Counseling women about safe sex practices

By Laura S. Dalton, DO

Sexually transmitted diseases (STDs) do not play fair—especially for women! To illustrate this point, I would like to share the following facts:

- Women have more risks for, and may have fewer warning symptoms of, STDs than men.1,2
- Women are more likely to receive sexually transmitted infections from their male partners than vice versa.1,2
- Risky behaviors are the determinants of a woman’s STD risk—not age, ethnicity, or socioeconomic status.3
- The STD risk status of a woman is frequently out of her control, depending on the sexual activities of her partner.
- STD risk assessment may be difficult in a busy primary care practice.

Safer sex means being smart and staying healthy. The lowest-risk sexual behaviors are, first, abstinence and, next, a long-term, mutually monogamous relationship. However, because these behaviors will not be characteristic of many of our patients, we have to abandon the “all or none” thinking approach to patients’ sexual practices.

The spectrum of patients’ STD risk ranges from very low (eg, having one sexual partner and using condoms 100% of the time) to very high (eg, having frequent unprotected sexual intercourse with multiple partners).

In the counseling of a sexually active female patient, the physician’s goal should be to help the patient realistically view her present level of risk and establish her comfort zone along the continuum of risk. With this goal in mind, we can then assist her with a patient-centered plan of care.

Safer sex is risk reduction—not elimination of risk. Dogmatic approaches, such as “just say NO!” or “no sex until marriage,” may generate guilt, shame, and hopelessness—especially in young patients. As a result, these patients may not share their symptoms or fears with their physicians, and we lose our opportunity to promote healthy behavioral changes.

Physicians are good at negotiating healthy, incremental changes in patients with obesity, diabetes mellitus, and cardiovascular disease. We can use these same skills to help our patients reduce their morbidity and mortality from STDs.

Effective STD prevention counseling for women incorporates the following elements:

- Risk assessment and accurate evaluation of present sexually transmitted infections.
- Identifying barriers to STD risk reduction.
- Identifying misconceptions about, and denial of, STD risk.
- Encouraging skill-building strategies for reducing STD risk.
Acknowledging STD risk-reduction efforts.

Developing a patient-guided plan of behavioral change.

Referring patients with comorbidities to appropriate healthcare centers.

Risk assessment and evaluation

Project RESPECT was a large, multicenter, randomized controlled trial illustrating the effectiveness of STD prevention counseling in patients, especially those in high-risk populations. According to the trial results, short face-to-face counseling interventions using personalized risk-reduction plans can increase condom use and prevent new STDs. The Project RESPECT researchers found that this kind of effective counseling can even be conducted in busy public clinics. Reductions of new STDs among trial participants were greatest for adolescents and adults who had STDs diagnosed at enrollment.4

Anyone engaging in sexual activity—whether oral, vaginal, or anal in nature—is potentially at risk for STDs. Risk assessment of a patient can be accomplished with several open-ended questions about that patient’s sexual partners, condom and contraceptive use, previous STDs and current concerns. A short interview with the patient, conducted in a nonjudgmental manner, or the use of a questionnaire with verbal follow-up are effective vehicles for identifying STD risk.5

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Barriers to risk reduction and misconceptions

The physician should help the patient identify potential barriers to reducing her STD risk, such as inconsistent use of condoms, lack of contraception, multiple sexual partners, lack of partner notification about sexually transmitted infections, and failure to treat or follow-up on previous infections. The physician should allow the patient to suggest a solution for achieving risk reduction, such as “I will buy the condoms” or “I will abstain from sexual intercourse until my partner and I are free from infection.” The patient can best decide which goals are most achievable.7

Various misconceptions that the patient might have about STDs can increase her risk. For example, many women believe “pregnancy or STD won’t happen to me.” Nevertheless, approximately 750,000 teenaged girls become pregnant, and some 4 million teenaged girls contract an STD every year.2 Sharing such statistics with patients may help correct common misconceptions.

A number of other misconceptions can lead to risky behaviors. In some cases, it may be necessary for a physician to point out that “serial monogamy” is not safe—unless both partners are evaluated and treated prior to their relationship and unless both agree to openly discuss their risks with each other. Teenagers often have one serious sexual partner, but also one or more casual sexual partners. They may incorrectly believe that, although condom use makes sense with their casual partners, it is not necessary with their steady partner because of a perceived lower risk.8

Hormonal methods of contraception have given many women confidence in avoiding unwanted pregnancies, but they may wrongly infer that STD incidence is also reduced with contraception. Thus, the need for protection against STDs must be reinforced by the physician at every contraceptive-related visit of the patient.

It is also beneficial for physicians to point out to patients that oral sex is not risk free. Studies have shown that chlamydia, gonorrhea, and human immunodeficiency virus (HIV) can all be spread with only oral sexual contact.9

Although condoms would help reduce
STD risk during oral sex, they are rarely used for this sexual activity.⁹ Many women may gain a false sense of security by assuming that, if their partner has an STD, he would use a condom to protect her during oral sex. This assumption, unfortunately, could prove dangerous.

**Skill-building strategies**
Interventions consisting of building patient skills for reducing their STD risks—such as role playing, managing partner expectations, negotiating with partners, and using condoms—have been shown to be superior to information-only counseling. Jemmott et al⁷ compared a 20-minute one-on-one skill-building counseling session, a 200-minute group skill-building counseling session, and information-only counseling sessions for their effects in reducing episodes of unprotected sexual intercourse and newly acquired HIV/STDs in high-risk patients. At 12-month follow-up, patients in the one-on-one and group skill-building sessions reported less unprotected intercourse and fewer positive results for their children—has been shown to reduce risky sexual behaviors in adolescent populations.¹¹

**Risk-reduction efforts**
Successfully reducing a patient’s STD risk is often a complex process involving many social and behavioral factors. For example, the patient has to initiate contact with a healthcare provider; acquire information about her present condition and future risks; consider her future sexual activity; take a potentially embarrassing public action (ie, purchasing condoms); use the condoms and other contraceptives correctly; communicate and negotiate with her partner; and arrange future STD evaluations and treatments.

The patients with the least social support often have difficulty mastering this complex process. Thus, help from a patient’s physician and the physician’s staff are essential for reducing her risk. Healthcare providers should acknowledge and support even small improvements that women make in their STD prevention.⁷

**Patient-guided plan of change**
With patient involvement in risk-reduction efforts, an effective individualized plan of behavioral change and risk management can be developed.⁸

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safe from either pregnancy or STDs.

Physicians must remember that women who are in violent relationships may not be able to make their own healthcare and contraception decisions. Furthermore, these women may not be aware of additional personal risks that they face as a result of their partners’ unsafe sexual behaviors. Thus, when physicians make referrals for women in violent relationships, these factors must be carefully considered.

Final notes
Any female patient who is sexually active—including oral, vaginal, or anal sex—is at risk for an STD. We need to help her accurately assess her risk and apply behavioral improvements where possible. A healthy sexual relationship is built on love, trust and communication. Physicians need to appreciate the difficulties that many women have in seeking help with STD risks and treatment, and we should acknowledge and support even small improvements that these women make in STD prevention.

References

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