Appendix T

First Assessment Interview With A Heterosexual Couple

(The following is a compilation of several taped and edited interviews with different patients, together with comments on what was said by me and why. Names and other identifying information have been changed for confidentiality purposes.)

WLM: Let me first explain what I'd like to do. I'd like to meet with you together today, separately on another occasion, and then together again after that. Each visit will be for about one hour. The purpose of these first few visits is to get a clear understanding about why you're here, what sort of help you're looking for, and what I might do to be of some assistance to you. It usually takes more than one visit to accomplish all of that. Do you have any questions about what we're going to be doing?

Comment: The couple is greeted in the waiting room. Introductions and handshakes are exchanged and they are then ushered into my office.

Comment: I explain as much as possible about the process beforehand on the telephone (I make my own appointments) so that there are no surprises such as the unexpected presence of a student. However, repeating the information in the office is also essential. People often do not fully absorb an explanation the first time it is given. Also, a question may have arisen since the telephone conversation.

Patients: No.

WLM: I received some information from your family doctor. I know that you're here because of sexual concerns, but before talking about that subject, I'd like to get to know both of you a little better. Perhaps each of you could tell me something about yourself such as your age, your living circumstances, and how you spend your days.

Comment: I always acknowledge the existence of a sexual problem at the beginning of an interview before going on to ask about "identifying information" (see Chapter 6). As I learned from experience, people wonder why questions are being asked about issues that, seemingly, have nothing to do with sexual matters. Also, I strongly believe in the value of a few minutes spent on "neutral" subjects at the beginning of a first interview to allow patients to "settle in" to new surroundings and adjust to the idea of talking with a stranger to whom they are about to reveal very private information. This allows people a few moments to decide whether I seem to be trustworthy or not.

Woman: (They look at each other) You go first.

Man: No, you.

Woman: Well, I'm 32 and working as a school teacher. I've been doing that for seven years. We've been married for three years but knew each other on and off for about twelve.

WLM: Does anyone live with the two of you?

Woman: Just our cat.

WLM: (Directed to the man) What about yourself?

Man: I'm 32 and work for the telephone company installing phones.

WLM: (To the woman) May I ask why you made an appointment before, cancelled it, and then changed your mind about wanting to be here?

Comment: I feel it necessary to discuss issues that could potentially hinder the interview process and to do so as early as possible to minimize that interference. When someone is ambivalent about being in my office (apart from the expected and virtually universal nervousness and embarrassment), I like, if possible, to resolve that before talking about any specific sexual problems.

Woman: When your secretary said that you wanted to see both of us . . . it's my problem . . . I spoke to my family doctor again after I spoke with you . . . She said both of us should go. So, I spoke to my husband and he agreed to come.

WLM: Well, how do you feel now about him being here today?

Woman: I still think it's my problem. I had it before

Comment: It is not unusual for both partners to be unhappy about an initial conjoint visit but for different reasons. In this case she was prepared to shoulder complete responsibility for the existence of their trouble and its solution. In some instances, the other person arrives with a grumbling attitude about having to attend a visit and is prepared to do so only as someone giving information about the partner, rather than as an equal participant.

When either situation exists, it can seriously clash with the interviewing process. Usually, talking about this potential interference and explaining the benefits of having both of them there is enough for both people to be considerably more accommodating.

we met.

WLM: (to the man) What do you think about being here today?

Man: No problem. It makes sense to me for both of us to be here.

Comment: His wife may well have thought that he was not sincere in telling her about his willingness to join her in the treatment process. His positive answer to a third party becomes important for her to hear.

WLM: (to the man) As I mentioned to your wife on the phone, my own opinion is that quite a bit of information can be obtained from talking to one person alone, but in terms of changing things, it's usually best if both partners are here. From my viewpoint, I'm very pleased that you're here.

Let me continue where we left off before. Is this the first marriage for both of you?

Woman: Yes.

WLM: Healthwise, how are the two of you doing? Do you have any major health troubles?

Comment: Ordinarily, I avoid asking someone two questions at the same time. When this happens, patients don't know which to answer. If it is more advantageous to answer one over the other, the person doing the answering will usually take the path of least resistance (as President Kennedy discovered in the Cuban Missile Crisis). The interviewer may be the loser (and, of course, ultimately, the patient). My only excuse in this instance was that the first question was more of a preamble to the second rather than an actual question. It would have been better phrased as a statement than a question.

This question is essential because some medical disorders can seriously interrupt sexual functioning.

Woman: I have an ulcer.

WLM: Tell me about that.

Woman: The pain started about two years ago. I had an X-ray but it didn't show anything. I took some medication . . . I don't remember the name . . . until about six months ago. It's much better now.

Man: My health is OK.

WLM: Do either of you take medications on a regular basis?

Woman: Nothing.

Man: Nothing.

WLM: Street drugs?

Woman: Neither of us has used any for years and even then just an occasional joint.

WLM: What about tobacco? Do either of you smoke?

Woman: We used to but stopped before we met.

WLM: Alcohol? What is usual for both of you?

Man: Only at parties. Hardly ever at home.

WLM: I understand that you do not have children. Has this been by choice or is there some other reason?

Woman: That's part of the reason we're here. We'd like to start a family.

WLM: Let me just ask you one more question before we talk about the reasons for the two of you being here. Have either of you had any kind of counseling in the past for sexual difficulties or any other problems?

Woman: No one apart from our family doctor and my gynecologist. I'm very selective about whom I talk to. I just can't go and talk to anyone about it.

WLM: You said something before about wanting to start a family and that was part of the reason for coming here. Could you explain that further?

Woman: Well, a lot of the problem is dealing with

Comment: Some medications can interrupt sexual functioning also; therefore this, too, is a necessary question.

Comment: The same can be said of street drugs.

Comment: The use of tobacco can have deleterious effects on relationships and on some aspects of sexual function.

Comment: Alcohol, as well, can have very serious effects on relationships and sexual function.

Comment: I have found this to be the most nonjudgmental way I can obtain this extremely sensitive information. The question is entirely descriptive and simply asks for explanation rather than justification. I prefer to avoid sounding like a reproachful relative.

Comment: My motivation in asking about experiences with other health professionals is not to be critical of others but rather to find out what approaches have been used in the past, and what has and has not been helpful. I would not be of much assistance to a patient if I simply repeated treatment methods used before without knowing why they were unsuccessful.

Comment: I did not need to ask them what the main problem was since she offered this spontaneously. As it was, I interrupted her somewhat by my previous question, something I am ordinarily loath to do. Patients do not easily explain the major reasons for coming to see me without my first asking. If someone does, I usually listen and don't ask questions until they finish talking.

sexuality. We thought we could come and talk to you and that you might be able to help us. I have a habit of blocking things out that are unpleasant . . . I put things off . . . my family doctor thinks I'm nervous and tense about everything. . .and that maybe that has something to do with getting . . . you know . . . pregnant. We've . . . um . . . never done it . . . you know . . . intercourse. The gynecologist suggested an operation to make it easier but my family doctor said we should have counseling before considering that. We love each other very deeply but unfortunately this one area has been a problem.

WLM: Is it OK if I ask you some questions about intercourse?

Comment: Ordinarily in interviewing, it would be reasonable to ask an open-ended question at this point, for example, "Tell me more about the difficulty you have had with intercourse". In fact, I usually do so but I am never surprised when I receive a vaguely worded answer. I know by experience that patients find it onerous enough to indicate what the general area of the problem is, much less give details. She was hesitant about telling me and undoubtedly was embarrassed. An open-ended question at this juncture often meets with the type of reply that says "What is it that you want to know?" or "Ask me some specific questions." When this happens, I simply go on to ask direct questions about the specifics. In this particular instance, I used the "permission" format of asking the initial question. I did this for reasons explained in Chapters 2 and 3.

Woman: Yes.

WLM: Has there ever been a time when the two of you tried to have intercourse?

Woman: Yes. We've tried it quite a few times but it's always been painful for me and . . . um . . . my husband's so caring and understanding . . . he knows the way I am . . . he never forced it.

WLM: When was the first time the two of you tried?

Comment: I deliberately phrased it as the "two of you" so as not to force her into revealing information about sexual experiences with other partners, recently or in the past, that she may not have discussed previously with her husband. I wanted to know if the problem of not having intercourse was lifelong or acquired (see Chapter 4). With both partners together, I could

find this out only in the context of this relationship (see Chapter 6).

Woman: Well, it was before we were married. I couldn't tell you exactly when . . . it was so long ago.

WLM: Has he ever actually entered your vagina, even part-way?

Woman: I really don't know. I mean . . . it's hard for me to know.

WLM: (to the man) can you shed some light on that question?

Man: Not really. I couldn't add anything to what she's said.

WLM: (to the woman) I'd like to ask you some questions about your experience with other things that might commonly be inserted into a woman's vagina. For example, have you ever used tampons?

Woman: No. I remember once I tried to use something that a doctor gave me for a yeast infection . . . it was to be inserted there and I couldn't.

WLM: A suppository?

Woman: Some sort of . . . there was this thing . . . I think it was a big pill actually . . . I told her I couldn't . . . she gave me something else . . . a cream or something. I think that's the only time I ever tried . . . I'm really squeamish . . . I don't like touching or looking down there.

WLM: Sometimes, for one reason or another, a woman might insert her own finger into her vagina. Have you ever had that experience?

Comment: This is an example of the statement/question technique described in Chapter 2. It combines information as a preamble, with a question that follows.

Woman: No. My family doctor suggested that I try to stretch myself . . . I should have told her right then and there that I couldn't do it.

WLM: (to the man) Sometimes, a sexual partner might insert a finger into the woman's vagina as part of a couple's sexual activity. Has this ever been part of your experience together?

Comment: I was conscious of the fact that most of the discussion so far had been between myself and the woman, and that I needed to incorporate him in the conversation to a greater degree. From the viewpoint of being an observer of the communication pattern of

Man: I wanted to but she won't ever let me. She used to jump when I went near that area so I don't do that anymore.

WLM: (to the woman) How have you felt about that?

Woman: It's sore enough when the doctor does it . . . she's the only one who's ever done that.

WLM: Tell me more about that.

Woman: I nearly jumped off the table.

WLM: When's the first time a doctor examined you?

Woman: The doctor that I've got now.

WLM: When did that occur?

Woman: When I was referred here.

WLM: When your doctor examined you, do you know if she put one finger inside or two?

Woman: I don't know.

WLM: Doctors often use what's called a speculum. It's made of metal or plastic and opens up inside a woman's vagina. Has your doctor ever inserted a speculum into your vagina?

Woman: I think she tried once and it didn't . . . it was too sore . . . is that for . . . like a Pap Test?

WLM: Yes. That's one of the reasons.

Woman: She couldn't go . . . or I couldn't go through with it and she said that would be OK until after I saw you.

the couple, it had (up to now) been enormously informative to me to see that she controlled the information flow and that he was passive.

Comment: My questions about tampons, suppositories, fingers, and doctor examinations were all asked in an attempt to establish whether the problem was generalized or situational (see Chapter 4). Except for the possibility of intercourse with other partners (which I did not want to ask about with her husband present), it seemed at this point that the problem was generalized.

WLM: Let me interrupt what we're doing and ask you how you're doing so far in talking here today?

Comment: I frequently stop the first interview midway and ask patients about the interview process and how it's affecting them. In so doing, I acknowledge that it is not easy for anyone to talk about this subject, since few people are used to doing so and it may feel strange to talk, in particular, with someone who is neither a family member nor a friend. I indicate that some discomfort is natural and even to be expected. After the process is discussed, I also talk about gender imbalances in the office (that is, the fact that there are two men and one woman) and invite patients (especially the woman) to mention any concerns they might have about this. It is rare that anyone ever does but simply raising the issue indicates sensitivity to the subject on my part and obviates worries that someone might have had before the visit. I always add, as well, that if this becomes a concern in the future, someone should let me know.

Woman: Good. It's not as bad as I thought it would be.

Man: It's OK.

WLM: Let me go back and ask you some other questions about your sexual experiences. I want to ask you about the location of the pain when your husband tried to put his penis inside. If you were to compare the opening of your vagina to the face of a clock, where did you feel the pain? Was it in any one location or was it all around the clock?

Comment: I attempt to obtain a partial description of the pain she initially was concerned about by asking about the location (see Chapters 4 and 13).

Woman: It was all around . . . I don't . . . a lot of it's in my head too.

WLM: What do you mean?

Woman: Well, with me being the way I am about pain . . . just something telling me this is going to hurt before it even . . . you know . . .

WLM: Do you mean that it's kind of frightening?

Comment: I try as much as possible to avoid leading questions. In this situation, I was trying to help her find the word she seemed to be looking for.

Woman: Yes. A lot has to do with that too.

WLM: It sounds like you're saying you might not even get to the point of experiencing pain?

Woman: I might have already told myself it's going to hurt.

WLM: I'd like to ask you one more question about the pain. Do you feel it only when he tries to enter or at other times too like when you are wearing tight jeans?

Woman: Only when he tried to go inside.

WLM: (to the man) I'd like to ask you some questions about the kinds of sexual experiences you and your wife might have together apart from attempts at have intercourse. Often when couples have intercourse troubles, they engage in other kinds of sexual activities such as, for example, holding each other, touching, and possibly bringing one another to orgasm outside of intercourse. Do the two of you have sexual experiences together apart from trying to have intercourse?

Comment: I avoid the word "sex", and talk instead about "sexual experiences" or "sexual activities." The word "sex" is often used by patients as a synonym for "intercourse," a method of speaking that I deliberately attempt to change. The point I wish to make for patients is that "sex" is much more than intercourse. To underline that concept, I might say that few quarrel with the idea that "sex" includes, for example, two individuals stimulating one another outside of intercourse to the point of orgasm. From the perspective of the interviewer, it is of great importance to discover all that is sexual in the life of an individual or couple, quite apart from intercourse.

Man: Yes.

WLM: How often might that occur? I realize that it might vary from one time period to another.

Comment: Questions about the frequency of intercourse or other sexual activities, are, indeed, hard to answer, since sexual experiences tend to cluster in time, rather than occur at evenly spaced intervals.

Man: It does vary. Usually a few times a week.

WLM: Who's idea is that usually?

Man: She usually instigates it. I instigate it too but . . .

Woman: He's very laid-back (laugh). Maybe I shouldn't use that word! He is the type of person who appears very calm and is not what you call aggressive.

Comment: Sexual jokes told by an interviewer are quite inappropriate in an interview situation. However, humor sometimes arises out of words that patients use. A sincere laugh helps lighten the atmosphere without diminishing the importance of the subject being discussed. The vital distinction is laughing "with", rather than "at."

While I particularly wanted to find out about their sexual desire levels, I was satisfied for the moment to obtain information about the subject of initiation. Desire and initiation are not identical. A person might be interested but not initiate sexual overtures. Likewise, a person can initiate a sexual encounter but not necessarily be interested.

WLM: How affectionate are the two of you with one another?

Woman: When we watch TV in the den or pass one another, we are always touching each other. He puts his arm around me and I will have my leg across his when he is sitting. So it's not as if we avoid one another. We are very loving toward each other and agree on everything and we don't raise our voices. It's the problem in the sexual area that is stressful for us.

WLM: (to the woman) I understand. (to the man) Let me go back and ask you some other questions about your sexual function. Do you have any problems with your erections.

Man: No.

WLM: Does it sometimes happen that your wife stimulates your penis to the point where you'd ejaculate?

Man: That's what usually happens.

WLM: Any problems with your ejaculation?

Man: No.

WLM: (to the woman) Any problem with your own level of sexual interest or desire?

Woman: At some times. Most of the time I'd like to as long as he stays away from . . . you know.

WLM: Generally, when women feel a sense of desire, they also often experience some vaginal wetness or moisture as well. Does that happen with you?

Woman: Yes.

WLM: What about coming to orgasm? Has that been part of your experience?

Woman: Uh-huh.

Comment: An interviewer must find out about intercourse and non-intercourse related sexual activities and also about the extent of affectionate exchanges such as hugs and kisses, between partners (see Chapter 4). The presence or absence of affectionate gestures may have great meaning, now in the history of the couple.

Comment: At this point, I return to my task of defining the problem (see Chapter 4) after having obtained some information about sexual activities that do not continue on to intercourse, and exchanges of affection.

WLM: Can I ask you some questions about that?

Woman: OK.

WLM: Is that something that happens just occasionally or frequently or most of the time?

Woman: I'd say most of the time nowadays.

WLM: How does that usually happen?

Woman: Well . . . uh . . . he . . . we . . . uh.

WLM: Would it be easier if I asked you some questions?

Woman: Yes.

WLM: Do you let him touch you with his fingers between your legs?

Woman: No.

WLM: Would you touch yourself in that area when you're with him?

Woman: No.

WLM: Sometimes a couple may not have intercourse but the partners find that they enjoy rubbing their genital areas against one another. For example, the man might rub his penis against the wet area between a woman's legs. Does something like that happen when the two of you are together?

Woman: Yes.

Comment: I again deliberately used the "permission" question (see Chapters 2 and 3) at this juncture, since I anticipated that this might be an area that she would be hesitant to talk about.

Comment: As described in Chapter 4, I obtain information from both partners about aspects of their sex response cycles that I do not already know.

Comment: There are times when allowing a patient to struggle through an answer is productive as, for example, in giving someone time to think through the answer to a question that had not been formulated previously in the patient's mind. This was not that kind of situation. Here, the patient knew the answer to the question but was embarrassed to reveal the information. Silence on my part would have been cruel if all that was accomplished was watching the patient squirm.

WLM: Do you come to orgasm when that happens?

Woman: Yes. Usually.

WLM: (to the man) Do you try to go inside when that's happening?

Man: I haven't for a long time.

WLM: Do you usually ejaculate when that's happening?

Man: Yes.

WLM: (to the woman) How do you feel about the wetness from his ejaculation . . . from his semen?

Comment: Attitudinal statements about sexual practices, body parts, and "sexual fluids", represent information that can be useful diagnostically and therapeutically.

Woman: It's not very pleasant.

WLM: How unpleasant is it to you?

Woman: Oh, it doesn't bother me. It's just messy, that's all.

WLM: Altogether, is it an enjoyable experience for you?

Woman: Yes. At least it's not painful.

WLM: I'd like to ask the two of you something else. (to the woman) How has this affected you . . . the fact of not being able to have intercourse?

Woman: It just makes you . . . like I feel like a freak . . . or . . . you know . . . you feel like you're abnormal.

WLM: How long have you felt this way?

Woman: Well, since . . . well, the longer your marriage goes on . . . as the years pass . . . at first you think, well, maybe a lot of people have this trouble . . . then my family doctor was sending me to a gynecologist and she wanted to operate . . . I told her the problem but she didn't want to talk about it . . . one thing I didn't like about her office . . . you could hear what other people were saying through the walls and so I didn't want to talk to her too much any-

Comment: Privacy in talking about sexual matters was obviously crucial to this patient, as it is for most. It was, clearly, one factor that inhibited conversation about this problem with her gynecologist.

way.

WLM: (to the man) What about yourself? How have you felt about this?

Comment: The impact of the sexual problems on both partners has to be included in the assessment (see chapter 4). This also can have diagnostic and therapeutic significance. For example, information may be revealed about the relationship between the two people, their motivation to solve the sexual problems, and how damaging the difficulties have been.

Man: It's up to her. If she wants to do something about this, that's OK with me. I'm ready for some little ones to be running around.

WLM: We need to stop in a moment or two. We've talked about quite a bit today and I hope we can talk more but I wanted to ask you today if there's anything that we haven't talked about that we should have . . . that would help me understand the difficulties you've faced as a couple?

Comment: Among other things, this open-ended question allows the patient to raise issues that have not yet been discussed but nevertheless are of concern to her. Such matters may be etiologically significant.

Woman: I can't think of anything. You've certainly asked a lot of questions.

WLM: How do the two of you feel now about talking here today?

Woman: OK now. Not so good at first.

WLM: How were you feeling before?

Woman: Just . . . well, embarrassed about telling someone everything.

WLM: I think you've done very well. It's not easy to come in here and talk about what we've discussed today.

Comment: I often give this kind of reassurance. Patients usually seem grateful for this. Since this was (and usually is) an alien experience for which people don't have a frame of reference, a sincere statement from the interviewer represents useful feedback. In addition, I like to end a session on a positive note and saying something like this allows me to do so.

Woman: That's true. The more you put things off . . . and it builds up in your mind . . . it's usually not as bad as it seems . . . but try and tell me that months ago (laugh)!

WLM: (to the woman) Let me briefly explain what I think. It sounds as though you might have what health professionals who work in this area call vaginismus.

Comment: Some explanation is reassuring. It helps to "hang your hat" on something that has a name and also allows the interviewer to be sincerely hopeful. Although a pelvic examination is extremely important in this situation diagnostically and therapeutically, presenting this idea now might make her needlessly

That involves a spasm of the lower part of the vagina and prevents intercourse altogether or makes it painful. Women are not able to control this spasm. There are several reasons for this spasm but fear is especially prominent in women who have never had intercourse. Fortunately, I see many couples each year who have this problem and seem to be of major help to the majority. To confirm the diagnosis of vaginismus, one of the things we need to do is to spend some more time talking. Are you feeling up to coming back and talking some more?

Woman: Oh sure.

Man: Yes.

WLM: As I mentioned when we began, it usually takes more than one visit to get a clear understanding about a couple's sexual difficulties. Have you done any reading about the treatment of sexual problems generally, or intercourse pain in particular?

Woman: No.

WLM: Are you interested in doing some reading?

Woman: Yes.

WLM: I like to suggest that you read a few chapters from a paperback book about sexual problems. I'll write down the title for you. We can talk about your impressions of the book when you are here next time.

Woman: Thanks.

WLM: I'd like to meet each of you separately as I mentioned when we started. Let's see if we can figure out some times to meet within the next week or two . . .

apprehensive. While I never "spring" an examination on anyone without ample warning, it might be needlessly anxiety provoking to a patient to mention it on the first visit.

Comment: Readings are often helpful to people with sexual difficulties because people have so little knowledge about many sexual problems. Experience has taught me that people find the main benefit of readings to be not in the area of learning about the specifics of a treatment program, but rather understanding that they are not alone in having such trouble. That can be extremely reassuring: others have had similar problems and overcame them.