

Psychosexual medicine, general practice, you and me

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"Experiencing and understanding the IPM training, transformed my working life. It helped me grow as a general practitioner, not just as a psychosexual doctor".

WHY ME?

I had been a general practitioner (GP) in Jersey for nearly 20 years when the Internet and PDE5 inhibitors, among other things, changed patients' knowledge, awareness and expectations of sexual problems. The 'Swinging Sixties' and the availability of the Pill probably started it all, but more and more patients started attending the practice with 'door-handle' questions about sex. As an experienced GP, I'd previously found there weren't many problems with which I felt unable to help. If I didn't have the answer then I had an excellent network of specialist colleagues who could provide assistance, either via telephone advice or formal referral. Help with sexual problems, however, drew a blank, as there was no-one running a specialist clinic on Jersey, an island of 100 000 inhabitants.

It was my late sister-in-law, Dr Mary Gabbott, a doctor trained in psychosexual medicine back in its early days and one of the first psychosexual specialists to work in a joint clinic with a urologist, who challenged me to train with the Institute of Psychosexual Medicine (IPM) and see these patients myself. For those readers who may not know much about the IPM, I shall provide a brief overview. More information is available on their website (www.ipm.org.uk).

The IPM is a specialist training organisation recognised by the Royal College of Obstetricians and Gynaecologists (UK). It was initiated in the 1960s by a group of family planning doctors faced, like me, with increasing numbers of patients presenting with sexual difficulties, and with little help available. Originally an exclusive organisation for doctors, the IPM has recently changed its constitution and now welcomes allied health professionals

(AHPs) whose work involves 'body medicine'. In practice, these AHPs are mainly specialist nurses and physiotherapists, and indeed many readers of this journal will work in this field. (In this article I use the term 'doctor' to include AHPs.) The IPM approach, based on the work of psychoanalysts Drs Michael Balint and Tom Main, uses case discussion and analysis of the clinician-patient relationship to identify the effect of unconscious patterns, and learned behaviours on sexual well-being and ill health.

In 2003 I began my journey. Having completed the 2-year part-time Diploma course, I embarked on the 2-year part-time further training course, and on passing the Membership examination, gained the necessary credentials to accept referrals from colleagues. Rather like setting out on the open road in a car after I passed my driving test, I found this initial post-qualification period challenging, but listening to more patients' stories with the complexity of their psychosexual difficulties brought interesting new roadmaps, scenery and terrain. It also provided opportunities to meet like-minded colleagues at continuation seminars and IPM meetings who provided exciting, stimulating and often challenging case discussions.

Looking back, I would say that although the key to psychosexual difficulties can be difficult to find, training and experience allows me to elicit the cause and effect of the problem surprisingly quickly. The patient may sometimes gain sufficient insight after only one or two short sessions.

One thing which is different from any medical training I had encountered previously is that the IPM aims to teach skills rather than knowledge. Knowledge can be gained from studying text and facts, but skills can only be gained through practice and experience. Experiencing and understanding the IPM training transformed my working life. It helped me grow as a GP, as much as a psychosexual doctor.



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Box 1 Examples of how and where sexual problems are likely to present

- ▶ Direct requests with a problem
- ▶ Sexual difficulties – secondary to physical/medical problems
- ▶ Fear/avoidance of being examined (e.g. cervical smear)
- ▶ Anxiety about sexually transmitted infections/abnormal vaginal discharge
- ▶ Infertility/fear of pregnancy/labour/delivery
- ▶ Contraceptive problems
- ▶ During history taking: "When did you last have sex?"
- ▶ General practice, family planning clinics, genitourinary medicine clinics, outpatient clinics in gynaecology and urology

SO WHAT CONSTITUTES A PSYCHOSEXUAL PROBLEM?

We define a psychosexual problem as *"a disturbance of sexual functioning caused by mental and emotional difficulties concerning sexuality rather than physical disorders"*.¹

The problem may be a primary one that has always been present, or secondary in that something has changed or gone wrong. Common problems encountered by men include erectile difficulties and ejaculation disorders (i.e. premature or retarded ejaculation). Common problems women encounter include vaginismus, dyspareunia, pelvic pain and persistent vaginal discharge with the absence of a medical explanation. Both men and women can present with worries about the shape and size of their genitals, and there has been a particular increase in young women with anxiety about their genital appearance requesting labioplasty. Both sexes may complain of loss or lack of libido and anorgasmia. **Box 1** lists some examples of how and where many of these problems might present.

THE DOCTOR–PATIENT RELATIONSHIP

Before coming to a clinic, the patient will often have deliberated for days about what they were going to say; they may be embarrassed or frightened by what the doctor or nurse might say, and may have waited weeks or months to get an appointment. A diagnosis is usually made following the well-tried and tested route: history, examination and, if required, further tests. The doctor and patient have a good chance of finding the answer between them.

But, what about those patients for whom finding a solution defies the usual route – for example, where the patient does not seem to give a credible answer to a question? Consultations can become more interesting but also more challenging. What is going on? The doctor's position shifts from being the 'knowing expert' to one of 'ignorance'. New skills are required. Experience has incorporated many skills into our autopilot but we need to readjust and focus in a different way.

Box 2 Examples of open questions to use in a consultation

- ▶ "I wonder what you think is the cause of the problem?"
- ▶ "I wonder how are you feeling about that test result?"
- ▶ "I wonder what was happening when the problem started?"
- ▶ "I wonder why you have asked for help now?"
- ▶ "I wonder what were you hoping would happen today?"
- ▶ "I wonder what is it like for you to talk about this?"

LISTEN, OBSERVE AND THINK

What is the patient really saying and how are they saying it? What is their body language telling us? What effect is the patient having on us? Are we aware of the effect we are having on the patient? Does anything about them change? Using psychosexual training means being prepared and able to start afresh, concentrate on listening and observing while registering our feelings and then observe the patient again.

We are looking for underlying causes of the sexual dysfunction, including those present in the unconscious. Think of the sexual dysfunction as a symptom of something else going on rather than just a problem to be solved. Think of the 'here and now' in the consultation, the feelings we have and the feelings the patient may express. Where have those feelings come from? Are these feelings our own feelings or have they come from the patient? Can we interpret this in relation to the patient's symptoms? Why are they here now? Have they been sent?

THE DOCTOR'S URGE TO ASK QUESTIONS!

As in any medical history, we need to ask some questions, but we try not to bombard the patient with too many, instead asking just a few open questions (**Box 2**).

PAUSES AND REFLECTIVE COMMENTS

If there is an awkward pause, the patient may be experiencing difficulty. Most of us also find this difficult, as it is almost the opposite of our basic training and previous experience. If we feel we have to break a silence, rather than asking another question, a reflective comment may be more helpful (**Box 3**).

The dialogue may go something like this: "No wonder you don't feel like having sex if" ... "it hurts so much"/"you are so angry with your partner"/"you are so afraid of getting pregnant"/"you think it will tear"/"you find it difficult to get an erection"/"you think you have an infection".

The examination – a psychosomatic event

A significant part of the IPM training focuses on how to use the examination as a psychosomatic event. In

Box 3 Examples of reflective comments to use in a consultation

- ▶ "It sounds as if this is difficult to talk about."
- ▶ "You sound quite angry about that."
- ▶ "That must have been difficult for you."
- ▶ "You seem a bit embarrassed."
- ▶ "You seem very relieved about that."

other words, a vaginal or genital examination is used to examine the psychological as well as the physical. We may be able to provide alternative hypotheses (e.g. not all pain is pathological), challenge beliefs (e.g. that the vagina can be 'too small') or help correct other thoughts of abnormality.

When describing our work, Tom Main wrote: "*Sex is something more than a body matter, more than bodily acrobatics, it is also a matter of high passionate feelings. It is the giving and getting of intense bodily and mental pleasure in the most intimate relationship of all. The sex act is therefore, above all, psychosomatic which is why we meet the problems we do, for only we have easy access to the body as well as the mind.*"²

Recognising the difficulties and pressures we have with finding time for training, the IPM has introduced some introductory training for those who are interested in the subject but who may be unable to commit to the 2-year Diploma training. These 'Introductory Terms' (ITs) are 12 hours, usually spread over six 2-hour sessions, but some groups choose fewer, longer sessions. ITs have proved extremely popular. It is surprising what you can learn in 12 hours. If your enthusiasm is triggered, then the IT can count as the

first of the six terms towards the Diploma in Psychosexual Medicine; the following five terms would then be spread out over a 2-year period.

As I hope you can see, the doctor–patient relationship is central to our work, and this more open approach has made a huge difference to my work with patients, giving both parties more satisfaction. I would thoroughly recommend the IPM approach to psychosexual problems, and would encourage any reader who has found this short article interesting to think about trying an IT – who knows, it may open many doors and give you more confidence and satisfaction when dealing with puzzling, sometimes complicated cases. After all, in these difficult cases, the patient is the expert with regard to their problems, not me; my skill lies in working with the patient to help us find the solution together.

Correction notice Since this manuscript was first published online a dictionary.com citation has been added to the definition of a psychosexual problem.

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