CHAPTER 6

ASSESSING SEXUAL DYSFUNCTIONS AND DIFFICULTIES: THE PROCESS

In an age when scientific disciplines are becoming increasingly specialized, it is more and more difficult to bring together new knowledge in a manner that helps us comprehensively to understand the human condition. Sexuality is a prime example of the growing need for such a synthesis . . . for the medical profession, sex provides as good a model of psychosomatic relationships as one can find . . . a proper understanding of human sexuality demands *a truly psychosomatic approach.*

BANCROFT, 1989[1]

Not all clinicians who specialize in the care of people with sexual disorders agree on the necessity of the entire process described in this chapter and for the length of time it involves. For example, Kaplan[2] (pp. 91-92) states that:

- About 60% of her assessments take place in a single 40 minute session with a couple or a symptomatic patient alone
- A second session is necessary in about 20% of cases
- More time is required when a situation is especially complex

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A single history-taking session, while considerably less thorough than the process described in this and the previous chapter, is particularly applicable to a primary care setting. If nothing else, it indicates that much can be accomplished with many patients within a limited period of time.

WINDOW OF OPPORTUNITY

Patients often arrive alone when initially visiting a health professional and it is in this context that a sexual problem typically surfaces—frequently during a discussion of some other topic. What happens subsequently can develop in one of two ways:

- The focus immediately shifts to the area of "sex"
- A plan is developed with the patient to talk about this new topic at another time

Talking about a sexual problem when the subject is broached is appealing, since it allows an interviewer to take advantage of this "window of opportunity." However, the idea of talking at a later time is attractive because it allows for unhurried conversation. Time may be needed for the gradual unfolding of a painful story that may never have been told

The extent to which a patient feels a sense of urgency, the amount of professional time available, and the clinical skills of the professional dictate which path is taken. There are benefits to each approach. Talking about a sexual problem when the subject is broached is appealing, since it allows an interviewer to take advantage of this "window of

opportunity." However, the idea of talking at a later time is attractive because it allows for (presumably) unhurried conversation. Time may be needed to allow for the gradual unfolding of a painful story that may never have been told.

Some health professionals (especially nonpsychiatric physicians and health professionals who have a limited amount of time) prefer not to hear a lengthy account of a sexual difficulty, conduct only a brief assessment, then refer the patient. Part II considers when referral is reasonable and, conversely, when a sexual problem can be assessed more elaborately and managed on a primary care level. When undertaking a more comprehensive assessment, health professionals may want greater structure (outlined later in this chapter).

THE PATIENT'S PARTNER

Although patients may be unaccompanied when first seen, another person may be present in spirit, that is, the patient's sexual partner. Learning about the existence of this other person allows for the possibility of their inclusion on a subsequent visit. The partner may be initially absent for several reasons, including:

1. Involvement of a sexual partner on a first visit is unusual (unless the visit is structured this way)
2. People tend to blame themselves for sexual problems and therefore may not understand the necessity of including a partner
3. A patient may be embarrassed to talk explicitly when a partner is present and thus not want the other person to be present

If the professional thinks it is important to include the partner in discussions of the problem, this should be explained to the patient.

The rationale for including a partner is twofold:

- Diagnostic
- Therapeutic

While considerable diagnostic (past-oriented) information can be obtained from one person alone, a partner may have a different point of view. This was demonstrated by a study that compared separately obtained interview data from men with erectile difficulties and their wives.[3] Frequent discrepancies were found in the information obtained such that, for example, in 18% of the cases the diagnosis was changed. The authors provided several examples, one of which follows:

> A 59-year-old salesman: "Patient reports that impotence began within the last year, after years of infrequent sex. He said that in this, his second marriage, he feels desire but suffers fear of failure with his wife. He reports no erections with masturbation and partial morning erections. Pertinent medical history is a history of cocaine and heroin abuse, ending in 1961, and prostatitis. The patient's wife indicated that this was his third marriage, and that the potency difficulty began at least three years ago but that sex had been so infrequent (occurring only at her insistence) that she felt any erectile difficulties were less important than the low desire."[3]

Apart from the issue of diagnosis, the other person often needs to be involved when trying to effect change (future-oriented). The authors again provided an example:

> A 58-year-old accountant: "Patient reported no sexual problems in his first marriage, which ended with his wife's sudden death in 1982. He was unable to achieve intercourse with his new fiancee, despite a close and desiring relationship during the last 18 months. He has had diabetes for 10 years, and the NPT workup showed serious erectile abnormalities warranting prosthesis recommendation. Interview with patient's fiancee revealed that she was not at all dissatisfied with the status quo and may have chosen Mr. C in part because of lack of sexual intercourse in the relationship. Pre-operative conjoint counseling was recommended to explore issues of mutual motivation for surgery."[3]

The above examples demonstrates that, from diagnostic and treatment perspectives, what can be accomplished might be quite limited if discussions are held with only one partner.

When the connections between two people are substantial (planning to marry and living apart; single and living together; married), one should be skeptical when hearing that the other person does not want to be involved, since the statement may not be accurate. An invitation extended to the other person may, in fact, never have been delivered and, if it was, consideration must be given to *how* it was delivered. Often it becomes evident that the *patient* is the one who is reticent, saying that the problem is one's own and does not and should not involve the partner.

INTERVIEWING A SOLO PATIENT

The phrase "solo patient" describes someone who sees a health professional alone. The term reflects any of the following:

1. Absence of a current sexual partner
2. Marital status (unmarried)
3. Living arrangements (living alone)
4. Unwillingness of a partner to be involved

Solo patients referred to a sex-speciality clinic or professional are often men who have problems with erections or premature ejaculation. These difficulties are frequently cited as the major reason for the disintegration of a recent relationship. With the other person absent, an interpretation is one-sided and limited in scope

Solo patients referred to a sex-specialty clinic or professional are often men who have problems with erections or premature ejaculation. These difficulties are frequently cited as the major reason for the disintegration of a recent relationship. With the other person absent, this interpretation is one-sided and limited in scope. The tenacity with which a patient presents a problem needs to be judged. If the patient is equivocal, this might provide the health professional an opportunity to assist in reexamining the contribution of sexual problems to the fracture in the rela-

tionship. If the patient is inflexible, a confrontation only may increase the distance between the patient and his clinician.

A 25-year-old man was referred after the breakup of a two-year relationship with a woman with whom he had been living. When sexually stimulated, he was unable to develop a full erection. The same situation existed when he occasionally masturbated or when he woke up in the morning. The last occasion he recalled having a full erection under any circumstance was four years before. He was an intensely introverted man and one of few words. He said that erection problems were usual for him but worse now because he was depressed over the disruption of a relationship that he had hoped would end in marriage. He attributed the breakup to his sexual "performance" and was sure that nothing else (such as his inability to communicate or excessive drinking) could have contributed. His family doctor chose not to contradict directly and instead initially discussed the patient's sexual function in greater detail, as well as his depressed mood. As the patient's mood lifted, other issues were brought into the discussion without difficulty.

Despite being evaluated alone, the initial assessment of a solo man can be quite useful. He receives the powerful information that he is not alone in having whatever the problem is and that some of the possible origins can be investigated. In some instances (e.g., a primarily medical or psychiatric etiology of erection problems), one can also be therapeutically helpful. However, in some situations, the health professional may have to insist that for treatment purposes the patient must have a sexual partner. All too frequently, the patient's reply is that the very presence of this problem prevents him from establishing such a relationship, since women "expect" him to "perform" within a few dates. This dilemma may seem to be a "*Catch 22*" situation (except that some men seem to have no difficulty finding sexual partners in spite of their troubles). The interviewer might then reasonably conclude that personality issues and "social skills" are included in addition to "performance" problems. In such instances, the focus of treatment may shift to include these factors as well.

A smaller percentage of solo patients are women who describe trouble reaching orgasm or having pain with intercourse. They, too, worry about the impact of this on their relationship. The timing of a request for help is different from men in that solo women usually ask for assistance in anticipation of the dissolution of a partnership, rather than after. Their thinking is, typically, that if they are unable to fulfill the sexual needs of a man, he will leave.

A 22-year-old woman was referred because of vaginal pain that had been evident since she began to include intercourse in her sexual activities three years before. She had a regular sexual partner for the previous two years. In that relationship, her level of sexual desire had not diminished, she lubricated easily, and had no difficulty coming to orgasm on the rare occasions that intercourse occurred.

Avoidance of coital pain had been high on her list of sexual priorities. She and her boyfriend were sexually active with one another (not including intercourse) several times each week but she had become certain that he would not remain in the relationship much longer if intercourse was not included in their sexual experiences. Although the boyfriend appeared satisfied with the arrangement, her concept of the sexual requirements of men was that the absence of intercourse, however temporary, was unacceptable. She was not reassured by his protestations to the contrary. She was referred to a gynecologist and was found to have endometriosis after an examination for laparoscopy. Surgery resolved her dyspareunia; however, when the relationship ended, she had little choice but to consider nonsexual factors.

INTERVIEWING A COUPLE

The word "couple" obviously includes those who are married but it also includes individuals who are single (in terms of marital status) but living together, whether in a heterosexual or homosexual relationship.

Given a choice, many health professionals prefer to begin by talking with a couple together rather than with each person separately, recognizing benefits and limitations to both arrangements. The advantages of interviewing a couple together seem to far outweigh the disadvantages.

First, in an initial conjoint visit, the "therapist" is clearly established as responsible to both parties and therefore aligned with neither. When an individual is first seen alone, there is always the danger that the person not initially seen will feel:

- Left out
- That an alliance has been formed between the other two
- That the reason for including the partner is primarily as a target for blame

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Second, an initial visit together presents the clinician with the opportunity to:

- Evaluate the quality of the relationship between partners
- Consider the extent to which conflicts contribute to the genesis of the sexual problem
- Think about how discord might interfere with resolution of the problem

Affectionate gestures, sitting arrangements, and facial expressions may reveal clues about love or its absence.

Third, sexual problems are often complicated by an absence of the two partners candidly talking together. This reticence may have always been present or may have become a more recent casualty of their trou-

It is truly remarkable to observe two people sitting in the same room trying jointly to explain to a third person what happens sexually between them when they have not talked previously to one another about these very same events

Box 6-1 Areas to Avoid When Talking to a Couple in an Initial Assessment

1. Other recent or current sexual partners
2. Past sexual partners
3. Masturbation
4. Sexual fantasies
5. Past STDs
6. Atypical sexual practices

bles. It is truly remarkable to observe two people sitting in the same room trying jointly to explain to a third person (a stranger) what happens sexually between them when they have not talked previously to one another about these very same events. Although technically part of an "assessment," this process is almost invariably therapeutic. In other words, treatment often begins with the first visit.

Limitations of an initial conjoint visit extend to six areas and are self-imposed by the health professional because the information may be damaging to the couple or ruin the relationship between the interviewer and one of the two partners (Box 6-1). To be sure, information in all six areas can and should be gained when each person is seen individually (Box 6-1).

First, one should avoid asking about other recent or current partners, even if discussed by the couple before the visit. When previously revealed to the other person, often only the skimpiest of information was given. One is likely to hear about a third person in the context of an attack by one partner against the other. It is preferable not to worsen matters by increasing the high level of tension that may already exist. More information can be acquired harmlessly simply by asking the other partner (not the one who was active outside the relationship) what they understand about what had occurred.

A couple in their 20s and married eight years were referred because of two problems:

- The man's rapid ejaculation
- The woman's sexual disinterest

Before the first visit, the woman phoned to ask if she could be seen alone initially and requested that her phone call not be revealed in any subsequent visits when she and her husband were seen as a couple. It was explained to her that when an individual in a long-term relationship was referred, both people were ordinarily seen together initially and then separately. She agreed to the process and they were

seen together on the first visit. (In retrospect it might have been wiser to reverse the order.) The husband's ejaculation difficulty seemed lifelong, and the wife's sexual disinterest appeared acquired in that it had existed for about two years. She stated that about two years before, she had been briefly interested in another man who was also married. When the husband was asked what he understood about this relationship, he indicated that:

- The man had been a friend of his
- His friend and his wife had kissed a few times
- The romance lasted a few weeks
- His wife and the other man had not seen one another in over a year

When interviewed alone, the wife told a different story, namely:

- She had been in love with this other man for many years
- The relationship was continuing
- Sexual activities occurred regularly with him
- She was far from sexually disinterested in this other relationship

The wife continued to explain that because of attachments to their children neither she nor the other man wanted to break up their marriages. She asked if there was some way her husband's rapid ejaculation could be controlled and her sexual interest in her husband regenerated. As a result of the visit, she understood that the problem with her husband was only partly sexual, that the problem was mostly one that involved other aspects of their relationship, such as trust and commitment. She was unsure about what to do and accepted referral to a psychotherapist for continued exploration of her options.

Second, it is best to avoid asking about past sexual partners. Previous relationships are generally known to current partners but there is an almost unspoken agreement between couples not to discuss details, particularly sexual minutiae. Such information only invites uncomplimentary comparisons (such as penis size or a different way of coming to orgasm).

Third, the health professional should be very cautious about introducing the subject of masturbation. For many, this topic is very private, as well as embarrassing. If one partner introduces the subject, discussions can continue on an abstract level. One can also discover just how much this has been discussed between the two people. Individual experiences are best left to individual visits. The health professional should avoid forcing one partner into a revelation about masturbatory experiences in the presence of the other. At another time and when talking in confidence, one partner might be encouraged to reveal aspects of this activity to the other.

Fourth, questions about sexual fantasies should be omitted during an initial conjoint visit. Masturbation is a private act; what occurs in thought is even more so. Sexual fantasies often involve a person other than the usual sexual partner and therefore may be misinterpreted as meaning a lack of sexual desire or love.[4]

Fifth, although acquiring a history of past STDs is essential it is best to do so when the patient is seen alone to avoid potentially damaging a current relationship. When an interviewer asks about past STDs in the presence of a partner, the question may also entail coercing that person into talking about a past relationship that may have been private.

Sixth, it is not advisable to ask about atypical sexual practices when both partners are present. For example, when interviewing a couple, one would not ask a man if he dresses in women's clothing. A truthful answer is unlikely and could be damaging if it were revealed (see "The Second Visit" below in this chapter for further discussion of "secrets").

FIRST VISIT (see illustrations provided in Appendices I and II)

Explanation of the Assessment Process

Whenever meeting with a patient in response to a specific sexual complaint, one should first explain some aspects of what is about to occur. Patients have immediate questions: Who is this person we are about to talk to? What kind of professional experience do they have? What should I expect today? What is the matter with me? Can it be fixed? What will it take to do so? Why am I so nervous? How much will it cost? (As much related to humiliation and embarrassment as money.)

Some of these questions can be answered immediately (introductions, duration of visits, purpose of visits, the use of audio-visual equipment such as tape recorders) but others represent the very rationale for an elaborate inquiry-assessment and therefore must await the end of the process. Even then, a clear accounting may not be easily given.

Before discussing the sexual problem that resulted in the visit, the interviewer should:

1. Describe what is about to occur, since patients do not know what to expect in spite of any previous explanation
2. Be sensitive to the fact that in such circumstances repetition may be necessary, since people tend to absorb only a small amount of what is initially said
3. Be aware that talking about sexual matters is usually embarrassing and foreign
4. Be aware that discussing sexual matters with a stranger may be even more embarrassing and foreign, since the reaction of the stranger is an unknown factor

Introduction to the First Visit

The introduction to the first visit can begin with the declaration that, while its purpose is clearly to talk about sexual troubles, the interviewer wants to initially learn more about the background of the patients. Being explicit about the rationale for background questions is necessary; otherwise, people may wonder about the reasons for questions that might seem irrelevant.

The interviewer could then clarify:

- Ages
- Occupations
- Duration of the relationship

- Living arrangements
- Children
- Health (including psychological health)
- Medications
- Use of alcohol, drugs, and tobacco
- Previous efforts at resolving the sexual dilemma(s)

The purpose in asking about past therapeutic efforts of health professionals is not to denigrate colleagues but to know in a practical sense what has not worked previously, so that the same ineffective approaches are not repeated.

A nonjudgmental way to inquire about the absence of children is to ask if this is a result of infertility or a deliberate decision.

In asking about occupation, the interviewer should be aware that some people are involuntarily unemployed and feel guilty about this, an attitude one would like to avoid enhancing. One way to approach this subject is to not actually ask directly about occupation but rather to ask how one "spends their days."

Likewise, since some couples choose not to marry or have children (and the interviewer is best seen as nonjudgmental), direct questions about marriage and children can be avoided in favor of equally revealing questions about how long the couple has known each other and who else lives with them. If necessary, more direct questions can be asked at a later time. A nonjudgmental way to inquire about the absence of children is to simply ask if this is a result of infertility or a deliberate decision.

The Chief Complaint

The chief complaint (CC) is a brief and pointed statement of the patients' main concern. When, during the conversation, it is reasonable to turn to the specific sexual trouble, the interviewer may ask about it in (at least) one of two ways:

- Directly—by inquiring of each partner separately what, from their point of view, is the main reason(s) for the visit
- Indirectly—by asking the patient(s) to retrace the steps that resulted in the current visit

The latter seems less precipitous and thus somewhat softer. The indirect approach involves the patient(s) explaining, for example, whose decision it was to talk to a health professional, what was actually said, what the response was, and, if the partner was not involved, what feelings he or she had about the outcome. Since each partner may have a somewhat different perspective, both should be encouraged to state the chief complaint separately and from their personal point of view.

History of the Present Illness

The history of the present illness (HPI) refers to clarification of the chief complaint. Given the limitations of a first couple interview described above in this chapter (see "Interviewing A Couple"), this means the HPI of *this* relationship. Most of the first visit is occupied with the HPI and includes four areas of inquiry:

1. Definition of the problem using the outline described in Chapter 4

2. Elaboration of sexual activities that do not include intercourse (using the outline described in the portion of Chapter 5 titled "Present Context: Immediate Issues and Questions")
3. Extent of exchanges of affection between the two partners
4. Quality of the relationship

If the "patient" is a couple, the interviewer should ask frequently if what was just said by one also represents the opinion of the other.

SECOND VISIT

The portion of Chapter 5 titled "The Context of the Past: Remote Issues and Questions" is the focus of the second visit, when each of the partners are seen alone. However, it is usually best to *begin* by asking the person what their impressions were of the *first* visit. It is sometimes revealing to also ask whether sexual activities occurred since the last visit, and, if so, whether there was any change. Sometimes, talking on one occasion is sufficiently therapeutic to resolve the troubles. Dramatic change resulting from one visit is more likely to occur when there is a reformulation of the problem (e.g., the "problem" becomes a nonissue) rather than any actual change.

A 35-year-old woman was seen because of a concern that she did not have orgasms with intercourse. She was easily orgasmic in other sexual experiences with her husband. They lived together in another city but she was taking a refresher course elsewhere for six weeks and was determined to resolve their sexual difficulties during that time. It became clear during the first visit that the concerns about orgasm with intercourse were more her husband's concern. She was sexually content. Reassurance about the normality of her sexual response was gratefully received. When seen one week later, she related that her husband visited her on the weekend, and in talking together they decided that their sexual concerns had evaporated. As a result, they had mutually satisfying sexual experiences, including intercourse. The second visit was also the last visit and did not include a sexual-developmental history, since the problem had "disappeared."

Before beginning the sexual-developmental history, the interviewer might also ask if the patient deliberately omitted anything from the first interview because of not wanting to hurt their partner's feelings. This question provides an early opportunity for the emergence of secrets that may be significant in understanding the sexual problems. Secrets can include:

- The existence of other partners
- Desire for a form of sexual activity thought to be unacceptable to the partner
- Thoughts such as sexual fantasies
- Masturbation

Hidden information may be diagnostically important, since it may tell an interviewer whether, for example, a problem is situational (see introduction to PART II). Likewise, secret information may be therapeutically important in that it may influence the decision of the health professional to treat both partners together or recommend that they be seen separately. The interviewer cannot be neutral when in possession of a significant secret "belonging" to only one of the partners.

The second (and solo) visit also permits the interviewer to ask questions related to the six areas avoided on the first visit (see "Interviewing A Couple," discussed earlier in this chapter). The interviewer can explain the reasons for previously omitting these questions and the rationale for addressing these issues in the absence of the partner. An alternative approach is to integrate these questions (so they could be asked in context) into a sexual-developmental history (see Chapter 5).

Treatment is not separate from other aspects of the whole process and actually begins when patients are initially seen, that is, the assessment itself can be therapeutic

THIRD (OR FOURTH) VISIT

Meeting with a couple again after each partner is seen separately can accomplish several objectives.

1. It is always instructive to *listen* to the results of previous interviews. Treatment is not separate from other aspects of the whole process and actually *begins when patients are initially* seen. In other words, the assessment itself can be therapeutic. Communication difficulties and the couple's limitations in solving *any* problem together become apparent when previous visits *have not* promoted substantive discussion between the partners. For example, previous discussion may have resulted in:
    - Reformulation of a problem so that the initial sexual complaint is now seen as subsidiary to another problem that requires more immediate attention (e.g., intense relationship discord)
    - The decision that the presence of a third person (e.g., the health professional) in the endeavor is undesirable
    - Making the *etiology* of the sexual difficulty and therefore what is *therapeutically* required more evident than it might have been previously (e.g., the effect of a sexual assault in a patient's past)
    - Confirmation that the focus on a particular sexual complaint is, indeed, correct
2. Focus on the couple's sexual activity. Their description of any changes that occurred may also reveal reasons for the shift and provide information about interfering factors
3. The interviewer is provided with the opportunity to:
    - Review the main elements of the history
    - Consider the possibility of using other forms of investigation
    - Discuss therapeutic options (including the provision of reading materials), logistics of continued visits, or aspects of referral

Hawton suggested that a "formulation" be presented to the couple at this time in which predisposing, precipitating, and perpetuating factors are outlined[5] (pp. 118-122). He described the four reasons for doing so, as follows. A formulation:

- Provides the partners with further understanding of their difficulties
- Encourages a sense of optimism about the outcome
- Provides a rational basis for treatment
- Enables the therapist to check that the information obtained has been correctly understood

While providing a formulation is a desirable objective, it is not always easy to structure information in this way.

A 25-year-old woman was seen with her husband. They were married for two years and were seen because of her concerns about not reaching orgasm during sexual activity with her husband. She was regularly orgasmic when masturbating alone, a fact of which he was unaware until after the first visit. Both were shy and talked little together about sexual, and nonsexual, issues.

Information gained from meeting separately with the woman follows:

1. She was concerned about her husband leaving her because of her "inadequate" sexual response
2. She revealed a lifelong self-deprecatory opinion of herself
3. She had brief episodes of depression
4. She sometimes injured herself as punishment
5. She wondered what her husband saw in her
6. Her mother was a harshly critical person who implied that she (the patient) could not complete tasks productively
7. She talked fondly of her mother and worried only about her husband
8. She hoped that becoming orgasmic with her husband would result in him being more sexually content

Information gained from meeting with the husband alone follows:

1. He said that his biggest concern was his wife's (seemingly) unalterable negative view of herself
2. He hoped she would be more sexually active, if not orgasmic
3. Despite his many attempts at reassurance, she would not accept his protestations that he was sexually content

During the third visit, sexual and nonsexual issues were discussed, as well as the possible relationship between the two: her sexual self-depreciation being one more area of her life in which her mood disorder impaired her ability to function. Two treatment suggestions were made: (1) the Masters and Johnson format of sex therapy[6] as an approach to some of their sexual concerns with the objective being the wife becoming orgasmic with her husband and (2) that the wife's apparent mood disorder be given separate attention by a psychiatrist. The couple accepted both

recommendations.

PHYSICAL EXAMINATION

The main theme of Part I of this book is talk and thus the specifics of a physical examination are not reviewed here. This information can be found elsewhere.[1,5] ([5]pp. 111-117)[7] While there is disagreement among sex specialists about the need for a physical examination in all cases of patients appearing with sexual problems in a specialized setting,[1] there is no difference of opinion about the wisdom of such an examination by a *physician in primary care*. The objective of this examination can be one or a combination of the following:

Sex specialists disagree about the need for a physical examination in all cases of patients appearing with sexual problems in a specialized setting. However, there is no disagreement about the wisdom of an examination by a physician in primary care. The objective of this examination can be one or a combination of the following:

- Reassurance
- Diagnosis
- Education

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An examination can be reassuring, if only to inform a patient that no obvious disease is present. In addition, the primary care *physician* is the only health professional that can provide (initially and before any specialists are involved) diagnostic information based on a physical examination. Given the frequency with which there is contact between physicians and the general population, the primary care physician is also in an excellent position to provide educational input[8,9] (see introduction to PART II).

Bancroft reviewed the specific indications for a physical examination in the context of a specialized setting providing care for those with sexual difficulties[1] (p. 417). These also represent circumstances in which the primary care physician might be particularly vigilant. In women, the specific indications include the following:

1. Pain or discomfort during sex activity
2. Recent history of ill health or physical symptoms apart from the sexual problem
3. Recent onset of loss of sexual desire with no apparent cause
4. Any woman in the peri- or postmenopausal age group with a sexual problem
5. History of marked menstrual irregularity or infertility
6. History of abnormal puberty or other endocrine disorder
7. When the patient believes that a physical cause is most likely or suspects that there is something abnormal about her genitalia

In men (p. 424), specific indications are similar except for the additional suggestion of an examination for *all men* over the age of 50 with a sexual problem.

It is apparent that talking during a physical examination can provide a dimension of understanding that is not easily obtained otherwise. Outside of an examination room, the following dialogue between a sex-specialist and a woman patient is not unusual:

Q. Do you think that your genital anatomy is in any way abnormal?

In evaluating negative structural findings, one must recognize that people are examined in a sexually "resting" state and that the opposite is true of sexual troubles, namely, that they represent difficulties with function that often becomes apparent only in the "active" state. The two situations may not result in the same physical findings

A. I'm not sure.
Q. Well, have you ever asked your family doctor about it during a pelvic examination?
A. Not really. I figured I'd be told if there was anything wrong.
Q. Well, if nothing is said, a person might worry anyway that something isn't right.
A. That's true. Now that you mention it, there is something I wanted to ask someone about. . . .

A complete or partial physical examination should, under some circumstances, be included in the evaluation of a sexual complaint (see introduction to PART II). However, some humility is required in interpreting negative physical findings. A patient may conclude that "nothing was found" and therefore depart the examination room with the thought that "it's all in my head." In evaluating negative structural findings, one must recognize that people are examined in a sexually "resting" state and that the opposite is true of sexual troubles, namely, that they represent difficulties with function that often becomes apparent only in the "active" state. The two situations may not result in the same physical findings. This should be explained to patients *before* a physical examination so that the limitations of such an examination are understood, particularly if (as is often the case) no structural abnormality is, in fact, detected. The examiner could also explain before the examination that, if there is an obvious problem, it probably would have been discovered before the referral. This is said in an effort to diminish unrealistic expectations.

Some sexual dysfunctions such as a lifelong inexperience with orgasm in a woman and premature ejaculation in a man are rarely a result of disorders of the genitalia or other body organs and thus do not ordinarily require a physical examination as part of an assessment. However, in relation to some other sexual complaints, an understanding of the body's structural status must be an integral part of an assessment. Two examples are:

- Erectile dysfunction that is not clearly situational (see Chapter 11)
- Pain or discomfort associated with vaginal entry (see Chapter 13)

When including a physical examination in an assessment, the purpose should be explained as diagnostic and educational. In relation to the educational "agenda," the examiner might also suggest the possible inclusion of the person's sexual partner (with the explicit acceptance of both) in the examination room. There may be some hesitation in responding to this idea because it is, obviously, unconventional and the patient may be embarrassed as well. After the rationale is explained, the suggestion is often accepted, since in a harmonious relationship, the partner is an ally rather than an obstacle. The idea of having a partner present during the physical examination was first suggested by Masters and Johnson and was discussed by them particularly in relation to the assessment of vaginismus[6] (pp. 262-263). Their explanation of the purpose was that the partner would then have a clear demonstration of muscular constriction at the vaginal opening.

In conducting a woman's pelvic examination, a useful approach is for her to be lying (at about a 45 degree angle) on an examination table in such a way that she can observe the examination with the aid of a handheld mirror. The patient is invited to ask questions (as is her partner) while receiving a brief explanation of the structure and function of the genitalia. One patient was known to voice her appreciation of this method by comparing it to the usual alternative where she "would lie on (my) back and count the flies in the light fixture." Since this method encourages talk, it is particularly useful in the problem of intercourse-related vaginal pain in that the patient can describe exactly what hurts and where.

"Entry dyspareunia" inevitably results in the anticipation of discomfort when anything is inserted into the woman's vagina. Understandably, the expectation of pain is disconcerting to the patient during a physician's vaginal examination and in sexual activity with a partner. In an attempt to diminish the fear of anticipated discomfort, the examiner can explicitly transfer control to the patient by telling her:

> *You are the "boss" when it comes to your body. I won't put my finger into your vagina. You hold my wrist and gently and slowly insert my finger. I don't want to do anything that will cause you pain. During a vaginal examination, my intention is to get a clearer idea of the location of your discomfort and see if I can discover any particular reason for it.*

With the "you are the boss" theme, the examiner presents a model of communication that usually contrasts starkly with what occurs at home with the patient's partner and in the examination room with other physicians. In the past, the woman in this situation typically felt an absence of influence over what occurred sexually and "shut down" entirely to avoid the inevitable pain. In becoming "the boss" in the examination room, she exerts control over the amount of vaginal discomfort she feels and the conditions under which it occurs. After this occurs successfully in the examination room, the couple can adapt to her being the "boss" (at least over her vagina) in sexual situations at home.

The response of women patients to this suggestion is usually spectacular. A powerful rationale for the inclusion of the partner in the examination therefore may be as much in the area of couple communication as a demonstration of the control that the woman could exercise. This aspect of the physical examination is an example of a diagnostic procedure that is also therapeutic.

The pelvic examination of women is often taught with the assistance of women volunteers who provide "feedback" during the examination. Only a few medical schools provide a program for teaching the genital examination of men—to the detriment of women and men physicians and all of their male patients

There are at least two problem areas in the genital examination of men:

- Compared to women there is much less organized teaching in medical schools about practical aspects of examining male genitalia. The pelvic examination of women is often taught with the assistance of women volunteers who provide "feedback" during the examination. For reasons that are unclear, only the occasional medical school provides a program for teaching genital examinations of men—to the detriment of women and men physicians and all of their male patients.

  One might have legitimate concerns about the diagnostic capabilities of young physicians in relation to male genitalia. Other than sexual

dysfunctions, cancers of the male genital system represent one fourth of newly diagnosed cancers in American males.[10] Testicular cancer in particular, although unusual, is the most common malignancy in men 15 to 44 years of age.[11]

- Examination of the genitalia and anus is one of the reasons patients give for a preference for a physician of a particular sex (usually for the same sex—in contrast to "strictly medical areas" in which there was no preference).[12] Even for genitalia and anus examinations, the reasons why patients want a same-sex physician are not entirely clear. One of men's fears might be that of developing an erection during the examination. Some physicians seem apprehensive about this as well, not knowing what to do or say in such circumstances. Health professionals who work with men with spinal injuries know that simply touching a patient's penis might result in a reflex erection. Although erections in such men are often well received in spite of the presence of a health professional, the same can not be said of able-bodied men. However, something can be learned from the process of examining men with spinal injuries that might be of more general value. Professionals who care for these patients have learned to talk to them beforehand about the possible occurrence of an erection. With able-bodied men, talking about the possible development of an erection during an initial examination probably lessens the chance of it happening and certainly diminishes any potential embarrassment or self-consciousness if it does. One might say to an able-bodied patient:

Sometimes a man's penis gets bigger or erects in nonsexual situations such as during an examination. This is entirely normal and matches our knowledge that direct touch is an important way in which erections develop.

SUMMARY AND CONCLUSIONS

Although *assessment* is usually differentiated from *treatment,* the treatment of a sexual problem often begins immediately when the patient is first seen. In view of the secrecy that so often accompanies sexual problems, open discussion becomes therapeutic. The assessment of a sexual dysfunction is influenced by, among other things, whether the "patient" is an individual or couple. If a substantial relationship exists, both partners should be seen (otherwise, the clinician may encounter considerable therapeutic limitations). Ideally, the first assessment visit involves seeing both partners together. This is advantageous for the following reasons:

1. Both partners are "defined" as patients
2. The health professional is equally committed to both partners
3. The situation encourages partner discussion
4. The clinician can directly observe some facets of the relationship

Limitations of a first conjoint visit include avoidance of six topics:

1. Other recent current sexual partners
2. Past sexual partners
3. Masturbation
4. Sexual fantasies
5. Past STDs
6. Atypical sexual practices

Information about these issues should be obtained when an individual is seen alone.

The content of the first visit concentrates on the "chief complaint" and the "history of the present illness." This entails obtaining information about the problem using the structure outlined in Chapter 4 and in the part of Chapter 5 titled "Present Context: Immediate Issues and Questions," asking about non-intercourse sexual activities, affection, and quality of the relationship. During the second visit, each person is seen alone, and information obtained relates to another part of Chapter 5, titled "Context of the Past: Remote issues and Questions." In the third visit, both partners are brought together again and the focus of the content is on summarizing information from the previous two visits, formulating explanations for the difficulties, and discussing treatment options and approaches. A physical examination is included when this has not previously taken place or when there is a special need to clarify information obtained by history-taking.

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