Workshop 5: A Structured Sexual Health Interview

“Challenges in sexual health interview”

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Why Assess Sexual Function?

Sexuality is important to quality of life.

Sexual health is a basic human right.

Sexual problems are common.

Inquiry legitimizes and validates the problem.

Patients may be hesitant to bring up the topic: It is up to YOU!

You cannot treat a problem if you don’t know it exists.

Assessing sexual function improves patient satisfaction with HCP.

http://www.who.int/reproductivehealth/en
Barriers to Addressing Sexual Health

HCP embarrassment
Inadequate knowledge/skills
Fear of embarrassing patient
Lack of awareness of co-morbid conditions
Consider other issues as higher priorities
Assume reimbursement poor
Few FDA approved treatments - 26:2, ♂ ♀

PCPs and Routine Sexual History Taking

50 Lisbon PCPs, questionnaire

Medical issues triggered questions about sexuality
   – DM, medications with sexual side effects
   – Contraception

Routine sexual history taking motive: 22%

Low use of clinical guidelines (24%)
   – Lack of time, accessibility

*Sexual history taking improves detection and satisfies patients

Do Gyns Talk About FSD?

341 Swiss Gynecologists, self-report questionnaire

7.9% Gyns routinely explored sexual issues

<20% patients raised topic

28% offered specific appointments; 85% made referrals

Sexual physiology and basic counseling offered by 65-70%

Sex therapy recommended by 14%

Gyns with extensive training more likely to ask (78 vs. 22%)

Barriers: other priorities, time, “language”

What Ob-Gyns Don’t Talk About...

>1000 US Ob-Gyns (53% male)

Survey regarding communication practices about sex

Reported routinely asking about:
- Patients’ sexual activities (63%)
- Sexual problems (40%)
- Sexual satisfaction (28.5%)
- Sexual orientation/identity (27.7%)
- Pleasure with sexual activity (13.8%)
- Expressed disapproval of patients’ sexual practices (25%)

HSDD Dialogue Study Results

• 23% of visit (3.9 minutes) discussing sexual health
• 93% of questions closed-ended
• Few empathic closed-ended comments observed
• Only 1% of positive responses to closed-ended questions about sexual problems prompted an open-ended follow-up question
• 48% of visits included questions about life impact & distress
• 51% of PVIs revealed new information about patient’s emotions, relationship, partner, sexual function

• 55% of physician-patient pairs not aligned about patient’s level of distress.
• MDs (0) do not learn/advise about primary vs. secondary (postmenopausal orgasm phase)
• Discussions limited/vague and lacking detailed advice or follow up plans
• Benefit/risk discussion focused on benefit (20/22-90%)
• Patients and physicians were satisfied with discussions
  — 33% very satisfied, 60% moderately satisfied, no-one dissatisfied
  — 68% had never discussed this with any physician before

Parish. SMSNA Annual Meeting, May 2014
Sexual Medicine Communication Tasks

- Screen and identify sexual concerns
- Diagnose sexual problems, assess causes & factors
- Delineate impact and distress, empathically witness, offer support & partnership
- Reframe attention to sexual problem
- Explain impact of medical problem and/or treatment on sexual health
- Obtain informed consent for procedure or therapy
- Explain treatment and/or behavioral advice
- Recommend referral
When to Take a Sexual History...

Health-related conditions/life events
Prenatal/postpartum, infertility, menopause visit
Chronic illness follow-up
Related to urological or gynecologic surgery
New patient or annual gynecologic visit

Basson R. Clin Updates Women’s Healthcare. 2003; 1:1-84
Principles for Sexual History Taking

Patients prefer HCP to initiate topic and advise (90%)

Use simple, direct language

Compassionate honesty, normalizing statements

Declare & demonstrate lack of embarrassment

Be aware of patient’s cultural background

Ensure confidentiality

Avoid judgementalism & assumptions

May reverse open to close cone

“ALLOW” Algorithm

Managing sexual dysfunction in the office setting:

◦ “A”: Ask

◦ “L”: Legitimize

◦ “L”: Limitations → Refer

◦ “O”: Open up for further discussion and evaluation

◦ “W”: Work together to develop a treatment plan

Basic Screening for Sexual Function

Legitimize importance of assessing sexual function

Are you currently involved in a relationship...sexual?

YES  NO

With men, women or both? Any sexual concerns or pain with sex?

Any sexual concerns that you would like to discuss or that have contributed to lack of sexual behavior?

Screening for Sexual Dysfunction

• **Normalize/universalize** conversations about sexual health issues

• **Start with open-ended ubiquity-style question**
  ◦ “Many women with diabetes have sexual problems, how about you?”
  ◦ Some men notice changes in their erections with prostate cancer treatment. How about you?
  ◦ Higher yield than direct question

• **Continue inquiry with specific questions**
  ◦ Are you having any problems with desire/interest in sex?
  ◦ Are you having any problems with lubrication/dryness?
  ◦ Are you having any problems with orgasm or coming?

• **Follow-up positive response with open-ended invitation, “Tell me about it.”**

Sexual Problem Assessment

• Nature of the problem
• Phases affected and pain
• Single vs. combined (sequence)
• Lifelong vs. acquired (timeline)
• Generalized vs. situational
• Sudden vs. gradual (predisposing, precipitating, maintaining)

• Contributing factors (psychological, biological, socio-cultural, lifecycle)
• Impact & Distress
• Exacerbating and alleviating factors
• Partner response/related issues
• Treatments and their efficacy

Sexual Dysfunction vs. Concern

- Fantasy
- Disparate needs
- Timing
- Communication
- Knowledge
- Technique
- Fidelity
- Personal/societal attitudes
I just don’t want to have sex with Peter the way I used to. It’s got me so down, and he’s so… (pause). It’s just no good now.
Couple Interview

- Try to complete individual interview of each partner
- Emphasize that sexual problems are a “couple” issue
  - Allows provider to see emotional reactions
  - View couple discrepancies
  - Observe verbal and non-verbal cues
- Set realistic expectations
- Don’t underestimate environmental sexuality
  - Stress/fatigue/children
- Begin with effective communication skills
- Focus on a common goal

Office-Based Counseling: PLISSIT Model

**Permission** to talk about sexual issues, reassurance, empathy

**Limited Information**
- e.g., education about genital anatomy or educational resources

**Specific Suggestions**
- e.g., use of lubricants, altering position

**Intensive Therapy**
- e.g., referral for psychotherapy

Annon, 1976
Ex: Plissit Communication Tool For Sexual History

Permission pertinent to all levels of intervention

Limited Information  PERMISSION  Specific Suggestions

Intensive Treatment (referral)
Decision for Treatment is a Balance Between Perceived Need & Concerns

*Shared Decision-making*

Perceived need for treatment

Concerns about treatment
MI Tool for Sexual Health Counseling
ASK-TELL-ASK

**ASK**
Ask what the patient already knows:
“Tell me what you know about lubricants …”

**TELL**
Customize your message to the level of patient understanding

**ASK**
Ask the patient to repeat key elements, about emotional reaction, intention
Sexual Interview Communication Skills Strategies

**Detection & diagnosis**
- Open-ended questions, listening, empathic delineation
- Normalizing & universalizing inquiry and problems
- Ubiquity statement followed by open-ended question(s)
- “Tell me about a typical sexual experience”

**Evaluation**
- Open-ended questions about impact and distress
- Clarifying questions, summarizing statements

**Patient-centered education/intervention**
- Normalizing statements, treatment options, benefit-risk, shared decision making, ask-tell-ask