Sexual History Taking in Primary Care

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Abstract:
Sexual history taking is an important part of a comprehensive history. It affords the physician the opportunity to evaluate for sexual transmitted diseases (STDs), contraceptive history, sexual abuse, and sexual dysfunction. In addition, it gives the physician the opportunity to administer appropriate diagnostic tests, treatment, and prevention counselling. Only a small percentage of primary care physicians actually elicit sexual histories. There are many potential barriers to sexual history taking, including embarrassment, inadequate training, time constraints, and a belief that a sexual history is not relevant. The barrier we would like to address further is inadequate training of medical students and residents on how to elicit a sexual history. It is imperative for medical students and residents to receive proper instruction on how to elicit a sexual history. This includes didactic as well as clinical instruction on taking a sexual history. Modeling is a valuable tool in the learning process, and it is important that medical students and residents observe their preceptors eliciting a sexual history. This modeling is necessary for instructional purposes and for validation of the importance and relevance of taking a sexual history. The majority of medical students and residents are not expected to obtain a sexual history as a regular part of a comprehensive examination if there is no chief complaint that warrants a history. Their only opportunity to obtain a sexual history may arise when a patient has a chief complaint that requires a sexual history, and many times they are not supervised when they elicit those histories to ensure they do so appropriately. Increased training of practicing physicians, medical students, and residents on sexual history taking has the potential to have a positive impact on the number of physicians that elicit sexual histories.

Key words: Primary care, sexual, history taking.

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Introduction

The prevalence of sexual problems is not well defined in general population but estimated as 44% in males and 36% in females.[1,2] Attitudes and opinions for human sexuality varied lately especially in the developed countries causing more people seeking help for their sexual problems. Nevertheless, people still have sexual myths about sexuality.[3]

Sexual history taking is a chronological classification of human life cycle consisting sexual behaviour, emotions, expectations, experiences, and social changes.[2,4] It gives information about the characteristics (aetiology, onset, severity and duration of symptoms, psychosocial impacts) of the current sexual dysfunction, the changes causing trouble, available personal resources, aims and motivations of marriage, expectations from the therapy, and interpersonal relationship of partners.[2,4]

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Why do we need a sexual history?

Human sexuality is a complex of human biology, psychology, culture, and social circumstances. Individuals with sexual problems consult primary care physicians, more than one physician, use several, expensive laboratory tests.[5] Sexual functions are divided into phases (Figure 1). It should be kept in mind that these problems usually do not occur alone i.e. a situation causing dysparonia may cause orgasmic dysfunctions and loss of libido. The prevalent error in taking a sex history arises from the assumption that a “sex” history is a thing of meaning apart from a medical and psychosocial history reflecting the individual as a whole person. Even for purposes of structured social survey, significant material rarely is developed by sexually oriented questions uncorrelated with other aspects of an individual’s existence. In truth, in primary care when taken out of context of the total being and his environment, a “sex” history per se would be as relatively meaningless as “heart” history or a “stomach” history.

The essential reason of admission may be masked or covered by various other symptoms. Most of patients with sexual problems seek help from a family physician and they may feel embarrassed and shamed. They admit with low back pain for an orgasm problem or claustrophobia for erectile

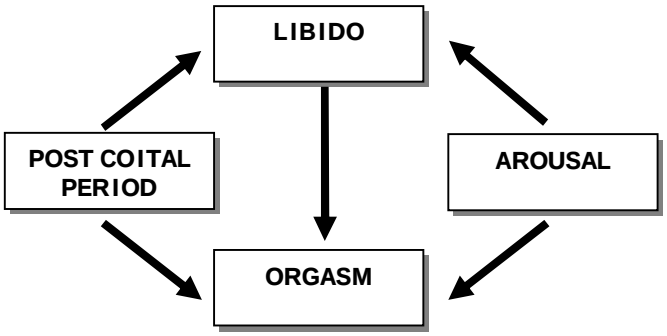


Figure 1: Cybernetic Model of Sexual Intercourse[6]

dysfunction.[6-8] The patient usually displays the pattern of "hand on the door knob syndrome". If the physician feels incompetent about management of sexual problems, he may prefer to deal with other organic problems that are easier to be identified and treated.[9] Some physicians think that they may define sexual problems easier if the patient has a complaint such as vaginal discharge, contraception or infertility. The questions such as "*What did you notice?"* "*How long does it exist?"* "Does the problem have a s*udden onset or progressive?"* "What are the p*ossible reasons?"* may be helpful.
The questions about sexuality have four main aims:[10-13]

a) Risk determination and prevention for unintended pregnancies and STDs
b) Understanding sexual behaviour as they may contribute to symptoms, diagnosis, treatment and prevention process
c) Opportunity to discuss sexual problems with a professional
d) Recognizing the relationship between drugs and sexual dysfunctions[14,15]

Medical problems usually interfere with personal relationships and sexual functions. Psychological problems such as depression, anxiety, insomnia and phobias may mask or cause sexual problems. Mental status of the patient and medical knowledge and experience of the physician affect the consultation. Advantages and difficulties of sexual history taking are presented in Table 1.

Table 1: Advantages and difficulties of sexual history taking

Advantages	Difficulties
Sexual problems are seen as a part of the other problems discussed with the physician.	The process may be embarrassing both for the patient and for the physician.
Talking about sexual topics may enhance the future consultations about sexual problems.	The patient may misunderstand the aim of the physician and may feel as judged.
Talking about sexual activities may give opportunity for health promotion.	The patient may begin to feel anxiety about something that has not been a problem for him/her before.

Obstacles in sexual history taking
Fears of the physician about irritating the patient, seeming curious, anxieties about inability to solve sexual problems or fear of going beyond the limits

of doctor-patient relationship are some of the obstacles in sexual history taking.[11] Others are; [16]

a) Prejudgements of the health professionals
b) Limitations in medical knowledge
c) False expectations and beliefs of health professionals
d) Cultural, religious, ethnic factors related to patient's attitudes and beliefs
e) Language and terminology problems

Table 2: Causes of sexual dysfunctions
Relationship problems
Individual attitudes
Attitudes related to sexuality
Post coital fear
Alcohol and drugs
Diseases
Inappropriate circumcision
Misunderstandings about sexuality

Obstacles and solutions[11,17]

- Fears of the physician about irritating the patient about seem to be curious: GP/FP should have specific training about sexual issues.
- Sexual history is not related to reason of admission: A short history of sexual life should be a part of routine medical history.
- Limited time: Consultations organised by appointments may avoid the delays in other patient consultations.
- The age and gender of the patient: The consultation is easier if the patient is young and the same gender with the physician.
- Fears of inability to solve problems: The physician should know his limits and use a network of consultation and referral.
- Others in the consultation room: Partners should be interviewed together and the interaction between them should be encouraged.
- Vague limits during consultation (example: seductive behaviour of some patients): Limits of the doctor-patient relationship should be definite. The same rules of confidentiality are valid also for long term relationships and familiar patients.

Inadequate knowledge about homosexuality, young generations, cultural and ethnic differences, fear of being judgemental or inconvenient in language: Physicians should be trained about the language they will use during sexual history taking. Explanations are useful before questions.

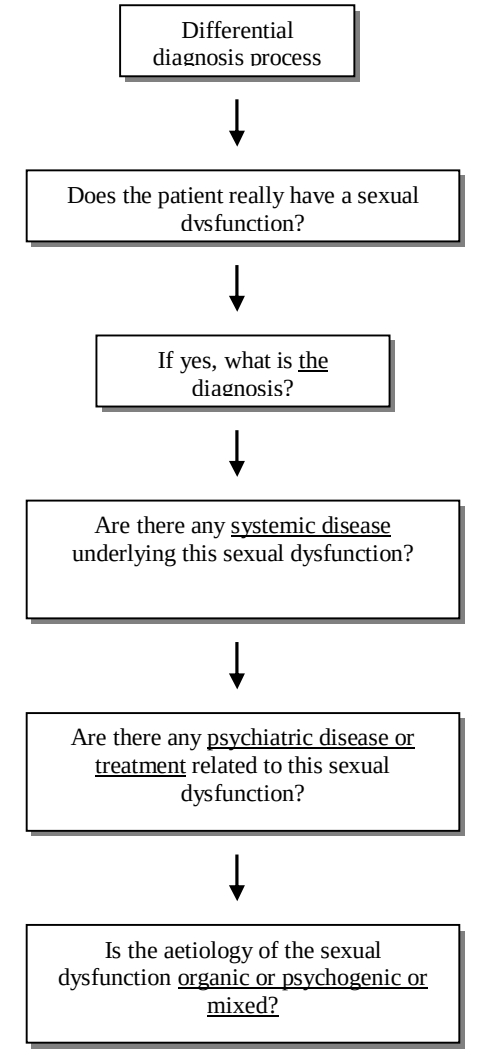
Anxieties of the patient about confidentiality: All patients should be given assurance about confidentiality of consultation and medical records.
History taking certainly must provide information sufficient to determine the character (etiological background, symptom onset, severity and duration, psychosocial affect) of the presenting sexual dysfunction. Equally important, history-taking must contribute knowledge of the basic personalities of the marital partners and develop o professional concept of their interpersonal relationship adequate to determine

- changes that may be considered desirable
- personal resources and the depth and health of the psychosocial potential from which they can be drawn
- marital-unit motivation and goals (what the marital partners actually expect from therapy).

Table 3: Common conditions which are not defined as sexual dysfunction	
A) Predictors	
Pressure	*Religious and cultural factors, feeling of guiltiness*
Traumatic sexual experiences	*Sexual abuse or violence*
Inadequate sexual education	*Unrealistic expectations*
Family relationship	*Oedipal complexes, overprotective behaviour*
Life style	*Stress, economic problems*
Personality	
B) Triggers	
Organic disease	
Aging	*Loss of libido, more time needed for arousal and orgasm*
Unfaithfulness	
Unrealistic expectations	
Depression and anxiety	
Loss of spouse	*Divorce, separation or death*

Methods of taking sexual history
Sexual life may be questioned during personal and social history or obstetric/gynaecological history for women.[18] If the complaint is related to genitourinary system sexual history may be taken inside the history of the current medical problem. Sexual life may also be questioned as a part of life style questions such as drug use, diet, exercise. The conditions such as chronic disease, severe pain or dysparonia may affect sexual functions and should also be questioned.[19]
Questions such as "*I have to ask you a few questions to understand the cause of this discharge and what we can do about it*". If the symptom is directly related to sexual disease the physician may use the statement "*I want to ask you some questions about your sexual life and health*".

Figure 2: Differential diagnosis of sexual dysfunctions



Satisfaction from sexual functions should also be questioned. Some examples of the specific questions are as follows: [20]
1. "*When did you last have physical intimacy with someone?*" "*Did this intimacy end with sexual intercourse?*" The term "sexual activity" should be avoided as it is not clear enough.
2. "*Do you have sexual intercourse with men women or both?*". Asking this question may help the physician to predict certain risks for heterosexual, homosexual and bisexuals.
3. "*How many sexual partners did you have during the last 6 months?*" This question implies that the patient may have more than one sexual partner. The aim is not to make embarrassed but to have conditions to let him/her accept the possibility of multiple partners.

4. Both men and women have to be questioned about contraceptive methods they use, especially the use of condom. "*Which method of contraception do you use?*" If the answer is none, the question "*Did you decide to be a parent lately?*" should be asked.
5. "*Are you satisfied with your sexual functions (life)?*" helps the physician to understand the assessment of the patient about his/her sexual life.
6. "*Do you have any idea about HIV or AIDS?*" helps the physician to ask risky behaviour.
These questions do not ask about marital status, sexual preferences, and behaviour of contraception or pregnancy.
The most common sexual problems are e*rectile dysfunction, premature and retrograde ejaculation, retarded ejaculation,* loss *of libido* and *Peyronie disease for men and* v*aginismus, orgasmic dysfunction and dysparonia for women.*
Adolescents require special interest and care. Adolescents tend to hide their sexual life and this needs more privacy and trust in doctor-patient relationship. [21]

Table 4: Sexual History	
Sexual games in childhood	•*Age when played* •*Where, with which sex* •*Caught and/or punished*
Circumcision for boys	•*age* •*reaction*
Menstruation	•*age of onset* •*preknowledge* •*source and level of information* •*reaction*
Sexual knowledge	•*age* •*source* •*level*
Masturbation	•*age of onset* •*frequency* •*beliefs, reactions, attitudes* •*fantasies* •*functionality*
Premarital sexuality	•*age of the first date* •*sex and number of partners* •*duration of relationships* •*kissing, fore playing, genital touching*
First intercourse	•*sex and type of partner* •*with or without money* •*marital or other kind of relationship* •*functional problems*
Type of marriage	•*with or without knowing each other* •*period before marriage* •*level of sexual behaviour* •*first night of the marriage* •*customs, traditions* •*reactions*
Libido	•*frequency* •*harmony with the partner* •*lust for others or willing to masturbate*
Frequency of sexual relationship	•*current* •*desired*
Fore play	•*duration* •*contribution* •*types* •*nakedness* •*avoiding genitals or semen*
Sexual arousal	•*Lubrication* •*Erection* •*Arousal problem in each intercourse*
Intercourse	•*Duration* •*Pain/ contraction*
Orgasm	•*With masturbation* •*Oral or manual* •*During intercourse*
Gynaecological history	•*Cycles* •*Menstruation problems* •*Deliveries* •*Abortus* •*Miscarriage* •*Intent to have a child* •*Method of contraception* •*Hymen* •*Gynaecological disease and treatments*

The physicians may figure out the differential diagnosis with the help of a complete medical history (Figure 2). A good medical history is one of the most important tools in assessing sexual dysfunctions. Unfortunately physicians tend to use complex and unnecessary laboratory and radiological tests. In the process of differential diagnosis the physician tries to find the aetiology of sexual dysfunction (Table 2).

The majority of sexual dysfunctions have psychogenic aetiology due to inadequate sexual education, myths, and exaggerated expectations. Vaginismus in women and premature ejaculation in men are psychogenic more than 90%. However organic aetiology such as alcohol/drug abuse, diabetes, multiple sclerosis, history of abdominal/pelvic operations should be kept in mind in dysparonia and erectile dysfunction. Secondary or late onset sexual dysfunctions have usually organic cause (Table 3).[22,23]

The most common inventory used for sexual problems is "*The Golombok Rust Inventory of Sexual Satisfaction*" (GRISS) which was developed by sex therapists in The Maudsley Sexual Dysfunction Clinic, was published by Windsor Nfer in 1995 and was standardized using a sample of 88 patients ongoing sexual therapy in various clinics in UK. It assesses the quality of sexual relationship and functions. It is for heterosexual couples having heterosexual relationships. Man and woman have separate forms.[24] Tugrul et al studied the validity and reliability in 1993 for Turkey. The last scores in the inventory are about sexual impotence, premature ejaculation, vaginismus, anorgasm, avoiding, dissatisfaction, and problems of communication. *The Golombok Rust Inventory of Marital State* (GRIMS) assesses the quality of a relationship and can be used with GRISS. It gives information about common interests of the couple, level of independency, communication, sexuality, intimacy, love, hate, trust, respect, roles, expectations, aims, decision making, and dealing with problems and crisis. Inventories are helpful in screening and rapid diagnosis however face-to-face consultation is of vital importance (Table 4).[25,26,29] Important issues of a sexual problem are presented in Table 5.

Other inventories are The Sexual Interaction Inventory (SII) developed by LoPicollo and Stegger, Derogatis Sexual Functioning Inventory (DSFI) developed by Derogatis and Melisaratos and Sexual History Form (SHF) by Schover et al.[5,27,29] The classification of sexual dysfunctions is presented in Table 6.[18]

Table 5: Important issues of sexual problem
•situational / global
•Primary / secondary
•Perception of the problem by the partner
•How does the problem affect the relationship?
•Expectations from the therapy
•Level of communication, conflicts between partners, coping with problems

Conclusion

Skills of taking sexual history in primary care can be improved by training. Sexual history should be a part of routine medical history. Both the physicians and the patient should know that sexual problems may be related to medical or social reasons or vice versa.

Table 6: Classification of sexual dysfunctions according to the aetiology	
Organic aetiology	*Psychogenic aetiology*
Erectile dysfunction	Vaginismus
Dysparonia	Primary premature ejaculation
Loss of libido	Primary retarded ejaculation
Secondary orgasmic disorders	Primary female orgasmic disorders
Secondary premature ejaculation	
Secondary retarded ejaculation	

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