercourse and sometimes it has always been impossible for the penis to enter the vagina; is that the situation for you?"

PROVIDE ALTERNATIVE ANSWERS

Rather than asking directly for explicit detail, which the patient may be too embarrassed to recount, supply alternatives, for example, "When intercourse is impossible, many couples discontinue sexual activity together. However, others are still sexual, using oral or manual stimulation, perhaps even using a vibrator." If you pose indirect questions, patients are much more likely to readily let you know their situation.

DEFER SENSITIVE QUESTIONS

Often it is necessary to ask about masturbation practices to evaluate the degree of ED, but this may be difficult to discuss early in the interview. We also need to defer sensitive questions to a time when each partner is interviewed alone, if the couple is seeing you together.

Questions about sexual, physical, and emotional abuse should often be included in your interview, especially when a patient reveals that there has been little healthy desire and functioning in the past—even before the onset of medical conditions. However, it may be unwise to ask about past abuse too quickly. Patients may incorrectly assume that we are automatically linking that abuse with the present sexual concern.

ENHANCED AWARENESS

As a physician addressing sexual concerns with your patients, your need for greater awareness is essential. You need to display heightened sensitivity to your patient's perceptions. Patient interviewing should be carried out in the consultation room rather than the examination room and the patient is, of course, fully clothed. It is wise to address sexual concerns only during regular office hours, when it is clear that another professional is in the immediate vicinity; note that giving explanations also avoids the perception of inappropriate questioning.

ENSURE CONFIDENTIALITY

We need to be careful when we have seen one partner alone. Ask if the findings can be shared with the absent partner—usually they can. If not, we need to clarify that the help we can provide may be limited, since the lack of trust and honesty between partners can often be a significant contributor to the sexual dysfunction.

Initiating the subject of sexual concerns

Usually, it will be your role to initiate subjects dealing with sexual health and functioning. This type of discussion most commonly occurs when the patient has a medical concern that is likely to impact on sexual health, as a component of a full routine health assessment, or when medication is prescribed that might impact on sexual health.

For example, when prescribing propranolol for preventing migraine, one side effect can be decreased sexual desire. However, the common complaint of a migraine does not usually lead to a discussion of sexual concerns. By avoiding such a discussion, we may be preventing one medical problem, but creating another.

DISEASES THAT MAY AFFECT SEXUAL FUNCTION

You can introduce the subject of sexual health when you examine the patient for a condition that could potentially interfere with sexual function. For example, when evaluating a woman with diabetes you may say, "Diabetes can quite often affect sexual function in men and women. Are you concerned about this at all? Have you experienced any problems with your level of arousal or desire?" If the answer is no, you might respond, "If at any point you have any concerns with your arousal or desire or comfort with intercourse, we can address them then, even if they are not necessarily related to the dia-

betes." If the answer is yes and you have the time, evaluate the concern; otherwise, arrange for a second appointment.

Likewise, when you examine a woman postpartum, it may be useful to ask, "Lovemaking can be quite difficult in those first few months after having a baby. Apart from sheer tiredness, there are some hormonal changes that can make intercourse uncomfortable. Do you have any concerns?"

DRUG-INDUCED SEXUAL PROBLEMS

When prescribing drugs, we must make patients aware that their medication may have adverse sexual effects. Using the previous example of prescribing a beta-blocker for migraine prophylaxis, you might say, "This drug is usually well tolerated. The main adverse effect is that of precipitating asthma in people with a history of asthma. Occasionally people experience sexual difficulties, although if you have none at present, this is most unlikely.

We can review this at any time, if it does present a problem." In follow-up, it is then reasonable to inquire whether or not there are sexual side effects.

SEXUAL REVIEW IN THE CONTEXT OF A GENERAL HEALTH ASSESSMENT

You can use different ways to introduce the topic of sexual health; for women, this area is typically reviewed during the gynecological history, and in men, in association with a urinary history. It is also perfectly reasonable to include questions on sexual drive, interest, and function when the questions of mood and depression are reviewed.

I suggest giving the same weight to the sexual function inquiry as you would to other systems, for example, respiratory. You might say then, "Do you have any concerns in the respiratory area, for instance, any chest pain, shortness of breath, unusual cough, tightness in your chest?" Similarly, you could ask, "Do you have any concerns in the sexual area, such as difficulties with sexual desire, arousal, lubrication? Any pain with any sexual act, or difficulties reaching high arousal or orgasm?"

This is important because even if the answer is no, the patient knows that you take sexual health seriously, and if there is ever a problem this patient would feel more at ease bringing it up if necessary. Examples of how to incorporate sexual health questions while taking the patient's general history are provided in Table 3.

Your patient will feel more at ease knowing you take sexual health seriously.

TABLE 3 Incorporating sexual health status in history-taking exam

In women

- Past medical history
- Current health status
- General
- Cardiovascular system
- Respiratory system and other systems (eg, abdominal, nervous system)
- Gynecological system
 - Menses
 - Cycle details
 - Blood loss
 - Dysmenorrhea
- Sexual concerns
 - Desire, arousal, pain with intercourse
 - Birth control
 - STD or HIV infection
- Urinary system
 - Frequency
 - Dysuria

Example of how to move into a discussion of sexual health:

“You mentioned less cramping while you are on the pill—is this also used for birth control?” (If a woman’s orientation is not known to you, you could say, ‘You mentioned the pill—are you heterosexual? Do you currently have a partner? And so you are using the pill primarily for birth control?’) Are you in a long-term relationship? Do you have concerns regarding STDs? Are you having any sexual difficulties, such as pain with intercourse or difficulty getting aroused? Is anything happening sexually that is negative for you?”

STD=sexually transmitted disease; HIV=human immunodeficiency virus

In men

- Past medical history
- Current health status
- General (eg, energy, mood)
- Cardiovascular disease
- Respiratory and other systems
- Urinary system
 - Flow
 - Frequency
 - Delay in initiating stream
 - Nocturia
- Sexual concerns
 - Erections, desire, ejaculation, orgasm
 - STD or HIV infection
 - Birth control

Example of how to move into a discussion of sexual health:

“You mentioned you are up at night to pass urine. I need to ask you about your sexual function, starting with erections—are they occurring at night and are they firm? Are you having any difficulties with erections when you want to have sex? Are you currently with a partner? (If the man’s orientation is not known to you, you could ask ‘Are you heterosexual or gay?’ Alternatively, ‘Is your partner a woman or a man?’) Are you in a long-term relationship? Do you have concerns about STDs or birth control? Do you have any sexual concerns, for instance, with your ejaculation or orgasm or your sexual desire? Is anything negative currently happening for you in the sexual area?”

CLARIFYING THE SEXUAL CONCERN—ONE OR BOTH PARTNERS?

Once sexual problems have been elicited, they can be assessed in about 10 minutes, using the simple questions outlined in Table 1. Clearly, the order will vary from patient to patient. Patients will often volunteer a lot of detail regarding their reaction to the situation before you are actually aware of the exact problem. Regardless of the order, we should always consider getting information about the sexual partner. Although many physicians are accustomed

to involving the patient’s sexual partner (even though they may not be the partner’s attending physician), other physicians rarely do this.^{12,13} This practice is highly recommended, as can be seen in the following example.

A 65-year-old man with generalized ED has had no intercourse—in fact, no sexual activity at all with his partner—for the past 15 years. The patient says he has no idea if his wife would have any pain if intercourse were to be resumed. He is not particularly clear whether she herself really wants sexual activity, including inter-

course, to be reinstated. Any intervention without some information, even indirectly, about the woman's wish for the situation to change may be harmful; she may be very content with the status quo, perhaps she never enjoyed sexual activity with her partner and was relieved when it was no longer possible because of his ED. When we cannot see the sexual partner, we must state to the patient our limitations in both diagnosing and treating the sexual problem. †

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