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Introduction

CASE STUDY 1.1

Ken, a 44-year-old physician, is evaluating Nina, a 15-year-old, who complains of menstrual cramps relieved with 800 mg of over-the-counter ibuprofen; her mother, Amy, is requesting a prescription for this. Ken has a 16-year-old daughter, Sidney, who has begun steadily dating an 18-year-old boy. Ken and his wife have placed curfews for which nights Sidney can go out on dates and at what time she must return home. Neither Ken nor Amy has raised the topic they fear most, – sexual activity. In fact, they are uncomfortable talking about the topic with each other. Ken asks Amy to leave in order to check in on Nina's agenda.

Nina had heard from friends that doctors often prescribe birth-control pills to help teens manage painful cycles. She is hoping that Ken will bring this up as an option. Nina and her 17-year-old boyfriend, Eric, have been sexually active (mutual masturbation) for over a year now but have not had any form of intercourse. Both want to have sex but don't want to risk pregnancy. They are both virgins. They have agreed to use condoms along with pills to be "extra sure." Both plan to attend college. Nina and Eric feel uncomfortable speaking with their parents about their relationship. The parents are aware of their steady relationship but believe that they are "good kids."

The importance of sexual health

Definition and why the topic is important

Sexuality is an important part of one's health, quality of life, and general well-being. Sexuality is an integral part of the total person, affecting the way each individual – from birth to death – relates to him-/herself, to a sexual partner or partners, and to every other person[1]. A healthy sense of sexuality can provide numerous benefits, including: (1) a link with the future through procreation; (2) a means of pleasure and physical release; (3) a sense of connection with others; (4) a form of gentle, subtle, or intense communication; (5) enhanced feelings of self-worth; and (6) a contribution to self-identity[2]. Additionally, a longitudinal study found that frequency of intercourse for men and enjoyment of intercourse for women are significant predictors for longevity[3]. Because this study found almost no relationship between marriage and longevity, in contrast to previous studies, the authors conclude that perhaps it

is sexual activity, not marital satisfaction alone, that contributes to longevity. This most likely could be generalized to sexual activity within any relationship.

Sexuality is an integral part of human life, and sexual health is inextricably bound to both physical and mental health. Just as physical and mental health problems can contribute to sexual dysfunction and diseases, those dysfunctions and diseases can contribute to physical and mental health problems. The World Health Organization defined sexual health as "the integration of the somatic, emotional, intellectual and social aspects of sexual beings in ways that are positively enriching and that enhance personality, communication and love[4]." This definition encompasses the following essential elements: (1) the capacity to control and enjoy sexual behavior; (2) freedom from psychological factors that inhibit sexual response and relationships such as fear, shame, guilt, and lack of knowledge; and (3) freedom from physical factors (illnesses and/or their treatment) that interfere with sexual functions[4].

Sexual health is not limited to the absence of disease or dysfunction, nor is its importance confined to the reproductive years. It includes the ability to understand and weigh the risks, responsibilities, outcomes, and impacts of sexual actions and to practice abstinence when appropriate. It includes freedom from sexual abuse and discrimination, the ability to integrate sexuality into one's life and derive pleasure from it, and the ability to procreate if one so chooses. Sexually healthy individuals would then be defined as having accurate knowledge about sexual functions, a healthy, positive body image, self-awareness about their sexual attitudes and appreciation of their sexual feelings[4], a well-developed, usable value system that allows them to make rewarding sexual decisions, the ability to develop effective relationships with men and women, and some degree of emotional comfort, interdependence, and stability with respect to the sexual activities in which they choose to participate.

Challenges with sexual communication

Why talking about sex is difficult

Sexuality and sexual behavior also carry risks such as sexually transmitted diseases (STDs), including HIV/AIDS, unintended pregnancy, abortion, sexual dysfunction, and sexual violence. To enjoy the important benefits of sexuality, while avoiding negative consequences, some of which may have long-term or even lifetime implications, individuals should be sexually healthy, behave responsibly, and have a supportive environment to protect their own sexual health and that of others. Sexual health is important throughout the entire lifespan, not just the reproductive years. Individuals of all ages and backgrounds are at risk and should have access to the knowledge and services necessary for optimal sexual health. Given the public health impact that these risks have, clinicians are ideally situated as educators and should

be instrumental in promoting sexual health. For these reasons, quality health care includes access to sexual health care.

A clear rationale exists for why clinicians should screen for sexual concerns, including the following[5,6]:

1. Sexual activity includes the risk of morbidity and mortality through STDs, including HIV/AIDS, unplanned pregnancy, and sexual abuse or coercion.
2. Sexual functioning problems may signal an undiagnosed illness such as cardiovascular disease, depression, or diabetes.
3. Sexual functioning problems are frequently iatrogenic in nature. They can be caused by surgical and medication treatment side-effects such as prostate surgery and psychotropic agents.
4. Sexual concerns may arise out of significant past or ongoing psychosocial events that are often associated with significant morbidity and occasional mortality, such as sexual abuse and domestic violence.
5. Sexual functioning is potentially lifelong.
6. Sexual difficulties, dysfunctions, and concerns are common in the general population and even more prevalent in clinical populations.
7. Research has found an association between satisfactory sexual functioning with health, happiness, and quality of life.
8. Not screening for sexual concerns could potentially be considered negligent when one considers child abuse, domestic violence, and diagnosis of a sexually transmitted infection in a couple assumed to be monogamous.
9. Given physician inquiry into other intimate aspects of a patient's life and health, such as social, genitourinary, and gastrointestinal, the question remains: "Why not include sexual health as an integral part of general health assessment?"

Issues around sexuality can be difficult to discuss because they are personal and because there is great diversity in how they are perceived and approached. No other topic has been neglected by the scientific community to the degree that sexuality and sexual health have been. A very sensitive subject, human sexuality was brought into professional and public awareness by Kinsey's report on sexual behavior in the male (1948)[7] and the female (1953)[8], Masters and Johnson's work on documenting the human sexual response (1966)[9] and human sexual inadequacy (1970)[10] and Hite's report on female (1976)[11] and male (1981)[12] sexuality, and in 1992 by the National Health and Social Life Survey (NHSLS) by Laumann *et al.*[13]. Many more studies are needed not only to identify patient needs in sexual health but also to advance our capability to manage sexual health care needs.

Our society's reluctance to address sexuality and sexual health openly has been acknowledged; the former Surgeon General has made promoting responsible sexual behavior a top 10 leading indicator for Healthy People 2010. In his call to action, he asks that a (US) national dialogue on issues of sexuality, sexual health, and

responsible sexual behavior be initiated[14]. This is well stated in the Institute of Medicine report, *No Time to Lose*[15]:

> Society's reluctance to openly confront issues regarding sexuality results in a number of untoward effects. This social inhibition impedes the development and implementation of effective sexual health and HIV/STD education programs, and it stands in the way of communication between parents and children and between sex partners. It perpetuates misperceptions about individual risk and ignorance about the consequences of sexual activities and may encourage high-risk sexual practices. It also impacts the level of counseling training given to health care providers to assess sexual histories, as well as providers' comfort levels in conducting risk-behavior discussions with clients. In addition, the "code of silence" has resulted in missed opportunities to use the mass media (e.g., television, radio, printed media, and the Internet) to encourage healthy sexual behaviors.

Sexuality is a fundamental part of human life. Sexuality encompasses more than physical sexual behavior – it includes mental and spiritual aspects, and sexuality is a core component of personality. Human sexuality also has significant meaning and value in each individual's life. Dr. Satcher, charges us (the USA) with understanding the importance of sexual health in our lives, being aware of sexual health care needs for patients, training professionals to manage these needs and, in general, promoting an open and honest national dialogue about sexuality and sexual health[14].

Using this book for personal and professional self-development

> We need to use sexuality to see ourselves, literally and figuratively[16].

As clinicians, we are not immune to difficulties communicating about sexual topics. Understanding our own sexual development is essential to providing high-quality care for our patients. Learning about sexuality is lifelong. It may be useful for you, the clinician, to do some self-exploration about sexuality in your own life. Some useful questions, which you could do with your own sexual partner, are given in Table 1.1[17,18].

How effective you are at making sexual activity a priority in your busy life? Are you able to take time to enjoy sensuality with or without a partner? How about massage or others ways of heightening eroticism in your sex life? Are you willing to spice up your own sex life? How are you doing at keeping the passion alive if you are in a long-term relationship? How often do you simply touch, hug, or hold hands with your partner without the expectation of sexual activity? This is known as non-demand, affective touch. If you are not monogamous, how easy is it for you to negotiate safe sex? How easy is it for you to give feedback to your partner about your satisfaction with your sex life? Equally important, how easy is it for you to allow your partner to be honest about feedback to you about your relationship,

Table 1.1[18,20]

Sources of sexual information	When you were a child, where did you get most of your information about sexuality? (examples: parents, other family members, school, friends, sexual partners, spouse, reading books, magazines.)
	How have these sources changed over the years?
Discussion of sexuality in family of origin	How easy was it to discuss issues around sexuality when you were growing up?
	How did the topic of menstruation or wet dreams come up?
	How easy is it now to discuss sexuality with your family or friends?
Expression of affection in family of origin	How was affection expressed in your family when you were growing up? (hugging, touching, laughing, teasing)
	How has this changed over the years?
	How has expression of affection in your family of origin impacted on your sexuality?
	How often do you touch someone affectionately without it meaning a signal for sexual activity?
Family of origin Religiosity	Were you raised in a religion?
	How strong was your religious upbringing?
	How has this changed over the years?
	How did religion in your family of origin impact on your discussion of sexuality?
Purpose for sex	As a child, what messages did you receive about the purpose for sex? (i.e. the purpose of sex is to procreate, for pleasure, to build self-esteem, to express love/caring, to satisfy your partner's needs, etc.)
	How has this changed over the years?
	How do messages about the purpose for sex impact on sexuality?
Talking about sex	Have you ever wanted to confide in anyone about sexual issues?
	Have you ever been a patient?
	Have you ever been asked your sexual history?
	Would you have liked to discuss sexual issues at your last health visit?

in general, and about your sexual relationship in particular. How open are you to trying new expressions of sexual activity?

Are you a survivor of abuse or in an abusive relationship now? Are you wrestling with age-related or lifecycle changes yourself? How about self-esteem or body-image concerns? What about issues of orientation or sexual expression?

It may be worthwhile for you to look at the references on sexuality in your local book store. We have provided helpful references throughout this book, some of which you may find both professionally and personally rewarding. Learning more about your own background, and growing more comfortable with the topic of

sexuality, will have added benefit to your sexual health promotion in your clinical practice.

Clinicians sometimes worry that discussions around sexual matters may be misconstrued by patients, creating boundary dilemmas or allegations of sexual harassment. The next section reviews boundary dilemmas. It is important for clinicians to be aware of times when they are most vulnerable and thus at risk for crossing or losing sight of professional boundaries. For example, starting to incorporate sexual history-taking into clinical practice, when this has not been a usual practice, at a time when the clinician is him-/herself undergoing relationship or personal turmoil can blur the boundaries.

Boundary dilemmas in the doctor–patient relationship

CASE STUDY 1.2

Pat, 39 years old, is presenting for an office visit that you scheduled at the end of your day. Pat recently separated from a long-term partner. Today you dressed wearing clothing on which Pat has previously complimented you. You feel thrilled to see that the appointment has been kept. Pat seems thrilled also. The two of you exchange a hello hug. Pat is one of your favorite patients. You have been working to help Pat through the separation and managing feelings. You have been so concerned for Pat that you have given out your private pager number and home phone number – this is not your usual practice. You feel particularly worried for Pat, because you know how hard it is when a significant relationship breaks down: you've just experienced this yourself.

Boundary is the invisible line between health care professionals and patients. A distinction is made between boundary crossings and boundary violations[19]. A "violation" is a "crossing" that is harmful. The American Psychological Association is much clearer in its definition of a patient and health care professional: "once a patient, always a patient."

Sharing your own experience, or self-disclosure, with the aim of benefiting the patient might be a boundary crossing, whereas ventilating about relationship concerns with a patient for the sake of making you feel better would potentially be a boundary violation. Argument exists that "excessive distance" from a patient is a violation, so ignoring sexual health questions might be viewed as an act of omission that could constitute a boundary violation (Table 1.2)[20].

If taking a sexual history worries you about boundary issues, you could always start with an unloading and permission question: "I consider sexual health to be an important aspect of people's lives. I include sexual health questions as part of a health inquiry. Would you mind if I ask a few questions concerning your sexual health?" Patients now have permission to declare their boundaries with a simple yes

Table 1.2 Managing sexual feelings in physician–patient relationships[21]

Recognize that it is entirely normal to experience some sexual feelings towards a patient at times during your career
Realize that most sexual relationships with patients begin with relatively minor boundary violations
Be careful to monitor your own thoughts, feelings, and impulses toward patients. If in doubt, get supervision or consultation
Set limits on professional relationships before a crisis develops. This is the best way to avoid the "slippery slope"
Be aware of risk factors, such as: being male and having female patients; using non-sexual touch more with some patients than others; experiencing a life crisis; engaging in substance abuse; paraphiliac sexual interests; previous involvement with other patients
It is not considered ethical to terminate a physician–patient relationship in order to begin a sexual relationship
Remember that the burden of avoiding boundary crossing is always that of the physician – not the patient

or no. If a patient declines to talk about sexual concerns, you can always leave the door open: "When you wish to talk about matters concerning your sexual health, I want you to feel comfortable speaking with me about your concerns."

Boundaries are a very gray ethical area, argued by differing professional boards, and interpreted differently by state medical boards. It would be worthwhile reviewing your state's recommendations concerning the doctor–patient relationship. Remember that feelings and fantasies are not the same as acts. It is very common for physicians to have occasional feelings or fantasies about their patients. Acting on these feelings and fantasies is a boundary violation. This becomes much more challenging for the single physician in a rural community where potential sources for partners are limited (Table 1.3).

If you find yourself developing a relationship with a patient, take the following actions: terminate the patient care relationship and refer the patient to another colleague for medical care; seek counsel; and offer the patient the opportunity for counseling.

When and how to refer patients for intensive therapy

Unless you provide counseling in your clinical practice, patients who require intensive therapy would benefit from referral. Intensive therapy is most often needed when intrapersonal, interpersonal, or history of abuse interacts with sexual problems. For instance, your history may reveal that premature ejaculation is acquired as a result of relationship issues. Talk or relationship therapy would augment pharmacological therapy in this situation.

Table 1.3 Red flags for boundary dilemmas[21]

Thinking about the patient often while not in a treatment setting
Having recurring sexual thoughts or fantasies about the patient in or out of the treatment setting
Dressing or grooming in an uncustomary conscious fashion on the patient's appointment day
Looking forward to the patient's visits above all others
Attempting to elicit information from the patient to satisfy personal curiosities, as opposed to eliciting information that is required to achieve therapeutic goals
Daydreaming about seeing the patient socially as a "date"
Becoming mildly flirtatious or eliciting discussions of sexual material during treatment when not therapeutically relevant
Indulging in rescue fantasies or seeing yourself as the only person who can heal this person
Believing that you could make up for all the past deficits, sadness, or disappointments in the patient's life
Becoming sexually aroused in the patient's presence
Wanting to touch the patient

Lack of success with interventions you have made is another indication that a patient needs more intensive therapy and would benefit from referral to either a medical subspecialist or psychotherapist. For instance, a man having erectile dysfunction unresponsive to Erectaid and intracavernosal injections might be an ideal candidate for a penile prosthesis. He would benefit from consulting with a urologist who performs the procedure as well as a psychotherapist to help him and his partner decide if this is the best option for them.

The nuances of your practice area and your patient's insurance or lack of insurance coverage will add to the complexity of referral. The patient's insurance plan may have limited options for therapists. There may be fewer therapists in rural compared to urban or suburban areas. Patients may be unable to afford medical consultation or surgical procedures that are not covered by health insurance. They might benefit from counseling to help them make the transition to an alternative mode of sexual expression. Some people with significant health problems that limit their own sexual functioning still derive tremendous sexual satisfaction from being able to provide sexual pleasure for their partners. They learn to adopt a different mode of sexual exchange that brings them satisfaction.

It is sometimes challenging to refer patients. They may consider counseling or therapy as only appropriate for people who are "really crazy," rather than considering psychotherapy a legitimate mental health maintenance. There is an art form to recommending therapy. How you present it to your patient is important. Unloading techniques can be beneficial, such as: "Individuals with issues similar to what you are sharing with me today often benefit from a more intense counseling relationship. I have had many people tell me how satisfied they were with counseling.

Table 1.4 Examples of situations to consider referral[5]

Abuse: history or ongoing	Suicide ideation or attempt
Depression and anxiety	Lack of response to treatment
Symptoms worsen with treatment	Your level of comfort or sense of competence is exceeded
Collaborative care or second opinion purposes	Patient request
When intensive therapy is needed and this is not part of your practice	Assistance with accepting alternative sexual expression or deciding upon treatment options
Red flags for boundary dilemmas exist (Table 1.2)	The sexual behavior is dangerous to self or others
Your personal values conflict with your ability to provide unbiased health care to the patient	Drug or alcohol dependence
Significant intrapersonal or interpersonal conflict	Sexual health promotion is not part of your practice

In fact, they have been thankful for the referral. I think you might benefit. What are your thoughts about working with a behavioral therapist on these issues?" (See Table 1.4.)

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