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Chapter 12: Obtaining a Gender-Affirming Sexual History

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INTRODUCTION

Transgender and gender diverse (TGD) individuals deserve high-quality health care in which they feel safe and empowered. Critical to achieving this aim is creating a clinical space where a comprehensive health history can be discussed, free of judgment or shame. No such history is complete without a respectful understanding of patients' sexual experiences and behaviors; therefore, it is recommended that a **sexual history** be obtained from all patients. Because all patients need an open-minded and nonjudgmental approach to feel comfortable discussing their sensitive personal experiences, use of a gender- and sexuality-inclusive framework is of paramount importance. Studies suggest that many TGD people do not disclose their gender identity to a health care professional; as many as 60% of TGD patients do not disclose they are transgender or gender diverse to some of their health care professionals, and 30% do not disclose to any of them.[1] Other patients may not yet be aware of being TGD when they first begin care with a health care professional. Therefore, it is not uncommon for many health care professionals to have TGD patients whom they inaccurately believe to be **cisgender**. Due to the spectrum of possibilities in clinical practice, it is important to maintain an open and neutral approach with all patients that fosters opportunities for disclosure instead of creating barriers. This chapter has been written particularly with primary health care professionals in mind; those in other specialties and disciplines, however, may also benefit from incorporating aspects of obtaining a gender-affirming sexual history into their practice.

IMPORTANCE OF GENDER AFFIRMATION IN HEALTH CARE ENCOUNTERS

Currently, few clinical training programs offer instruction on how to provide health care that is affirming for TGD people.[2,3] Most education and practice models have been developed with cisgender people in mind and do not consider the different identities, experiences, bodies, and needs of TGD individuals. Given that at least 1 out of 200 people identify as TGD,[4] such neglect means that a large population of people receives suboptimal health care, leading to delayed or missed diagnoses and worse health outcomes than their cisgender peers.

Additionally, although familiarity with gender diversity is increasing, the majority of Americans report that they do not personally know an openly transgender person.[5,6] Clinicians likely mirror this statistic, though most see TGD patients throughout their careers whether they know it or not. Without personal familiarity or dedicated training, it is likely that even those health care professionals who have some working knowledge of trans health still do not have an understanding of the adverse impacts of gender non-affirmation, particularly when it occurs in a health care setting.

In this chapter, gender non-affirmation comprises behaviors and actions—either intentional or unintentional—that signal to a person that they are not being viewed as the gender that they identify as or know themselves to be. Such behaviors include using the incorrect name or pronouns, interacting with a person's body in ways that center the sex they were assigned at birth (e.g., referring to a **trans masculine** person as "biologically female" or assuming the presence of certain anatomy), or using gender-coded language misaligned with a person's identity (e.g., "buddy" or "dear").[7] For many TGD people, instances of non-affirmation, especially as they accumulate, are experienced as painful invalidations of one's sense of self. In the 2015 U.S. Transgender Survey,[1] a transgender respondent is quoted describing their experience of a hospital stay: "I was consistently misnamed and **misgendered** throughout … I passed a kidney stone during that visit. On the standard 1–10 pain scale, that's somewhere around a 9. But not having my identity respected, that hurt far more." This profound hurt is not a passing emotion. Perceived disrespect and mistreatment by health care professionals is associated with depression and suicidal thoughts among TGD people,[8] while the cumulative effect of non-affirmation (within and outside of health care contexts) is predictive of symptoms of **posttraumatic stress disorder (PTSD)**.[9,10] Unfortunately, such non-affirming health care experiences are common among TGD communities, even more so among those with additional intersecting marginalized identities and experiences: specifically for trans women who are Black, Indigenous, and people of color (BIPOC); those with **nonbinary** gender identities; and sex

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workers and others who exchange sex for money and resources.[1,11]

In addition to the negative impact on psychological well-being, receiving non-affirming health care functions as a barrier to the patient–clinician relationship and impairs health outcomes in TGD communities. Many TGD people report avoiding or delaying needed health care to protect themselves from mistreatment or disrespect. Again, avoiding or delaying health care is even more likely among BIPOC and sex workers.[1] Studies have found that between 20% and 50% of TGD people decided not to seek care within the past year because they feared **discrimination** and non-affirmation. The risk of avoidance is understandably higher in individuals who have already directly experienced mistreatment in a health care setting or who know of other transgender adults who have.[12] Conversely, TGD people who report being treated with respect by health care professionals and feeling understood are more likely to be engaged with continuous health care, be up-to-date on preventive screening, and report better health outcomes.[13–15]

This research suggests that using a gender-affirming approach to interacting with patients not only allows health care professionals to offer the most appropriate and holistic care but also reduces harm. Interactions that are respectful and validating empower patients to participate more effectively in medical decision-making. Building a trusting and respectful relationship with patients creates an accepting environment in which sensitive topics, particularly those related to sex and sexuality, can be discussed with patients.

INTERSECTION OF MEDICINE AND SEXUAL HEALTH

Medical professionals, educated in a culture steeped in scientific inquiry and academic assessment, have met with challenges in addressing the more sensitive aspects of the human lives they serve. Possibly the most frequently omitted part of a patient's clinical history is that of their sexual practices and behaviors. Clinicians tend to struggle with this element of discussion due in part to academic medical education: instruction in obtaining a sexual history is usually linked to identifying pathology, such as sexually transmitted infections (STIs), or providing contraception to reduce the risk of unintended pregnancy. Little to no instruction is given on how to holistically and meaningfully engage with a patient on the topic of sexuality, including discussions of pleasure and pain. Most health care professionals cite a lack of training and awareness about sexual issues while also minimizing their importance.[16]

In addition, many sociological and cultural factors complicate the task of discussing sex with patients. Western medicine invariably centers cisgender heteronormativity with few exceptions, which puts any patient who does not adhere to these norms at a significant disadvantage in clinical spaces. Clinicians' discomfort or lack of knowledge about the sexual practices of **LGBQIA+** and TGD patients often leads to patient dissatisfaction with how their medical care is handled.[15] A survey of health care professionals at U.S. Veterans Affairs hospitals found that 40% avoided asking about sexuality because they believed a patient's sexual orientation was not relevant to their health care.[17] Clinicians are also less likely to obtain sexual histories in patients who are older, BIPOC, and/or have disabilities.[16] Anecdotal experience suggests this avoidance is likely true for larger-bodied patients, as well. Additionally, in the United States (and many other societies), there is a prevalent culture of shame around sex that serves as a challenging backdrop to having these conversations, regardless of the gender identities and sexual orientations of those involved.

Despite these challenges, obtaining a comprehensive sexual history is crucial to understanding the overall health and well-being of a patient.[18] A necessary first step for health care professionals is to identify and address potential sources of personal discomfort or avoidance of this topic. Next, it is important to expand the working definition of sexual health. Most medical models of sexual behavior identify the absence of disease as evidence of "sexual health," but this description is only a fraction of what should be a multidisciplinary paradigm. In contrast, the World Health Organization defines sexual health as:

> … a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.[19]

This approach creates a holistic view of a patient's sexual health that can offer key insights into other aspects of their general well-being. A person's experience of sexuality—attraction, desire, arousal, intimacy, pleasure—is heavily informed by their overall health.[20–22] A disruption of any of these components can be secondary to mental health changes, medication side effects, progressive medical conditions, or surgical sequelae. For example,

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painful receptive vaginal or anal intercourse can be a signal of infection or high-tone pelvic floor disorder. A loss of libido can be secondary to relational issues, mental health concerns, or medication side effects. Impaired clitoral/penile erections or vaginal lubrication can be due to physiologic or age-related changes; these can also be secondary to hormonal contraception, gender-affirming hormones, or postoperative alterations to natal anatomy. Similarly, pleasurable sexual experiences can both demonstrate and contribute to positive aspects of a patient's health. Sexual satisfaction is associated with healthier stress responses and well-being,[23] and there is a large body of literature on the health benefits of sex and pleasure in multiple aspects of patients' sex lives.[24] For discussions of these topics to happen effectively, health care professionals must make space for them. When patients can discuss this sensitive topic freely and without shame in the clinical encounter, they will come to a deeper understanding of the relationship between their sexual lives and general health. Comprehensive sexual histories reduce the possibility of missed diagnoses and improve opportunities for patients to participate in their sex lives with autonomy.

Patients *want* their health care professionals to make more space for these conversations. In a study of Swiss patients, more than 90% of surveyed patients reported wanting to talk to health care professionals about their sex lives, but only 41% of those patients had ever had such discussions.[25] U.S. surveys show that between 25% and 63% of health care professionals routinely obtain or document sexual history, and often these inquiries do not include exploration of patients' satisfaction, sexual orientation, or even sexual dysfunction.[26] Because most patients feel uncomfortable bringing up sexual health concerns, the task ultimately falls on the health care professional to incorporate it as part of the general approach to health care. In addition to asking about sleep, nutrition, and mental health at an annual physical, a simple question, such as, "Do you have any concerns about sex or intimacy?" can also be asked. Respectful, affirming questions about sex can be incorporated into any clinical encounter, provided that all experiences of gender and sexuality are considered, including those on the asexuality spectrum.

TRUST AND TALKING ABOUT SEX

Discussions about sex, sexuality, and sexual health are sensitive in nature. Furthermore, they may involve or be adjacent to topics that elicit shame or trigger emotional reactions from patients. Assessing sexual health and history cannot be done effectively without specific attention to building trust. Patients deserve to know why such information is relevant to clinical decision-making, and they should be allowed space to decline to share if they feel uncomfortable. Building trust may be particularly important when working with TGD patients, who report being asked invasive, unnecessary, and voyeuristic questions in health care settings.[27] Some patients need several sessions with a health care professional to build enough trust to discuss this topic. Because each patient has different requirements for feeling safe enough to have these conversations, health care professionals must be flexible in their approach and center the patient's needs at all times.

Possibly the most important aspect of building trust is in equalizing the traditional power dynamic inherent in clinician–patient relationships. The classic model of obtaining a history centers the clinician as entitled to the information the patient has to give. The reality is that patients possess the power to share or withhold information based on the level of comfort and trust that they have in the clinical space.[28] Although clinicians have the expertise necessary to guide patients toward healthy decision-making, it is important to remember that the patient is the expert on their own body, behaviors, and needs. Starting the patient interview with a statement such as, "I know it can be hard to talk about sensitive topics with a clinician, but please know that I am here to serve as a facilitator for your needs, not to judge you" can help to equalize the dynamic and put the patient at ease.

Further complicating clinician-patient power dynamics are the insidious impacts of oppression. Distrust of health care professionals and medical institutions is particularly high in marginalized communities.[29] The medical community has historically failed to meet the needs of patients who hold intersecting marginalized identities, especially with regard to race and **gender identity**. Patients, particularly those who are Black, Indigenous, and Latinx, have experienced extensive **trauma** at the hands of the American medical community. These traumas include being subjected to nonconsensual medical experimentation, involuntary sterilization, and having pain dismissed by clinicians, resulting in delayed or missed diagnoses of serious illnesses.[30] Experiences of **bias**, including microaggressions, can lead to a poor clinician–patient relationship and low levels of trust. In addition to BIPOC patients, other marginalized groups such as people with disabilities, people with larger bodies, sex workers, and TGD individuals report distrust that results from discrimination and disrespect in clinical visits.[31,32]

Western medical and mental health professionals have long pathologized noncisgender identities and gender diverse presentations; health care professionals and institutions have thus been complicit in labeling TGD people's identities as abnormal, wrong, or bad. Currently, despite a growing movement (and some victories) to depathologize TGD identities, many TGD individuals still report having health care professionals who are not culturally responsive or clinically skilled in caring for them.[27] Although awareness of TGD patients' needs is growing among the general medical

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community, a large majority of health care professionals still report insufficient knowledge to deliver high-quality transgender health care.[3,12] Understandably, TGD patients may enter health care encounters with a protective skepticism that can make more sensitive and vulnerable discussions (like a sexual history) challenging.

Similarly, individuals who have experienced sexual or physical violence may struggle with conversations about sex due to a guardedness that stems from trauma. Hypervigilance is a common symptom of PTSD that can manifest in the clinical encounter as suspicion or a reluctance to engage. Reminders of trauma can trigger an emotional response in patients that leads to avoidance and fear, thereby shutting down the clinical encounter. TGD people are more likely than the general population to have experienced trauma, so awareness of the potential for these responses is particularly relevant when providing care for TGD populations.[33]

In general, TGD patients are more likely to feel trusting and comfortable when they are affirmed in their identities and experiences. For this reason, it is imperative to make the clinical space affirming of all gender identities and sexual orientations from the moment a patient engages. The entire patient experience should be affirming, including an inquiry of correct name and pronouns at each level of access, from the front desk staff to medical assistants to clinicians (see Chapter 11, "Basic Principles of Trauma-Informed and Gender-Affirming Care"). If a patient feels affirmed throughout their engagement with a clinical setting, they are more likely to trust the health care professional with their personal information and feel empowered to choose what information is relevant to disclose.

Given the likelihood that TGD patients, particularly those with intersecting marginalized identities, have had negative health care experiences, health care professionals must work to create an environment that alleviates or calms distrust. It is important to let patients set the rate of disclosure of sensitive information; they should never be pushed to say more than they are ready to. Recognition of potential trauma-related responses can help defuse stressful encounters with patients who may be defensive or shutting down. Importantly, creating a holistically gender-affirming patient experience offers the strongest chance of building trust with a patient. Use of gender- and sexuality-inclusive language during the sexual history is especially important.

Case Study 1: KB

27-year-old KB, a white-presenting person, sits in Nurse Practitioner Johnson's office with eyes downcast, arms folded. NP Johnson asks KB why they are in clinic today. "I just don't feel right," KB replies. KB is listed as "female" in the electronic health record and has a close-shaved haircut, traditionally masculine clothing, and does not wear makeup. They also smell strongly of cigarettes. NP Johnson reviews the chart and notes the patient has a history of irregular menstrual periods but otherwise no major issues. She asks the patient some follow-up questions about physical symptoms, but KB shrugs repeatedly and does not offer much of an answer to anything. NP Johnson sees the patient identified as "lesbian" in the chart and asks, "How is your personal life? Are you dating any new women? Having relationship troubles?" KB looks up angrily and replies, "What?" then looks back down at the floor and shrugs further into their coat. NP Johnson, realizing she has made a mistake, backtracks. "KB, I'm sorry. I really want to help you today, but I'm definitely asking the wrong questions. I realize that must be stressful for you. Did I miss something?" KB looks up at NP Johnson and says, "Well for starters, you can ask me if I've had sex with any dudes lately, and that might be something." NP Johnson then says gently, "Ok, then. Have you had sex lately with any people who have penises?" KB then quietly tells her that they had sex with a guy at a party and are worried because they have chest tenderness and their menstrual period is late. "I have periods that are all over the place, but this is different." NP Johnson asks, "Was the sex consensual?" KB replies that they had a lot to drink at the party, so they're not entirely sure. "It was a friend of mine. I'm not sure what happened exactly. I'm pretty messed up about it." NP Johnson then obtains a urine pregnancy test, checks for STIs, and refers KB to her clinic's social worker for counseling. KB's test results confirm pregnancy. KB opts not to continue the pregnancy, and NP Johnson refers them to an abortion provider within a manageable distance. KB starts counseling with a queer-affirming violence recovery program.

Discussion Questions

- NP Johnson, informed by the patient's chart and perhaps by their presentation, assumed that KB was not having sex with people with penises and, therefore, might have missed their pregnancy risk. What initial assumptions might you make about KB in a similar situation, and how might they lead to misdiagnosis or inadequate treatment?
- If you were seeing this patient, how might you assess KB's chief complaint of "not feeling right" to avoid some of the initial missteps NP Johnson made?

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- A turning point occurs in the encounter when NP Johnson says, “KB, I’m sorry. I really want to help you today, but I’m definitely asking the wrong questions. I realize that must be stressful for you. Did I miss something?” What about this approach might have opened up the interaction between KB and NP Johnson? What language and tone do you use when you need to course-correct during a challenging dynamic with a patient?
- How might KB’s whiteness affect this encounter and subsequent follow-up? Consider what might be different in this case if they were Black, Indigenous, or Latinx? What communities access your clinical space and how might your perceptions influence your care of non-White populations?
- Multiple aspects of the follow-up plan in this case are dependent on access to resources: (1) a social worker with immediate availability who is able to work with KB in a way that feels affirming; (2) available and affordable abortion care; (3) a violence recovery or survivors network/program that is queer-affirming. What factors limit access to or availability of these resources for patients where you practice? Are you familiar with similar resources in your community, particularly those that focus on BIPOC communities? How would you adapt this case if any or all of these resources were not options for KB?

OBTAINING A GENDER- AND SEXUALITY-INCLUSIVE HISTORY

Perhaps the most important principle in obtaining an affirming sexual history is to do so in a gender- and sexuality-inclusive way. As reviewed in the chapter introduction, TGD people experience trauma from micro- and macroaggressions in the clinical space. Much of this trauma occurs when they are misgendered or assumptions are made about their lives and bodies, which happens because the standard health care space operates from a norm of cisgender heterosexuality. Most health care professionals assume that the patient in front of them has a binary gender identity, anatomy traditionally associated with their outward gender expression, and a sex life that involves penile-vaginal intercourse. Conversely, clinicians may assume that patients who present in a more gender-expansive way (e.g., a more masculine-presenting woman or a more feminine-presenting man) are lesbian- or gay-identified with cisgender partners, and potentially miss pregnancy or STI risk. Such false assumptions may in turn lead to frustration and distrust among patients. At worst, mistaking a patient’s gender identity or sexual behaviors can rupture a clinician–patient relationship, but more commonly it leads to patients withholding information from clinicians, thereby impairing the level of care they ultimately receive.

Of paramount importance to the gender-affirming paradigm is the detachment of clinical vocabulary from gendered language.[7] First, it is necessary to recognize and then unlearn the gendered ways in which clinicians engage with patients. Words like “sir” or “ma’am” have the potential to cause harm to a patient for whom those words are non-affirming of their gender. Using gendered terms of endearment (e.g., “buddy” or “dear”) are equally problematic. It is critically important to have systems in place so that all office staff use the correct names and pronouns for all patients, but the subtle ways in which health care professionals engage with gender are just as important to evaluate as they can cause significant harm. Similar to this, using terms like “female-bodied” and “male-bodied” to describe people’s anatomy is another common pitfall.[34] For example, a clinician might describe a transgender man or nonbinary person as “female-bodied” in discussing the patient with a colleague, or document a transgender woman or nonbinary person as “male-bodied” to indicate these individuals have their natal organs. Health care professionals often use the terms “biologically male” and “biologically female” in similar ways. For most surveyed TGD people, this terminology is problematic and harmful as these terms are incongruent with the patient’s gender identity. They center patients’ sex assigned at birth and potentially dysphoria-inducing parts of their bodies, while invalidating their affirmed gender.[34,35] Such practices also contribute to the erasure of people with differences of sex development, whose biologic milieu can transcend binary male/female designations. See Table 12-1 for suggestions on ways to adapt sexual health and history terminology to be gender-inclusive and affirming.

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Table 12-1

Adapting Sexual Health and History Terminology

Use Gender-Neutral or Less-Gendered Language	In Lieu of...
People with vaginas People who menstruate People with ovaries People with penises/testes People with prostates People who produce sperm	Women, men, females, males
Assigned male sex at birth	Biologically male, male-bodied
Assigned female sex at birth	Biologically female, female-bodied
Pregnant person/people	Pregnant woman/women
Parent, birth/gestational parent Parent, nonbirth/gestational parent	Mother, father
External genitals/genitalia, external pelvic area[4]	Vulva, clitoris
Genital opening, frontal opening, internal canal, front hole	Vagina
Outer folds	Labia, lips
Uterus, ovaries, internal reproductive organs	Female reproductive organs
External genitals/genitalia	Penis, testes
Chest	Breasts
Chest-feeding	Breastfeeding
Menstruation, bleeding	Period
Internal condom	Female condom

In assessing sexual behaviors, open-ended, anatomy-driven questions should be asked to allow space for a patient to disclose the breadth of experiences they might have. It is important to start from an inclusive framing that considers diverse potential experiences of asexuality, physical or

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emotional intimacy, and romance, as well as nonmonogamy, kink, and sex work. (These terms and concepts are defined in a later section.) Health care professionals should be aware that relationships and behaviors can be complex and traditional labels are restrictive. Before embarking on this part of the discussion, consent should be obtained from the patient to discuss their sexual history as part of establishing trust with the patient and equalizing the power dynamic in the encounter.

Once consent is obtained to ask about sex, the health care professional should begin by asking the patient what terms should be used when discussing the patient's sexual practices. TGD patients can have complex relationships with the gendered parts of their bodies, so it is important for them to dictate how their bodies are discussed. The foundation of this approach is to have a clear idea of what information is relevant and necessary for medical decision-making. When obtaining a sexual history, it is important to be flexible and allow the patient to determine the rate of disclosure. Sexual and romantic relationships exist in countless permutations. The health care professional's task is to assess the risks and positive aspects of a patient's sexual behaviors and offer recommendations that facilitate harm reduction and improve well-being. The following section illustrates how to structure a comprehensive sexual history using a gender- and sexuality-inclusive framework.

Case Study 2: JW

Dr. Brown washes her hands, turns toward her new patient, JW, and says, "Hi there! I'm Dr. Brown. My pronouns are she and hers. Do you mind sharing your name and pronouns with me?" JW replies uncertainly, "I go by Jessica and my pronouns are she and hers, too." Dr. Brown sits, opens the patient's electronic health record chart, and asks about JW's medical, surgical, and family histories, which are all unremarkable. She looks kindly at JW and says, "For the next bit, I'd like to ask you some sensitive questions about your personal life, including sex, if you have any. Is that ok? You need only tell me the things you think are relevant to your health." JW assents. Dr. Brown asks, "What words should I use to refer to body parts, whether they are yours or someone else's?" JW asks her to use formal anatomic terms for body parts, like "penis" and "vagina." "Thank you, I certainly will. Are you currently emotionally or sexually intimate with anyone?" JW replies that she does not really date much, as she has been out and socially affirmed as a woman for a few years, and it has made dating a bit tough. "Do you typically prefer folks with penises or vaginas, or do you not have an anatomy preference?" JW is a bit confused at that question, but replies that in general she prefers women, as far as she knows, "women with vaginas, but I'm open to seeing all women… I just don't know yet because I'm new at this." Dr. Brown reassures her that sexual exploration is a normal part of life, particularly with new lived experiences, and offers her counseling on pleasure and STI prevention when the time comes. JW thanks her and schedules a follow-up in 6 months.

Discussion Questions

- Imagine yourself as Dr. Brown. How different is this encounter from the ways in which you currently practice? Which parts of this encounter feel uncomfortable for you? Explore potential sources of your discomfort and whether there are situations or language with which you need more practice.
- How does Dr. Brown work to build trust in this initial visit? Is Dr. Brown effective? How do you know?
- Although you read that JW is trans, the case did not provide any information about her various intersecting identities or cultural background. Who did you picture when you read this case, and what might that signify about your internalized norms? In what ways might this case look different depending on a patient's race, class, geographic location, age, body size, disability? Are there other factors that might impact the interaction between clinician and patient?

THE EIGHT P'S OF A GENDER-AFFIRMING SEXUAL HISTORY

The sexual history can consist of one question or several. The approach can be modified depending on the context of the visit, how much time is allotted, and the relationship with the patient. For example, sexuality can be addressed as part of a general physical exam with a simple, "Do you have any concerns about sex or intimacy?" If, however, someone has presented specifically with a physical symptom such as dysuria or rectal pain, the specifics of sexual practices and past history of STIs have more relevance. Health care professionals should always be prepared to incorporate aspects of obtaining a sexual history into an encounter, because symptoms that patients themselves have not linked to sexual function may very well be related (e.g., painful stooling due to herpes proctitis, or a cough from undiagnosed HIV).

The Centers for Disease Control has outlined five "P's" of obtaining a sexual history to assess behaviors and risk: Partners, Practices, Protection from

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STIs, Past History of STIs, and Prevention of Pregnancy (Table 12-2).[36] In this chapter we present an adapted version, with a few changes made to promote an affirming and holistic clinical space. The last item has been changed to "Pregnancy considerations," rather than "prevention," and three items have been added that offer important insight into sexual well-being: Preferences, Pleasure, and Power dynamics. Their meaning and importance are outlined below. All of the items noted do not need to be addressed in each clinical encounter. In most settings, there is insufficient time and bandwidth to do so. Additionally, the suggested questions should not be considered a rigid "script" that must be followed without modifications. Rather, this list presents a menu of options that can be adapted to fit a health care professional's own style and context, bearing in mind the core framework of gender- and sexuality-inclusive language.

Table 12-2

Eight "P's" of Obtaining a Sexual History

Preferences	Patients' needs for a safe and empowering discussion about sex (e.g., preferred terminology for anatomy and behaviors)
Partners	Number and type of intimate partners a patient has, thinking beyond traditional labels for sexual orientation
Practices	The sexual behaviors in which a patient engages, inclusive of various anatomy permutations and nontraditional relationships
Pleasure and Pain	Degree to which patients enjoy or do not enjoy sexual activity, including the presence or absence of arousal and orgasm
Protection from STIs, HIV	Respectful identification of barriers to STI prevention methods, including PrEP and PEP
Past History of STIs	Prior STIs—especially syphilis, herpes, and rectal gonorrhea/chlamydia—can predict future HIV and STI risk
Pregnancy Considerations	Facilitation of healthy pregnancies when childbearing is desired; protection against pregnancy when it is not desired
Power Dynamics and Partner Violence	Universal, gender-inclusive screening of patients for IPV to increase uptake of resources and improve outcomes

Data from Centers for Disease Control and Prevention. A Guide to Taking a Sexual History https://www.cdc.gov/std/treatment/sexualhistory.pdf.

Preferences

The first task is to obtain consent from the patient to discuss their sexual history and clarify what words should be used to discuss sensitive topics like anatomy. A patient may prefer the term "breasts" instead of "chest" (or vice versa) or "front hole" instead of vagina, for example. If certain terms are off-limits (e.g., breast, vagina, or penis), the clinician should ask open-ended, inclusive questions to allow the patient to disclose information on their own terms. Eliciting preferences offers patients autonomy in this exchange and is key to minimizing experiences of dysphoria.

- "Is it ok for me to ask about your sexual history today?"
- "Do you have sex? Are you physically intimate with anyone?"
- "In asking about your sex life, I need to know specific information about what you do during sex. How would you like for me to discuss this with you?" "What words should I use to refer to your anatomy or specific things you do sexually? Are there words I should try to avoid?"

Partners

Sexual dynamics and relationship structures can be complex and require more specific inquiry than the label a patient uses for their sexual orientation

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identity. Traditional labels like “lesbian,” “gay,” “bisexual,” and “straight” may insufficiently capture the practices of a particular person; simultaneously, more recent sexual orientation identity terminology (e.g., “pansexual,” “queer”) does not communicate necessary details about partners and practices. While these labels may be critical for identity development and sense of self, clinicians need specific information for a thorough sexual history. It is now common practice for health care professionals to ask, “Do you have sex with men, women, or both?” Unfortunately, this question is inadequate because it does not sufficiently capture the breadth of intimate experiences that two or more bodies can have with each other. First, it erases people who do not identify as men or women. Second, it suggests that the clinician assumes the sexual anatomy of “women” and “men.” And third, this question also misses those who do not have sex, who identify as asexual, or both.

An additional challenge is that nontraditional sexual orientations and relationship structures, such as asexuality and nonmonogamy, have historically been omitted from clinical consideration. These are common, however, and require space and affirmation to be discussed. Asexuality includes a diversity of sexual orientations for which sexual activity is not centered as paramount in a person’s life. Many people on the asexuality spectrum are intimate or romantic with people with whom they do not have traditional sexual intercourse. Ethical nonmonogamy involves a system of multiple simultaneous relationships in which there are clear consensual boundaries around how people engage with each other in romantic and sexual ways, which can be different for each set of relationships. Nonmonogamy may also be relevant in **kink** and bondage/discipline, dominance/submission, sadism/masochism (**BDSM**) communities, which include a wide range of consensual activities that center particular fetishes or power dynamics. For example, a person may exist in a monogamous sexual relationship with one partner and engage in activities like spanking or bondage, which do not necessarily involve sexual intercourse, with outside partners (these activities are discussed in more detail in a subsequent section). People engaged in sexual activity outside of the agreed-upon boundaries of their relationship(s) (e.g., people having extramarital affairs or any intimate interactions outside their established relationship rules) also need to be able to discuss those aspects of their sex lives with health care professionals. It is important to always ask about outside intimate partners, even if patients describe themselves as married or monogamous.

The language used in determining a patient’s sexual partners is crucial to understanding their range of practices and experiences. Do not assume that a patient has sex, and if they do, do not assume that a patient has sex with only one partner. Avoid restrictive labels and instead ask anatomy-based questions. Finally, assess a patient’s level of comfort with their partners as this can help to uncover potential challenges they may be having with intimacy or relationship dynamics.

- “Are you currently intimate or sexual with anyone? Have you been in the past?”
- “Do you typically have one partner or multiple partners? What about currently?”
- “Can you tell me what anatomy your sexual partners have? Is it likely you will have future partners with different anatomy?” (Or, “can you tell me what body parts your sexual partners have?” if “anatomy” feels too cumbersome.)
- “Are you comfortable discussing your sexual needs with your partners?”

Practices

Once the clinician has ascertained the anatomy involved in the patient’s sexual behaviors, the next task is to discuss the behaviors themselves. The clinician’s job in the sexual history is to assess a patient’s sexual well-being and risk. It is important not to become mired in labels for sexual orientation. Use of a consensual, anatomy-based approach to obtaining a history allows the health care professional to understand which body parts are involved in sex, and how.

It is important to be mindful of sexual or sex-related practices that are commonly stigmatized by health care professionals. Patients may use recreational drugs, like methamphetamine, MDMA (“ecstasy”), or amyl nitrite (“poppers”), to augment their experience of penetration and orgasm. It is important to create a judgment-free clinical space to determine whether drugs are used as part of sex. Patients often withhold details of their substance use from health care professionals because of fear of stigma and inadequate medical care. Sex work is similarly often stigmatized by the medical profession, with consequently high rates of patient nondisclosure.[32] Sex work is different from sex trafficking, which is nonconsensual. Transgender people enter survival sex work at a higher rate than the general population because antitrans discrimination can make it difficult to find adequate employment elsewhere. Sex work is not protected by federal employment agencies and is illegal and unregulated in most of the world.[37] It is important that, in an affirmative clinical model, drug use and sex work are regarded respectfully by health care professionals. These practices are relevant to patients’ sexual and general health, and patients must be able to feel safe when discussing them with their health care professionals.

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Another highly stigmatized area of sexual practices is BDSM and kink. BDSM is an umbrella term for an array of erotic behaviors that center interpersonal power dynamics. Sometimes these behaviors involve bodily striking (e.g., impact play) that can leave injuries. BDSM is a consensual practice. Patients can present with consensual bruising and abrasions that may be incorrectly interpreted as abuse. Kink is an even wider catch-all term for non-normative sexual behavior, including everything from fetish to fantasy, some of which can make nonpractitioners uncomfortable. Health care professionals must strive to depathologize their understanding of consensual nontraditional sex practices. Creating an affirming clinical space in which these practices are normalized will help patients trust and engage more effectively with their health care. All patients should be asked about nonmainstream practices and informed that such questions are a routine part of obtaining a history so they do not think they are being singled out due to stereotypes about TGD people.

- "What parts of your body touch your partners when you are having sex? What parts of your partners' body/bodies touch you?"
- "Do you prepare for sex in any way? Do you use lubricants or use an anal douche? Do you use medications or drugs to help sex feel better?"
- "Do you ever have sex in exchange for money or housing?"
- "Are drugs or substances part of your sex life?"
- Are you part of any BDSM or kink communities that would impact your medical health?"
- "Is there anything about your sex life that you feel might be relevant to your health?"

Pleasure and Pain

The experience of sexual pleasure and pain is a significant part of a patient's overall well-being. The World Health Organization deems sexual pleasure to be a human right, but many clinicians do not have the vocabulary or knowledge to engage with this topic effectively.[16] Furthermore, due to shame and stigma, many patients who experience pain or impaired pleasure do not mention it to their health care professionals. Pleasure and pain may be particularly relevant to TGD individuals' health care needs, because a patient's experience of their body can deeply impact their sexual experiences. Trauma can lead to dissociative episodes that impair a patient's ability to experience pleasure or pain. Trauma responses may also lead to physical hypervigilance, causing increased musculoskeletal tension throughout the spine and pelvic floor; this tension can reduce the experience of pleasure and increase risk of injury. **Gender dysphoria** can similarly lead to dissociation and physical tension, thereby heightening negative sensations during sex. Additionally, painful sex can be a signal of treatable medical conditions, such as STIs, other infections, pelvic floor dysfunction, neuropathy, postoperative healing changes, and medication side effects. A wide range of medical interventions can impact a person's ability to feel pleasure during sex, the most common being antidepressant medications. All gender-affirming medical and surgical interventions can significantly affect sex in both negative and positive ways. There are some specific considerations to bear in mind for those experiencing changes in physical sensations or pain during sex and intimacy. Note that the effects listed below are risks and not at all universal outcomes of these interventions.

- Estrogen, androgen blockers: altered or reduced libido, fewer or less firm erections, thinned or nonexistent ejaculate, testicular aching
- Testosterone: altered or increased libido, clitoral swelling and sensitivity, increased incidence of vaginitis and urinary tract infections (UTIs) or dysuria
- Assigned Male at Birth genital reconstruction: change in orgasm sensation, different stimulation to orgasm, increased incidence of pelvic floor dysfunction, pain with penetration of neovagina due to granulation or scar tissue, changes in urinary stream and control, increased incidence of UTIs and dysuria
- Assigned Female at Birth genital reconstruction: change in orgasm sensation, different stimulation to orgasm, increased incidence of pelvic floor dysfunction and pelvic pain, changes in urinary stream and control, increased incidence of UTIs and dysuria
- Gonadectomy: fatigue, change in libido, hot flashes (both), erectile changes (orchiectomy) and vaginal dryness, vaginitis, UTIs (oopherectomy);
- Hysterectomy: possible increase in vaginitis, postoperative pain

It is important to remember that the majority of TGD people who engage in sexual activity report satisfaction with sexual functioning and are able to

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achieve orgasm, regardless of whether they have had genital surgery.[38] Accordingly, impaired orgasm and sexual pain or dysfunction should not be assumed to be solely related to gender-affirming medical or surgical interventions. Such concerns should be fully evaluated. It is important to note, however, that sexual satisfaction is not always centered on achieving orgasm and should be defined by the patient. Although an assessment of sexual function may seem like a time-consuming endeavor, it is nonetheless an important component of a patient's overall health and well-being and worth the health care professional's attention. Straightforward questions can open the topic with ease. Because pleasure and pain are such large topics to discuss, it may be wise to dedicate an entire patient encounter to this subject.

- "Are you able to enjoy your sex life?"
- "Do you experience any pain during sex or intimacy?"
- "Is orgasm important to your sex life? Are you able to experience orgasm, either alone or during partnered sex?"

Protection from STIs and HIV

Safer sex behaviors rely heavily on access to health care and education, as well as multiple social and economic factors like family support and financial stability. Marginalization at systemic, institutional, and interpersonal levels leads to increased experiences of trauma due to violence, as well as substance use disorder, both of which can increase risky sex practices such as unprotected receptive anal intercourse.[39,40] Furthermore, a marginalized sex industry means that sex workers may engage in condomless sex to satisfy the requirements of maintaining survival income. An additional barrier to protection from STIs is that most HIV prevention strategies have been formulated with cisgender men who have sex with other cisgender men in mind. These strategies have been shown to be insufficient to meet the needs of the TGD community, particularly Black trans feminine people, who are 50 times more likely to contract HIV than the general population.[41] For these reasons, it is important to have community members who are affected by HIV at the table when preventive strategies are being formulated. In the individual clinical encounter, it is important to check in with patients about what safer sex practices they are currently using and if not, identify barriers and troubleshoot with them about possible changes. Offering protection like condoms, lubricant, and dental dams for free in the office is very important. All health care professionals should feel comfortable discussing and prescribing **preexposure prophylaxis (PrEP)** against HIV. Nonoccupational postexposure prophylaxis against HIV, or nPEP, should be offered as well, with workflows to allow patients to access this therapy as soon as possible after an exposure. If a clinic consults with affected community members about best practices to reach the intended target population, they should be paid for this work. Community outreach programs should be helmed by these same community members to improve the chance of success.

Starting the conversation about safer sex practices is best done using a straightforward, affirmative approach:

- "Are you interested in discussing ways to protect yourself against STIs?"
- "What percentage of the time do you use condoms [or dental dams, other barriers] during sex? 50%? 25%? Do you understand how these things work to protect you from STIs?" "What prevents you from using condoms during sex?"
- "Do you know about the pill that protects against getting HIV?"

Past History of STIs

The most significant predictor of a patient's future STI risk is having had an STI in the past. For all of the reasons stated above, TGD people have a higher rate of STIs than the general population.[42,43] A history of syphilis, rectal gonorrhea, or genital herpes puts patients at a higher risk of contracting HIV in the future. Unprotected receptive anal intercourse confers a 14-fold higher risk for acquiring HIV than insertive anal and receptive vaginal intercourse taken together. Unprotected insertive vaginal intercourse carries twice the risk for HIV acquisition than receptive vaginal intercourse.[44] Therefore, the anatomy involved in sex is the primary concern for risk assessment. Open-ended and anatomy-driven questions about sexual practices and partners, as outlined above, are critical. The following questions about STI history are direct and affirmative:

- "Have you ever been treated for an STI?"
- "Do you know if any of your contacts have an STI?"

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Pregnancy Considerations

Although research about pregnancy intention and reproductive planning in the TGD community is sparse, surveyed patients have reported wanting to know more from their medical professionals. TGD people often want to have children and deserve access to information on assisted reproduction, adoption, and foster parenting.[45] Although gender-affirming hormones can impair fertility, many TGD people have successfully used their gametes to achieve pregnancy, both with and without assisted reproduction. It is also important to educate TGD people on potential risks of pregnancy and methods of pregnancy prevention if they do not wish to have a child. In the United States, 45% of pregnancies are unintended, which increases the risk of the carrying parent's mortality as well as infant health outcomes.[46] People who are on gender-affirming hormones can either impregnate or become pregnant if they are engaging in penile-vaginal intercourse. For sperm-producing people, any ejaculate deposited into a partner's vagina can carry sperm that may fertilize an egg, regardless of whether their ejaculate has diminished in amount or changed in color or consistency. For people with ovaries, ovulation can occur even if they are amenorrheic or have therapeutic levels of testosterone. Should a pregnancy occur while a patient is on testosterone, the testosterone can have a teratogenic effect on the fetus and should be immediately stopped if the pregnancy is desired. Options counseling and referrals should be used in the event of pregnancy. It is important to assess for pregnancy intention at regular intervals with all patients, as intention can change with time and circumstances.

- "Do you plan on having children in the next year?"
- "Do you have any kinds of sex that can lead to pregnancy, bearing in mind that hormones are not sufficient birth control?"
- "Are you interested in discussing pregnancy planning or prevention today?"

See Chapter 19, "Reproductive Health, Obstetric Care, and Family Building," for more information about contraception, pregnancy, and other aspects of reproductive health and family building.

Power Dynamics and Partner Violence

TGD people experience violence, including **intimate partner violence (IPV)**, at much higher rates than their cisgender peers due to antitrans bias and systemic risk factors.[47] Furthermore, IPV is particularly damaging to TGD communities because legal assistance, criminal justice pathways, and social services are often inadequate and even harmful when TGD victims seek support—especially if they are members of marginalized and stigmatized racial or ethnic groups.[48,49] Screening for IPV reduces the incidence of physical and emotional violence through increased uptake of helpful interventions. It is important to be aware of TGD-specific resources in your community, as mainstream organizations may be insufficiently trained to meet the needs of the TGD community. Universal IPV screening of all patients is recommended, but it is critical to ensure that this measure sufficiently reaches your TGD patients with gender- and sexuality-inclusive language:

- "In the past year, did a current or former partner…"
- "…make you feel cut off from others, trapped, or controlled in a way that you did not like?"
- "…make you feel afraid that they might try to hurt you in some way?"
- "…pressure or force you to do something sexual that you didn't want to do?"
- "…hit, kick, punch, slap, shove, or otherwise physically hurt you?"

HOW TO REPAIR A MISSTEP

For many, shifting from existing practices to an affirming framework can be difficult. Cis-heteronormativity has been deeply centered in most aspects of culture and society. It may take time for health care professionals to adapt their terminology to be gender- and sexuality-inclusive. Mistakes and missteps happen, so health care professionals must plan for recovery to alleviate patient distress and maintain the relationship. In the event of a negative event, the health care professional should apologize swiftly and simply and proceed with the encounter. Doing anything more centers the health care professional and may increase the level of non-affirmation the patient may be experiencing. Efforts should be made not to repeat the mistake, which may lead to further distress for the patient. It is important for all health care professionals to undergo basic training in transgender

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health care and terminology to minimize the risk of patient non-affirmation.

SUMMARY

- A thorough understanding of patients' sexual histories and sex lives is a fundamental component of comprehensive, high-quality health care.
- Patients from marginalized groups, including TGD people, may enter clinical encounters with suspicion and guardedness due to traumatic prior experiences; it is the clinician's responsibility to help patients feel safe and empowered in the clinical space, which is crucial to effectively obtaining an sexual history.
- Health care professionals should avoid assumptions about the gender, reproductive anatomy, and sexual behaviors of their patients, and must approach obtaining a sexual history in an anatomy-based, gender- and sexuality-inclusive way.
- Holistic evaluation of patients' sexual health and history includes the eight P's: Preferences, Partners, Practices, Pleasure/Pain, Protection from STIs, Past History of STIs, Pregnancy Considerations, and Power Dynamics and Partner Violence.

Case Study 3: LB

LB, a Black, 30-year-old, masculine-presenting person wearing a suit, had been struggling with a cough for 3 weeks. He was very reluctant to seek medical care due to countless bad experiences with health care professionals in the past. Nonetheless, he felt sick enough to schedule an appointment at a nearby free clinic. As part of the intake paperwork, LB was asked which pronouns he wanted to be used for him, and he wrote "he/him/his." Soon, a physicians' assistant named Jerry came to interview him. Jerry asked LB the usual questions about his health, then moved on to the personal questions. "Do you mind sharing some personal information with me?" Jerry asked. LB had never been asked if he minded before, but it felt nice to be consulted first. He said he did not mind. Jerry then asked, "Before I ask you any questions, what terms should I use to talk about your bottom parts?" LB replied, "Well, I'd prefer you call my front part my 'front hole' and my back part my 'back hole,' but everything else is ok I guess." Jerry asked him if he had one partner or more than one partner. LB thought for a second, "I have a boyfriend, but sometimes we have sex with other people, like if we're at a party or something." Jerry: "What bottom parts does your boyfriend have?" LB chuckled nervously and replied, "He has a penis. All of my partners have penises." Jerry then asked, "Do penises go in your front or back hole, or both?" LB replied, "I only use my back hole for sex. Not the front." Jerry then asked, "Do you ever use drugs to help sex feel better? Like poppers or anything?" LB had never been asked this before, but nervously replied, "Uh, yeah, poppers, a little cocaine if it's around, sometimes crystal but I try not to mess with that stuff too much." Jerry nodded, then asked if LB would be willing to get an HIV test that day given he's been feeling run down and has had receptive anal intercourse with new partners lately. LB's test was negative, so Jerry took that time to discuss pre-exposure prophylaxis for HIV (PrEP) with him after he treated his cough.

Discussion Questions

- Given what you've learned about LB, what factors might have contributed to his previous negative experiences with health care professionals? Why else might he be nervous and avoidant of care? Can you name his separate and intersecting identities that put him at risk for suboptimal medical care?
- How likely is it that you would explore a sexual history with a patient who presents with a benign-seeming cough? What are the benefits of Jerry obtaining a sexual history in this case? What could have been the consequences of Jerry *not* obtaining a sexual history?
- What steps did Jerry take to begin to build trust with LB? Did they work? How do you know?
- What do you imagine would be different about this case vignette if you were in Jerry's place? LB is a Black masculine-presenting person. If you were seeing LB in a clinic, how might your own race, gender, and appearance affect the clinician–patient relationship and aspects of this encounter?
- Jerry never explicitly asks about words LB uses to describe his gender or sexuality. Are these relevant? Do you find yourself making assumptions about these identities or being curious? What would be some potential benefits and consequences of explicitly inquiring about labels for sexual orientation and gender identity?
- LB reported recreational use of poppers and occasional use of cocaine. What follow-up assessment would be beneficial here? What are the risks

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and benefits of engaging LB in a motivational interviewing intervention around his substance use?

Case Study 4: DJ

DJ thought it was time to go to the clinic to get her HIV levels checked, so she called to set up an appointment. She saw a new health care professional, Dr. G, who seemed ok. DJ wasn't going to tell them anything unless they asked, though. She was tired of doctors acting like she owed them her personal information. Dr. G asked her about her antiretroviral medication adherence, and DJ rolled her eyes and told them that yes, she takes her medications every day, and has done so consistently for 10 years. (DJ believes everyone suspects she doesn't take her meds the way she's supposed to and finds this frustrating.) Dr. G asked DJ if it was ok to talk about her sex life. DJ raised an eyebrow and said, "Why do you want to know?" Dr. G replied, "You don't need to tell me anything you don't want to. Sex is a really important part of people's health, and sometimes it's helpful to talk about it." DJ thought it over for a moment and said it would be ok to discuss sex, as long as it is relevant to the appointment. Dr. G then said, "Thank you for understanding. To start with, do you have sex with one partner or more than one partner?" DJ replied, "Depends on how you mean." Dr. G replied, "Well, what does sex look like for you?" DJ mulled it over and then said, "Well, it depends. I have a life partner who's a man. We have sex the old-fashioned way, like he goes into me. But I'm also an escort." Dr. G: "What do you mean when you say, 'he goes into you?' Can you be more specific about body parts?" DJ: "His penis or whatever. My vagina. I had the surgery a few years ago, so since then nothing goes into my back part." Dr. G: "Ah ok, thank you. I get it. When you are escorting, do you have sex the same way?" DJ: "Oh no, I'm a dominatrix who just bosses people around for money. I don't have any other sex partners." Dr. G: "Ok then. Do you have any concerns about STIs? Are you worried about transmitting HIV?" DJ replied that she had no concerns, that she has been virally suppressed for years, and neither she nor her partner are worried about that. "I don't have sex with anybody but my husband, and I know I'm his only partner." Dr. G replied, "That sounds great. I trust you to know what is best for your health. Remember that STIs usually don't have symptoms and that sometimes it's good to get checked even when you are confident in your partner. If you ever change your mind, I'm happy to help, no questions asked." DJ thanked Dr. G for their advice and exited the exam room, meeting her smiling husband in the waiting area.

Discussion Questions

- What do you think of Dr. G's response to DJ's "Why do you want to know?" How might you have responded? What would you say to provide DJ with a rationale for obtaining a sexual history?
- How did Dr. G attempt to build trust with DJ? Did it work? How do you know?
- You learn halfway through this case vignette that DJ has "had the surgery" and has a vagina. How does learning this information affect your thinking about this case and her health needs? How, if at all, is her surgical history relevant to her needs in this encounter? How, if at all, is it relevant to her sexual health overall?
- Dr. G decided to follow DJ's lead with regard to STI testing. What factors do you think contributed to that decision? What benefits and consequences are there to Dr. G's approach? Would you handle this differently? And if so, what are the potential benefits and consequences to your chosen approach?

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